Calderdale and Huddersfield NHS
NHS Foundation Trust

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

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

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Cllr Bob Metcalfe, Nominated Stakeholder MC	Chair	**VERBAL**	**Note**
2	**Apologies for absence:** David Birkenhead, Executive Medical Director Jackie Green, Interim Director of Workforce and OD Lesley Hill, Executive Director of PPEF	Chair	**VERBAL**	**Note**
3	**Declaration of interests**	All	**VERBAL**	**Receive**
4	**Minutes of the previous meeting** held on 26 May 2016	Chair	**APP A**	**Approve**
5	**Matters arising and review of the Action Log**	Chair	**APP B**	**Review**
6	**Patient Story:** 'Mrs Campbell' presented by Barbara Schofield, Nurse Consultant for Older People	Chair	**Presentation**	**Note**
7	**Chairman's Report**	Chair	**VERBAL**	**Note**
8	**Chief Executive's Report:** a. **Joint Yorkshire Chair/CEO Meeting – 8.6.16**	Chief Executive	**VERBAL**	**Note**
Transforming and improving patient care				
9	Consultation Process - Update	Director of Transformation and Partnerships	**VERBAL**	**Note**
Keeping the base safe				
10	Risk Register	Executive Director of Nursing	**APP C**	**Approve**
11	Governance Report	Company	**APP D**	**Approve**

	a. Q4 Response from Monitor b. Board Workplan c. Use of Trust Seal d. Declaration of Interests e. Attendance Register f. Workforce Well-Led Committee - Terms of Reference g. Calderdale Artefacts	Secretary		
12	Well Led Governance Review Action Plan Update	Company Secretary	**APP E**	**Approve**
13	Nursing Revalidation	Executive Director of Nursing	**APP F**	**Note**
14	Integrated Performance Report - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Monitor Indicators - Finance	Chief Operating Officer “ Executive Director of Nursing Executive Director of Nursing Executive Director of Nursing Chief Operating Officer Executive Director of Finance “ “	**APP G**	**Approve**
Financial Sustainability				
15	Month 2 – May 2016 – Financial Narrative	Executive Director of Finance	**APP H**	**Approve**
A workforce for the future				
16	**Update from sub-committees and receipt of minutes & papers:** ▪ Quality Committee – minutes of 24.5.16 and verbal update from meeting 28.6.16 ▪ Finance and Performance Committee – minutes of 24.5.16 and verbal update from meeting 28.6.16 ▪ Audit and Risk Committee –		**APP I**	**Receive**

	minutes from meeting 26.5.16 ▪ Workforce (Well Led) Committee – minutes from meeting 14.6.16			
Date and time of next meeting Thursday 28 July 2016 commencing at 1.30 pm **Venue:** Boardroom, Sub Basement, Huddersfield Royal Infirmary				

Resolution

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

APPENDIX A

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th June 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 26.5.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 26 May 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 26 May 2016.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 26 May 2016.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC - 26.5.16(2).pdf

APPENDIX A

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 26 May 2016 in the Boardroom, Sub Basement, Huddersfield Royal Infirmary

PRESENT

Andrew Haigh	Chairman
Helen Barker	Chief Operating Officer
Dr David Birkenhead	Executive Medical Director
Keith Griffiths	Executive Director of Finance
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Richard Hopkin	Non-Executive Director
Philip Oldfield	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director
Owen Williams	Chief Executive

IN ATTENDANCE/OBSERVERS

Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary
Aimee Church	Observer – HFMA
David Furness	Observer – Public
Jackie Green	Interim Director of Workforce and OD
Mandy Griffin	Director of The Health Informatics Service
David Himelfield	Huddersfield Examiner Reporter (for part of meeting)
Peter Adu	Observer – Public
Victoria Pickles	Company Secretary
Sophie Rowe	Observer – HFMA
Lindsay Rudge	Acting Director of Nursing
George Richardson	Membership Councillor

Item

77/16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

78/16 APOLOGIES FOR ABSENCE

Apologies were received from:

Dr Linda Patterson	Non-Executive Director
Dr David Anderson	Non-Executive Director
Cllr Naheed Mather	Nominated Stakeholder Membership Councillor

79/16 DECLARATION OF INTERESTS

There were no declarations of interest to note.

80/16 MINUTES OF THE MEETING HELD ON THURSDAY 28 APRIL 2016

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

81/16 MATTERS ARISING FROM THE MINUTES/ACTION LOG

62/16 – PATIENT CARE HOME PLACEMENTS – Following discussion at the last Board of Directors Meeting the Chief Operating Officer advised that information had

been circulated to the Board earlier that day regarding the number of patients on wards awaiting social services and other partner support.

STATUS: Closed

45/16 – BOARD APPOINTMENTS UPDATE – It was noted that the appointment of Brendan Brown to the post of Executive Director of Nursing had been published in the Trust News.

STATUS: Closed

165/15 - INTEGRATED PERFORMANCE REPORT - The new format had been circulated to the Board although it was noted that this was still work in progress. It was noted that this had been presented to the Finance and Performance Committee and Quality Committee but neither of these Committees had opportunity to look at the details in depth. It was agreed that the Chief Operating Officer would take the opportunity of going through the report in detail later in the meeting.

STATUS: Closed

25/16a - IMPLEMENTING THE FORWARD VIEW - The Director of Transformation and Partnerships advised that plans were being developed with partners and draft documents were being prepared based around the 5 year strategy and future plan to develop care closer to home. It was agreed that this input 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 - It was noted that arrangements were in hand for the Chairman and Chief Executive to review the Board having Mental Health Champions and this would be brought back to a future BOD Meeting for discussion.

STATUS: Open

30/16 - RISK MANAGEMENT POLICY – Professor Roberts identified that for the Board to undertake discussion around risk appetite at the Board Workshop on the 14 July it was necessary for further work to be undertaken on the Risk Management Policy. It was agreed that the Company Secretary, Head of Governance and Risk, together with Professor Roberts would meet during June 2016 to take this issue further in readiness for the Board Workshop.

ACTION: VP/AM/PR

82/16 CHAIRMAN'S REPORT

a. REGIONAL CHAIRS' EVENT – 6.5.16

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

- NHS Improvement/Monitor – plans for dealing with the handover of the work from Monitor to NHS Improvement had been previously circulated to the Board.
- It was expected that NHS Improvement would be regionally led in the future.
- Consideration to be given to targets on diversity of Boards.

83/16 CHIEF EXECUTIVE'S REPORT

a. BOARD APPOINTMENTS UPDATE – The Chief Executive reported that Brendan Brown had accepted the post of Executive Director of Nursing with effect from 13 June 2016. The Chief Executive confirmed that the Board was now complete with the inclusion of Ian Warren, Executive Director of Workforce and Organisational Development who would be commencing with the Trust on the 1 August 2016.

84/16 CONSULTATION PROCESS - UPDATE

As advised at the last meeting the Director of Transformation and Partnerships confirmed that the Commissioners had commenced the Consultation Process which would be effective from 15 March 2016 to the 21 June 2016. It was noted that to date 15 drop in sessions had taken place together with themed events and a total of 3 events were scheduled before the end of the Consultation period

It was noted that a further public meeting had been arranged for 6 June 2016 at the John Smiths' Stadium, Huddersfield commencing at 6.00 pm.

It was noted that meetings within the Trust had taken place with staff and information had been included in Trust Newsletters.

As reported at the last meeting the Director of Transformation and Partnerships advised that once all the feedback and findings have been collated the CCG will submit the findings to the Scrutiny Panel in possibly October 2016 and the Scrutiny Panel will take a view whether to accept the findings. The result will then be subject to Secretary of State intervention if required.

OUTCOME: The Board noted the progress with the Consultation.

85/16 RISK REGISTER

The Acting Director of Nursing reported that 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
6723 (20): Suspension of capital programme
6732 (20): Cost improvement delivery

Risks with increased score:-
The Board noted that there were no risks with increased scores.

Risks With Reduced Score
The Board noted that there were no risks with reduced scores.

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

The new risks added were:

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

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

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

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
- Family and Specialist Services.

Karen Heaton, Non Executive Director enquired about the risks around the Junior Doctors Strike Action. It was noted that once the ballot had been announced this would be reviewed and escalated or reduced as appropriate.

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

86/16 STRATEGIC PLAN – YEAR 1 ENDING MARCH 2017

The Company Secretary reported that the paper presented to the Board had been collated as a result of the Board/Membership Council Workshop held on the 10 May 2016.

It was agreed that the questions raised at the Board/MC Workshop on the 10 May would be circulated to the Board and Membership Council outside the public meetings.

It was noted that work was on-going regarding the 'Keeping the Base Safe' item under the local quality priorities and this would be forwarded to the next Board Meeting, subject to approval by the Quality Committee.

ACTION: 1. Company Secretary to circulate the feedback from the 10.5.16 Workshop to Board and Membership Councillors.

2. Local Quality priorities to be presented to a future Board of Directors Meeting, subject to approval by the Quality Committee.

OUTCOME: The Board approved the Strategic Plan – Year 1 Ending March 2017 and it was agreed that the local quality priorities would be presented to a future Board of Directors Meeting

87/16 NURSING AND MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENT

The Acting Director of Nursing presented the Nursing and Midwifery Staffing – Hard Truths Requirement Report. The key highlights from the report were:-

- **Investment Update** - Nursing Spend had increased within the last 6 months which had been attributed to increased flexible capacity requirements; Registered Nurse/
  Midwife (RN / RM) vacancies and absence levels.
- Significant focus on reducing agency spend for the nursing workforce has been completed. Despite focused efforts in both recruitment and reduction in agency spend there remains a risk that CHFT will not be able to meet the ceiling of 3% applied by Monitor.
  The percentage of agency spend on RN's of the total substantive RN's

continues to be monitored on a monthly basis in line with Monitor Caps.

- Liaison continues with the University of Huddersfield regarding trajectories for recruitment.
- Sickness and Absence – significant improvement noted following the work of the Attendance Management Team.
- Significant assurance given by the Internal Audit Report for the Hard Truths Report.
- Divisional recruitment information was noted.
- Flexible workforce/1:1 patient support – pressures noted.
- Best Practice from Health Education England was noted together with the Trust's proposed actions against this and timeline for these actions received and the Executive Director of Finance questioned whether the deadlines were realistic.

Discussion took place regarding the implications of the Trust breaching the NHS Improvement/Monitor agency cap. It was noted that no guidance for Trusts breaching this cap had been received to date. The Acting Director of Nursing advised that additional tools had been developed to monitor the issue at team level.

Philip Oldfield advised the Board that this paper had been discussed by the Finance and Performance Committee when concern had been expressed regarding the retention issues and the lack of ability to recruit.

The Board noted the discussions at the last Finance and Performance Committee and it was agreed that the issue of recruitment would be triangulated with the Patient Flow Team through the Acting Director of Nursing and Chief Operating Officer. This information would be presented to the Finance and Performance Committee before being finalised for the Board of Directors.

ACTION: Acting Director of Nursing/Chief Operating Officer/Executive Director of Finance

OUTCOME: The Board received a progress report on Nursing and Midwifery Staffing – Hard Truths Requirement.

88/16 HEALTH AND SAFETY ANNUAL REPORT

The Executive Director of Planning, Performance, Estates and Facilities presented the Trust's Health and Safety Annual Report. The key issues within the report were noted together with the approval of the Health and Safety Workplan for 2016/17:-

- Review and update CHFT's Health and Safety Policy.
- Fully implement COSHH management and awareness training.
- Embed risk assessment knowledge and understanding into the organisation.
- Improve understanding of RIDDOR Injuries, illnesses and dangerous occurrences to ensure accurate reporting and learning.
- Review moving and handling arrangements within the Trust to ensure robust training and recording.
- Introduce inspection programme for non-clinical areas.
- Introduce a Needle-stick Injury working group to investigate needle-stick & splash related incidents to embed learning within the Trust.
- Ensure robust arrangements are in place for the safe management of medical devices and provide monthly updates to the Health & Safety Committee.
- Provide a two day health and safety training programme for Managers / Supervisors.
- Ensure appropriate staff side representation at Health & Safety Committee.

The challenges for staff in achieving the training requirements and balancing this against direct patient care was discussed and acknowledged.

The Board received and discussed the Annual Report and Karen Heaton requested that the previous years' comparative information around training rates be built into these reports.

OUTCOME: The Board approved the Health and Safety Annual Report.

89/16 FIRE SAFETY ANNUAL REPORT

The Executive Director of Planning, Performance, Estates and Facilities presented the Trust's Fire Safety Annual Report. The key issues within the report were noted:-

- Four Fires had been reported – two at HRI, two at CRH – none serious
- Robust systems were in place with Fire Warden checks.
- Interrogation of Alarm system often prevents Fire Service being called out.
- Fire Training now undertaken by all staff via a booklet.
- Possibility of face to face fire training commencing this year for some staff.
- Acquisition of smoke machine to use for training purposes.
- Greater liaison with Fire Service staff.
- Capital work continues to meet fire standards.

OUTCOME: The Board approved the Fire Safety Annual Report

90/16 CAR PARKING CHARGES

The Executive Director of Planning, Performance, Estates and Facilities presented the Car Parking Charges paper which had been revised following feedback from the Membership Council. The Chairman reported two further comments received from individual Membership Councillors which were noted by the Board. The key changes from the report were noted:-

Staff Permits

Colleagues with earnings from £17,979 - £19,655 (Band 3) will see no change, other higher bands will see a small to moderate increase and priority parking charges will also be increased. Staff on Bands 1 and 2 will see a small reduction. It was noted that discussions had taken place with Staff Side representatives who had been largely supportive of the increases.

Public Parking

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

OUTCOME: The Board approved the Car Parking Charges

91/16 DIRECTOR OF INFECTION, PREVENTION AND CONTROL QUARTERLY REPORT

The Executive Medical Director presented the quarterly report. The key highlights of the report included:-

- **End of year position** – largely positive

- **MRSA bacteraemia** - To the end of March 2016, there have been 3 post admission cases MRSA bacteraemia: 1 unavoidable and 2 avoidable. 3 pre MRSA bacteraemia cases: 2 unavoidable, 1 avoidable and
- attributed to CHFT. Year on year reduction in MRSA infections within the Trust was noted.

- **CDiff –** Breaching position. Currently 25 reported cases against a Trust ceiling of 21 cases noted.

- **Isolation of Patients** – It was noted that this was problematic due to insufficient availability of side rooms and on-going work to investigate what work can be done with the geographical restraints was on going.

- **Link Infection Prevention & Control Practitioners (LIPCPs)** – Continued workshops throughout the year to help education and training requirements.

George Richardson, Membership Councillor advised the Board that he had recently undertaken a PLACE visit and wished to commend the Trust for the high levels of cleanliness within the Trust which has improved year on year.

OUTCOME: The Board approved the Director of Infection, Prevention and Control Quarterly Report

92/16 INTEGRATED PERFORMANCE REPORT (IPR)

As discussed earlier in the meeting, the Chief Operating Officer introduced the revised Integrated Board Report as at 30 April 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 to the Quality Committee and Finance and Performance Committee earlier that week.

The key areas of specific note were:

- The Trust has remained busy with AED attendances and admissions high and excess bed days above the norm for this period. The impact is that the Trust continues to rely on additional capacity and flexible staffing.
- The Medicine Division has a high number of Consultant vacancies some of which are filled with agency locums and other rota gaps covered by substantive colleagues.
- There were 2 days of industrial action in April where emergency cover was withdrawn requiring Consultants to cover wards and AED.
- Flow across the Health and Social care system remains a challenge with a daily mismatch between admissions and discharges compounded by the timing of these which often occur later in the day
- Package of Care capacity remains limited, 2 further Nursing homes are closing in Calderdale and Social Worker staffing is limited.
- Several specialties are being supported with improvement including Invited Service Reviews in Stroke, Respiratory Medicine and Complex care.
- Professor Mohamed Mohammed has presented on mortality for a second time to the senior leadership team.
- Complaints into the Trust remain high for the period and reflect the pressures on capacity and flow in quarter 4.
- There remains a focus on the data capture for Friends and Family Test however greater focus is now being given to the output of the responses and action plans being developed in each area reflecting a 'you said, we did' approach.

- Additional capacity was open in some areas through April requiring additional staffing, where shifts not covered through bank or agency. Redeployment of existing staff was required and fill rates in some areas reduced.
- Vacancy rates in Nursing and Medical Staffing remained high particularly in the Medicine Division. A Task and Finish Group has been established to focus improvement on flexible workforce use and a self-assessment using NHSI toolkit has been undertaken.
- There has been an increase to staffing in the HR department focussed on absence management with Clinical Divisions.
- Surgical bed capacity released from Medicine from the 2nd week in April impacting on elective activity and theatre utilisation.
- Industrial Action for 2 days in April required the cancellation of all elective inpatient and a percentage of day case activity.
- There remained high numbers of patients fit for non-acute care but unable to be discharged.

The Board received the new format report which had been received and discussed at WEB. It was noted that work continued on refining this document. It was requested that any additional areas which were required should be notified to Helen Barker outside the meeting for consideration.

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

93/16 MONTH 1 – APRIL 2016 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 1 report (including the contents of the Integrated Board Report). It was noted that this information had been discussed in detail at the Finance and Performance Committee held on the 24 May
2016:-

The key issues included:-

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

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

The underlying trading position in Month 1 is subject to greater pressure than the year to date deficit reveals due to a number of one off financial benefits in month. There

has been a catch up in Cardiology discharges in April following delays in March caused by Catheter Lab issues. In addition, Dermatology and Neurology outpatient work has been high in month as these specialties aim to get ahead in advance of anticipated capacity gaps later in the year. Finally, there has been a particularly long staying patient discharged from Critical Care. In income terms, these factors offset the shortfall driven by the strike action and underperformance on planned activity.

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

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

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

94/16 STAFF SURVEY ACTION PLAN

The Chief Executive presented the Staff Survey Action Plan. The paper sets out the key findings from the focused work with colleagues on the actions to address the feedback through the 2015 staff survey. The Board was reminded that in March a paper was brought to the Board regarding the IIP and Family and Friends Test. Following informal feedback received from the CQC at its inspection in March, it was agreed that an Action Plan would be developed to incorporate all feedback.

It was noted that the workforce had been involved in developing the Action Plan, along with Executive Directors. The key themes within the Action Plan included:-

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

The Board noted the key timelines for actions which would ensure that the Trust was in a position to achieve actions before the next staff survey. Concern was expressed that some timelines would be difficult to achieve and it was agreed that work should be undertaken to aim towards these timelines but it was acknowledged that some may require additional time. It was agreed that feedback on the progress from all work streams would be brought to the Board of Directors Meeting in September 2016.

OUTCOME: The Board received and approved the Staff Survey Action Plan
ACTION: Feedback on progress from all work streams to be brought to the BoD in September 2016.

95/16 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 26 April 2016 and a verbal update from the meeting held on 24 May 2016 was received from Jan Wilson. Matters arising from the May meeting included:-

- **Regulation 28 Coroners Reports**
- **CQC Comments**
- **PSQB Divisional reports**
- **Nursing and Midwifery Staffing - Hard Truth Report**
- **Complaints**
- **Community Models of care**
- **Family Nurse Practitioner Service to be tendered**
- **Estates**

b. **Finance and Performance Committee** – minutes of the meeting held on 26 April 2016 were received and noted and a verbal update from the meeting held on the 24 May 2016 was received from Phil Oldfield
Matters arising in the May meeting not already discussed at the Board included:-

- **Trading position deficit.**
- **Agency impact**
- **Cash implications**
- **Patient flow work –** Chief Operating Officer to provide an update in September 2016.
- **Workforce**
- **Clinical Negligence Claims – report received. Further report to be presented in August and also taken to Quality Committee**

c. Audit and Risk Committee – minutes of the meeting held on 20 April 2016 were received and noted and a verbal update from the meeting held on 26 May 2016 was received from Prof Peter Roberts. Matters arising from the May meeting included:-

- **Annual Report and Accounts** – following reports recommended to Board for approval:-
  - **Going Concern Report**
  - **Audited Annual Accounts and financial statement**
  - **Draft Letters of Representation**
  - **Annual Governance Statement**
  - **Annual Report**
  - **Head of Internal Audit Opinion**
  - **Year-end report from External Auditors**
  - **Long form Audit Report from External Auditors**
- **Quality Report and External Assurance on Trust's Quality Report**
- **Whistleblowing and expressions of concern** – 1 incident under investigation.

d. Workforce (Well Led) Committee – The minutes from the meeting held on the 21 April 2016 were received and noted.

e. Membership Council Meeting – The draft minutes from the Membership Council Meeting held on 7 April 2016 were received and noted.

f. Charitable Funds Committee – The minutes from the Charitable F Funds Committee held on the 9 May 2016 were received and noted.

The Chairman thanked everyone for their attendance and contributions.

96/16 DATE AND TIME OF NEXT MEETING

Thursday 30 June 2016 commencing at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital

The Chairman closed the meeting at 16:00 hours.

APPENDIX B

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th June 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - 1 JUNE 2016 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 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 Action Log for the Public Board of Directors Meeting as at 1 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 Action Log for the Public Board of Directors Meeting as at 1 June 2016

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 June 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
29.10.15 (165/15)	**INTEGRATED PERFORMANCE REPORT** Review to take place on how information is presented and summarised	Chief Operating Officer	**17.12.15** The Associate Director of Community Services and Operations and the Executive Director of Planning, Performance, Estates and Facilities (DPPEF) reported that they had met to discuss the level of detail required in the IBR to ensure that the Board receives information at the correct level from the various committees. It was suggested that a summarised version of the Integrated Board Report would be developed in the future and a more formal reporting back system from the various Board sub-committee Chairs put in place. This would allow the Board to be more forward focussed going forward. **26.5.16** New format circulated. Acknowledged that this was still work in progress.			26.5.16
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT** Update on pilot to be brought in February 2016.	COO	**25.2.16** Report received. Likely implementation to be July 2016.	? July 2016		
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	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.	Sept 2016		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 June 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
	levels/Trust's role had been finalised					
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		
30/16 25.2.16	**RISK MANAGEMENT POLICY** The draft policy was agreed subject to further work to include non-clinical as well as clinical risks. The Chairman reported that it was some time since the Board had discussed appetite for risk and with the new Board Members now being appointed this was felt to be the right time. It was agreed that this topic would be scheduled into the Board Development programme session to be held on 13 July 2016.		**26.5.16** Company Secretary/Head of Gov and Risk and Prof. Roberts to meet during June 2016 to take this issue further in readiness for the Board Workshop on 13.7.16.	13 July 2016 Board Dev Session		
33/16 25.2.16	**QUARTERLY QUALITY REPORT** The Board agreed that the level of detail being reported to the Board should be reviewed by the Quality Committee. Juliette Cosgrove agreed to ascertain the level of information required for the various sub-committees and make recommendations accordingly.	DoN		29.9.16		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 June 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
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 future BOD Meeting, subject to approval by the Quality Committee.	CE/Co Sec		30.6.16		
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		August 2016		
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		

APPENDIX C

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 30th June 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Corporate Risk Register - Corporate Risk Register - Corporate Risk Register - This paper presents to the Board the corporate risk register as at June 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 14 June 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 June 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 20 risks and the associated controls and actions to manage these. There is one new risk;

- 6753 re: inappropriate access to personal identifiable information

Next Steps:

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

Recommendations:

Board members are requested to:

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

Appendix

Attachment:

Corporate Risk Register - combined June 2016.pdf

CORPORATE RISK REGISTER REPORT

Risks as at 20 June 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

Risk 6722, relating to cash flow - previously scored at 16 has 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

Risk 6723 suspension of capital programme has reduced from a risk score of 20 to 16 as internal review has determined that expenditure on the capital programme could be curtailed without excessive risk to the organization.

The previous risk relating to junior doctor industrial action, has been reduced from a risk 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.

NEW RISKS

One new risk has been added, **risk 6753**, scored at 16. This relates to the risk of inappropriate access to personal identifiable information and Trust data on some Trust computers.

CLOSED RISKS

None

RISKS TO BE DISCUSSED AT NEXT MEETING

Risk regarding Athena system, Family and Specialist Services.

CORPORATE RISK REGISTER –20 June 2016 Summary of Risks by Risk Type

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	February 2016	March 2016	April 2016	May 2016	June 2016
		Strategic Risks						
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme	Director of THIS (MG)	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	Deputy Director of Workforce and OD (JE)	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
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
6722	Financial sustainability	Cash flow risk	Director of Finance (KG)	-	-	-	!15	↑20
6723	Financial sustainability	Suspension of capital programme	Director of Finance (KG)	-	-	-	!20	↓16

6732	Keeping the base safe	Not delivering cost improvement plan	Director of Commissioning and Partnerships (AB)	-	-	-	!20	=20
		Performance and Regulation Risks						
6658	Keeping the base safe	Inefficient patient flow	Chief Operating Officer	16 =	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 20 June 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 mortality 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 ↓6723 Suspension of capital programme ! 6753 Inappropriate access to patient identifiable date	= 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 ↑6722 Cash Flow risk
Possible (3)					= 6299 Medical Device failure levels
Unlikely (2)					
Rare (1)					

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

Corporate Risk Register (risks 15+)

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. March Update: Calderdale and Greater Huddersfield CCGs started public consultation on the proposed reconfiguration of hospital services on the 15th March. The period of public consultation will extend over a 14 week period. Public meetings and information sessions have been scheduled - with CCG and Trust representation at all of these. Calderdale and Kirklees Joint Overview and Scrutiny Committee has scheduled and commenced a series of meetings to review the proposals and these are being attended by CCG and Trust representatives. April 2016 Update: Programme of consultation meetings underway. May 2016 Update: Consultation continues June 2016 Update: Consultation continues	Jul-2016	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 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. June 2016 Update: as April	Jun-16	Aug-2016	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	20	16	4 x 5	4 x 5	4 x 4	- To complete the work in progress - CQUINS to be monitored by the Trust - External review of data and plan to take place - assistance from Prof Mohammed (Bradford) August update: Further information received with increased risks to mortality. Action plan reviewed and presented to WEB. PMO approach to be adopted for reliable implementation of care bundles Sept update: Compliance with mortality reviews for last month significantly increased. April update: Two Invited Service Reviews have been completed by the Royal College of Physicians to look at the Elderly Care service and the Respiratory Service. We are awaiting the final reports for both the services but some recommendations have been made that are being progressed. Improvements in coding continue to be made. Mortality reviews not showing increased levels of avoidable death. May 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.	Jul-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 and effective high quality care and experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths workforce model) - lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties (A&E, 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 - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	**Nurse Staffing** To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible labour used for shortfalls (bank/nursing, internal, agency) and weekly report 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 All staff Contribute to Health Education England survey to inform future commissioning / provision of education / training	Medical Staffing Lack of: - workforce plan / strategy for medical staff identifying level of workforce required - dedicated resource to develop workforce model for medical staffing - centralised medical staffing roster (currently divisional) / workforce planning for medical staff - system /process to identify, record and manage gaps in planned medical staffing, particularly for junior doctors - measure to quantify how staffing gaps increase clinical risk for patients Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	Nursing recruitment - investigate the possibility of outsourcing flexible workforce department Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) Secure resource to develop medical staffing workforce planning (Medical Director) Improved operational management of medical staffing workforce (Medical Director) Set up a Task and Finish Group led by Assistant Director of Operations to agree the response to manage the medical workforce risk (September 2015). **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. 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 Scope alternative internal medical locum rates to reduce reliance on agency secured locums	Jun-2016	Sep-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&C group via the Cerner Portal if required, any escalations from transformation group will be brought to R&C by the programme leads Mar 2016 - Programme Risk log to be presented at April R&C group to understand the current position and how programme risks could relate to Trust risks. April 2016 Update - Risk and Compliance Group to review EPR risk register in May. Risk summary (Transformation Group) to be brought to R&C monthly. May / 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.	Jul-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	**June update:** At the end of Month 2, May, the year end forecast position is to deliver the planned £16.1m deficit. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit. Based on current levels of vacancies and recruitment profiles it is likely to be extremely challenging to significantly reduce agency expenditure whilst striving to maintain safe staffing levels. Recruitment and retention and bed capacity issues bring risk to delivery of elective and daycase activity. Against the £14m CIP target £6.48m 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.	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. **June update**: The Trust is having to manage and prioritise payments to suppliers in order to maintain required cash balances. Further action is being taken to maximise collection of receivables and the profile of cash management is being raised at Divisional level. Confirmation has been received of approval of the loan drawdown for June 2016 at a higher level than originally planned which will allow settlement of a greater number of creditor payments in the short term, whilst all actions are pursued to collect outstanding receivables.	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	**June 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-June 2016 NHSI have 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	Kirst Archer

6658	Medical	Emergency Network	Accident & Emergency	Mar-2016	Keeping the base safe	There is a patient safety risk and a risk to patient experience from ineffective patient flow due to increase in demand, with peaks and troughs, slow internal pathway decision-making, bottlenecks in internal capacity and exit blocks resulting in an increased mortality risk, excessive movement of patients between wards, increase in outliers, impact on elective activity and failure of emergency care standard.	1 Patient flow team supported by on-call Management arrangements 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.	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	Update March 2016. 1 and 4. Unplanned care expert appointed on fixed term contract - from February 2016 - focused on coaching of patient flow team and empowerment of ward staff delivered through roving multi-disciplinary team . Emergency Care Improvement Programme to undertake a diagnostic of the local health social care system on 18 March 2016 Joined next ambulatory care cohort commencing April 2016 to enable a health and social care system increase ability to avoid admissions, Command and Control arrangements in place at times of pressure. 5. Some late non - recurrent funding provided by Calderdale CCG used for additional beds and associated staffing 6. Working directly with local social care providers to look at options to increase out of hospital capacity. **June 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.	Jun-2016	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 personal idenitfiable information (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 - Removal of generic logons through roll out of single sign-on/VDI - 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	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 - Understand potential completion dates for SSO and VDI	Aug-2016	Sep-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.	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.	Jul-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 - Interim resource in place in Risk Management to oversee management of Serious Incident Investigations	1. Lack of capacity to undertake investigations in a timely way and 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	1. Capacity - recruitment taken place for dedicated investigation resource in Governance and risk team - final stages of recruitment process being completed 1. Ongoing delivery of Effective Investigation Training Course (1 day, monthly) 2. Greater identification and sharing of learning from each SI, sharing within PSQBs and across division through reporting and SI review group April Update Progress made with clearing outstanding serious incidents however need to embed within divisions process for managing red and orange incidents in a timely way. 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.	Jul-2016	Jul-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 essential skills matrix which aims to identify all the essential skills training within the organisation. There is a training strategy proforma to capture the target audience for essential skills subjects. Clinical supervision/preceptorship structures are in place to monitor staff compliance with essential skills training. We have a learning management system, Oracle Learning Management (OLM) which can centrally record training attendance and compliance against a target where one is set within it's functionality limitations.	1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. A manual system to facilitate the actions above will be require1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. A manual system to facilitate the actions above will be required.	16 4 x 4	16 4 x 4	12 4 x 3	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 process: - aseptic non touch technique (ANTT) basic life support (BLS) documentation malnutrition universal screening tool (MUST) pressure ulcer care infection prevention and control end of life (EoL) care The priority subjects will be completed by September 2016 with the further matrix subjects being completed by 31st March 2017. This work will be led by Pam Wood. Alternate learning management systems (LMSs) are being explored with initial system demos on the 25th May 2016. Following the demos decisions about whether to progress to a full business case/tendering procurement process will be taken. Should this progress the tendering process will take 8 to 12 weeks to complete. Implementation will then require a further 4 to 8 months. The Education and Learning Group has the responsibility for reviewing mandatory and essential skills elements that form the overall programme. The Group has been established with Terms of Reference which will be reviewed when fully operational in June 2016.	Jun-2016	Jun-2016	NA	Interim Director of Workforce and Organisational D	Bev France

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	4 x 4	16	4 x 4	8	4 x 2	- CQC compliance Steering Group - Implementation CQC Compliance action plan - CQC Operational Group - Further embedding of CQC assurance into the Divisions and Corporate Governance structures May update:The first meeting of the CQC response group took place, plans were received at the meeting and some improvements were noted. Some sustainable improvements have been made in the care of patients on CDU, further actions required. A change in the pathway for Acute Gastro Intestinal haemorrhage patients will take place in the coming weeks. **June Update** The revised Acute Gastro Intestinal Haemorrhage pathway commenced on 1 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.	Jul-2016	Jul-2016	WEB	Julie Dawes	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	4 x 4	16	4 x 4	8	4 x 2	Review of governance support to divisions Application of standardised governance approach to PSQBs April Update Work continues with governance managers and divisional leads to embed new terms of reference for PSQBs. May update Significant progress is being made within the divisions particularly in the management of serious and moderate harm incidents **June update** Improved performance management arrangements are being implemented with Divisions receiving data in a more timely way and increasing accountability for performance.	Jul-2016	Dec-2016	QC	Director of Nursing Julie Dawes	Juliette Cosgrove

6732	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	May-2016	Keeping the base safe	Risk of: not achieving £14m cost improvement (CIP) delivery due to : - failure to identify sufficient aggregate value of CIP schemes (approach being taken is that to deliver £14m CIP - schemes to the value of £16m is required). Currently £12m of schemes are fully developed with a further £1.2m of high level/ high risk ideas. · failure to deliver or under-performance of the CIP schemes that are identified as fully developed · inability to deliver transformational bed reduction CIP schemes due to increased demand for hospital admission or insufficient community health and social care capacity. · income CIP schemes are challenged by Commissioners and income is not paid. resulting in not achieving £14m CIP target Not achieving the Trust's financial control total for 16/17 Regulatory action by NHSI Loss of reputation	· Divisions challenged with identifying 4% of influenceable spend as a minimum. CIP principles to ensure the schemes through the gateway 2 process are achievable e.g. income schemes tested with contract ADF · Turnaround Executive meeting reviews RAG rated performance status of the CIP development & delivery programme on a weekly basis. · Executive Sponsor(s) accountable for CIP scheme delivery are in place. · Programme Management Office is in place, supporting and tracking all schemes using established gateway review process and reporting to Turnaround Executive. · CIP planning is focused on development of cost reduction schemes with aim to minimise percentage of contract income CIPs required to achieve £14m. Star Chambers are held where schemes are off-track to identify additional CIP opportunity and corrective actions / replacement schemes. · The Carter recommendations and benchmarking is being assessed in every Division to identify additional cost reduction CIP schemes with the requirement these are developed to Gateway 2 by end June. · The Safer Patient Flow work programme has been established to enable the planned reduction in beds. · Each Division has a monthly Board meeting that reviews CIP delivery. This is also reviewed at monthly meetings of senior Divisional teams with Executive Directors. · The Trust Board reviews CIP delivery every month.	A specific risk which is outside the direct control of the Trust is the demand for hospital admission and capacity of community health and social care to enable CIP bed reduction. This has the potential to impact on a number of productivity related schemes. The CCG and other external commissioners refusal/ inability to pay additional income	20 5 x 4	15 5 x 3	10 5 x 2	Consideration of external support to construct plans for and deliver the £14m Regular discussion at Calderdale and Huddersfield SRG on the actions of partners to reduce demand for hospital admission and support care closer to home capacity required to enable bed reductions. Ongoing dialogue with commissioners regarding income schemes	Jul-2016	Sep-2016	FPC	Anna Basford	Sharon Appleby

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.	Jul-2016	Nov-2016	QC	Lindsay Rudge	Jackie Murphy

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. 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 and 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 Scope alternative internal medical locum rates to reduce reliance on agency secured locums	Jun-2016	Sep-16	WLG	Helen Barker, B Brown, D Birkenhead, K Griffiths	Jason Eddleston, Gary Boothby, Lindsay Rudge

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	1. PPM Programme to be competed by end October 2015 by V. Wotherspoon 2/3. Medical devices database audit by V. Wotherspoon, completion August 2016 to ensure accurate picture of devices needing maintenance and location of devices.. 4. Review final report and actions of independent assessor (due September 2015) and amend plans accordingly. 5. Newly recruited Medical Engineer to start September 2015 6. Medical Engineering team to move to Estates from end of September 2016 to ensure systems and processes for medical devices are closely monitored. APRIL update. PPM scheduling continues using bank resource. Number of devices seen continues to grow as validation of database continues. Slower progress in March due to annual leave and major influx of new devices due to end of year spend. Recruitment of additional engineer to vacant post is proving difficult, positive candidate declined position. Process re instigated.Significant amount of high risk devices now scheduled and work completed. Work continues in a positive direction. MAY update. job offer in progress for vacant post. Bank resource still helping with PPM scheduling etc (53% of inventory) devices now on schedules. Asset verification continues using existing resource 49% complete. **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.	Jun-16	Mar-2017	DB	Lesley Hill	V Wotherspoon

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th June 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - JUNE 2016 - This report brings together a number of governance items for review and approval by the Board.	
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:

This report brings together a number of governance items for review and approval by the Board:
1. Q4 Response from Monitor/NHS Improvement
2. Board Workplan
3. Use of Trust Seal
4. Board of Directors Declaration of Interest Register
5. Board of Directors Attendance Register
6. Workforce Well Led Committee - Terms of Reference
7. Calderdale Artefacts

Main Body

Purpose:

This report brings together a number of items that evidence or strengthens the corporate governance arrangements and systems of internal control within the Trust.

1. Q4 Response from Monitor/NHS Improvement

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

The Board is asked to RECEIVE the Q4 feedback.

2. Board Workplan

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

The Board is asked to CONSIDER whether the items allocated for the meetings are correct and whether there are any 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 sealing is 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.

The Board is asked to RATIFY the sealings.

4. Board of Directors Declaration of Interest Register

The Board of Directors Declaration of Interest Register is at appendix 4

Board members are asked to CONFIRM that their entry on the Register is correct before publication on the Trust website.

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 from April to February 2016 is attached at appendix 5.

The Board is asked to NOTE the attendance register.

6. Workforce Well Led Committee - Terms of Reference

The Board is asked to receive and APPROVE the revised Terms of Reference for the Workforce Well Led

Committee at Appendix 6.

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.
The Board is asked to NOTE the letter of thanks received from the Management Company attached at appendix 7.

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the report and
- Receive the Q4 Feedback from Monitor/NHS Improvement
- Agree the items on the Board Workplan and consider any outstanding
- Ratify the Sealings
- Confirm the entries on the Declaration of Interest Register
- Note the attendance register
- Approve the revised Terms of Reference for the Workforce Well Led Committee
- Note the transfer of Calderdale Artefacts under an Exhibition Agreement to Halifax Royal Infirmary Hospital Management Company

Appendix

Attachment:

COMBINED GOVERNANCE REPORT - 30.6.16.pdf

1 June 2016

Mr Owen Williams
Chief Executive
Calderdale and Huddersfield NHS Foundation Trust
Trust Headquarters
Acre Street
Lindley
Huddersfield
West Yorkshire
HD3 3EA

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@improvement.nhs.uk
W: improvement.nhs.uk

Dear Owen

Q4 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q4 submissions is now complete. Based on this work, the trust's current ratings are:

- Financial sustainability risk rating: 2
- Governance rating: Red

These ratings will be published on NHS Improvement's website later in June.

NHS Improvement is the operational name for the organisation which brings together Monitor and the NHS Trust Development Authority. In this letter, "NHS Improvement" means Monitor exercising functions under chapter 3 of Part 3 of the Health and Social Care Act 2012 (licensing), unless otherwise indicated.

The trust is subject to formal enforcement action in the form of enforcement undertakings. In accordance with NHS Improvement's Enforcement Guidance, such actions have also been published on our website.

NHS Improvement will raise any concerns arising from our review of the trust's Q4 submissions as part of our regular Progress Review Meetings.

A report on the aggregate performance of all NHS providers (Foundation and NHS trusts) from Q4 2015/16 will be available in due course on our website (in the News and alerts section), which I hope you will find of interest.

For your information, we will be issuing a press release in due course setting out a summary of the report's key findings.

We are developing the new Oversight Framework, which will be consulted on and will replace the Risk Assessment Framework in due course.

If you have any queries relating to the above, please contact me by telephone on 02037470484 or by email (kemi.oluwole@nhs.net).

Yours sincerely

Kemi Oluwole
Senior Regional Manager

cc: Mr Andrew Haigh, Chair, Mr Keith Griffiths, Director of Finance

DRAFT BOARD WORK PLAN 2016-2017 - WORKING DOCUMENT - To be agreed by BOD 30.6.16

Date of meeting	28 April 2016	26 May	30 June	28 July	25 Aug (Prov)	29 Sept	27 Oct	24 Nov	15 Dec	26 Jan 2017	23 Feb 2017	30 March 2017
Date of agenda setting/Paper Review of drafts	18.4.16	16.5.16	20.6.16	18.7.16	15.8.16	19.9.16	19.10.15	14.11.16	5.12.16	16.1.17	13.2.17	20.3.17
Date final reports required	20.4.16	18.5.16	22.6.16	20.7.16	17.8.16	16.9.15	21.10.15	16.11.16	7.12.16	18.1.17	15.2.17	23.3.17
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DIPC report	-	✓	-	-	✓	-	-	✓	-	-	✓	-
REGULAR ITEMS												
Board Assurance Framework (Quarterly)	-	-	✓	-	-	-	✓	-	-	-	✓	-
Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance report: to include such items as: - Standing Orders / SFIs review - Non-Executive appointments - Board workplan - Board skills / competency - Code of Governance - Board meeting dates - Committee review and annual report - Annual review of NED roles - Use of Trust Seal - Quarterly Feedback from Monitor - Declaration of Interests - Attendance Register			✓			✓			✓	✓		✓

DRAFT BOARD WORK PLAN 2016-2017 - WORKING DOCUMENT - To be agreed by BOD 30.6.16

Date of meeting	28 April 2016	26 May	30 June	28 July	25 Aug (Prov)	29 Sept	27 Oct	24 Nov	15 Dec	26 Jan 2017	23 Feb 2017	30 March 2017
Care of the acutely ill patient report	✓			✓		✓		✓		✓		✓
Patient Survey				✓								✓
Quarterly Quality Report			✓			✓			✓			✓
Colleague Engagement /Staff Survey (NB - Gold Standard by 2018 and Platinum Standard by 2020 agreed at 25.2.16 BOD)	✓					✓						✓
Nursing and Midwifery Staffing – Hard Truths Requirement		✓			✓ (update following report to F&P)			✓				
Safeguarding update – Adults & Children	✓ (Annual report)				✓				✓			
Review of progress against strategy (Qly)	✓	✓	✓			✓			✓			
Quality Committee update & mins	✓	✓	✓	✓	✓		✓	✓		✓	✓	
Audit and Risk Committee update & mins	✓	✓		✓	✓		✓	✓		✓	✓	
Finance and Performance Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Well Led Workforce Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Risk and Compliance Group mins												
ANNUAL ITEMS												
Annual Plan												✓
Annual Plan feedback from Monitor				✓								
Annual report and accounts (private)		✓										
Annual Quality Accounts		✓										
Annual Governance Statement		✓										
Appointment of Deputy Chair / SINED						✓						
Emergency Planning annual report					✓							

Health and Safety annual report		✓					✓ (UPDATE)					
Date of meeting	**28 April 2016**	**26 May**	**30 June**	**28 July**	**25 Aug (Prov)**	**29 Sept**	**27 Oct**	**24 Nov**	**15 Dec**	**26 Jan 2017**	**23 Feb 2017**	**30 March 2017**
Capital Programme												✓
Equality & Inclusion update				✓ (update)						✓(AR)		
Security Management annual report						✓						
DIPC annual report					✓							
Fire Safety annual report		✓										
Medical revalidation	✓						✓					
Nursing revalidation			✓					✓				
Annual Organ Donation plan				✓								
End of Life Report					✓						✓	
Whistleblowing Annual Report										✓		
Review of Board Sub Committee TOR							✓					
ONE-OFF ITEMS												
Membership Council Elections	✓											
Support on Junior Doctors Contract	✓											

DRAFT BOARD WORK PLAN 2016-2017 - WORKING DOCUMENT - To be agreed by BOD 30.6.16

Date of meeting	28 April 2016	26 May	30 June	28 July	25 Aug (Prov)	29 Sept	27 Oct	24 Nov	15 Dec	26 Jan 2017	23 Feb 2017	30 March 2017
STANDING PRIVATE AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Private minutes of sub-committees	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ADDITIONAL PRIVATE ITEMS												
Contract update										✓	✓	✓
Monitor quarterly submission	✓			✓			✓			✓		
Board development plan	✓						✓					
Feedback from Board development workshop			✓	✓			✓	✓				
Urgent Care Board Minutes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
System Resilience Group minutes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
EPR update (monthly)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5 Year Strategic Plan								✓	✓	✓	✓	✓
Property Partnership/St Luke's Hospital/PR (as required)												
Equality and Diversity (discussion)		✓										

REGISTER OF SEALINGS OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED	PERSONS ATTESTING SEALING OR EXECUTION
240	7.4.16	7.4.16	Sale of 38 Acre Street (Occupational Health Building). Sold subject to contract for £125,500.00	**Name:** Julie Pang **Title:** DoN **Name:** V Nicholls **Title:** Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
241	20.4.16	20.4.16	Renewal Lease for Park Valley Mills site (Community Midwives and Child Health Teams) from Holmfirth Dyers Limited. £11,250 per annum rent	Name: JULIE DAWES TITLE Director of Nursing
				Name: VICTORIA PICKLES V Pickles TITLE Company Secretary

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
242	18.5.16	18.5.16	Sub Underlease to extend lease agreement between the SPC, Trust and WH Smith at CRH	NAME: Victoria Pickles TITLE Company secretary
				NAME: Helen Barker TITLE Chief Operating Officer

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
243	18.5.16	18.5.16	HRI Communities Together – Lease Lease relating to radio apparatus being installed at HRI for the broadcast of Radio Sangam a community radio station – no rental cost.	NAME: Victoria Pickles TITLE Company Secretary. NAME: HELEN BARKAS TITLE CHIEF OPERATING OFFICER

Calderdale and Huddersfield NHS

NHS Foundation Trust

DECLARATION OF INTERESTS – BOARD OF DIRECTORS
AS AT 11 APRIL 2016

DATE OF DECLAR-ATION	NAME	DESIGNATION	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES
2.10.14	David Anderson	Non Executive Director	Director of Prime Health Huddersfield Limited and Grange Prime Health Limited Director of Synergy P, Partner in Grange Group Practice -Member practice of Greater Huddersfield CCG	As 'Directorship'	-	-	-
12.3.12	Keith Griffiths	Director of Finance	Pennine Property Partnership	-	-	-	-
8.3.12	Andrew Haigh	Chairman	NED Furness Building Society	-	-	-	-
18.9.14	Lesley Hill	Director of Service Development	Pennine Property Partnership	-	-	Trustee – Dean Clough Foundation	-
28.3.12	Peter Roberts	Non Executive Director	Catchweasel (Partner) First Ark Group (Chair) Genisis Housing (Non Executive Director) Pennine Property Partnership (Director) Northern Ireland Housing Executive (Vice-Chair) Ty Hen Holidays LLP (Partner)	-	-	Planning Exchange Foundation (Chair) Town and Country Planning Association (Vice President)	-
1.4.14	Julie Dawes	Director of Nursing	Company Secretary – Ian Dawes Maine Industry	-	-	-	-
5.3.12	Jan Wilson	Non Executive Director	Director/Chair Groundwork UK Jobmatch UK WhitwoodGolf Club	-	-	-	Yorkshire & Humber Postgraduate Deanery South West Yorkshire Partnership FT

DATE OF DECLAR-ATION	**NAME**	**DESIGNATION**	**DIRECTORSHIP**	**OWNERSHIP**	**CONTROLLING SHAREHOLDING**	**AUTHORITY IN A CHARITY**	**VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES**
1.7.14 16.12.15	Owen Williams	Chief Executive	-	-	-	-	• Trustee – NHS Confederation • Director – York Health Economics Consortium
17.2.12	Dr David Birkenhead	Consultant Microbiologist Executive Medical Director	-	-	-	• Trustee Childrens' Forget Me Not Hospice	• Provide Infection Control advice to the BMI, Hudds. • Wife – GP and member of Huddersfield Federation
1.9.13	Linda Patterson	Non Executive Director		Sole Trader Dr Linda Patterson Ltd Health Service Consultancy	-	Trustee Health Quality Improvement Partnership	Chair Medical Specialties Expert group, Patient Safety NHS England Consultancy Health care Improvement in NHS, Price Waterhouse Coopers Chair, CQC inspections
19.8.13	Philip Oldfield	Non Executive Director	Director Sue Ryder Director and Owner of Tanzuk Consulting	-	-	-	-
9.3.16	Helen Barker	Chief Operating Officer	-	Husband owns a lighting company which sells to NHS. I am Company Secretary.	-	-	Company Secretary of husband's business.

DATE OF DECLAR-ATION	**NAME**	**DESIGNATION**	**DIRECTORSHIP**	**OWNERSHIP**	**CONTROLLING SHAREHOLDING**	**AUTHORITY IN A CHARITY**	**VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES**
17.3.16	Richard Hopkins	Non Executive Director	Capri Finance Ltd – own consultancy company. All part of 'Derwent' Group:- • Derwent Housing Association Ltd • Derwent FHH Ltd • Centro Place Investments Ltd	-		Finance Director (part-time) of Age UK Calderdale & Kirklees	Unpaid – Treasurer of Community Foundation for Calderdale
31.3.16	Karen Heaton	Non Executive Director	One Manchester				• University of Manchester – Director of Human Resources • Prison Service Pay Review Body – Independent Member

STATUS: COMPLETED

P:Declaration of Interest-bod - kb

Attendance	✓	Apologies	×	Not BOD members	-

ATTENDANCE REGISTER – BOARD OF DIRECTORS
1 APRIL 2016 – 31 MARCH 2017

DIRECTOR	28.4.16	26.5.16	30.6.16	28.7.16	25.8.16 (provision)	15.9.16 JOINT AGM	29.9.16	27.10.16	24.11.6	15.12.16	26.1.17	23.2.17	30.3.16	TOTAL
A Haigh (Chair)	√	√												
D Anderson	√	x												
Helen Barker	√	√												
D Birkenhead	√	√												
B Brown (from 13.6.16)	-	-												
K Griffiths	√	√												
K Heaton	√	√												
L Hill	√	√												
R Hopkin	√	√												
P Oldfield	√	√												
L Patterson (Sabbatical leave 1.1.16 to Sept 2016)	-	-	-	-	-									
P Roberts	√	√												
I Warren (from 1.8.16)	-	-	-	-										
O Williams	√	√												
J Wilson	√	√												
Vicky Pickles	√	√												
J Green (Interim Dir W & OD from April 2015 – 30.6.16)	√	√												
A Basford	√	√												
Mandy Griffin	√ (private)	√												
Lindsay Rudge (Acting DoN)	√	√												

Calderdale and Huddersfield NHS
NHS Foundation Trust

WORKFORCE (WELL LED) COMMITTEE

TERMS OF REFERENCE

Version:	1.1 (first draft circulated for review to Chair / Julie Dawes) 1.2 Amendments prior to Board 1.3 Amendments after submission to Workforce (Well Led) Committee 1.4
Approved by:	
Date approved:	
Date issued:	
Review date:	

WORKFORCE (WELL LED) COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Workforce (Well Led) Committee. The Workforce (Well Led) Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

2.1 The Workforce (Well Led) Committee is constituted as a Standing Committee of the Board. Its constitution and terms of reference are subject to amendment by the Board.

2.2 The Committee derives its power from the Board and has no Executive powers, other than those specifically delegated in these terms of reference.

2.3 The Committee is authorised by the Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1 The purpose of the Workforce (Well Led) Committee is to provide assurance to the Board of Directors on the quality of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. For these purposes Workforce (Well Led) includes but is not limited to:-

- Colleague Engagement, Health and Wellbeing Group
- Education and Learning Group
- Human Resources Management Group
- Medical Workforce Group
- Nursing Workforce Group.

3.2 In particular, the Committee will assure the Board of Directors of the achievement of the objectives set out in the 'A workforce fit for the future' section of the Trust's five year strategy.

3.3 The Committee is supported by five subgroups aligned to the areas set out in 3.1 above. The terms of reference for the subgroups are attached as appendix 1.

4. Duties

4.1 The objectives of the Committee are to:-

4.1.1 Consider and recommend to the Board of Directors, the Trust's overarching People strategy and plan.

4.1.2 Consider and recommend to the Board of Directors the key workforce performance targets for the Trust. To receive regular reports to assure itself that these targets are being achieved and to request and receive exception reports where this is not the case.

4.1.3 Review the workforce risks of the workforce risk register and the corporate risk register and to specifically review individual workforce risks rated 15 and above.

4.1.4 Hold the Executive Director of Workforce and OD to account for keeping the Committee informed on risk mitigation and future activity/plans.

4.1.5 Receive and consider the Trust's annual Workforce Equality Report and monitor the implementation of the workforce aspects of the Trust's Workforce Race Equality Scheme and Public Sector Equality Duty Report.

4.1.6 Receive regular reports in relation to internal and external quality and performance targets relating to workforce, including but not limited to CQC safe staffing standards. To assure that these targets are being achieved and to request and receive exception reports where this is not the case.

4.1.7 Monitor and approve all Trust workforce policies and ensure existing policies are received in a timely manner.

4.1.8 Recommend to the Board the Trust's Colleague Engagement Strategy and monitor implementation.

In regard of objective 4.1.7 the Workforce (Well Led) Committee gives delegated approval authority to the Chair of the Committee to take Chair's action in respect of policy documents in appropriate circumstances.

5. Membership and attendance

5.1 The Committee shall consist of the following members:-

- Two Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee.
- Executive Director of Workforce and Organisational Development
- Deputy Director of Workforce and Organisational Development
- Chief Nurse and Deputy Chief Executive/Deputy Director of Nursing
- Chief Operating Officer
- Medical Director
- Each of the Chairs of the five sub groups
- Divisional Director
- Clinical Director
- Assistant Divisional Director
- Assistant Divisional Director – Community
- Associate Director of Nursing
- Deputy Director of Finance
- Company Secretary
- Head of Therapies.

5.2 The Committee shall consist of the following attendees:-

- Membership Councillor
- Chair – Staff Management Partnership
- Chair – Local Negotiating Committee
- Secretary, Workforce and Organisational Development (notes).

5.3 Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.4 A quorum will be seven members and must include at least one Non-Executive and one Executive Director.

5.5 Attendance is required at 75% of meetings, Members unable to attend should indicate in writing to the Committee Secretary at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who

is appropriately briefed to participate in the meeting.

5.6 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Committee shall be supported by the Secretary, whose duties in this respect will include:-

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting
- Maintaining a record of attendance.

7. Frequency of meetings

7.1 The Committee will meet every two months and at least 5 times per year.

8. Reporting

8.1 The Committee Secretary will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2 An action schedule will be articulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers.

8.3 The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4 Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next board of directors meeting.

8.5 A summary report will be presented to the next board meeting.

9. Review

9.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2 The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

HRI
HMC

Halifax Royal Infirmary Hospital Management Company
Free School Lane, Halifax

Website: www.theroyalhalifax.com
email:theroyalhalifax@outlook.com

Mr Andrew Haigh
Trust Chairman
Trust Offices
Huddersfield Royal Infirmary
Acre St
Lindley
HUDDERSFIELD |
HD3 3EA

Dear Andrew

On behalf of the Board of Directors at the Halifax Royal ,members of the Civic Trust and our small Steering committee ,may I thank you for allowing us to be the custodian of the Artefacts of the Halifax Royal Infirmary .
Victoria Pickles and Kathy Bray have worked tirelessly with us to bring the Artefacts 'Home'!

There is now much work to be done in restoring some of the items so that we can use them .
Eg. The brass ward Plaques .
When we have made progress I will be back in touch to invite you and anyone from the board /staff to come and visit and have a Hidden Gems Tour of the Old Infirmary site .

In the meantime please pass on our appreciation to all concerned .

With kind regards

Christine Harris DL
Chair, the Halifax Royal Management Company
Free School Lane
Halifax

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th June 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: WELL LED GOVERNANCE REVIEW - UPDATE ON ACTION PLAN - The Board is asked to receive and approve the update on the Well Led Governance Review Action Plan	
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 final version of the Well Led Governance Review action plan was approved by the Board at its meeting in August. It was agreed to receive quarterly updates on progress against the actions. This is the fourth of those progress reports which shows significant progress from the version presented to the Board in March.

Main Body

Purpose:

The paper describes the progress made against the outstanding actions from the Well Led Governance Review.

Background/Overview:

At the March meeting there were five areas where additional work was required.
- Risk management.
- Clinical leadership.
- Board development.
- Data quality
- Multi-professional leadership.

The progress against these is described in the action plan attached.

The Issue:

There are two remaining areas for further action:

- Multi-professional leadership - The newly developed divisional and clinical structures describes which roles are open to any clinical profession. This is alongside the work done to bring together education and learning structures for different professions. While this work has been completed it will need to be reviewed by the newly appointed Director of Nursing and Director of Workforce and OD.

- Board development - A programme of initial work was completed with Greengage and a draft board development plan is in place and being delivered for 2016/17. This needs to be reviewed and finalised alongside the wider organisational development work once the Director of Workforce and OD is in post.

Next Steps:

Once approved by the Board, the action plan will be shared with NHS Improvement in advance of the progress review meeting in July.

Recommendations:

The Board is asked to receive and approve the update on progress against the Well Led Governance Review Action Plan

Appendix

Attachment:

WLGR milestone action plan updated June 2016.pdf

WELL LED GOVERNANCE REVIEW ACTION PLAN	
Start date:	**November 2015**
Latest update:	**June 2016**
Lead Manager:	**Victoria Pickles, Company Secretary**
Lead Director:	**Andrew Haigh, Chair**
Monitoring Committee:	**Board of Directors**
Date signed off as complete	

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
1	**Audit Committee** The private session of the Audit Committee should not include members of management, including the Director of Finance.	Chair of the ARC / Company Secretary	Immediate		Meetings now taking place before each meeting without management representatives
2	**Accountability framework** The Trust should consider the introduction of a more formal accountability framework as an enabler to performance management and operational delivery. This internal contractual agreement between the Trust Board, divisions and directorates should be used as a basis to define an appropriate level of devolution across the Trust.	Chief Operating Officer	1-3 months		The Performance Management Framework has been approved. This will now be used to form the basis of key performance indicators which will be used through the performance meetings to ensure accountability is clear from ward to board.
3	**Capacity** The Trust must assess and reflect on the capacity of the Board and staff at all levels to deliver operational improvement and future strategic priorities, and therefore the resilience of the organisation and individuals.	Chief Executive	1-3 months		All Non-Executive posts filled. Appointments made to Director of Workforce &OD and Director of Nursing

4	**Turnaround Executive** The Trust should seek to adopt and adapt the lessons learnt from the Turnaround Executive structure within divisions and consider how this process, developed during turnaround, could be adapted to strengthen performance management more generally (that is, not just to facilitate CIP delivery), allowing the Trust to meet the ongoing challenges that it will face.	Chief Executive	1-3 months		Lessons from the Turnaround Executive process have been built into divisional performance reporting arrangements and linked to the Performance Accountability Framework
5	**Divisional risk management** The Trust should undertake an in depth review of risk management, incident reporting and escalation in the divisions to ensure that these processes are robust and aligned to the Trust's strategic priorities (see also actions 12 & 14).	Executive Director of Nursing	1-3 months		Revised Incident and Serious Incident reporting policy and revised Risk Management Policy clearly setting out the responsibilities within Divisions. Terms of reference for PSQBs revised to ensure clear review and assessment of risks and incidents. Investigation lead and team being appointed. Tighter serious incident panel process implemented. Divisional Risk Registers have been reviewed. Additionally work on completion of Risk Registers and Risk Management. Additional external resource being utilised to continue to strengthen the risk capability.

6	**Clinical Leadership** The Trust should evaluate the current clinical leadership models as a means of strengthening leadership roles. The Trust should build on the leadership training provided to clinicians by clearly defining the job description and responsibilities of Divisional and Clinical Directors, and ensuring that there is sufficient ring-fenced time in their roles for this to be completed. There are several well established models of medical leadership that may provide further insight, for example, the Clinical Leadership Model developed at University Hospital of South Manchester NHS Foundation Trust.	Medical Director / Chief Operating Officer	1-3 months		Workshop undertaken with Divisions to describe divisional structure and role description for Clinical Director in place including appropriate time for responsibilities set out in the role description. Options developed for structure of role to be discussed at WEB and subsequent paper presented to Commercial Investment Committee and agreed. The paper also describes the strengthening of medical management within the Trust. Will now be fully implemented across all divisions.
7	**Board challenge** Board debate and challenge could be enhanced by ensuring that all aspects of issues are considered, and that the debate "closes the loop" by identifying the actions to be taken, their expected impact, how this will be measured and under what timeframe.	Chairman /Company Secretary	1-3 months		Externally facilitated workshop held with Non-Executives. Development programme for both Non Executives and Executives in place. Will be refreshed following the new appointments.
8	**Board reporting** The Board needs to be assured that the Trust is delivering its strategic priorities. Information presented to the Board should be integrated and triangulated to enable to the Board to make efficient judgements as to whether strategic and operational objectives are being achieved as expected. The Board should receive intelligence distilled from a more detailed review at the sub-committees.	Chairman / Chief Operating Officer	1-3 months		Quarterly report to Board on progress against strategic priorities. Integrated Board Report and key strategic risks reviewed at each of the sub-committees. Cycle of more detailed reporting on major programmes of work has been built into the Board work plan. Already looked at EPR and mortality.

9	**Data and data quality** Further development of the data quality kite mark will allow Board members to gain assurance over the reliability of each measure and could provide greater assurance that there are no unknown data quality issues. The Board should consider how the skills within the Trust (in particular, within the Health Informatics Service) could be leveraged to take a more transformation approach to data and data quality, and should consider the development of an information strategy to achieve this.	Chief Operating Officer	1-3 months		Data quality assessment included in the Integrated Board Report. Internal audits being undertaken around specific indicators. Data quality requirements being considered as part of implementation of the EPR. Interim Head of Performance appointed to work with THIS. Regular meeting in place between Operations and THIS
10	**Executive Portfolios** To address a perceived lack of clarity over responsibility for planning, and to more closely align structures and processes relating to planning, the Trust should ensure that the responsibility and oversight for planning is clearly defined in Executive portfolios.	Chief Executive	1-3 months		Chief Operating Officer recruited to. Planning agreed within portfolios. Annual planning – LH; Strategic planning - AB
11	**Development of the strategy** The Trust should formalise the process for refreshing the strategy annually, ensuring involvement with external stakeholders, staff, patients and the wider public.	Chief Executive	1-3 months		Completed as part of development of 5 Year Strategic Plan

12	**Risk and safety culture** The Trust should continue its focus on improving its risk management and safety culture. This could include applying the "go see" methodology by observing an organisation with a strong risk management and safety culture. For example, Mid Cheshire Hospitals NHS Foundation Trust was the highest acute trust nationally for "Fairness and effectiveness of incident reporting procedures" in the 2014 staff survey. Salford Royal NHS Foundation Trust achieved outstanding for the well-led domain in a recent CQC inspection; risk management culture and processes were praised in a number of divisions by the CQC (link to actions 5 & 14)	Director of Nursing	1-3 months		Support in place working with divisions to improve their risk registers with experience in other trusts. Newly recruited Assistant Director of Nursing for Medicine brings experience from one of the recommended Trusts to be shared. Internal Audit report on Learning from Experience tested the sharing of learning across the Trust and gave an opinion of significant assurance.
13	**Lessons learnt** The Trust should review the processes in place for sharing issues, lessons learnt and good practice between teams and consider whether further mechanisms at ward and service level might be required.	Director of Nursing	1-3 months		Learning lessons process reviewed and an internal audit completed setting out further actions to be undertaken. Investigation lead and small team to support divisions in conducting investigation to improve learning from incidents. Learning lessons bulletins in place.
14	**Divisional risk management** The Trust must strengthen risk management capability within the divisions as they are a foundation to manage and mitigate risk. The Trust should could consider using external support to engage with divisions to improve risk management culture, in the same way that this has been done at a Board level. (link to actions 5 & 12).	Director of Nursing	4-6 months		Capacity brought in to support divisions in improving quality reporting including risk management. Risk management training delivered across divisions. Further risk management training delivered in April / May. Internal audit report on divisional risk management undertaken in Q4 2015.16 has been given an opinion of significant assurance.

15	**Board sub-committees** The ongoing development of the Board sub-committees should be continued. This should focus on the strength of challenge from all members and the presentation and use of information, to ensure that appropriate scrutiny is applied and that assurance can be given to the Trust Board.	Company Secretary	4-6 months		Self-assessment and review process tested with Audit and Risk Committee and built into work programme for all sub-committees. This includes an assessment of the information they receive and how this can be improved. Formal induction agreed for each sub-committee and checked with Internal Audit good practice Annual meeting of sub-committee chairs, led by Chair of Audit and Risk Committee diarised.
16	**Board awareness of data quality** As the Board development programme is refreshed, the Trust should consider the inclusion of data quality and interpreting information to inform judgments as a subject for Board training, to ensure that the Board are equipped to identify potential indicators of poor data quality and challenge these. (link to action 9)	Chairman /Company Secretary	4-6 months		Data quality mark added to Integrated Board Report. Data quality session built into the development plan for 2016/17 so can include new Non-executive directors
17	**Cultural barometer** The Board should seek assurance that the programme of work generated from the PwC review of quality of care in October 2014 is having the planned impact on the culture of care. The Trust should could consider the use of a cultural barometer or similar tool as a way of assessing this.	Director of Workforce & OD	4-6 months		Agreement reached at WEB that the Trust's Investor in People assessment would support this. Received a Bronze award.
18	**Multi-professional leadership** The Trust should consider how to ensure that all professions are included and represented in leadership across the Trust. This will be of particular importance as the service model of the Trust continues to develop.	Medical Director / Director of Nursing	4-6 months		Revised multi-professional education structure reviewed at WEB and being implemented. Will sit alongside workforce and organisational development. This will be reviewed by the newly appointed Director of Nursing and Director of Workforce & OD once both are in post. New divisional structures describe the clinical director role as being appointable from any clinical profession.

19	**Community engagement** The Trust should consider the use of wider community networks to ensure that the diversity of the local population is reflected in its membership, Membership Council and Board.	Chairman	4-6 months		The approach has been built into the recently revised Membership Strategy and the Patient and Public Involvement Plan to ensure that community networks are engaged in the Trust and encouraged to become part of its membership.
20	**Board development** In recognition of recent Board changes, and the changing context the Trust operates in, the Trust should consider the Board and organisational development needs to ensure that leadership, the desired behaviour and delivery capacity is optimised. This should reflect lessons learnt from previous development programmes, and how leadership can be enhanced at all levels in the Trust.	Chairman /Company Secretary	6 -12 months		The capacity of the Board was assessed and is being addressed through the recruitment of the Chief Operating Officer and the additional Non-Executive Director post. Director of Workforce and OD post reviewed to ensure sufficient focus on organisational development. Board development programme in place.
21	**Development of the strategy** Strategic development must include alignment of structures, processes and KPIs to the Trust's strategic priorities. The more robust planning process from 2015/16 should be embedded to ensure plans reflect capacity and workforce constraints, as well as the financial position.	Chief Executive	Ongoing		Planning process agreed as part of development of 5 Year Strategic Plan. Will be rolled out as part of the updated 1 Year Plan and appraisal process for 16/17.
22	**Communication of the strategy** The Board and those in leadership and managerial positions must consistently communicate strategic priorities to ensure the development and delivery of the operational plan.	Chief Executive	Ongoing		Strategic priorities built in to all communications channels including CHFT weekly; Big Brief. Re-instating CE blog; Four pillars / compassionate care posters up around the Trust.

APPENDIX F

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Lindsay Rudge, Deputy Director of Nursing
Date: Thursday, 30th June 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Nurse Revalidation - This paper provides an update to the Board of Directors on progress within CHFT on the implementation of revalidation within the nursing and midwifery workforce.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper provides a brief update to the Board of Directors on 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 3 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 has been implemented in line with national guidance. The Trust has a monthly trajectory of colleagues who are due to complete revalidation and this paper provides assurance to the Board that the processes in place support colleague's within the Trust to meet regulatory requirements.

Main Body

Purpose:

see report

Background/Overview:

see report

The Issue:

see report

Next Steps:

n/a

Recommendations:

The Board is recommended to receive and endorse this summary of the Trust' progress to ensure effective processes are in place to support nursing and midwifery revalidation.

Appendix

Attachment:

Nurse Revalidation BOD Final June 2016.pdf

BOARD OF DIRECTORS – JUNE 2016

NURSE REVALIDATION

1.0 INTRODUCTION

This paper provides a brief update to the board on progress within Calderdale and Huddersfield NHS Foundation Trust (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 3 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.

2.0 PURPOSE

The purpose of revalidation is to improve public protection by making sure that nurses and midwives continue to be fit for practise throughout their career. Furthermore, it ensures that employers can be assured that the nurses and midwives are deemed fit to practise.

Registrants need to stay up to date in their professional practice, develop new skills, keep up to date on standards and understand the changing needs of the public they serve and fellow healthcare professionals with whom they work.

3.0 REVALIDATION STANDARDS

Revalidation is a process that all nurses and midwives are required to comply with to demonstrate that they are fit to practise throughout their career.

All nurses and midwives will have ownership of, and will be held accountable for their own revalidation process.

All nurses and midwives are currently required to renew their registration every three years; however, revalidation strengthens the renewal process by increasing professionalism and introducing new requirements. Nurses and midwives are required to;

- Declare they have practised for 450 hours during the three years.
- Demonstrate up-to-date practice and professional development; 35 hours over 3 years, 20 hours of which is interactive.
- Produce five reflective pieces on the professional standards of practice and behaviour as set out in the Code;- **http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/**
- Ensure the reflection is discussed with another registrant.

- Demonstrate engagement in professional discussions with other registered nurses or midwives.

- Obtain five pieces of feedback based on practice (this can be formal or informal, written or verbal and for peers, professional's or patients.

- Registrants need to ensure they have indemnity insurance.

The revised system requires an additional level of monitoring as every nurse and midwife will need to be signed off by their manager or someone in a similar position.

The NMC requires confirmation is received from someone well placed to comment on a nurse or midwife practice. This will confirm that a nurse or midwife is performing to the standard set out in the Code and it will be based on information available at the time.

If a nurse or midwife fails revalidation, they will not be registered to work legally in the UK.

4.0 IMPLEMENTATION PROGRESS

A Task and Finish approach led by the Deputy Director of Nursing has been adopted to ensure the Trust was prepared to implement and support revalidation for nurses and midwives.

Colleagues due for revalidation in April, May and June have been identified and offered personal support to confirm they were prepared and able to submit the required documents to the Nursing and Midwifery Council (NMC)

Line Managers receive an alert of colleagues due to revalidate to ensure they can be offered support if necessary.

Nurses and Midwives are contacted by the NMC to inform them when they are due to revalidate.

The appraisal tool indicates the requirements of revalidation to act as a prompt to discuss the expectations and this has been updated by the task and finish.

Presentations have been undertaken to inform the nursing and midwifery workforce of revalidation, including reflection and lifelong learning.

A number of workshops have been held for Confirmers using the NMC guidance tools.

A monthly trajectory of actual number of colleagues due to revalidate has been developed.

5.0 SUMMARY

The trust is actively supporting colleagues to achieve revalidation through engagement and training events, providing appropriate documentation, utilising ESR, and ongoing performance management.

The board is recommended to receive and endorse this summary of the Trusts progress to ensure effective processes are in place to support nursing and midwifery revalidation.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 30th June 2016	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Board Report - Integrated Board Report - The Board is asked to receive and approve the Integrated Board Report for May 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:

Safe

• Inpatient Falls with Serious Harm - there were 7 falls in May, which are currently being investigated. This is 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 address.

• Never Event - There was one Never Event reported in May relating to feeding by a dislodged NG tube. This is 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 - % PPH 1500ml - An improvement in overall PPH rates has been recorded in May 2016, however, the Trust is 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. Report is expected end of June.

Effective

• Total Number of Clostridium Difficile Cases - There were 3 cases in May. 2 were avoidable.

• Perinatal Deaths (0-7 days) - at 0.65% 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.

• Stillbirths Rate - at 0.65% is above expected levels for the second month running. New SOP in place for stillbirth reduction and action plan 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 is 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 HRI is much higher than in-hospital HRI deaths or any in CRH. This is currently unexplained and is subject to investigation at present.

• Hospital Standardised Mortality Rate (1 yr Rolling Data 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 has 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 PSQB for implementation.

• Crude Mortality Rate - has peaked at 1.6% for May 16. This will be reviewed by the Mortality Surveillance Group.

• Average Diagnosis per Coded Episode - there has 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 #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge is 68.3% against 85% target. In May 26 of 34 people received an operation within 36 hours. There were 3 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 is the lowest position in the last 12 months and is 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 are 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 are in place to address concerns around the perception of poor staff attitudes, standards of communication and expected behaviours are discussed across the division at every meeting.

Responsive

• Emergency Care Standard 4 hours. May's position has 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 are achieved the Trust aims to secure a quarter one position of 94% and are seeking to achieve 95% for June. The Trust is 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 has 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 26weeks highest since July 2015 - need for further validation.
• 38 Day Referral to Tertiary has improved to 66.7% against 85% target. Action plans went to Divisional Performance reviews in May with a requirement to achieve by July reflecting changes to reporting rules from Q3.

Workforce
• Sickness Absence rate has 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 are a key contributor to effective sickness management and are currently only running at 34.6% against 100% target. The Trust also has the highest Turnover rate when compared to surrounding Trusts.
• Mandatory Training and appraisal compliance remains a challenge. Appraisal training proposal paper to be received at the Education Learning Group meeting on 22 June 2016.

Efficiency / Finance
• 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.
• Theatre Utilisation has improved in month. However there is still 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 in ED 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 has begun in June.

Activity
• Planned day case and elective activity performance is improved at 3.3% above the month 2 plan. This is driven by over-performance within day case activity, with elective activity remaining below plan. Non-elective activity overall is 3.2% below the month 2 plan which is a continued reduction from April. This continues to be mainly driven by emergency long-stay. A&E has seen activity 7.6% above the month 2 plan which is a significant increase from month 1. Outpatient activity has seen a significant increase across first and follow-ups and is 5.3% above the month 2 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 May 2016

Appendix

Attachment:

Integrated Performance Report - May 2016.pdf

Quality and Performance Report

May 2016

Contents

RAG Key	
Not achieving target or threshold	
Achieving target	
Between target and threshold	

Executive Summary

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

Area	Domain
Safe	• **Inpatient Falls with Serious Harm -** there were 7 falls in May, which are currently being investigated. This is 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 address. **Never Event** - There was one Never Event reported in May relating to feeding by a dislodged NG tube. This is 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 - % PPH ≥ 1500ml -** An improvement in overall PPH rates has been recorded in May 2016, however, the Trust is 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. Report is expected end of June.
Effective	• **Total Number of Clostridium Difficile Cases -** There were 3 cases in May. 2 were avoidable. • **Perinatal Deaths (0-7 days) -** at 0.65% 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. • **Stillbirths Rate -** at 0.65% is above expected levels for the second month running. New SOP in place for stillbirth reduction and action plan 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 is 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 HRI is much higher than in-hospital HRI deaths or any in CRH. This is currently unexplained and is subject to investigation at present. • **Hospital Standardised Mortality Rate** (1 yr Rolling Data 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 has 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 PSQB for implementation • **Crude Mortality Rate** - has peaked at 1.6% for May 16. This will be reviewed by the Mortality Surveillance Group. • **Average Diagnosis per Coded Episode -** there has 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 #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge is** 68.3% against 85% target. In May 26 of 34 people received an operation within 36 hours. There were 3 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 is the lowest position in the last 12 months and is 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 are 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 are in place to address concerns around the perception of poor staff attitudes, standards of communication and expected behaviours are discussed across the division at every meeting.

Background Context

Overall activity is ahead of plan against all points of delivery with the exception of elective and non-elective inpatients. Planned day case and elective activity performance is improved at 3.3% (121 spells) above the month 2 plan. and Theatre utilisation seeing a positive trend

Non-elective activity overall is 3.2% (140 admissions) below the month 2 plan which is a continued reduction from April. A&E has seen activity 7.6% (960 attendances) above the month 2 plan which is a significant increase from month 1. Outpatient activity has seen a significant increase across first and follow-ups and is 5.3% (1,424 attendances) above the month 2 plan.

The impact is that the Trust , on occasions had to rely on additional capacity and flexible staffing.

The Medicine Division continues to experience a high number of Consultant vacancies some of which are filled with agency locums and other rota gaps covered by substantive colleagues and Surgery had some unexpected Consultant absence.

Flow across the Health and Social care system remains a challenge with the Transfer of Care list remaining high with Calderdale social worker capacity limited and Package of Care capacity an ongoing limitation; both issues recognised by Special Services.

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

The Community services division has now been in existence for 12 months with a significant amount of work undertaken to strengthen governance arrangements and develop effective systems to monitor incidents, complaints and risks.

The division is focused on transforming the services offered in the following ways:-
1. Locality integrated teams are being developed to support the system wide approach to care closer to home
2. Community staff in-reaching into the Emergency department and acute medical units to support admission avoidance, ambulatory care pathways and short stay.
3. Development of specialist teams supporting people in their own home to avoid hospital admission or ED attendance.
4. Development of early supported discharge and pathways to facilitate smooth discharge.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours.** May's position has 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 are achieved the Trust aims to secure a quarter one position of 94% and are seeking to achieve 95% for June. The Trust is 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 has 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 26weeks** highest since July 2015 - need for further validation. • **38 Day Referral to Tertiary has improved to 66.7%** against 85% target. Action plans went to Divisional Performance reviews in May with a requirement to achieve by July reflecting changes to reporting rules from Q3.
Workforce	• **Sickness Absence rate has 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** are a key contributor to effective sickness management and are currently only running at 34.6% against 100% target. The Trust also has the highest **Turnover rate** when compared to surrounding Trusts. • **Mandatory Training and appraisal** compliance remains a challenge. Appraisal training proposal paper to be received at the Education Learning Group meeting on 22 June 2016.
Efficiency/ Finance	• **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. • **Theatre Utilisation** has improved in month. However there is still 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 in ED 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 has begun in June.
Activity	• Planned day case and elective activity performance is improved at 3.3% above the month 2 plan. This is driven by over-performance within day case activity, with elective activity remaining below plan. Non-elective activity overall is 3.2% below the month 2 plan which is a continued reduction from April. This continues to be mainly driven by emergency long-stay. A&E has seen activity 7.6% above the month 2 plan which is a significant increase from month 1. Outpatient activity has seen a significant increase across first and follow-ups and is 5.3% above the month 2 plan.

Background Context

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

Vacancy rates in Nursing and Medical staffing remain high particularly in the Medicine Division. Vacancy control processes have been enhanced and will be further developed in June with the intention of increasing scrutiny as well as speeding up decision making.

Division Management Teams are working closely with ward sisters weekly to ensure controls on non-contracted spend are in place, roster management is efficient and a 'buddy system' is in place.
The absence management team are working closely with Clinical Directorates.

Demand for diagnostics, both inpatients and Direct Access remain high and with vacancy rates in Radiology this remains a challenge however maintained high level of achievement of the 6 week standard at 99.85%.

Assisted conception has now begun providing services to patients from Bradford working with a GP Federation. In May activity increased associated with this development (up 25% on the same period last year)

The Safer Patient Flow Programme launched with over 50 staff involved and local improvement initiatives have been agreed with clinical teams. These are Ambulatory, Frailty, SAFER bundle, Patient flow coordination, Rehabilitation and End of Life.

Decisions on Theatre and ward estate works have been confirmed enabling operational teams to proactively plan developments

Overall performance remains positive in comparison with Peers across the majority of Regulatory Metrics and a range of selected benchmarking reflecting the delivery of the 'we put the patient first' pillar

Performance Summary

CHFT

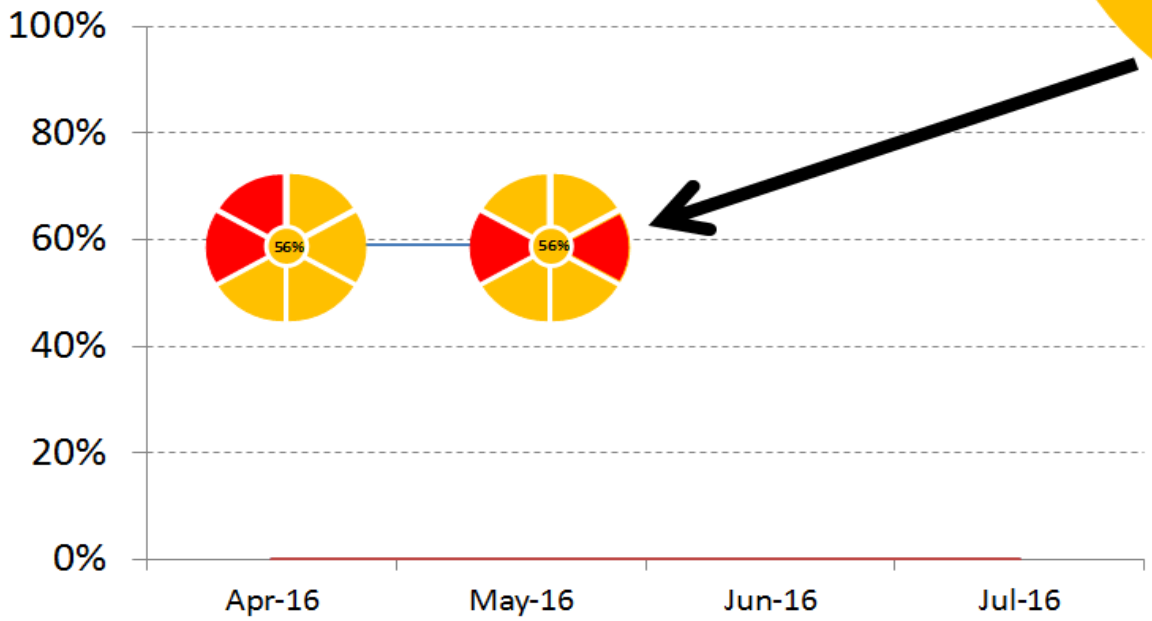
Most recent month's performance

RAG Movement

Within the **Effective** domain deteriorating performance within number of CDiff cases, number of E.Coli - Post 48 Hours, Perinatal deaths and Emergency Readmissions for GH CCG have resulted in a RED rating.

Within the **Efficiency & Finance** domain improved performance in total expenditure, deficit excl. restructuring, surplus/(deficit), I&E: surplus/(deficit), capital, Failed Day Cases (patients that stayed overnight) and theatre utilisation (Main Theatre –HRI) resulted in an improved RAG rating from RED to AMBER.

Total performance score by month



The **Methodology for calculating the performance score** and the areas that have been considered **"Key" targets** can be found in the Appendices.

Carter Dashboard

		Current Month Score	Progress Against Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.7%	97.1%	↑	96%
	Inpatient Complaints per 1000 bed days	2.2	2.10	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	5.4	5.32	↓	5.17
	Delayed Transfers of Care	2.31%	2.90%	↑	5%
	Green Cross Patients (Snapshot at month end)	90	93	↑	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	111.60	114.04	↑	100
	Theatre Utilisation (TT) - Trust	85.60%	84.13%	↑	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	1.04%	0.71%	↓	0.6%
	Emergency Care Standard 4 hours	93.40%	93.87%	↓	95%
	% Incomplete Pathways <18 Weeks	96.0%	96.2%	↓	92%
	62 Day GP Referral to Treatment	87.9%	92.3%	↓	85%
SAFE	% Harm Free Care	93.94%	94.16%	↓	95.0%
	Number of Outliers (Bed Days)	1363	1115	↓	495
	Number of Serious Incidents	6	3	↓	0
	Never Events	1	0	↓	0

MOST IMPROVED

Improved: Delayed Transfer of Care has further improved however this partly relates to overall bed capacity changing the denominator and delays for assignment which mean not yet applicable for reporting

Improved: Sickness Absence rate is 4.23% against 4% target the lowest position for several months. Long term sickness is 2.73% against 2.7%, short term 1.48% against 1.3%.

Improved: Friends and Family Test A & E Survey - Response rate has improved from 8.37% in March to 15.66% achieving the threshold for the green rating (14%). Staff capturing accurate mobile numbers to increase the success with the text messaging service.

MOST DETERIORATED

Deteriorated: % Last Minute Cancellations to Elective Surgery, some specialities this is a direct result of bed pressures e.g. Gynaecology but the majority of cancellations did not relate to bed pressures and are being reviewed by the Divisions currently

Deteriorated: 62day Cancer performance deteriorated reflecting several bank holidays across April & May impacting on pathway capacity

Deteriorated: Agency staffing continued to trend above control limit particularly in Medical and Nursing.

ACTIONS

Action: Division of Surgery asked to undertake a deep dive on cancellations and all Divisions re-enforcing the agreed authorisation process of ADD

Action: Development session held between Divisional Teams and Lead Cancer team where clarity on performance management and tracking were discussed. Urology and UGI implementing pathway changes that have improved performance

Action: Internal processes regarding agency are being tightened within the Division. Monthly review of any ongoing agency posts. Improved recruitment turnaround. Expected improvement in sickness rates.

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.

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Progress Against Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	Available from Q2			
Sickness Absence Rate	4.23%	4.60%	↑	4.0%
Turnover	14.8%	14.50%	↓	NA
Vacancy	496.71	494.92	↓	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4	82.00%	Different division samples 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	Progress Against Previous Month	Trend	Target
Income vs Plan var (£m)	£0.53	£0.26	●	
Expenditure vs Plan var (£m)	-£0.78	-£0.63	●	
Liquidity (Days)				
I&E: Surplus/(Deficit) var (£m)	-£0.06	-£0.30	●	
CIP var (£m)	£0.02	-£0.05	●	
FSRR	2	2	●	
Temporary Staffing as a % of Trust Pay Bill				

Safe, Effective, Caring, Responsive - Community Key messages

Area	Issue	Corrective actions	Impact & Accountability
Safe	**Harm free care** There have been 2 significant incidents in relation to falls in recent months.	**Falls** Falls have been investigated fully. The departments where the falls took place have been fully involved and actions have been implemented to reduce the risk of similar incidents occurring. Community staff are engaging with the CHFT falls strategy development.	No further falls of a similar nature in therapy area to occur **Accountable: Head of Therapy** Falls strategy that can be implemented across the whole organisation. **Accountable: ADN**
Effective	A focus of attention for Community Services is in relation to **Admission avoidance**. The Community matrons recorded that they prevented 14 people from being admitted to hospital in May. **Leg ulcers healed within 12 weeks** 32 out of 36 patients with leg ulcers healed within 12 weeks. This is a slight reduction	**Admission avoidance** This performance measure is being extended in June to include Quest matrons, respiratory team and the heart failure team. **Leg ulcers** District nurses reviewing those that have not healed to determine they are on appropriate treatment plans.	**Admission avoidance** Further admissions will be avoided moving forward. **Leg ulcers** Improved % of leg ulcers healed within 12 weeks. **Accountable: ADN**
Caring	**Patients dying in their preferred place** 12/16 patients died in their preferred place of death. **FFT** 13% of responders have reported they would not recommend the service. One major theme emerging is attitude. **Community - No access visits** 228 no access visits in May.	**Patients dying in their preferred place** Matrons reviewing the 4 that did not. Supporting staff to be more confident with new ICOD pathway. **FFT** Standards for communicating effectively by telephone and email to be shared across division. To share messages re behaviour expectations across the division at every meeting. **Community - No access visits** Reviewing reasons and developing a strategy to increase compliance .	**Patients dying in their preferred place** To provide the opportunity for all patients to die in their preferred place. **Accountable: ADN** **FFT** To reduce the % not recommend by end August 2016. **Accountable: Head of Therapy** **No access visits** Reduce number of no access visits in community nursing by 1% month on month. **Accountable: Directorate Manager**
Responsiveness	**ASI's for MSK** Issue is generally in spinal pathway. Whilst capacity has remained there has been a 7.5% increase in demand for this service in the last year. **Typing turnaround** There is currently an 11 day delay turnaround for typing letters post clinic for MSK.	**ASI's** Job planning is being undertaken through June where it is expected change to job plans will enable some additional clinical activity. Identified that podiatry have a system that could be shared with MSK to reduce ASI issue. **Typing turnaround** Review of admin support to MSK to support this standard.	**ASI's** Reduce the number of ASI's in MSK. **Accountable: Head of Therapy** **Typing turnaround** Week on week improvement on typing turnaround **Accountable: Head of Therapy**

Safe, Effective, Caring, Responsive - Community - Month & YTD

	15/16	TRUST	Division	Adult Nursing	Intermediate Care	Adult Therapy	Children's Therapy	Children's Public Health	Divisional Monthly Trend	TRUST	Division	Adult Nursing	Intermediate Care	Adult Therapy	Children's Therapy	Children's Public Health	DIVISION Annual	DIVISION Monthly	TRUST Annual	TRUST Monthly
Safe																				
Community acquired grade 3 or 4 pressure ulcers	29	0	**0**	0					↑	1	**1**	1					<29	2.4		
Falls that caused harm whilst patient was in receipt of Community Services	20	1	**1**						↑	3	**3**						<20	2		
Harm free care	95.5%	93.2%	**96.3%**						↓	93.7%	**96.1%**						95.0%	95.0%	95.0%	95.0%
Urinary Catheter Management	3127	286	**286**	286						574	**574**	574								
Effective																				
Number of Hospital admissions avoided by Community Matrons service	319	17	**17**	17						36	**36**	36								
Patients who attended A&E while on a Community Matron Caseload, who readmitted within 30 days	2.6%	**1.9%**	**1.9%**	1.9%					↑	1.9%	**1.9%**	1.9%					<10%	10.0%		
Reablement - Start to discharge Average (days)	33.4	36.5	**36.5**		36.5					36.4	**36.4**		36.4							
House Bound leg ulcers healed within 12 weeks	92.2%	88.9%	**88.9%**	88.9%					↓	90.9%	**90.9%**	90.9%					75.0%	75.0%		
Caring																				
Community No Access Visits -Adult Nursing	1.2%	1.1%	**1.1%**						↓	1.0%	**1.0%**						<1%	1.0%		
HV Achieved Targeted Visits	93.2%	104.0%	**104.0%**					104.0%	↑	103.4%	**103.4%**					103.4%	95.0%	95.0%		
End of life patient died in preferred place of death	98.2%	75.0%	**75.0%**	75.0%					↓	77.4%	**77.4%**	77.4%					95.0%	95.0%		
Friends and Family Test - Likely to recommend	89.0%	87.0%	**87.0%**						↓	87.3%	**87.3%**						95.0%	95.0%	95.0%	95.0%
Responsive																				
Average time to start of reablement (days)	5.1	9.2	**9.2**		9.2					8.7	**8.7**		8.7							
Appointment Slot Issues for MSK and Podiatry	N/A	33	**33**			33				46	**46**			**46**						
Waiting Times - 18 week RTT	92.2%	96.8%	**96.8%**		100.0%	96.3%	98.2%		↑	96.4%	**96.5%**		88.5%	95.8%	98.5%		95.0%	95.0%	95.0%	95.0%
MSK Responsiveness	N/A	11	**11**			11				11	**11**			11						
Well Led																				
% Complaints closed within target timeframe	29.6%	37.9%	**20.0%**						↓	49.6%	**20.0%**						100.0%	100.0%	100.0%	100.0%
Staff sickness rate	3.9%		**3.6%**						↑		**3.6%**						<4%	4.0%		
Finance - Planned variance against actual (£'000)	1178.03		**184.48**								**232.63**									
Finance - Planned CIP saving against actual savings (£'000)	1205.98		**66.0**								**132.70**									

Safe - Key messages

Area	Issue	Corrective actions	Impact & Accountability
Falls/Incidents	**Inpatient Falls with Serious Harm** The current number of patients who have had a fall resulting in harm exceeds planned trajectory which was based on the 10% reduction from 2014/15 . There were 7 falls in May, which are currently being investigated as part of the SI/orange panel processes. This is a further increase on what was already a peak in April. **Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)** Community division had presented a de-log request to the CCG for SI 2015/34961 in January 2016 . The de-log was not accepted and further information to support the de-log was requested. This was also declined and an RCA report provided	To enable improvements there has been an appointment of a specialist falls lead who will lead an agreed Falls quality improvement initiatives. In Quarter 1 work has commenced in line with a new local CQUIN to seek to reduce rates of falls by the introduction of safety huddles into areas with high falls rates. The falls multidisciplinary collaborative meeting is recommencing in June which will engage clinicians across the trust to engage in a strategic approach to reviewing current practice and in managing a reduction in falls.	There will be a 10% reduction in falls by the end of Q1 2016 in the areas identified for safety huddle implementation as part of the CQUIN. Improvement will be seen across the Trust following the reimplementation of collaborative work commencing June 2016. **Accountable: Deputy Director of Nursing**
Harm Free Care	Harm free care for the trust is at 93.15%. The harm events contributing to this are primarily old pressure ulcers, of which there were 34, this is a decrease from the 36 in April. These are ulcers which are present on admission or developed within the first 72 hours of admission. Alongside this there were also 4 new pressure ulcers, 13 harm falls, 12 UTI's in patients with a catheter and 6 VTEs.	The improvements in place to reduce harm events in each of the harm categories will impact here. Please see sections on Falls/Pressures ulcers for further details.	The improvements being rolled out to address Falls and Pressure ulcers will impact on the overall harm free care %. Please see the individual sections for details. **Accountable: Director of Nursing**
% PPH > 1500ml - all deliveries	% of PPH continues to be above target.	PPH's monitored on a weekly basis as part of weekly Governance meeting. Changes to measurement of blood loss now in place.	An improvement in overall PPH rates has been recorded in May 2016, however, we are still above the target. A reduction in overall PPH rates will lead to improved patient experience following delivery. **Accountable: Head of Midwifery/ADN**
Pressure Ulcers	Current performance being monitored against 15/16 thresholds. There is further investigation into the causes of the category 3 & 4 cases. New targets are to be set in Q2.	Further cluster investigations into category 3 ulcers to increase learning. Report expected at the end of June. Implementations of safety huddles into areas of high incidents commenced this quarter.	Improvement expected with Q2 and Q3. Improvement trajectories will be set in Q2. **Accountable : Assistant Director of Quality**
Never Event	A never event investigation is underway. The investigation will look at Trust compliance with NPSA alert 2011/PSA002 reducing the harm caused by misplaced ng feeding tubes. A report is to be submitted by 11th August to the CCG	A reiteration of the of the protocol's and guidance regarding NG tubes has been cascaded through the clinical teams to address any knowledge gaps whilst the investigation is underway.	**Accountable: Medicine DD**

Safe - Key measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	Annual Target	Monthly Target
Falls / Incidents and Harm Free Care																	
All Falls	2033	146	167	144	155	172	180	168	194	187	167	156	152	**165**	**317**	Not applicable	
Inpatient Falls with Serious Harm	29	3	4	2	2	4	3	0	2	3	3	2	6	**7**	**13**	<=12	<=1
Falls per 1000 bed days	-	6.6	7.8	6.8	7.4	8.3	8.1	7.7	8.9	7.9	7.2	6.7	6.9	**7.1**	**7.0**	TBC	TBC
% Harm Free Care	93.63%	95.04%	94.69%	93.96%	92.19%	93.46%	93.30%	93.29%	92.27%	93.47%	93.25%	93.04%	94.16%	**93.94%**	**94.05%**	>=95%	95.00%
Number of Serious Incidents	78	4	15	5	5	7	13	10	2	2	3	3	3	**6**	**9**	Not applicable	
Number of Incidents with Harm	1751	114	201	89	111	176	159	203	97	147	139	156	160	**169**	**329**	Not applicable	
Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)	-	21.00%	50.00%	100.00%	100.00%	90.00%	0.00%	0.00%	21.00%	33.00%	28.00%	100.00%	80.00%	**66.00%**	**75.00%**	100.00%	100.00%
Never Events	2	0	0	0	0	0	0	0	0	0	1	1	0	1	1	0	0
Total Duty of Candour informed		80.00%	100.00%	100.00%	100.00%	100.00%	89.66%	70.59%	100.00%	100.00%	100.00%	80.00%	65.00%	**82.00%**	**72.00%**	100.00%	100.00%
Total Duty of Candour shared within 10 days	-	80.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	86.00%	91.00%	85.71%	100.00%	**91.00%**	100%	100%
Maternity																	
Elective C-Section Rate	9.00%	11.46%	7.50%	8.50%	7.50%	9.60%	9.60%	9.10%	9.00%	7.60%	9.50%	9.00%	9.10%	**9.60%**	**9.40%**	<=10%	10.00%
Total C-Section Rate	23.90%	**24.20%**	**21.90%**	**24.20%**	**25.30%**	**20.40%**	28.30%	22.60%	25.70%	22.60%	23.10%	23.60%	22.20%	**21.30%**	**21.90%**	<=22.5%	22.50%
Major PPH - Greater than 1000mls	10.40%	9.38%	14.60%	9.60%	**9.50%**	7.60%	11.60%	11.00%	9.60%	11.20%	11.80%	10.60%	10.20%	**7.30%**	**9.40%**	<=8%	8.00%
% PPH ≥ 1500ml - all deliveries	3.78%	3.30%	6.90%	4.80%	2.30%	3.30%	4.20%	3.50%	2.90%	4.00%	2.80%	3.60%	2.90%	**2.90%**	**2.90%**	<=2.2%	2.20%
Antenatal Health Visiting Contact by 32 Weeks	91.80%	74.00%	96.00%	98.00%	85.00%	113.00%	95.00%	100.00%	77.00%	95.00%	87.00%	100.00%	103.00%	**115.00%**	**109.00%**	>=90%	90.00%
Pressure Ulcers																	
Number of Trust Pressure Ulcers Acquired at CHFT	498	42	61	65	53	32	35	41	20	24	29	44	39	**32**	**71**	<=300	25
Pressure Ulcers per 1000 bed days	-	1.9	2.8	3.1	2.5	1.5	1.6	1.9	0.9	1.0	1.3	1.9	1.8	**1.4**	**1.6**	TBC	TBC
Number of Category 2 Pressure Ulcers Acquired at CHFT	403	36	51	53	46	26	25	38	13	21	22	35	29	**22**	**51**	<=204	17
Number of Category 3 Pressure Ulcers Acquired at CHFT	86	6	9	10	7	6	9	3	6	3	7	8	9	**10**	**19**	<=96	8
Number of Category 4 Pressure Ulcers Acquired at CHFT	9	0	1	2	0	0	1	0	1	0	0	1	1	**0**	**1**	0	0
Percentage of Completed VTE Risk Assessments	95.30%	95.20%	95.20%	95.90%	95.60%	95.20%	95.20%	95.30%	95.40%	95.40%	95.10%	95.10%	95.01%	**95.14%**	**95.08%**	>=95%	95.00%
Safeguarding																	
Alert Safeguarding Referrals made by the Trust	157	23	18	29	12	8	16	6	7	12	8	11	20	**16**	**36**	Not applicable	
Alert Safeguarding Referrals made against the Trust	99	8	9	10	6	4	9	6	8	7	12	13	7	**10**	**17**	Not applicable	

Effectiveness - Key messages

Area	Issue	Corrective Actions	Impact and Accountability
Infection Control	The trust had 3 C. Diff cases in May. Following the RCA processes, the ICU case as seen as unavoidable, the other 2 cases were deemed as avoidable One related to SAU as a result of possible cross contamination. The patient on MAU had 2 previously negative c-diff samples prior to being positive on this occasion. There was incomplete documentation on Bristol stool chart.	Although the ICU case was deemed unavoidable, there was learning around discharge cleaning and an action plan is being implemented which addresses all of the issues working closely with domestic services., this will help to address the issues identified in the avoidable cases. An outbreak meeting was held but cases ribotyped and are not the same.	Matrons working with IPCN to ensure FLO audit captures issues identified pre CQC particularly around the leadership elements. **Accountable : All matrons**
Average Diagnosis per Coded Episode/ Average co-morbidity score	Whilst there has been an improvement in the coding score since last year, Surgery is still below target for diagnosis per episode and the comorbidity score. The service has focused on improving coding through the use of Bluespier as part of the pre-op process as well as the operation notes. These are currently not used for coding purposes. **Childrens:-** Venkat Thiyagesh (Consultant Paediatrician) is the FSS Divisional lead for coding and he has done significant work in ensuring that co-morbidities are recorded accurately on the ward. However, the Average Diagnosis per coded episode in paediatrics is still lower than the national average despite a small increase in the last few months.	Find a solution to coding information on bluespier. Reap the benefits of the additional time spent in clinical coding from the service. **Childrens:-** The work done on the paediatric ward needs to be extended to the Paediatric Assessment Unit where the co-morbidity documentation is rarely completely. By September 2016 (extra time allocated as more complex on the assessment unit due to short length of stays).	An improvement in the Average Diagnosis rate has helped improve the Trust's quality of documentation and has resulted in additional income from capturing additional complexities and has had a minor positive impact on the Trusts overall HSMR/SHMI. Expect to see continued improvement month on month across each average diagnoses and average co-morbidity, with a trajectory to hit targets in 2016/17 **Accountable: ADD Surgery/Director of THIS/Head of Clinical Coding**
Fracture Neck of Femur - Best Practice Guidance	**Year to date the Trust is at national average by admission.** In May 26 of 34 people received an operation within 36 hours. There were 3 clinical breaches and 5 organisational breaches. 2 of these 5 required a total hip replacement; a surgeon could not be arranged within 36 hours in either case. 1 of these 5 became rapidly unwell and sadly died. An RCA has been requested in order to assure ourselves that the delay in surgery did not contribute to the deterioration of her condition. The other 2 were delayed due to competing trauma priorities. The mean time to theatre for the organisational breaches was just over 47 hours. Research suggests that mortality does not increase with delays up to 48 hours post admission. Of the remaining Best Practice Tariff standards only 3 were missed across all components and patients. 2 of these were for the same patient, who sadly died.	Twice daily updates with Trauma coordinator and GM "Plans for every trauma patient" Automatic allocation of fallow laminar theatre lists to Orthopaedics. Investigate use of flexible theatre to extend "trauma 1". From autumn have increased scheduled theatre time with the use of the 6th Theatre at HRI being back in clinical use. Further analysis on trauma capacity required for the whole trauma service. Further work is underway regarding the timeliness of all trauma capacity with a view to improve the whole service for patients. Continue RCA for every patient that breaches with a focus on quality and experience.	**The whole plan will be completed in Autumn, with a number of actions in train.** **Accountable : GM for Orthopaedics**

Effectiveness - Key messages

Area	Issue	Corrective Actions	Impact and Accountability
Hospital Mortality	**Local SHMI - Relative Risk (1yr Rolling Data)** The latest release is for Oct 14 - Sept 15. More up to date data is expected at the end of June. Data continues to scrutinised closely. The two diagnostic groups that are negative outliers within our SHMI data currently are Acute Cerebrovascular Disease and Pneumonia, and both stroke and respiratory are subject to service review at present. **Hospital Standardised Mortality Rate (1 yr Rolling Data)** 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** As has been noted before, the completion rate for Level 1 reviews has been declining, and for YTD May deaths was 34%. Recruitment of more reviewers has been discussed on several occasions but feedback from Divisions shows that the current system of a nursing-dominated review team is not sustainable. **Crude Mortality Rate** For May 16 the crude in-hospital death rate at CHFT was 1.6%, which is a new peak.	Further analysis by Professor Mohammed Mohammed, splitting SHMI data by site, and also into in-hospital and 30-day post-discharge deaths, shows that the SHMI for post discharge deaths from HRI is much higher than in-hospital HRI deaths or any in CRH. This is currently unexplained and is subject to investigation at present. There is a stroke service improvement plan overseen by the Medical Director. **Mortality Reviews** Awaiting review of guidance for roll out of the Trust's new mortality reviews by consultants. In addition, further mortality reviews in respiratory service and stroke medicine have occurred. No key themes but additional work completed by Dr Nair.	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. Mortality review compliance will rise once the new process for involving all consultants in the process is established This will not be until the end of Q2. **Accountable : Associate Medical Director**
Still Births	Stillbirth rate at 0.85% remains above expected levels of 0.50%.	All stillbirths reviewed using the NPSA Intrapartum related stillbirth process by at least two clinicians/midwives and findings shared with Medical and Midwifery staff. New SOP in place for stillbirth reduction and action plan in place which is monitored on a weekly basis. Quarterly report produced and findings discussed at stillbirth reduction group and Audit meetings.	**Accountable :** Head of Midwifery /ADN FSS
Peri-natal Deaths	Perinatal deaths at 0.65% are above the expected level of 0.10%.	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.	. **Accountable:** Head of Midwifery /AND FSS

Effectiveness - Key measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	Target	Threshold/Monthly
Infection Control																	
Number of MRSA Bacteraemias – Trust assigned	3	0	0	1	0	1	0	0	0	0	0	0	0	**0**	**0**	0	0
Total Number of Clostridium Difficile Cases - Trust assigned	25	0	1	1	3	3	4	2	1	3	3	2	2	**3**	**5**	<=21	< = 2
Avoidable number of Clostridium Difficile Cases	5	0	1	0	0	1	1	1	0	0	0	0	1	**2**	**1**	0	0
Number of MSSA Bacteraemias - Post 48 Hours	9	2	1	0	2	0	1	0	1	1	1	0	1	**1**	**2**	<=12	1
Number of E.Coli - Post 48 Hours	26	3	5	3	3	0	5	4	1	0	1	0	2	**3**	**5**	<=26	2.17
MRSA Screening - Percentage of Inpatients Matched	99.52%	97.00%	95.74%	96.78%	93.60%	95.29%	96.00%	95.55%	96.08%	96.08%	96.37%	95.11%	95.35%	**In arrears**	**95.35%**	>=95%	95%
Mortality																	
Stillbirths Rate (including intrapartum & Other)	0.41%	0.21%	0.21%	0.41%	0.00%	0.64%	0.80%	0.20%	0.42%	0.42%	0.68%	0.22%	0.66%	**0.85%**	**0.76%**	<=0.5%	0.5%
Perinatal Deaths (0-7 days)	0.16%	0.21%	0.00%	0.21%	0.21%	0.00%	0.43%	0.00%	0.00%	0.21%	0.00%	0.22%	0.00%	**0.65%**	**0.33%**	<=0.1%	0.1%
Neonatal Deaths (8-28 days)	0.04%	0.00%	0.00%	0.00%	0.00%	0.22%	0.00%	0.00%	0.00%	0.21%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**	<=0.1%	0.1%
Local SHMI - Relative Risk (1yr Rolling Data)	109.10	112.41	**112.41**	113.88	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	in arrears	**In arrears**	**113.88**	<=100.0	100
Hospital Standardised Mortality Rate (1 yr Rolling Data)	113.00	112.89	114.33	116.16	116.43	116.41	116.49	116.38	116.82	116.62	114.04	111.60	in arrears	**in arrears**	**111.60**	<=100.0	100
Mortality Reviews	48.80%	40.50%	20.20%	21.10%	75.20%	50.80%	60.70%	56.80%	60.30%	63.40%	37.90%	38.10%	34.10%	**In arrears**	**34.10%**	100.00%	100%
Crude Mortality Rate	1.34%	1.41%	1.19%	1.08%	1.18%	1.22%	1.21%	1.33%	1.41%	1.53%	1.46%	1.49%	1.43%	**1.60%**	**1.52%**	<=1.32%	1.32%
Coding and submissions to SUS																	
Completion of NHS numbers within acute commissioning datasets submitted via SUS	99.94%	99.97%	99.94%	99.94%	99.93%	99.94%	99.93%	99.93%	99.94%	99.93%	99.95%	99.95%	99.92%	**99.94%**	**99.94%**	>=99%	99%
Completion of NHS numbers within A&E commissioning datasets submitted via SUS	99.04%	99.20%	99.10%	99.10%	98.80%	99.10%	98.80%	99.00%	99.10%	98.50%	98.60%	98.89%	98.99%	**99.21%**	**99.10%**	>=95%	95%
% Sign and Symptom as a Primary Diagnosis	9.63%	9.69%	9.57%	10.03%	9.43%	10.81%	10.08%	9.65%	9.46%	8.99%	8.90%	9.37%	9.14%	**8.70%**	**8.90%**	<=9.4%	9.40%
Average co-morbidity score	3.48	3.1	3.32	3.15	3.27	3.36	3.51	3.59	3.82	3.62	3.94	3.84	3.77	**4.16**	**3.97**	>=4.4	4.40
Average Diagnosis per Coded Episode	4.34	3.71	3.94	3.98	4.11	4.35	4.39	4.53	4.74	4.68	4.84	4.89	4.94	**5.05**	**5.00**	>=5.3	5.30
CHFT Research Recruitment Target	1029	46	44	49	75	79	142	128	114	111	96	96	in arrears	**In arrears**	**in arrears**	>=1008	92
Best Practice Guidance																	
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	69.40%	56.52%	76.74%	66.67%	63.16%	55.56%	73.81%	79.49%	86.00%	71.79%	70.70%	61.29%	67.50%	**68.30%**	**68.20%**	>=85%	85%
IPMR - Breastfeeding Initiated rates	79.80%	80.00%	79.20%	77.30%	76.10%	80.20%	80.20%	83.90%	77.60%	79.50%	77.60%	78.30%	77.50%	**78.50%**	**78.00%**	>=70%	70%
Readmissions																	
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	7.85%	8.30%	8.30%	7.77%	6.35%	7.13%	8.73%	7.09%	6.60%	6.78%	7.81%	7.08%	7.70%	**6.77%**	**7.24%**	<=7.97%	7.97%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	7.95%	9.31%	8.96%	8.34%	7.21%	6.45%	7.35%	6.95%	7.06%	7.51%	8.07%	8.06%	7.88%	**9.14%**	**8.51%**	<=7.05%	7.05%
% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days	4.20%	5.90%	4.30%	2.70%	3.30%	2.60%	6.30%	3.40%	5.70%	5.70%	3.30%	2.75%	4.20%	**in arrears**	**4.20%**	<=10%	10%

Caring - Key messages

Area	Issue	Corrective Actions	Impact and Accountability
Friends & Family Test A&E	A much improved position has been achieved in month increasing response rate to 15.7%. This is just above the threshold for the green rating (14%). Staff in the department have been working together to improve this, with increased use of postcards and greater vigilance in capturing accurate mobile numbers to increase the success with the text messaging service. The impact has been more successful to date on the HRI site.	The team will continue with the good practice introduced during April 16, with a focus now on the CRH site. The teams are also aware that text messages are not sent to children under 16 and therefore will target this patient group with the postcard.	Given the level of improvement achieved in month, it is anticipated that the target will continue to improve and the team are working on sustainable plans.. **Accountable : Emergency Network Matron**
Friends & Family Test - Outpatients	May's performance (90.8%) continues in line with the previous month (90.5%) with just under 91% of patients recommending outpatient services against a target of 95%. The previously identified themes surrounding car parking and waiting times in clinics continue to feature.	**Car Parking**: Following feedback from patients and FFT a new car parking system is to be installed at Acre Mill. The Trust is currently out of tender, anticipated installation July/August 2016. **Waiting Times:** Clinic Delays slips have been introduced in all OP departments; these slips are completed where trends in delays in clinic are evident and returned to the OP PMO for detailed analysis of clinic start/finish times and clinic templates, recommendations for change taken to the Clinical Division Access Meetings	An Outpatient group continues to meet weekly to review and respond to feedback to FFT and the local patient survey which is coordinated by the OP Managers, to measure impact of improvements made including car parking. Improvement anticipated from July 2016. **Accountable: Outpatients Matron**
Friends & Family Test - Community	An analysis of the comments made by patients who would not recommend the service shows that a major theme centers on staff attitudes.	Standards for communicating effectively by telephone and email to be shared across division. To share messages re behaviour expectations across the division at every meeting.	The % not recommend is expected to reduce by the end August 2016.
Friends & Family Test - Maternity	Women wanted more information during the induction of labour, this would enabled them to be more aware of the time factors that can be involved and the potential for it to be a slow process. Women also suggested that they would like to see allocated times for post natal visiting in the community.	Information sheet produced to explain induction of labour, and the facilities available to women and their partners. Further PN clinics planning to be offered in central locations, morning and afternoon appointments offered. Work ongoing to improve the clinic templates, and reduce waiting times. Work ongoing to improve the efficiency of discharges from the	**End of Q2** **Accountable: Maternity Matron**

Caring - Complaints Key messages

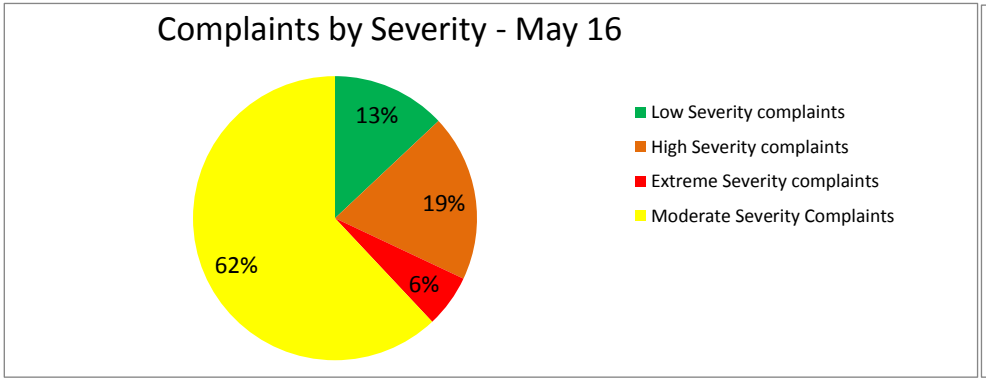
Area	Issue	Corrective Actions	Impact and Accountability
% Complaints closed within target timeframe	65 complaints were closed in May, which is a 38% increase from April. The split by Division is SAS 10, Medicine 37, FSS 15 and Community 3. Of the 65 complaints closed 38% were closed with agreed timescales; this is a 17% decrease from April, the focus remains closing overdue complaints. The total number of overdue complaints is 68 this is an increase of 13% from April. The majority of these complaints still remain in the 0-1 month overdue bracket; however there has been an increase in the number of complaints within the 1-2, 2-3 and 3-4 month overdue brackets. Whilst Medicine have the highest number of overdue complaints (33), proportionally Medicine, FSS and SAS all have approximately 50% of their complaints overdue.	Weekly meeting with Divisions and Complaints Team continue, help to improve responsiveness of complaints by weekly performance report, with guidance given for older more complex complaints. We are also attending Divisional PSQB meeting to discuss complaints. Complaint investigation training has also been developed and will be started towards end of June which should help get back on track.	The number of overdue complaints is slowly increasing and we are currently working on getting back on plan with the responsiveness to complaints. **Accountable : Head of Risk and Governance**

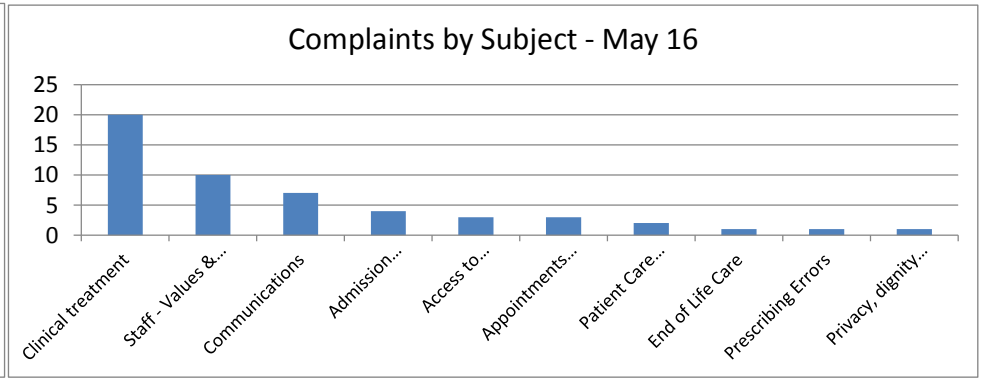
Complaints Background

The Trust received 53 new complaints May 2016, which is only one complaint more than April, and reopened 5 complaints a 44% decrease from April. The Trust received a total of 58 complaints in May 2016. Whilst there has been little change in the total of new complaints received in April, the total number of open complaint (new and reopened) has decreased by 8%, with 68 of these being overdue.
The 68 overdue complaints split by Division is SAS 17, Community 5, Medicine 33, and FSS 13.

The top 3 Complaints subjects were:
Clinical Treatment
Staff – Values and Behaviours
Communication
These subjects were the same in April 2016.

Severity: The Trust received 3 new Red complaints in May which is a decrease of 57% from April 2016.
PHSO Cases:
The Trust received 4 new Ombudsman / PHSO case received in May 2016. The PHSO have requested the records for all 4.
1 PHSO complaint was closed in May 2016, which was partially upheld.
There were 17 active cases under investigation by the Ombudsman as at the end of March 2016.





Caring - Key measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	Target	Threshold/ Monthly
Complaints																	
% Complaints closed within target timeframe	48.45%	47.22%	55.68%	61.11%	56.41%	51.85%	61.11%	39.68%	39.73%	47.73%	43.94%	45.45%	66.67%	**37.88%**	**49.55%**	100.00%	100.00%
Total Complaints received in the month	641	51	62	50	41	48	52	58	49	55	51	65	52	**53**	**105**	To be confirmed	
Complaints re-opened		Not collected for 15/16											9	**5**	**14**	To be confirmed	
Inpatient Complaints per 1000 bed days		2.11	2.42	2.23	1.77	2.27	2.35	2.36	2.24	2.26	2.05	2.72	2.10	**2.20**	**2.10**	To be confirmed	
Friends & Family Test																	
Friends & Family Test (IP Survey) - Response Rate	28.60%	21.40%	21.94%	26.50%	28.10%	24.40%	31.10%	32.90%	34.30%	32.10%	33.50%	30.70%	30.98%	**31.41%**	**31.19%**	>=28.0%	28.00%
Friends & Family Test (IP Survey) - % would recommend the Service	96.90%	96.90%	97.37%	96.60%	97.10%	96.50%	96.70%	96.70%	96.40%	97.10%	97.00%	96.94%	97.09%	**97.70%**	**97.39%**	>=96.0%	96.00%
Friends and Family Test Outpatient - Response Rate	13.50%	13.90%	13.60%	13.80%	13.50%	13.30%	13.20%	13.10%	12.90%	13.60%	13.70%	13.20%	13.50%	**12.79%**	**13.14%**	>=5.0%	5.00%
Friends and Family Test Outpatients Survey - % would recommend the Service	89.60%	87.90%	88.40%	89.50%	89.20%	89.20%	90.20%	90.50%	91.60%	90.50%	89.70%	90.70%	90.50%	**90.79%**	**90.64%**	>=95.0%	95.00%
Friends and Family Test A & E Survey - Response Rate	8.50%	**10.00%**	**8.60%**	**5.70%**	**2.70%**	**9.50%**	12.10%	9.20%	9.10%	10.20%	9.70%	8.37%	13.27%	**15.66%**	**14.47%**	>=14.0%	14.00%
Friends and Family Test A & E Survey - % would recommend the Service	86.90%	90.50%	91.10%	91.10%	**84.80%**	86.20%	86.80%	81.60%	85.40%	86.50%	84.80%	84.59%	90.02%	**88.58%**	**89.30%**	>=90.0%	90.00%
Friends & Family Test (Maternity Survey) - Response Rate	30.80%	18.90%	26.30%	27.50%	29.60%	42.60%	30.90%	40.80%	33.60%	30.30%	30.70%	34.47%	26.99%	**32.75%**	**29.87%**	>=22.0%	22.00%
Friends & Family Test (Maternity) - % would recommend the Service	96.30%	89.30%	95.30%	97.80%	95.20%	98.80%	95.00%	97.00%	96.50%	97.80%	96.80%	97.82%	96.32%	**96.90%**	**96.61%**	>=96.9%	96.90%
Friends and Family Test Community - Response Rate	11.60%	8.00%	6.00%	7.00%	7.00%	6.00%	2.00%	14.00%	10.00%	11.00%	10.00%	10.00%	13.20%	**9.00%**	**11.10%**	>=3.4%	3.40%
Friends and Family Test Community Survey - % would recommend the Service	88.80%	89.00%	90.68%	92.00%	90.00%	92.00%	91.00%	85.00%	86.00%	87.00%	86.00%	85.80%	87.50%	**87.00%**	**87.25%**	**>=96.2%**	96.20%
Maternity																	
Proportion of Women who received Combined 'Harm Free' Care	72.43%	77.78%	67.70%	70.40%	60.90%	73.50%	76.92%	76.92%	70.73%	91.84%	66.00%	78.95%	71.15%	**in arrears**	**71.15%**	>=70.9%	70.90%
Caring																	
Number of Mixed Sex Accommodation Breaches	14	0	2	0	0	7	0	0	0	5	0	0	0	**0**	**0**	0	0

Caring - What our patients are saying

Some of the positive feedback we have received

HRI 22 - Everything was perfect. I was looked after and reassured when I was scared.

NISCBU - Everything went well with my daughter's treatment. They were always there when we needed anyone.

DAYCASE - CRH - Excellent care. Very friendly and very efficient staff. Nothing was too much trouble. Left in no doubt as to what I should do when I leave the hospital. Thank you.

CRH 2AB - Everything from entering A&E and on both wards. Fantastic staff and treatment.

CRH 2CD - All staff - Cleaners, Nurses, Doctors and everybody was fantastic. Could not do enough for me. Thank you very much.

CRH 8D - The operation and the staff's attention to detail when you are coming round from the op - very friendly and make you feel comfortable at all times.

HRI SAU - Transfer to ward and seen quickly by Medics. Nurses all very nice and attentive. Pain relief sorted out quickly. Ward clean and staff helpful.

A&E - CRH - All staff were professional and made my son feel comfortable while he was treated for an asthma attack. Thank you..

Where can we improve

Ensure a morning procedure is carried out in the morning and not the afternoon - long wait!

Would be nice for restaurant to be open on a weekend as, being coeliac, I could find nothing to eat when it was closed.

Communicate the plan to us earlier. We were here 5 hours before we were told we'd be staying and this came out of the blue.

The food ordering system isn't good. Whatever I ticked on the list, I got the opposite which is not good when you have food allergies.

The level of noise was terrible, even at night. The number of people who walk around with pieces of paper, doing very little and interrupting the staff when they are flat out busy - 10 minutes of them helping would be better. 2 Matrons at night, walking in to check on spare beds and then leaving!

Better communication between all parts of the local NHS - HVMH, patient Transport, Endoscopy, patient and carer, especially around medicines management.

I would change the waiting around. People, in general, are frightened, nervous and worried in case anything goes wrong, so by the time they arrive in theatre, they are distressed.

Responsive - Key messages

Area	Issue	Corrective Actions	Impact and Accountability
Emergency Care Standard 4 hours	Improving patient flow through the Emergency Department and the hospital through to discharge into the community is essential. Patients continue to experience long waits for inpatient beds. Lack of compliance with achieving 'bed before 11' - this prevents good capacity and demand management. Whilst the Trust has seen a sustained reduction in the patients over 100 days, the number of patients with a LOS over 10/50 days has increased. High number of patients waiting for social assessment and Package of Care (POC).	*Continuous Improvement* Safer Patient Flow Programme launched. This includes : 1. Introduce Internal Professional Standards - which includes launch of 'bed before 11', Perfect ward round, 2. Launch of the Ambulatory Emergency Care Collaborative - National Programme to deliver improvements in patient experience, reduce LOS, improve patient flow and aid the delivery of the 4 hour ECS. 3. Acute Frailty model being developed which will look to integrate with the care closer to home frailty model. 4. Escalation through SRG to improve system response to delays. 5. Review options for CHFT to provide rehab services in the community and social care in the community.	**If all actions achieved the Trust will deliver a quarter one performance of 94%.** **Accountable : ADD Medicine**
Patient Flow	Pre 12 o'clock Discharges The pre 12 o'clock discharges has improved in month but still some distance from required 40% performance. Green Cross The number of patients with a LOS on or over 10/50 has increased, whilst the number of patients over 100 days has reduced. Lack of internal professional standards. Increasing delays due to lack of social assessments and POC . Number of Outliers (Bed Days) Increase LOS from 5.9 to 6.0 days continues to drive the outlier position. This is predominantly due to lack of social work capacity for assessment and social care provision in the community, highest proportion of outliers is on the Calderdale site, which is impacting on patients within the hospital bed base but also patients in intermediate care and the reablement service.	Pre 12 o'clock Discharges 1. ADN leading by supporting ward sisters with small tests of change to improve compliance. May 16 performance improved with 2 wards now achieving 50% to be spread across Divisions. 2. Divisional Director engaging with consultants with a focus on identification of next day discharges, robust discharge planning, timely completion of TTO's and criteria led discharge. Green Cross 1.Focused MDT discharge planning for all patients over 50/100 days in place. 2. Introduction of internal professional standards. 3. Discharge coordinators now using a case management model to improve patient experience, discharge planning, continuity and integration with social care. 4. Escalation through SRG to improve system response to delays Number of Outliers (Bed Days) 1.Discharge coordinators are pre-screening patients so ensure a coordinated approach prior to social care assessment which prevents delays. 2.Dedicated consultant and junior medical team to support outliers. 3. Escalation to SRG to ensure wider visibility of the reality. 4. Safer Patient Flow Programme (all projects)	**Pre 12 o'clock Discharges** A weekly meeting with ward sisters to monitor impact of tl 'tests of change' is in place. Division expects a month on month improvement of 10% f March to achieve full compliance with the target of 40% by end of Q1. **Accountable : ADN Medicine** **Green Cross & Outliers** Internal actions expected to eliminate outliers by 1st Octol facilitate surgical bed changes. System Resilience Group workshop completed with aim of identifying actions to reduce Transfer of Care delays but nc definitive outcomes agreed Meeting agreed between CMDC, CHFT and Package of Care providers to discuss options to increase capacity **Accountable: ADD Medicine**

Responsive - Key messages

Area	Issues	Corrective Actions	Impact and Accountability
Stroke	SNAPP data showed that the service had moved from a D to a B rating. Some patients who were missed as a 1 hour scan despite meeting the urgent imaging criteria were due to being a late diagnosis of stroke, some due to the stroke nursing staff not referring timely, some due to lack of action taken by clinical team. **90% stay on stroke ward** 83.3% of patients spent 90% of their stay on a stroke ward. This is the same level as last month's performance. The principle reason for this is due to the bed pressures and patients on the rehabilitation wards having a prolonged stay in hospital due to the lack of POC. **50% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival**. Direct Admission – Patients who were not directly admitted on to the stroke ward from A+E are mainly due to late diagnosis or lack of beds on ASU.	**Scanned within 1 hour where indicated** The stroke audit and data officer has completed an audit on this matter that has been shared with weekly stroke group. All scans that meet the criteria to be completed within the hour. This was commenced in June 16, this should improve the imaging times in future, the stroke nurses are now also seeing all possible stroke patients and referring for scan earlier to help avoid late/wrong diagnosis of patients. **90% stay on stroke ward** Actions to get back on plan: On going management through patient flow meetings. Close monitoring through the weekly stroke improvement group. Plan for New protocol/SOP developed for rehab/Stroke Ward to enable increased ASU capacity. New process will be launched in July 16. **% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival** The stroke team are working with patient flow to prevent outliers. They are also ensuring any outliers that do occur are moved to the appropriate ward ASAP. The stroke nurses are also now personally reviewing all possible stroke patients to help make sure that a larger percentage of stroke patients are provided with the appropriate diagnosis the first time, which should have a positive influence on outcomes for the patients, 90% stay and patient flow therefore also helping direct admission times.	Improvements are expected across all indicators for stroke by the end of July 2016. **Accountable : GM IMS Directorate**
% Last minute cancellations to Elective Surgery	There are 3 main areas of concern highlighted from Surgical analysis: Emergencies/Trauma, list overrun, ward beds unavailable. Continued pressure from Medical outliers on the Gynaecology bed base at CRH. Monthly performance of 1.35% against a target of 0.6% (this represented a total of 4 patients that were sit-rep reportable).	Work is progressing to alleviate the 3 main areas of concern. Getting Trauma capacity right and a Lap Chole list will improve this. HRI site for Surgery is main issue for unavailable beds. Continue to closely manage elective flow - daily review of elective activity against anticipated capacity (ongoing). Discussions taking place to set criteria for outlying into Gynaecology beds and management of patient flow (by July 16)	**Impact and Accountability;** Impact on maintaining planned activity against plan and patient experience and safety. Improved patient experience. **Accountable:** ADD Surgery, GM, Women's

Responsive - Key messages

Area	Issues	Corrective Actions	Impact and Accountability
Referral To Treatment	There are increased waiting times for patients who are not clinically urgent due to capacity constraints caused by: Bed capacity and reduced surgical activity in preceding months Consultant sickness Consultant vacancies Junior Doctor strike The impact of this is that generally patients have waited longer than normal for their inpatient operations causing a deterioration in the incomplete target and the above 26 week waits. Reduced capacity within the surgical management team due to the re-planning of surgical work as a result of the bed capacity constraints has led to a reduction in capacity for validation. Increased waiting times due to outpatient capacity shortfalls have also led to a deterioration in the 18 week position and are caused by a reduction in capacity.	Fill vacancies asap – Panels to be held in June for a number of the posts. Provide full cover for sickness at the earliest opportunity Increase length of short term cover to enable recovery of lost capacity Increase operating for new hand surgeon by picking up cases from other surgeons, and thereby reduce waiting times. Ensure a Paediatric all day ENT weekend list is scheduled each month. Improve identification of capacity gaps Aim to reduce fallow lists to no more than 1 per week Ensure scheduling meeting is effective, by improved pre-work with specialties. Ensure all long waiting pathways are validated	It is expected that most capacity gaps within the Division will be covered in June which will stop the deterioration of the current position. Validation capacity is now back on track. As a result an improvement is expected in June with performance targets being met in August due to the time lag on the 18 week pathway. **Accountable : ADD Surgery**
Cancer	**Screening** **2 breaches were seen in relation to the bowel cancer screening service**. 1 patient experienced a delay in radiotherapy at Leeds. 1 Patient booked holidays which resulted in a long delay. Patient actively chose not to be seen earlier and therefore the breach was unavoidable. **38 day to Referral to Tertiary** Performance was affected by Lung Cancer Pathway Haemotolgy Pathway	**Bowel Cancer Screening** Focus on achieving the quarter with tight tracking and escalation in place. **Breast Symptomatic** Continued careful management of capacity. **Other specialties** Work underway with Urology regarding the revised prostate cancer pathway which should improve waiting times for patients. Implemented on the 1st June. Further work with UGI/Colorectal and Head and Neck about more definitive management of whether patients should be on a cancer pathway. **38 day to Referral to Tertiary** The Medicine Division has developed an action plan. Improvements seen, all patients are closely tracked. Respiratory Consultants are meeting with GPs to discuss the pathway, to look at opportunities to improve the timeliness of the pathway. Haematology patients are usually patients that have had another cancer diagnosis and are referred to Haematology later in the pathway. Therefore this area is extremely challenging.	**June 2016** **Accountable : GM for General Surgery**

Responsive - Key measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	Target	Threshold/Monthly
Accident & Emergency																	
Emergency Care Standard 4 hours	93.88%	94.80%	95.44%	95.44%	95.36%	95.37%	95.11%	94.87%	95.26%	91.49%	89.44%	89.30%	93.87%	**93.40%**	**93.62%**	>=95%	95.00%
A and E 4 hour target - No patients waiting over 8 hours	1351	88	78	55	57	60	72	69	84	192	250	273	108	**144**	**252**	M	M
A&E Ambulance Handovers 30-60 mins (Validated)	103	3	3	4	2	3	7	6	1	13	12	20	10	**14**	**24**	0	0
A&E Ambulance 60+ mins	23	0	0	0	1	2	0	0	2	8	2	7	0	**1**	**1**	0	0
A&E Trolley Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0	0
Patient Flow																	
% Daily Discharges - Pre 12pm	19.47%	16.81%	16.94%	18.09%	17.28%	17.03%	16.20%	14.85%	16.47%	15.09%	15.62%	14.41%	16.41%	**16.87%**	**16.64%**	>=40%	40.00
Delayed Transfers of Care	5.13%	6.30%	6.20%	7.04%	7.45%	5.30%	4.60%	4.50%	4.50%	3.35%	3.38%	3.30%	2.90%	**2.31%**	**2.61%**	<=5%	5.00%
Green Cross Patients (Snapshot at month end)	98	91	90	96	62	71	91	91	79	91	115	98	93	**90**	**90**	<=40	<=40
Number of Outliers (Bed Days)	9428	791	813	859	628	598	508	730	781	1035	989	883	1115	**1363**	**2478**	<=495	<=495
Stroke																	
% Stroke patients spending 90% of their stay on a stroke unit	83.00%	81.25%	80.39%	66.67%	73.40%	74.60%	97.80%	84.60%	80.00%	94.40%	81.30%	83.70%	83.30%	**in arrears**	**83.30%**	>=90%	90.00%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	60.67%	57.70%	59.30%	53.10%	48.40%	83.00%	65.40%	60.00%	66.70%	58.30%	56.70%	67.60%	50.00%	**in arrears**	**50.00%**	>=90%	90.00%
% Stroke patients Thrombolysed within 1 hour	55.20%	20.00%	12.50%	50.00%	28.57%	80.00%	50.00%	80.00%	50.00%	57.10%	100.00%	80.00%	66.70%	**in arrears**	**66.70%**	>=55%	55.00%
% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	68.42%	64.00%	75.00%	56.52%	75.00%	90.91%	72.00%	75.00%	66.70%	78.94%	50.80%	47.80%	64.30%	**in arrears**	**64.30%**	>=90%	90.00%
Maternity																	
Antenatal Assessments < 13 weeks	91.60%	93.10%	91.48%	92.10%	**91.10%**	90.40%	92.40%	92.10%	91.60%	88.10%	89.80%	93.80%	90.15%	**91.88%**	**91.00%**	>90%	90.00%
Maternal smoking at delivery	9.90%	11.30%	12.00%	11.30%	10.20%	**9.80%**	9.30%	8.50%	8.20%	7.80%	10.20%	9.70%	10.40%	**8.40%**	**9.40%**	<=11.9%	11.90%
Cancellations																	
% Last Minute Cancellations to Elective Surgery	0.67%	0.74%	0.50%	0.71%	0.51%	0.76%	0.43%	0.59%	0.75%	0.62%	0.69%	0.96%	0.71%	**1.04%**	**0.88%**	<=0.6%	0.60%
Breach of Patient Charter (Sitreps booked with 28 days of cancellation)	2	0	0	0	0	0	1	0	0	0	1	0	0	**0**	**0**	0	0
No of Urgent Operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0	0

Responsive - NHS Improvement Dashboard

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	Target	Threshold/ Monthly
Clostridium Difficile																	
Total Number of Clostridium Difficile Cases - Trust assigned	25	0	1	1	3	3	4	2	1	3	3	2	2	**3**	**5**	<=21	< = 2
Avoidable number of Clostridium Difficile Cases	5	0	1	0	0	1	1	1	0	0	0	0	1	**2**	**3**	0	0
Accident & Emergency																	
Emergency Care Standard 4 hours	93.88%	94.80%	95.44%	95.44%	95.36%	95.37%	95.11%	94.87%	95.26%	91.49%	89.44%	89.30%	93.87%	**93.40%**	**93.62%**	>=95%	95%
Referral To Treatment Pathways																	
% Admitted Closed Pathways Under 18 Weeks	91.92%	92.41%	92.67%	92.79%	92.03%	91.64%	90.20%	91.63%	92.04%	92.21%	91.86%	91.96%	92.12%	**92.42%**	**92.27%**	>=90%	90%
% Non-admitted closed Pathways under 18 weeks	98.48%	98.89%	98.63%	98.23%	98.55%	98.67%	98.48%	98.62%	98.44%	98.32%	98.39%	98.17%	98.42%	**98.49%**	**98.46%**	>=95%	95%
% Incomplete Pathways <18 Weeks	95.70%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%	96.04%	95.45%	95.95%	95.80%	95.70%	96.16%	**96.01%**	**96.01%**	>=92%	92%
Cancer																	
62 Day GP Referral to Treatment	91.19%	92.31%	90.00%	88.95%	93.94%	88.24%	91.77%	95.00%	93.98%	91.04%	94.53%	89.40%	92.31%	**87.88%**	**90.08%**	>=85%	85%
62 Day Referral From Screening to Treatment	95.74%	100.00%	100.00%	100.00%	100.00%	100.00%	95.65%	88.24%	96.67%	94.44%	100.00%	100.00%	91.30%	88.00%	**89.47%**	>=90%	90%
31 Day Subsequent Surgery Treatment	99.15%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=94%	94%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%	98%
31 Days From Diagnosis to First Treatment	99.81%	100.00%	99.24%	100.00%	100.00%	100.00%	100.00%	99.12%	99.30%	100.00%	99.09%	100.00%	99.14%	**100.00%**	**99.55%**	>=96%	96%
Two Week Wait From Referral to Date First Seen	97.34%	98.43%	96.55%	95.64%	93.78%	97.82%	98.73%	96.84%	97.06%	98.86%	99.27%	98.95%	94.98%	**98.08%**	**96.55%**	**>=93%**	93%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	95.82%	93.75%	94.92%	94.87%	98.60%	98.47%	94.85%	95.89%	94.05%	96.85%	96.55%	96.55%	90.07%	**93.71%**	**91.94%**	>=93%	93%

Workforce - Key messages

Area	Issue	Corrective Action	Impact and Accountability
Sickness Absence	1. Long term absence is above target at 2.73%. 2. Short term absence is above target at 1.48% 3. Return to work interviews are not consistently undertaken or recorded.	100% of long term sickness absence cases have a 'wrap around' management plan. This is monitored on a routine basis and reported to the Board monthly. Cases moving from short term to long term are monitored and reviewed by the end of the 2nd week each month. Establish an understanding of whether date of return to work interviews recorded on e-roster are transferred to ESR – 30 June 2016. Audit by Division of periods of absence when no return to work interview has been recorded or undertaken to target non-compliant areas - 30 June 2016. Return to work interview form returned to Attendance Management team to audit whether date has been recorded on ESR - 3 June 2016. Monitor compliance by line managers of action required in accordance with short term absence triggers - 30 June 2016. Guidance document on when to conduct an initial attendance review – 30 June 2016. Identify departments who constantly fail to conduct return to work interviews - 30 June 2016 NHS staff health and wellbeing CQUIN plan for health and wellbeing initiatives - 30 June 2016	December 2016 **Accountable : Director of Workforce and OD.**
Vacancies	1. 30 Consultant vacancies across hard to fill specialties 2. 189.23 FTE qualified staff nurse vacancies 3. 14.9% turnover rate	International recruitment continuing for qualified nursing posts – ongoing with proposal to expand search June 2016. 42 newly qualified nurses commence employment with the Trust - September 2016. International recruitment programme agreed for Consultant posts – June 2016. Consultant recruitment approval process (new and replacement posts) redesigned to speed up process. Vacancy approval process redesigned – June 2016. Recruitment process improvements – May to September 2016. Welcome event to be held on 20 June 2016 for newly qualified nurse recruits joining in September 2016 and regular monthly keep in touch dates until they commence in post. Scoping work commenced with Huddersfield University in relation to Band 4 Associate Nursing Posts.	30 June 2016 **Accountable :** **Medical Director** **Director of Nursing** **Chief Operating Officer** **Director of Workforce and OD**

Workforce - Key messages

Area	Issue	Corrective Action	Impact and Accountability
Appraisal	1. There is an absence of a sanction for non-compliance. 2. The appraisal scheduler tool which captures planned activity is not fully or consistently utilised. 3. Limited opportunity for appraiser training. 4. Appraisals scheduler not completed or submitted for 2016/2017	Appraisal compliance to be monitored monthly through the divisional performance meetings Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 30 June 2016. Clarity of requirement to use the appraisal scheduler and to complete it in June as set out in the email from Deputy Director of Workforce and OD in email dated 3 June 2016. Appraisal training proposal paper to be received at the Education Learning Group meeting on 22 June 2016.	30 June 2016 **Accountable : Director of Workforce and OD**.
Mandatory Training	The functionality of the Oracle Learning Management (OLM) system in the national Electronic Staff Record (ESR) is limited and is not user friendly which has deterred some colleagues from using the tool enabling them to be fully compliant. A specific functionality limitation has been highlighted regarding refresher training and the length of 'window' prior to renewal. This is currently set at 3/12 months before compliance expires. There is an absence of a sanction for non-compliance. The PREVENT element of mandatory training is delivered on a classroom basis through the Safeguarding team and capacity to deliver sufficient sessions to facilitate full compliance is limited. The requirement to deliver this training in a classroom environment is a DH requirement placed on all public sector bodies.	Business case for replacement learning management system to be submitted to the July Commercial Investment and Strategy Committee meeting. Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 30 June 2016. Prevent paper drafted for submission to Executive Board in June 2016 by Head of Safeguarding for discussion with the Deputy Director of Nursing. A paper describing the options to manage mandatory training compliance to be considered by Executive Board on 30 June 2016.	30 June 2016 **Accountable : Director of Workforce and OD**.

Workforce Information - Key measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	Target	Threshold/Monthly
Sickness YTD																	
Sickness Absence rate (%) *Target date - 31 Dec 2016*	4.60%	4.57%	4.53%	4.48%	4.43%	4.38%	4.44%	4.52%	4.57%	4.61%	4.62%	4.60%	4.23%	*	4.23%	4.00%	=< 4.00% - Green 4.01 -4.5 Amber >4.5% Red
Long Term Sickness Absence rate (%) *Target date - 31 Dec 2016*	3.10%	3.16%	3.15%	3.14%	3.10%	3.05%	3.05%	3.09%	3.12%	3.12%	3.12%	3.10%	2.77%	*	2.77%	2.70%	=< 2.7% Green 2.71% -3.0% Amber >3.0% Red
Short Term Sickness Absence rate (%) *Target date - 31 Dec 2016*	1.50%	1.41%	1.37%	1.34%	1.33%	1.33%	1.39%	1.43%	1.45%	1.49%	1.50%	1.50%	1.47%	*	1.47%	1.30%	=< 1.3% - Green 1.31% -1.5% Amber >1.5% Red
Sickness Monthly																	
Sickness Absence rate (%)	-	4.71%	4.45%	4.36%	4.23%	4.13%	4.76%	5.07%	5.04%	4.96%	4.69%	4.34%	4.23%	*	-	4.00%	=< 4.00% - Green 4.01 -4.5 Amber >4.5% Red
Long Term Sickness Absence rate (%)	-	3.29%	3.14%	3.11%	2.95%	2.80%	3.02%	3.34%	3.43%	3.14%	3.02%	2.89%	2.77%	*	-	2.70%	=< 2.7% Green 2.71% -3.0 Amber >3.0% Red
Short Term Sickness Absence rate (%)	-	1.42%	1.30%	1.25%	1.28%	1.33%	1.74%	1.74%	1.61%	1.82%	1.67%	1.46%	1.47%	*	-	1.30%	=< 1.3% - Green 1.31% -1.5% Amber >1.5% Red
Attendance Management KPIs																	
Sickness returns submitted per month (%) *Target date - 30 April 2016*	76.00%	Data unavailable for this period									100%	**100%**	100%	*	-	100.00%	100% Green 95%-99% Amber <95% Red
Return to work Interviews (%) *Target date - 31 Dec 2016*	38.00%										43.15%	33.10%	34.60%	*	-	100.00%	100% Green 95%-99% Amber <95% Red
Number of cases progressing/not progressing from short term absence to long term absence	-										***	9 / 556	12/606	*	-	-	
Long Term Sickness cases with a defined action plan *Target date - 30 April 2016*	-										100.00%	100.00%	100.00%	*	-	100.00%	100% Green 95%-99% Amber <95% Red
Number of short term absence cases managed at each stage in the formal procedure	-										***	344	385	*	-	-	
Number of visits to dedicated intranet web pages.	-										1261	1514	1339	*	-	-	
Staff in Post																	
Staff in Post Headcount	5820	5781	5732	5701	5701	5749	5696	5730	5721	5753	5806	5820	5812	5816	-	-	
Staff in Post (FTE)	5084.37	5003.42	4961.18	4934.68	4941.67	4986.92	4956.52	4995.31	4987.74	5021.53	5077.42	5084.37	5070.90	5074.47	-	-	
Staff Movements																	
Turnover rate (%)		1.37%	1.37%	1.32%	1.24%	2.40%	0.97%	1.18%	0.99%	1.13%	0.64%	0.82%	0.73%				***
Turnover rate (%)(Rolling 12m)	15.71%	14.51%	15.14%	15.64%	15.71%	16.76%	16.56%	16.57%	16.63%	16.84%	16.79%	15.71%	14.81%	14.15%	-	-	
Vacancies																	
Establishment (Position FTE)**	5572.34	Data unavailable for this period									5410.68	5572.34	5575.34	5575.37			
Vacancies (FTE)**	495.19										387.12	484.70	494.92	496.71	-	-	
Vacancies (%)**	8.89%										7.15%	8.70%	8.88%	8.91%	-	-	
Agency Spend*													£2.1M		-	-	
Mandatory Training																	
Fire Safety (1 Year Refresher)	73.38%	Packages launched 01 Jun 2015	19.00%	26.70%	31.50%	34.40%	60.80%	61.80%	63.50%	68.70%	73.10%	73.40%	7.52%	11.54%	11.54%	100.00%	16% (100% at 31 March 17)
Information Governance (1 Year Refresher)	84.24%		73.20%	73.30%	70.30%	70.90%	72.20%	72.90%	76.50%	79.10%	82.30%	84.20%	5.68%	8.27%	8.27%	100.00%	16% (100% at 31 March 17)
Infection Control (1 Year Refresher)	85.07%		8.50%	22.10%	31.40%	39.20%	49.30%	58.40%	66.70%	73.00%	80.90%	85.10%	6.07%	8.49%	8.49%	100.00%	16% (100% at 31 March 17)
Manual Handling (2 Year Refresher)	86.73%		8.10%	21.40%	31.30%	39.30%	58.60%	65.40%	72.00%	77.40%	83.10%	86.70%	88.36%	88.25%	88.25%	100.00%	100% Green 95%-99% Amber <95% Red
Health and Safety (3 Year Refresher)	84.60%		7.90%	21.10%	31.10%	38.50%	48.60%	58.40%	66.50%	73.00%	80.40%	84.60%	86.80%	87.18%	87.18%	100.00%	100% Green 95%-99% Amber <95% Red
Equality and Diversity (3 Year Refresher)	85.89%		18.90%	29.00%	37.70%	46.10%	56.00%	63.30%	70.40%	75.80%	82.40%	85.90%	87.61%	87.74%	87.74%	100.00%	100% Green 95%-99% Amber <95% Red
Safeguarding (3 Year Refresher)	78.34%		4.00%	12.20%	19.60%	25.20%	57.90%	61.00%	66.00%	69.80%	73.60%	78.30%	81.09%	81.37%	81.37%	100.00%	100% Green 95%-99% Amber <95% Red
Dementia Awareness (3 Year Refresher)	81.88%						8.40%	32.90%	54.10%	65.20%	76.60%	81.90%	84.90%	85.14%	85.14%	100.00%	100% Green 95%-99% Amber <95% Red
Conflict Resolution (3 Year Refresher)	77.63%						7.40%	27.80%	47.70%	58.70%	70.80%	77.60%	81.73%	82.58%	82.58%	100.00%	100% Green 95%-99% Amber <95% Red
PREVENT (No renewal)	61.59%	21.20%	32.70%	33.60%	35.50%	37.50%	39.90%	43.40%	51.40%	51.80%	54.80%	61.60%	63.71%	65.70%	65.70%	100.00%	100% Green 95%-99% Amber <95% Red
Appraisal																	
Appraisal (1 Year Refresher)	78.57%	4.10%	7.24%	10.74%	14.46%	25.17%	33.42%	45.70%	56.50%	60.10%	74.10%	78.57%	**1.68%**	**4.28%**	**4.28%**	100.00%	16% (100% at 31 March 17) 20% (90% 31 December 2016)

* Data one month behind

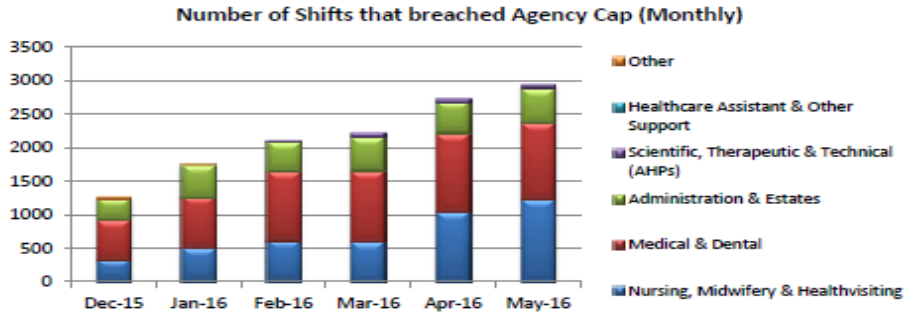
** Vacancy information is updated monthly and is based on the funded establishment in ESR, this is fed by the establishment information stored in the Trust's financial systems.

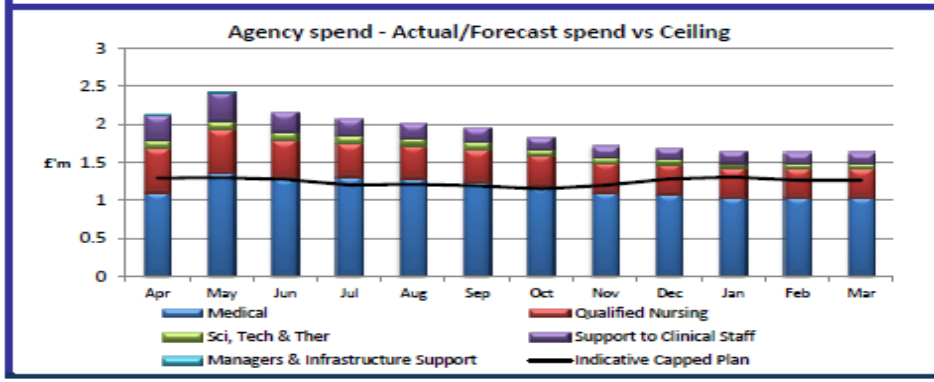
Workforce

WORKFORCE

Vacancies

	Sci, Tech &	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	56	71	92	191	80	490
Staff in post (WTE)	611	1,186	509	1,651	1,128	5,085
% Vacancies	8%	6%	15%	10%	7%	9%





For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement. This is in the context of actual expenditure incurred in 2015/16 of £19.93m. The Trust must do all that it can to aim to achieve this target which will be extremely challenging. A simple extrapolation of the year to date agency spend would suggest a potential to spend £27.4m in 2016/17, threatening both compliance with the ceiling but also delivery of the overall control total deficit. Capped hourly rates for agency staff were also introduced by NHSI in 2015/16 which are tightened to lower rates from April 2016 and there is a requirement for all agency staff to be booked through approved procurement frameworks.

Vacancies
In overall terms at the end of Month 2 the Trust was carrying 490 vacancies, a rate of 9% of the total establishment which is static from last month. The highest vacancy rates continue to be in directly patient facing staff groups, medical and nursing staffing at 15% and 10% respectively, which are essential to delivery of activity and maintenance of safe and high quality services. In order to quell the unaffordable use of agency staff recruitment to these posts must be a priority.

Agency rate cap
Price caps were introduced to support providers to control and reduce expenditure on agency staffing. Since November 2015 a weekly return has been completed showing the number of shifts that have breached either the rate cap or been booked outside a recognised framework of suppliers. During this period the actual rate cap has been reduced with the latest reduction being applied from April 2016 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 has increased again in May. The number of breaches is exceeding 700 shifts on a weekly basis and the cost in excess of capped rates is above £0.50m per month.

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 2, against a trajectory of £1.30m, actual spend is £2.44m. Divisional forecasts, informed by recent run rates but assuming a level of constraint going forwards based on actions that are being mobilised, project a full year spend of £22.97m illustrated by staff group on the graph opposite.

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. This provides a significant risk for the Trust.

Hard Truths: Safe Staffing

This is a routine, monthly report to the Board of Directors which will provide headlines on the nursing workforce staffing position in May 2016.

Fill Rates

Average fill rates reported to Unify for registered nurse (RN) day shift increased slightly in May on the HRI and CRH site in comparison to April 2016 (Table 1).

- Average fill rates for RN night shift decreased on both sites in comparison to April 2016, but remained above 94% (Table 1). One area achieved average fill rates of 116% for RN day shift (Ward 5) which is due to a level of supernumerary nurses being supported on shift through their induction period.
- Average fill rates for day shifts decreased this month for care staff in comparison to April 2016, and remain above 100% on day and night shifts on both sites.

Average Fill Rates:	Registered Nurses		Care Staff	
	Day	Night	Day	Night
May 2016 HRI	**91.94%**	**94.24%**	**107.48%**	**125.10%**
May 2016 CRH	**89.60%**	**94.55%**	**104.84%**	**113.97%**
April 2016 HRI	90.64%	97.30%	107.82%	123.86%
April 2016 CRH	89.46%	95.51%	105.79%	118.69%

Registered Nurses: Three clinical areas, in comparison to one in April 2016 fell below 75% average fill rate.

Ward 5AD continues to regularly report average fill rates of less than 75% (Day shift) due to the proportion of Registered Nurses working long days against planned.
Ward 8AB reported average fill rates of less than 75% (Day shift) for May 2016 in part due to 8B having closed beds and staff being redeployed to other areas and also due to Registered Nurse vacancies.
CCU have reported average fill rates of less than 75% (Night shift) for May 2016. Staffing levels for Registered Nurses have remained largely at 3 Registered Nurses per night against a planned level of 4. The decision to staff with 3 Registered Nurses has been risk assessed on a daily basis, due to vacancy level and a requirement to support the Angio Bay at present.

Care Staff: Three clinical areas fell below 75% average fill rate which are LDRP, 4C, and 3 (paediatrics). Recruitment to vacancies contributing to decreased fill rates are in process.

Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; realisation of supervisory time for band 7 registered nurses and for care staff supporting reduced fill rate of registered nurse hours.

Average Fill Rates:	Registered Nurses		Care Staff		Total
	Day	Night	Day	Night	
Red (less than 75% fill rate)	2	1	1	2	6
Amber (75 – 89% fill rate)	18	9	5	0	32
Green (90 – 100% fill rate)	16	8	27	7	58
Blue (greater than 100% fill rate)	2	19	5	24	50

Hard Truths: Safe Staffing (2)

Internal Staffing Never Events

Two clinical areas have reported having less than the minimum 2 RN at all times in May.

- Ward 8AB on four nights (1st, 2nd, 15th and 22nd May) had 1 RN and 1 HCA.

On 1st and 2nd the number of patients on the ward were 6 and 5 respectively. On the 15th and 22nd the number of patients on the ward were 11 and 10 respectively. On three occasions the second RN was moved to an alternative area within the hospital following risk assessment.

On all four night shifts 8AB was supported by night matron and RN's from 8C and 8D. No adverse impact on patient care was reported on the 4 shifts with reduced staffing levels recorded.

- 8D on Night Shift on 5th and11th May. On these shifts the qualified nurse on 8D was supported by the night matron and qualified nurses across the floor (8C and 8AB).

Care hours per patient day (CHPPD)

Data has been submitted in line national guidance.

Vacancies and Retention

Registered nurse vacancies have increased to 212.59 wte (Data reported from ESR). 122 registered nurses are currently in the resourcing pipeline.

- Recruitment events continue with monthly recruitment to band 5 nurses and additional events targeting areas with high levels of vacancies such as Medical Assessment Unit; Operating Department and Emergency Department.
- Engagement of third year student nurses at local universities has been completed (Leeds, Bradford, Huddersfield, UCLAN). A welcome event to meet both the senior nursing team and ward teams is scheduled for 20th June 2016 to continue our engagement with third year students due to commence as qualified nurses and midwives in September 2016.
- International recruitment activity from the EEA has reduced as anticipated following the introduction of IELTs. The Corporate Risk Register has been updated in light of the reduction in availability of nurses within the EEA.
- The Nursing Workforce team are working with the Workforce and Development and Procurement teams to ensure all nurses recruited from the EEA complete their NMC registration process at pace.
- The Nursing Strategy Group have reviewed current retention practices against best practice guidance from Health Education England. Actions have been identified and are under review from the Workforce and Development team to form part of the Trust wide retention strategy.
- The Nursing Strategy Group has met with a local university to identify actions required to ensure minimal impact from the introduction of fees for healthcare courses at University.

Conclusion

The Trust remains committed to achieving its nurse staffing establishments. A range of actions are being developed and undertaken to recruit and retain the nursing workforce, and to develop data collection and reporting to support the nursing workforce.

FINANCIAL POSITION

YEAR TO DATE POSITION: M2

	M2 Plan £m	M2 Actual £m	Var £m	
Total Income	**£59.37**	**£59.89**	**£0.53**	
Total Expenditure	**(£60.93)**	**(£61.71)**	**(£0.78)**	
EBITDA	**(£1.57)**	**(£1.82)**	**(£0.25)**	
Non Operating Expenditure	(£4.24)	(£4.05)	£0.19	
Deficit excl. Restructuring	**(£5.81)**	**(£5.87)**	**(£0.06)**	
Restructuring Costs	(£0.00)	£0.00	£0.00	
Surplus / (Deficit)	**(£5.81)**	**(£5.87)**	**(£0.06)**	

YEAR END 2016/17

	Plan £m	Forecast £m	Var £m	
Total Income	**£371.52**	**£374.79**	**£3.27**	
Total Expenditure	**(£361.96)**	**(£366.01)**	**(£4.05)**	
EBITDA	**£9.56**	**£8.77**	**(£0.79)**	
Non Operating Expenditure	(£25.66)	(£24.88)	£0.78	
Deficit excl. Restructuring	**(£16.10)**	**(£16.10)**	**(£0.00)**	
Restructuring Costs	(£0.00)	£0.00	£0.00	
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**	1

KEY METRICS: YEAR TO DATE M2

Year To Date

	M2 Plan £m	M2 Actual £m	Var £m	
I&E: Surplus / (Deficit)	(£5.81)	(£5.87)	(£0.06)	
Capital	£2.52	£2.38	£0.14	
Cash	£1.94	£1.93	(£0.01)	
Borrowing	£42.11	£41.93	(£0.18)	
CIP	£1.24	£1.26	£0.02	
Financial Sustainability Risk Rating	2	2		

KEY METRICS: YEAR END 2016/17

Year End: Forecast

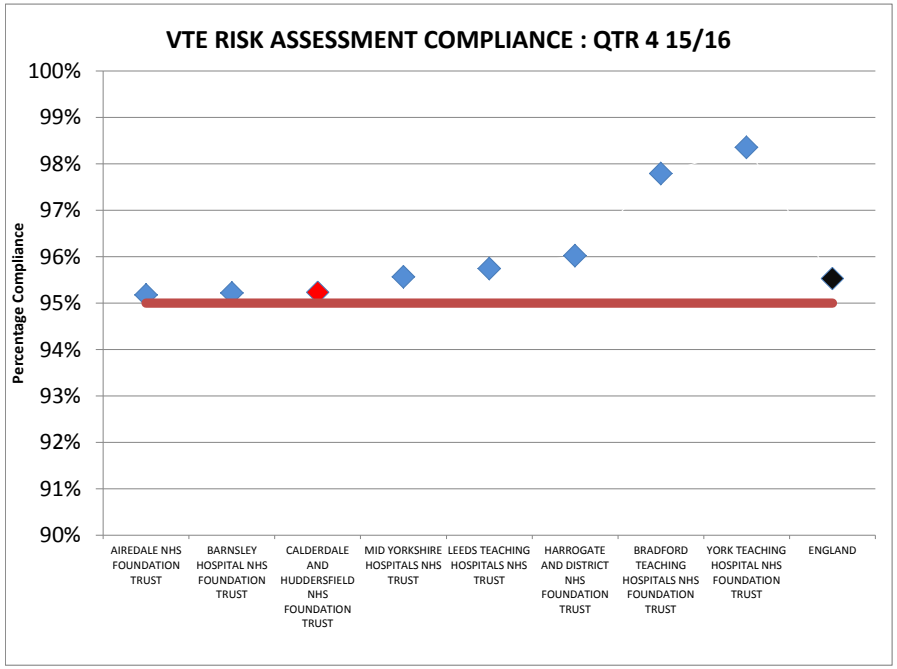
	Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£16.10)	(£16.10)	£0.00	
Capital	£28.22	£28.22	£0.00	
Cash	£1.95	£1.91	£0.00	
Borrowing	£67.87	£67.51	(£0.36)	
CIP	£14.00	£14.00	£0.00	
Financial Sustainability Risk Rating	2	2		

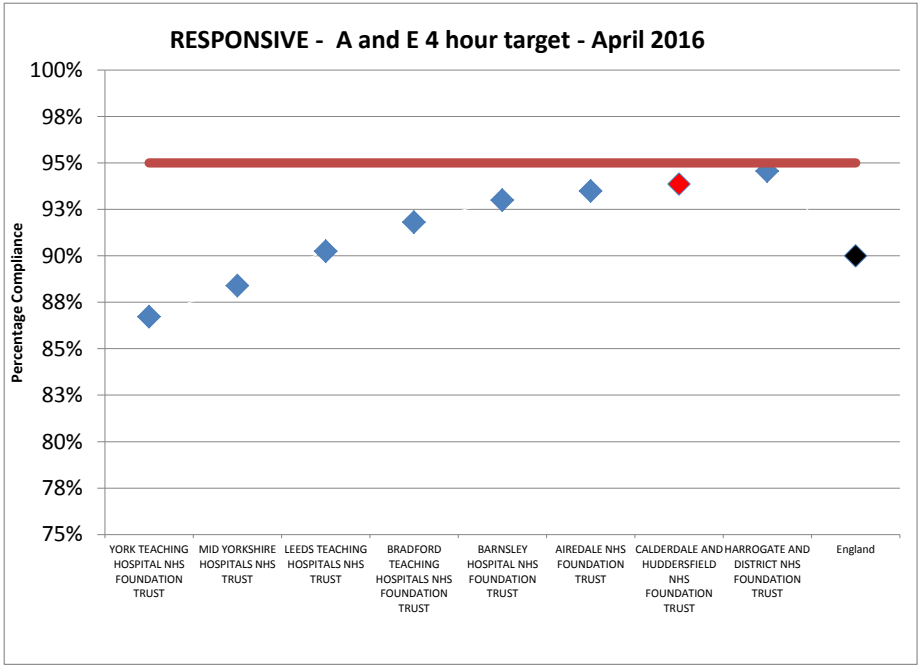
RAG KEY: (Excl: Cash)
- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

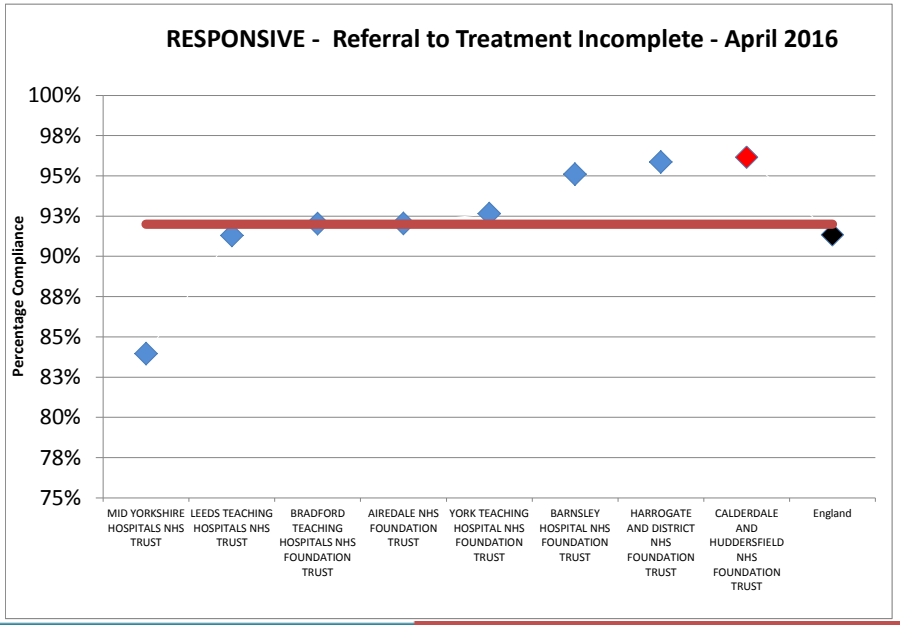
NB. In addition to the above rules, if Capital expenditure <85% of planned then Red, (per Monitor risk indicator)

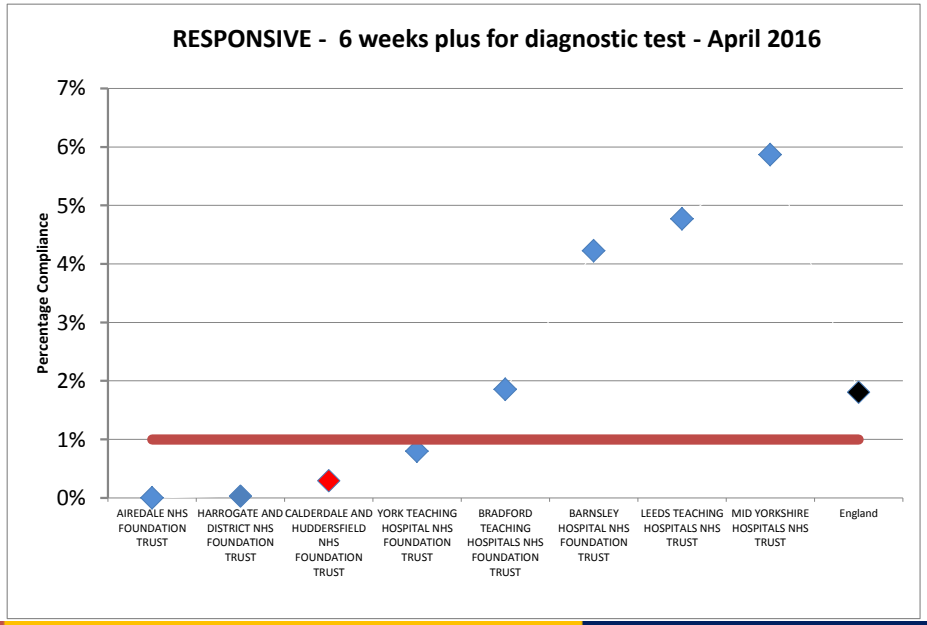
RAG KEY - Cash:
- At or above planned level or > £18.6m (20 working days cash)
- < £18.6m (unless planned) but > £9.3m (10 working days cash)
- < £9.3m (less than 10 working days cash)

Benchmarking - Selected Measures









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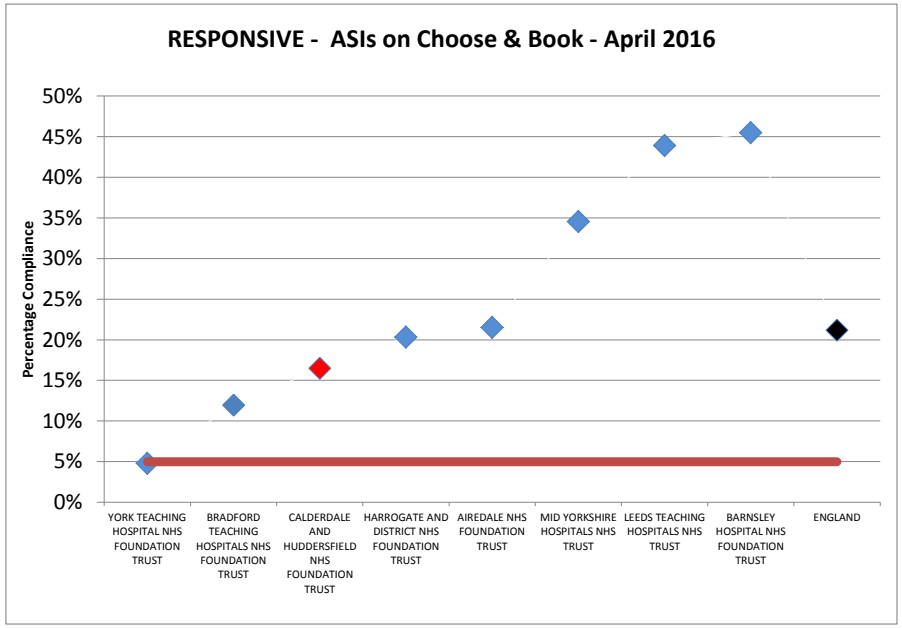

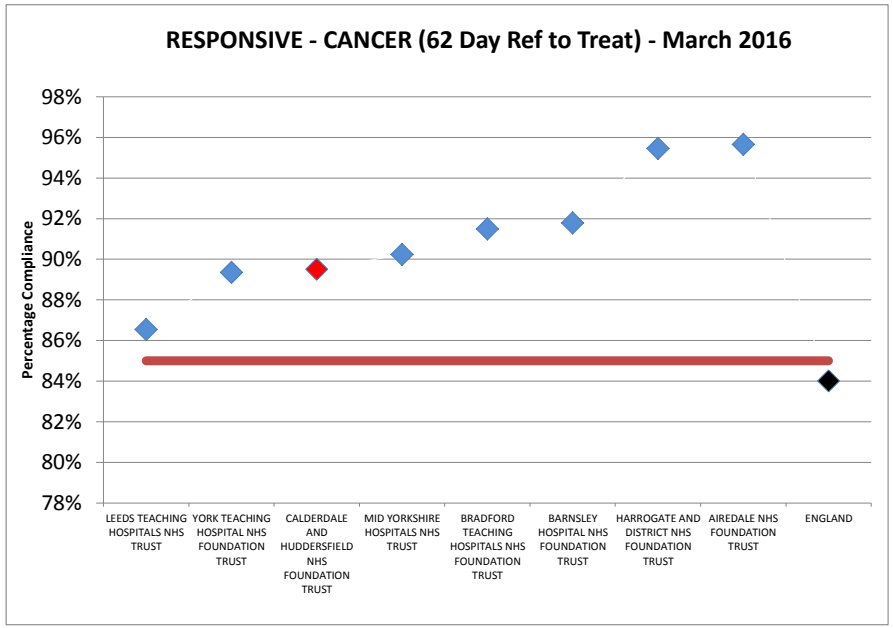

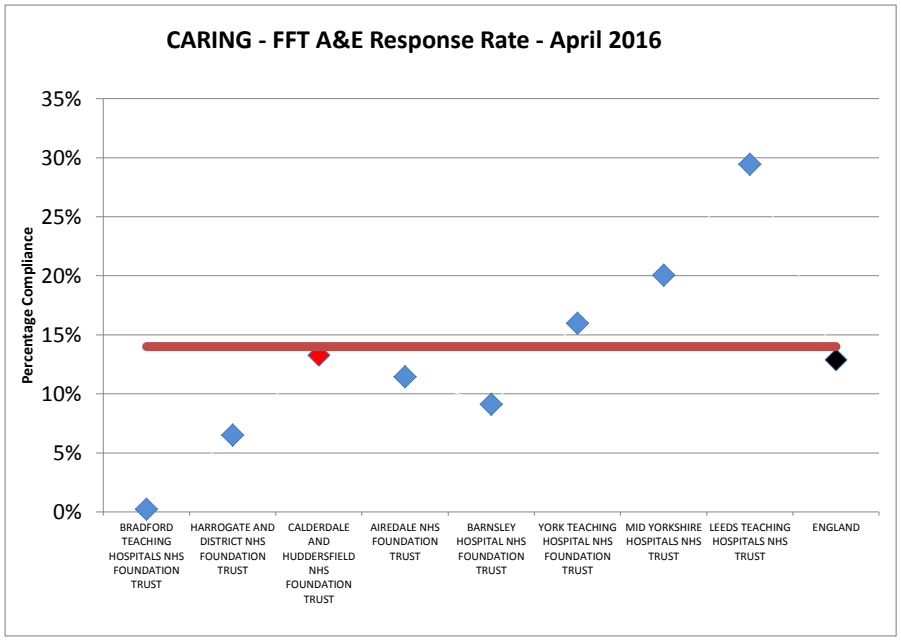

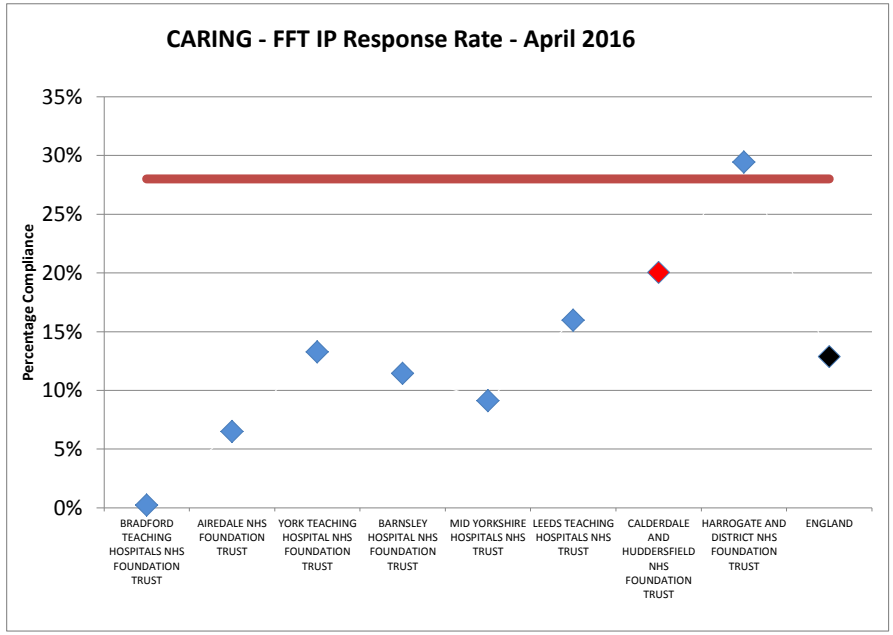

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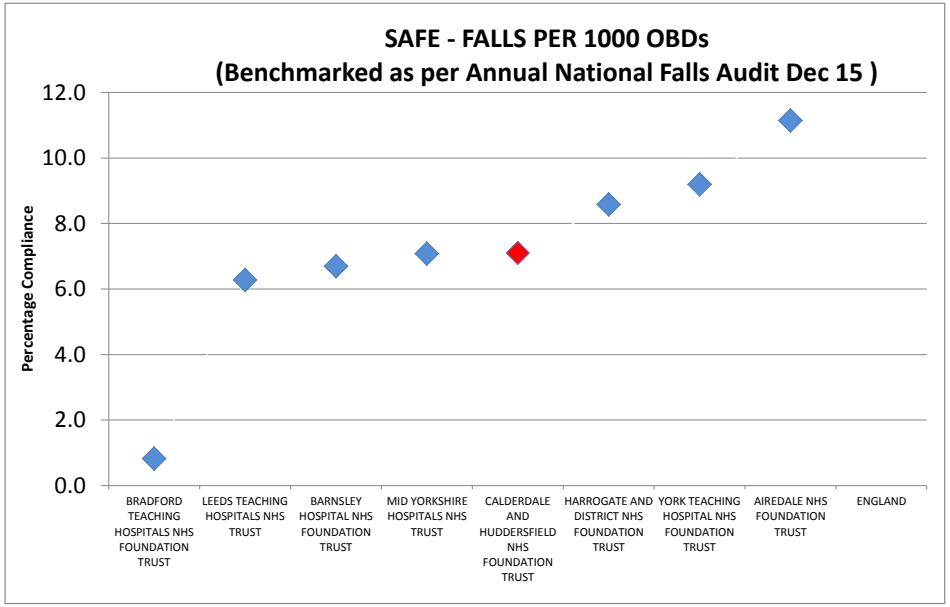

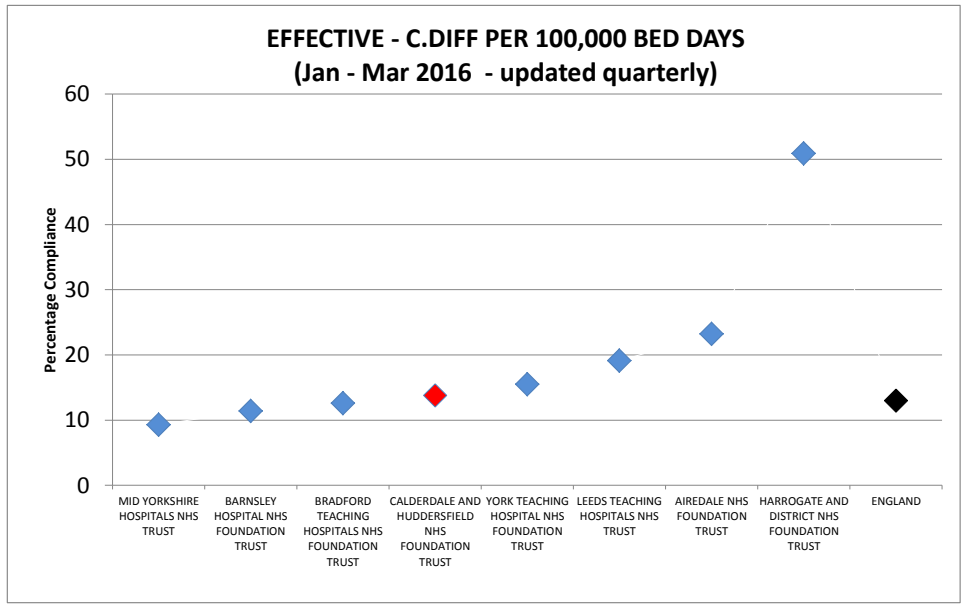

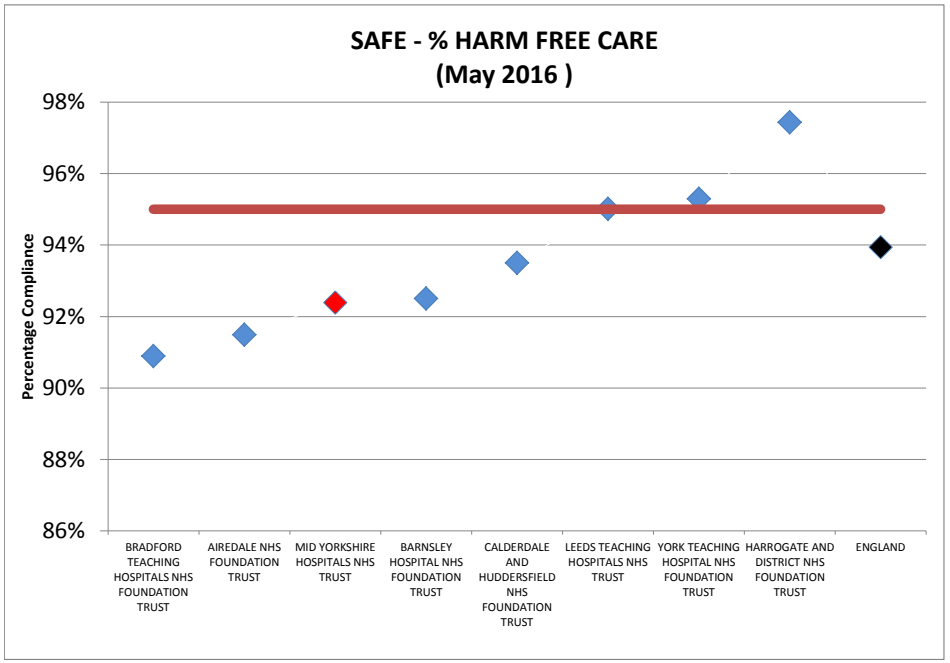

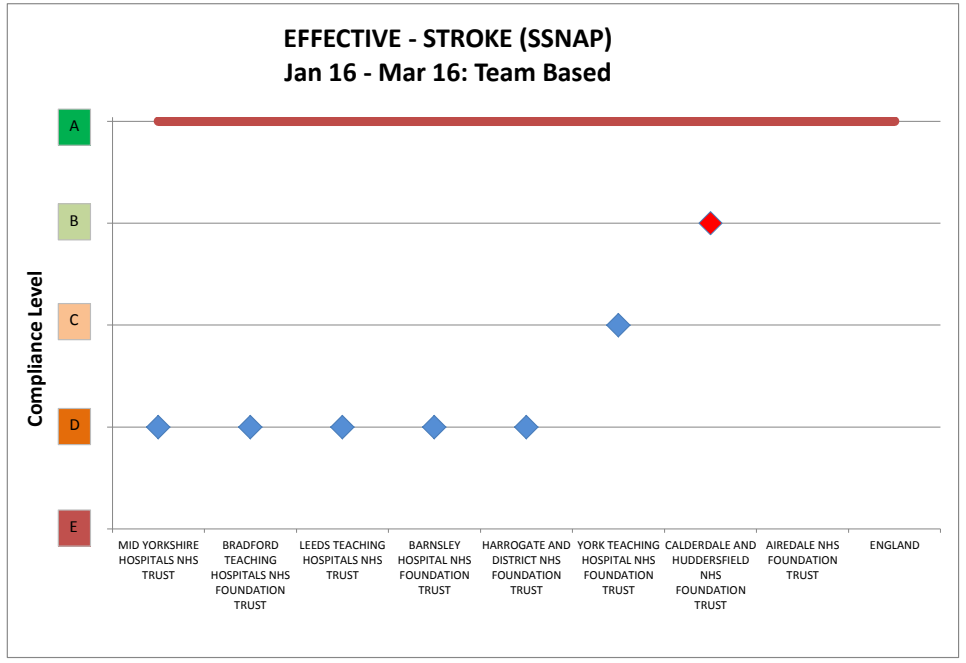

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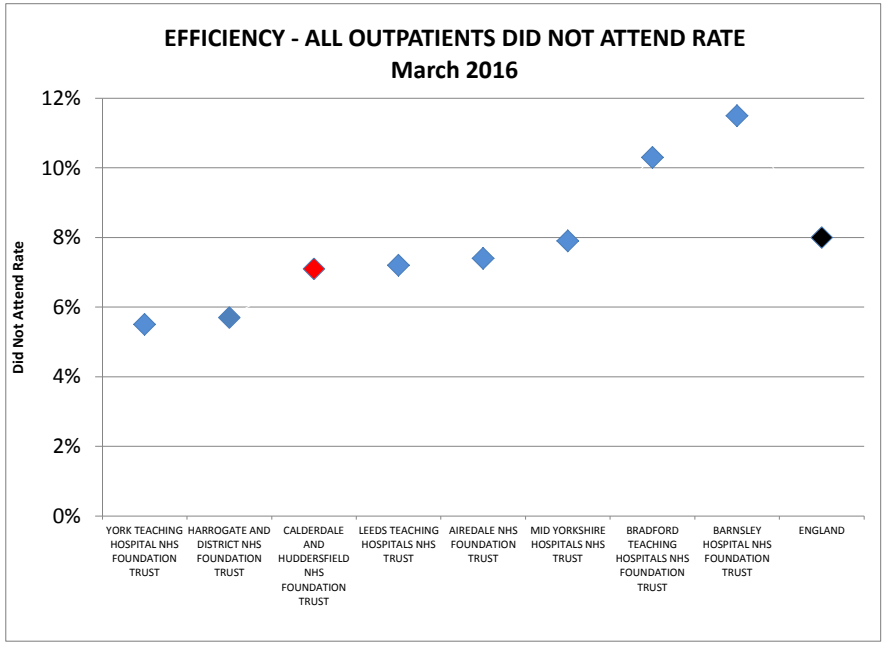

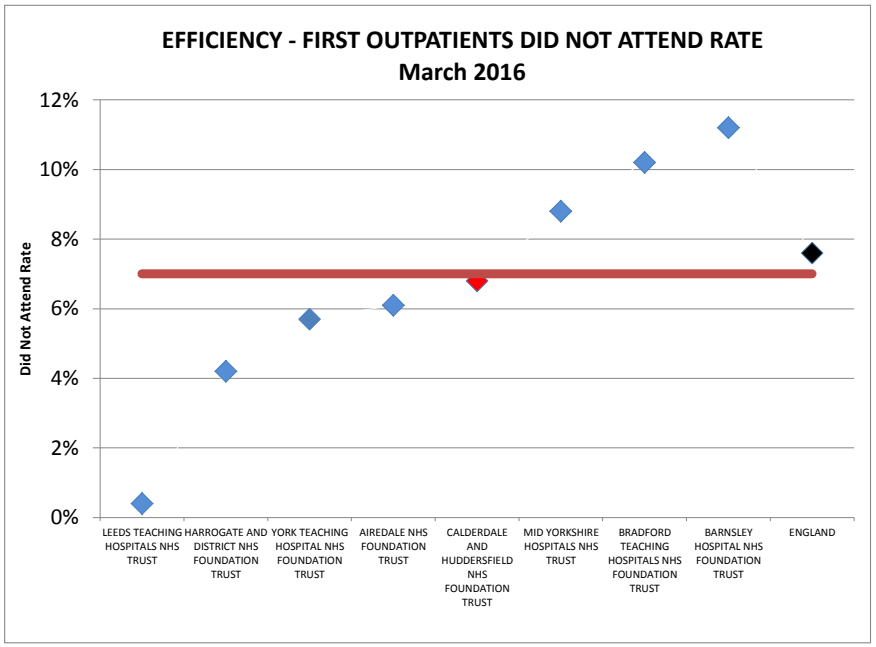

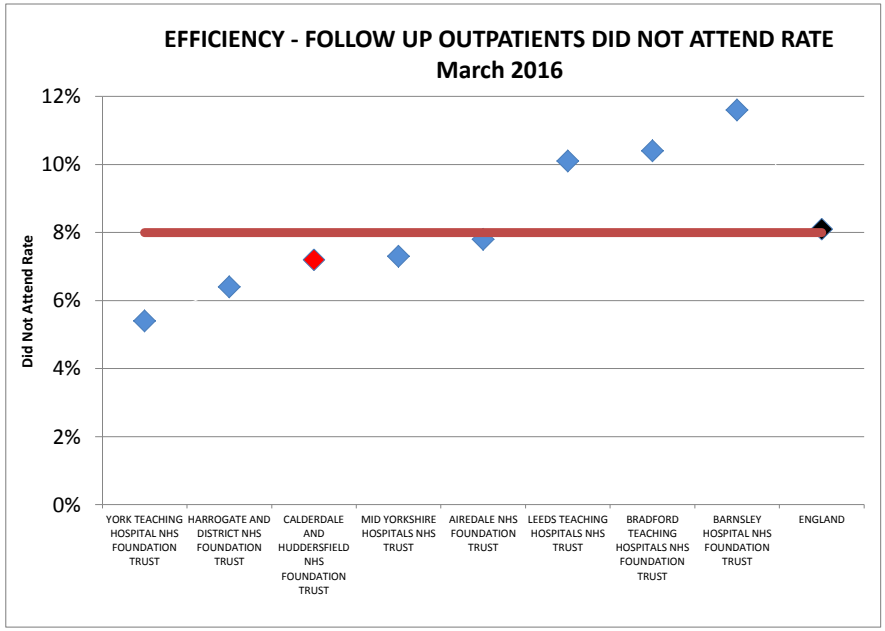

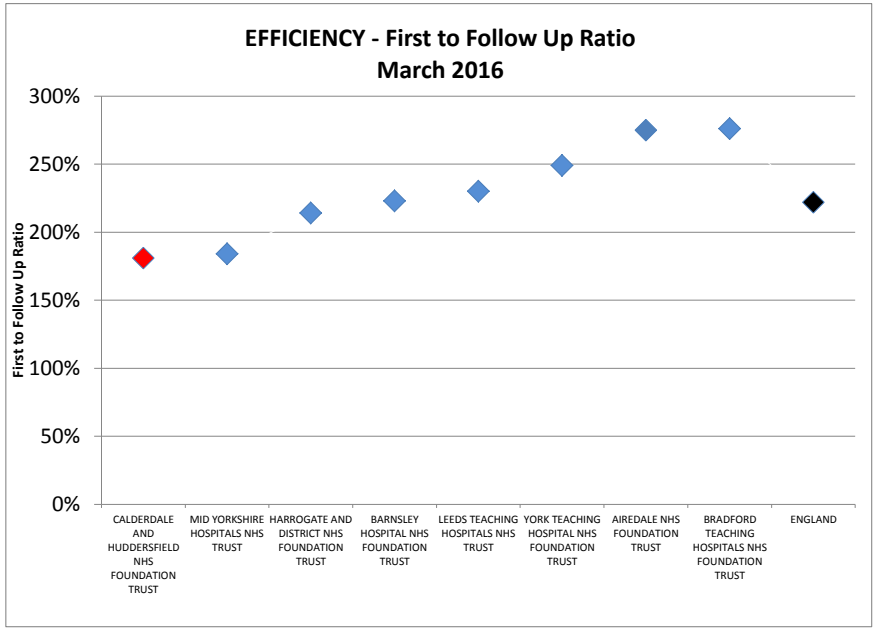

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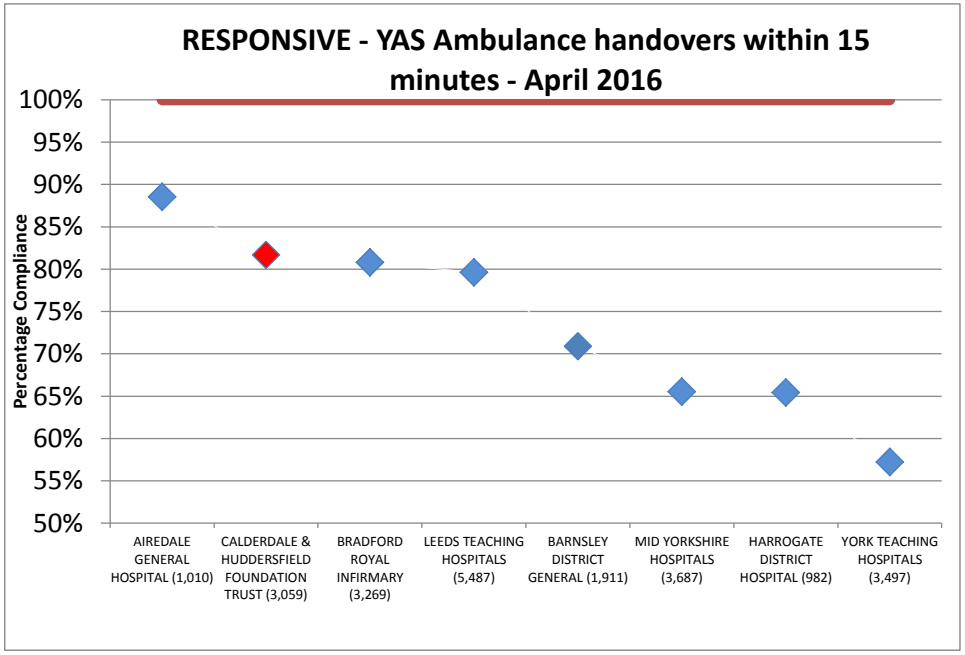

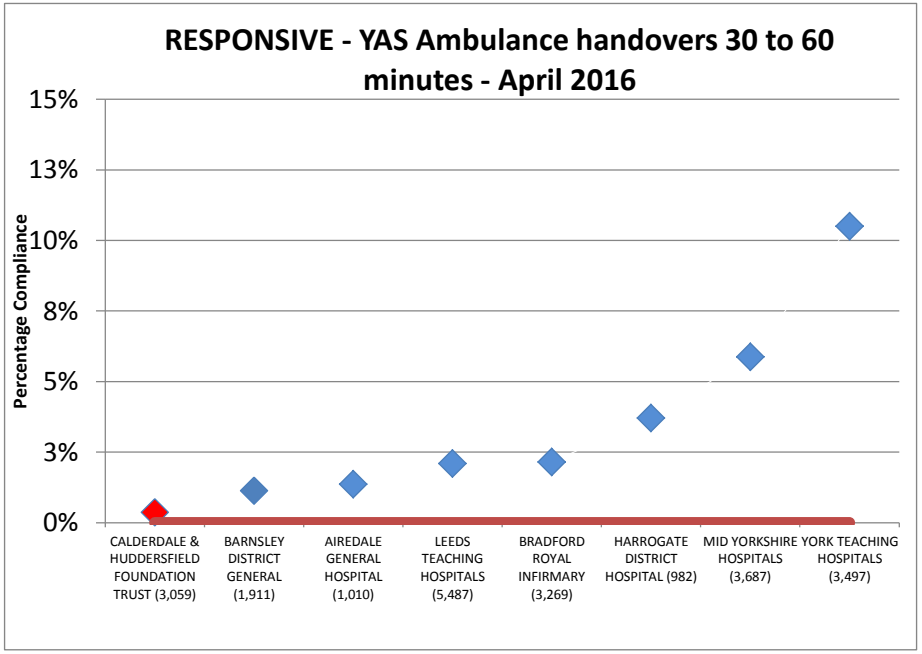

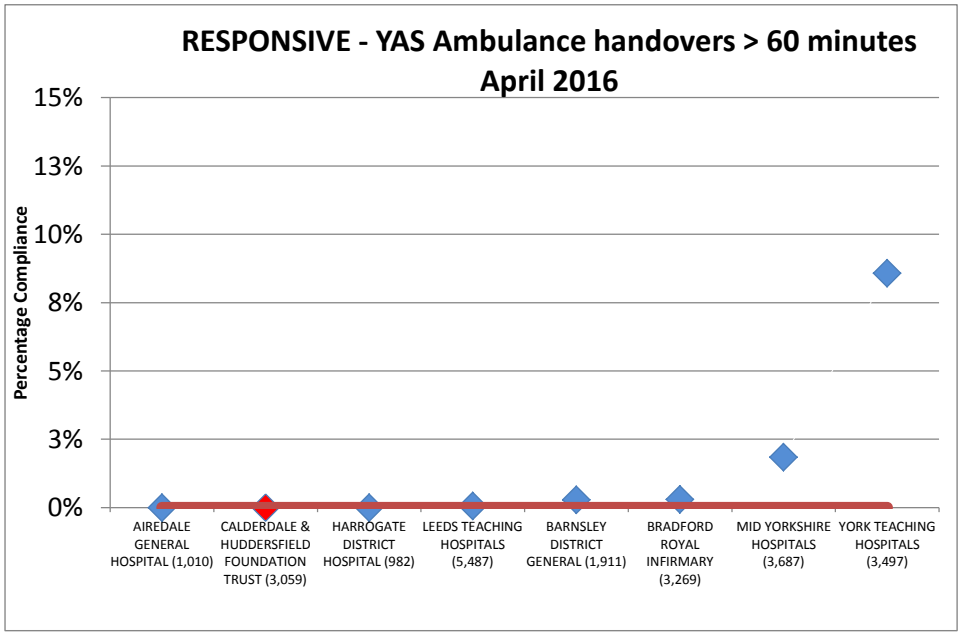

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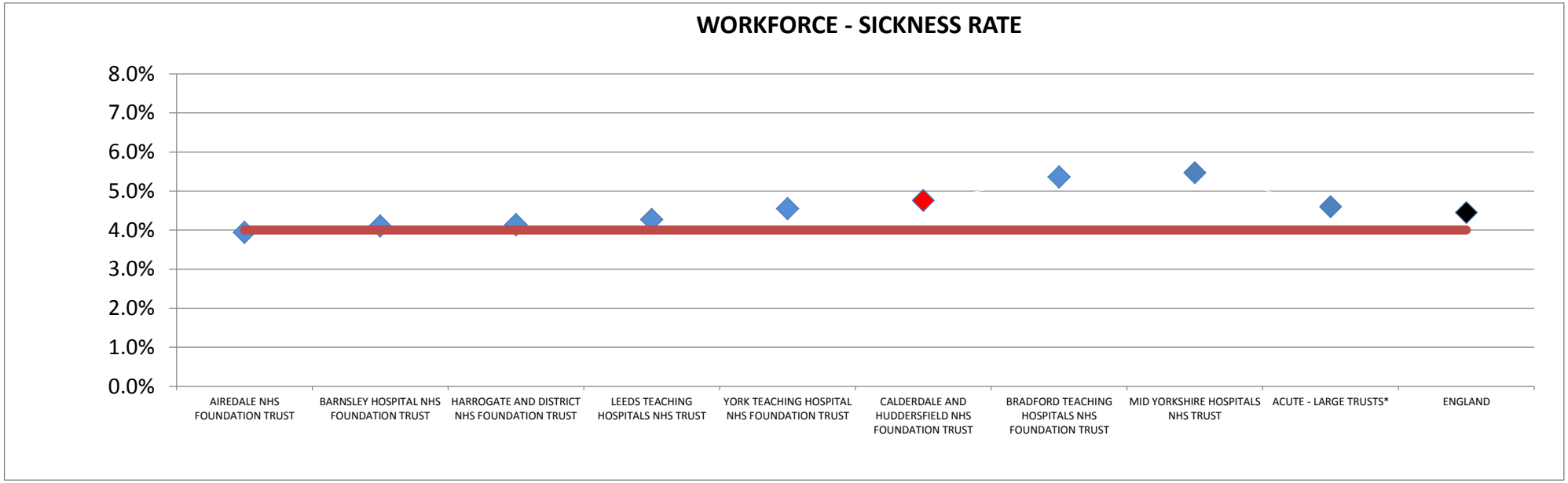
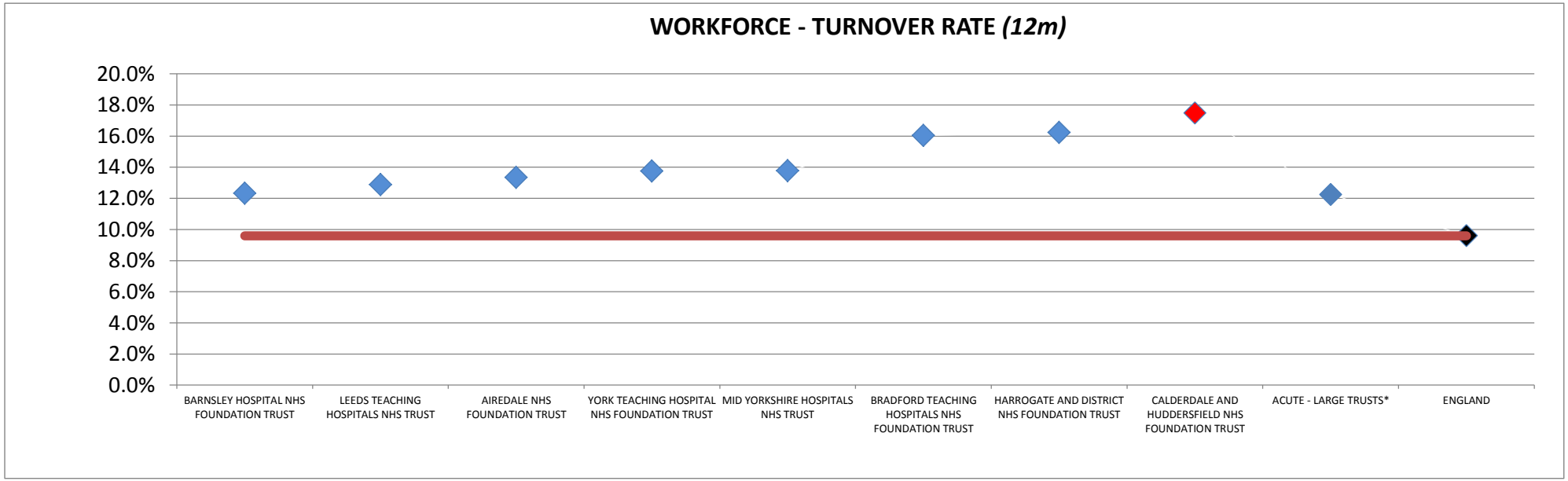


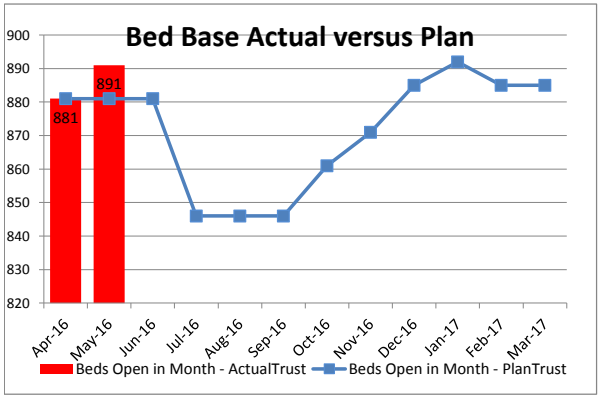


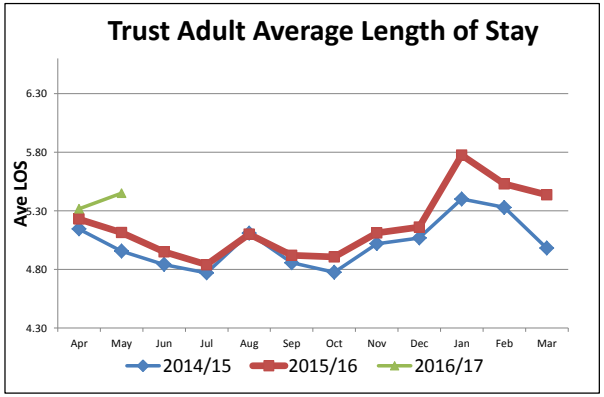
Efficiency & Finance - Efficiency Key Messages

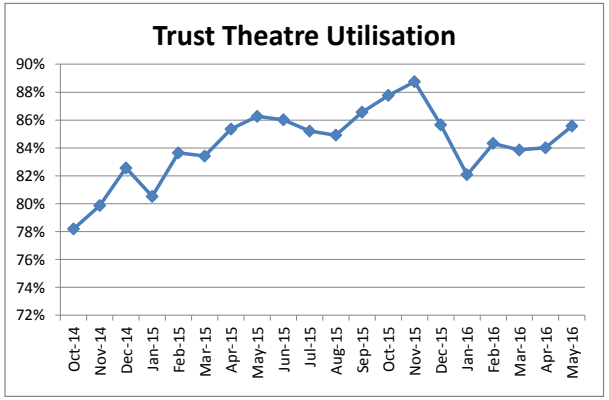
Area	Issue	Corrective Actions	Impact and Accountability
Theatre Utilisation	Theatre utilisation has improved in month. However there is still room for further improvement due to: - Insufficiently filled lists - Large number of patient cancellations	Review pre-assessment call out service to confirm patient is ready for surgery, confirm the date and ensure no clinical reasons for cancellation are known at that point Review all unfilled lists in the weekly scheduling meeting Theatre productivity slots on this month's consultant audit session to talk to consultant groups about the importance of theatre utilisation and share the most recent data. 1-2-1 consultant discussions where needed Continued involvement from the service improvement team. Refreshed service improvement group. Involvement of membership councillor to support with service improvement approach.	The Division will be working with clinical specialties to maintain that position for the remainder of the month. **Accountable: GM for Theatres**
Surgical Activity Variance	The Surgery Division has improved its performance against contract plan. There has been a positive movement in the YTD position. The causes of the changes have been: - a reduction in consultant vacancies and sickness compared to the April position - Continued focus through the theatre scheduling process.	Fill vacancies asap – Panels to be held in June for a number of the posts. Provide full cover for sickness at the earliest opportunity Increase length of short term cover to enable recovery of lost capacity Increase operating for new hand surgeon by picking up cases from other surgeons, and thereby reduce waiting times. Ensure a Paediatric all day ENT weekend list is scheduled each month. Improve identification of capacity gaps Aim to reduce fallow lists to no more than 1 per week Ensure scheduling meeting is effective, by improved pre-work with specialties. Ensure all long waiting pathways are validated.	It is expected that most capacity gaps within the Division will be reduce in June which will stop the deterioration of the current position. There remains a risk with Consultant capacity in Urology due to delays in recruitment. **Accountable: ADD Surgery**

Efficiency & Finance - Key measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	Target	Threshold/ Monthly
Did Not Attend Rates																	
First DNA	6.80%	6.83%	6.65%	7.86%	7.07%	6.52%	6.64%	6.55%	7.22%	6.37%	6.26%	6.80%	6.60%	**6.37%**	**6.51%**	<=7%	7.00%
Follow up DNA	7.70%	8.44%	7.66%	8.65%	7.91%	8.19%	7.54%	7.21%	7.63%	6.79%	6.60%	7.17%	6.55%	**6.34%**	**6.47%**	<=8%	8.00%
Average length of stay																	
Average Length of Stay - Overall	5.17	5.11	4.95	4.85	5.11	4.88	4.91	5.11	5.16	5.78	5.53	5.45	5.32	**5.45**	**5.38**	<=5.17	5.17
Average Length of Stay - Elective	2.85	2.75	2.87	2.72	2.90	2.82	2.73	2.89	2.80	3.25	2.92	3.07	2.50	**2.77**	**2.64**	<=2.85	2.85
Average Length of Stay - Non Elective	5.63	5.59	5.41	5.31	5.57	5.34	5.36	5.62	5.60	6.24	5.96	5.79	5.87	**5.97**	**5.92**	<=5.63	5.63
Day Cases																	
Day Case Rate	85.00%	84.64%	85.15%	85.14%	84.52%	84.74%	84.55%	84.30%	86.34%	86.35%	87.90%	88.50%	86.79%	**87.00%**	**86.89%**	>=85%	85.00%
Failed Day Cases	1440	137	121	**132**	116	147	136	119	93	103	112	93	138	**110**	**248**	120	120
Elective Inpatients with zero LOS	1630	118	171	163	136	152	132	142	122	135	110	97	115	**109**	**224**	136	136
Beds																	
Beds Open in Month - Plan		835	820	816	809	809	809	820	835	866	878	878	881	**881**	**881**	Not applicable	
Beds Open in Month - Actual		868	869	850	849	855	872	873	878	922	906	890	881	**891**	**1772**	Not applicable	
Theatre Utilisation																	
Theatre Utilisation (TT) - Main Theatre - CRH	86.05%	87.28%	87.10%	86.18%	85.64%	89.70%	88.07%	88.30%	85:93%	80.13%	81.36%	83.99%	87.41%	**85.59%**	**86.49%**	>=92.5%	92.50%
Theatre Utilisation (TT) - Main Theatre -HRI	94.92%	95.08%	96.08%	93.73%	89.87%	93.13%	96.00%	99.25%	95.01%	92.02%	101.14%	88.36%	89.04%	**94.67%**	**91.93%**	>=92.5%	92.50%
Theatre Utilisation (TT) - HRI DSU	78.04%	75.67%	76.41%	76.50%	75.31%	79.83%	81.42%	82.36%	76.33%	76.58%	79.92%	78.00%	75.08%	**78.09%**	**76.67%**	>=92.5%	92.50%
Theatre Utilisation (TT) - HRI SPU	82.73%	84.46%	83.48%	85.03%	84.41%	81.97%	80.01%	81.94%	80.94%	82.01%	83.98%	84.68%	79.95%	**81.00%**	**80.44%**	>=92.5%	92.50%
Theatre Utilisation (TT) - Trust	85.60%	86.07%	85.25%	84.38%	83.92%	85.57%	87.05%	88.18%	84.67%	81.77%	84.65%	83.82%	84.13%	**85.60%**	**84.80%**	>=92.5%	92.50%







Activity - Key measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	YTD % Change
GP referrals to all outpatients																
02T - NHS CALDERDALE CCG	41532	3419	3586	3514	3194	3681	3693	3368	2989	3555	3437	3651	3763	**3830**	**7593**	10.7%
03A - NHS GREATER HUDDERSFIELD CCG	38613	3069	3456	3357	2921	3465	3423	3206	2862	3171	3241	3367	3320	**3131**	**6451**	5.0%
03J - NHS NORTH KIRKLEES CCG	2830	199	256	227	193	222	243	224	198	246	296	299	283	**307**	**590**	38.0%
02R - NHS BRADFORD DISTRICTS CCG	3055	252	251	280	232	271	273	265	213	283	244	250	242	**265**	**507**	2.0%
03R - NHS WAKEFIELD CCG	444	34	41	36	26	40	37	29	25	35	48	52	56	**63**	**119**	58.7%
02W - NHS BRADFORD CITY CCG	519	42	37	35	58	53	66	41	49	39	40	37	24	**33**	**57**	-10.9%
01D - NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	206	10	3	17	8	22	23	19	9	25	35	30	42	**38**	**80**	433.3%
03C - NHS LEEDS WEST CCG	78	3	10	6	6	10	6	3	5	7	4	11	7	**3**	**10**	-9.1%
02N - NHS AIREDALE, WHARFEDALE AND CRAVEN CCG	63	4	9	**5**	7	3	5	7	5	6	2	**6**	6	**7**	**13**	62.5%
03G - NHS LEEDS SOUTH AND EAST CCG	19	**2**	**2**	**3**	**0**	**2**	0	4	2	0	1	0	0	**2**	**2**	-60.0%
02V - NHS LEEDS NORTH CCG	19	2	2	3	**0**	2	0	4	2	0	1	0	0	**2**	**2**	-80.0%
Other	993	62	79	97	64	74	71	96	82	103	90	99	68	**67**	**135**	-5.0%
Total	88371	7099	7730	7579	6711	7846	7841	7263	6442	7471	7438	7803	7812	**7746**	**15558**	9.2%
% Change on Previous year	3.5%	1.2%	9.4%	-2.0%	6.1%	4.9%	0.9%	7.1%	4.0%	16.3%	1.0%	-3.0%	9.3%	**9.1%**	**9.2%**	
Activity																
% of spells with > 5 ward movements (No Target)	0.06%	0.06%	0.07%	0.03%	0.03%	0.09%	0.06%	0.06%	0.06%	0.02%	0.16%	0.04%	0.06%	**0.06%**	**0.08%**	0.0%

ACTIVITY VARIANCE AGAINST CONTRACT																
Day Case Variance against Contract													**8**	**216**	**225**	
% Day Case Variance against Contract													**0.3%**	**7.4%**	**3.7%**	
Elective Variance against Contract													**-109**	**-95**	**-203**	
% Elective Variance against Contract													**-14.8%**	**-13.5%**	**-14.2%**	
Non-elective Variance against Contract													**-90**	**-140**	**-230**	
% Non-elective Variance against Contract													**-2.1%**	**-3.2%**	**-2.7%**	
Outpatient Variance against Contract													**-122**	**1424**	**1302**	
% Outpatient Variance against Contract													**-0.4%**	**5.3%**	**2.4%**	
Accident and Emergency Variance against Contract													**-212**	**960**	**748**	
% Accident and Emergency Variance against Contract													**-1.7%**	**7.6%**	**3.0%**	

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

CQUIN - Key Messages

Area	Issues	Corrective Actions	Impact and Accountability
CQUINS	There are several CQUINs which have not yet been assigned a target / threshold. A large proportion of them are establishing baseline measures in Q1.		
Staff Wellbeing:	At present the Staff Wellbeing is on plan to hit all Q1 Targets however a risk is being raised in achieving the third element, regarding 75% of front line staff receiving the Flu Vaccination. Previous year saw year end at 53%. The final payment is staged, 0-64% vaccinated = £0 64-75% vaccinated 50% payment = £324,701.15 >75% vaccinated = £649,402.30	The campaign planning is underway, with a number of event scheduled over Q1/Q2 to engage with the vaccinators from last year and address what barriers there were. The First National Flu Conference takes place in July with an opportunity to learn from the top performers in previous years	The Campaign starts in October 16 and ends 31st December 16. Performance will be monitored weekly during this stage. **Accountable: Director of Workforce**
Sepsis	**Sepsis CQUIN** is on plan to hit A1 elements from Quarter 2 onwards, a risk is being raised in achieving 90% of patients screened in ED for Q1. Performance is reducing on last year's year end of 70%. (this is partially due to the paediatrics element now being added.)	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 has begun in June. Corrective Action in place to deliver >50% for Q1 and receive 50% of the CQUIN (£16k). *Support Requested* - Development Matron with focus on Sepsis still awaiting approval decision, this is impacting on the ability of	The improvement in ED is expected to bring performance to around 60-70%, however this is still short of the target to achieve the full quarterly payment. Payments are as follows: 0-50% = £0 50% - 90% = £16,235.06 >90% = £32,470.12
Antimicrobial Resistance	At present this CQUIN is in on plan to hit all Q1 Targets . A risk is however being raised against achieving the: 1) Final quarter performance of 90% for Empiric Review. 2) The 1% reduction in the consumption of Carbopenum 1% reduction in the consumption of Tazobactam 1% in overall antibiotics consumption	Where non-compliance with a 72 hours review is noted, the pharmacy team feed back and reinforce the requirement. Performance has exceeded expectations so far in Q1 and achievement of the CQUIN is now expected for at least the first three quarter. The 1% reduction will be against a baseline of 13/14 consumption. Raw data for 13/14, 14/15 and 15/16 are being compiled and will be sent to PHE before 30th June. Following this PHE will release the baseline for performance. Internally the calculation is being replicated and high consuming wards will be the focus of improvement work in Q2.	Internal trajectories were expected to be set at the end of Q1; however this will not be fully confirmed until the release of data from PHE following submission of baseline figures. This however does not prevent the improvement work from commencing. The highest consuming wards will be identified by the end of June and improvements are expected to be seen at the end of Q2 onwards. **Accountable: Director of Pharmacy**

CQUIN - Key measures

	£ Annual Value	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD	Target	Threshold/ Monthly
Staff Well Being																
Well Being Initiatives	£649,402.30	Plan in Development for three Initiatives - Mental Health, Physical Health, MSK access													Qrtly Written Rpt to Commissioner	
Healthy Food for Visitors	£649,402.30	submit national data collection returns by July													Qrtly Written Rpt to Commissioner	
Flu Vaccination Uptake	£649,402.30	Campaign Starts in September 16													>75%	>75%
Sepsis																
% of patients Screened (admission Units)	£129,880.46	48.00%	40.00%											**44.00%**	>90%	90.00%
% of patients receiving Antibiotic in timeframe and undertake Antibiotic Review (admission units)	£194,820.69	71.00%	in arrears											**71.43%**	Yr End = To be agreed post Q2	Q1 = Baseline Data Only
% of patients Screened (Inpatients)	£129,880.46	14.00%	in arrears											**14.00%**	>90%	Q1 = Baseline Data Only
% of patients receiving Antibiotic in timeframe and undertake Antibiotic Review (inpatients)	£194,820.69	0.00%	in arrears											**71.43%**	>90%	Q1 = Baseline Data Only
Antimicrobial Resistance																
Antibiotic Consumption - All	£259,760.92	in arrears	in arrears											**in arrears**	TBC - Post Q1 data	Q1 = Baseline Data Only
Antibiotic Consumption - Carbopenum	£129,880.46	in arrears	in arrears											**in arrears**	TBC - Post Q1 data	Q1 = Baseline Data Only
Antibiotic Consumption - piperacillin -tazobactam	£129,880.46	in arrears	in arrears											**in arrears**	TBC - Post Q1 data	Q1 = Baseline Data Only
Empiric review of antibiotic prescriptions within 72 hours	£129,880.46	TBC	96.00%											**in arrears**	>90%	Q1 = >25%
Safety Huddle (SH) Roll Out																
Number of Wards with SHs in place	£1,168,924.14	2	2											**2**	**8**	2
Ulcer performance on SH ward		in arrears	in arrears											**in arrears**	TBC - Post Q1 data	Q1 = Baseline Data Only
Falls performance on SH ward		in arrears	in arrears											**in arrears**	TBC - Post Q1 data	Q1 = Baseline Data Only
Self Administration of Medication																
% of patients assessed for self medication	£389,641.38	67.00%	100.00%											**75.00%**	**>=50%**	50.00%
Hospital at Night																
Roll out of System	£1,168,924.14	Technical specification complete, testing started													Qrtly Written Rpt to Commissioner	
Community Experience																
Service Users experience of Community Care	£519,521.84	Reporting tool in development													TBC - Post Q1 data	Q1 = Tool Dev

Appendices

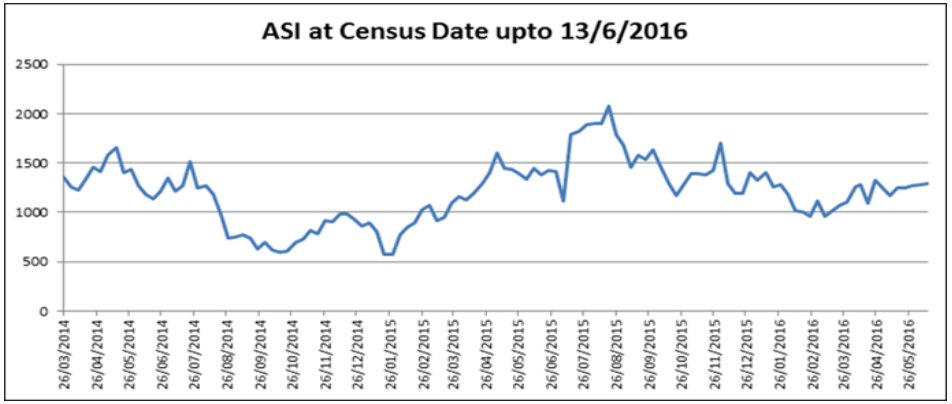
Appendix - Appointment Slot Issues

As at the 21 June there were 1294 referrals waiting appointment of which 396 are e-referrals. This is a reduction of 530 referrals from the 22nd July 2015 position of 1824.

The top 3 specialties with ASIs are Ophthalmology, Colorectal Surgery and Cardiology. The graph on the right shows the length of time (weeks) patients have been waiting for an appointment to be allocated (at 21/6).

ASI reporting and validation continues, and each specialty has an action plan in place to recover the position. The Divisional Information Teams are working up capacity and demand models.

	Ophthalmology		Total	Colorectal Surgery		Total	Cardiology		Total
Row Labels	ERS	Paper		ERS	Paper		ERS	Paper	
0 Weeks	15	2	17	12		12		1	1
1 Week	17	4	21	6	5	11		5	5
2 Weeks	6	25	31	10	7	17		22	22
3 Weeks	9	16	25	12	8	20	2	31	33
4 Weeks	1	25	26	11	12	23	9	19	28
5 Weeks	1	3	4	16	6	22	2	14	16
6 Weeks	2	8	10	17	17	34		21	21
7 Weeks	2	22	24	11	7	18		20	20
8 Weeks	8	23	31	14	7	21		5	5
3 Months	16	60	76	17	23	40	4	34	38
4 Months		10	10	2	12	14		1	1
5 Months		2	2	1	5	6		1	1
6 Months		1	1		1	1			
Grand Total	**77**	**201**	**278**	**129**	**110**	**239**	**17**	**174**	**191**



Appendix - Efficiency Key Measures

BEDS

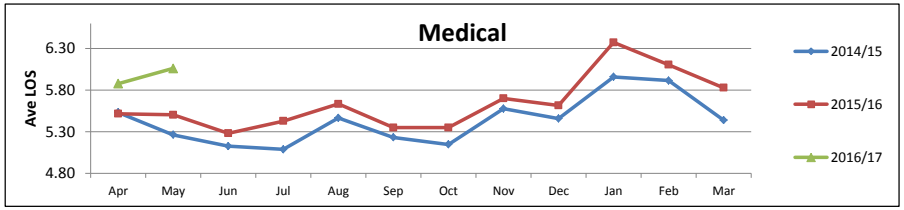
Divisional Breakdown of Bed Base - Actual versus Plan - 2016 / 2017

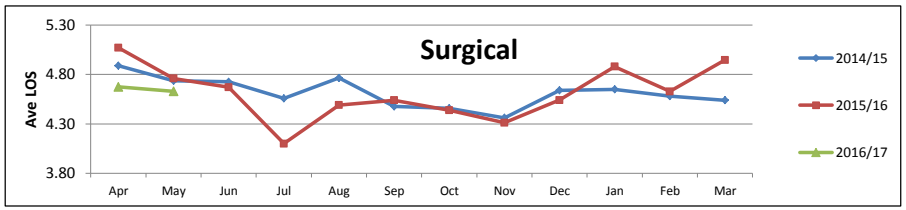
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Surgical Bed Base Plan	213	213	213	193	193	193	193	193	193	193	193	193
Surgical Bed Base Actual	209	213										
FSS Bed Base Plan - Adult	16	16	16	16	16	16	16	16	16	16	16	16
Paediatrics	43	43	43	43	43	43	43	43	43	43	43	43
Mother	63	63	63	63	63	63	63	63	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										
Beds Above (+ve) / Below (-ve) Plan	0	10										

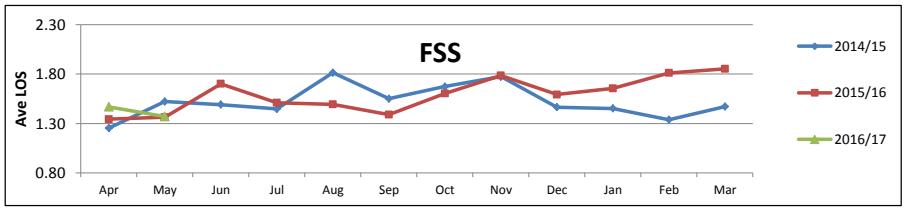
AVERAGE LENGTH OF STAY

- Trust length of stay (LOS) increased in May with increase relating to the Medical division.
- Surgical and FSS LOS have reduced in May.
- Medical LOS in month was 6.1 days, increasing from 5.9 (plan is 5.6 days).

- Contributing factors as follows -
- Reduction in Medical green x patients – from 93 to 90 as at 31 May 2016 (however profile is set at 70).
- Significant number of outliers increase inefficiency .. avg 31 per day in May 2016.
- High bed occupancy levels – 97% in month.
- Lack of nursing home/intermediate care beds.
- There has been a reduction in acute activity levels - 3.4% decrease in admissions YTD and 61 spell reduction (1%) on same month in 2015.
- Beds increase relates to opening of extra capacity (ward 4D) intermittently in May.



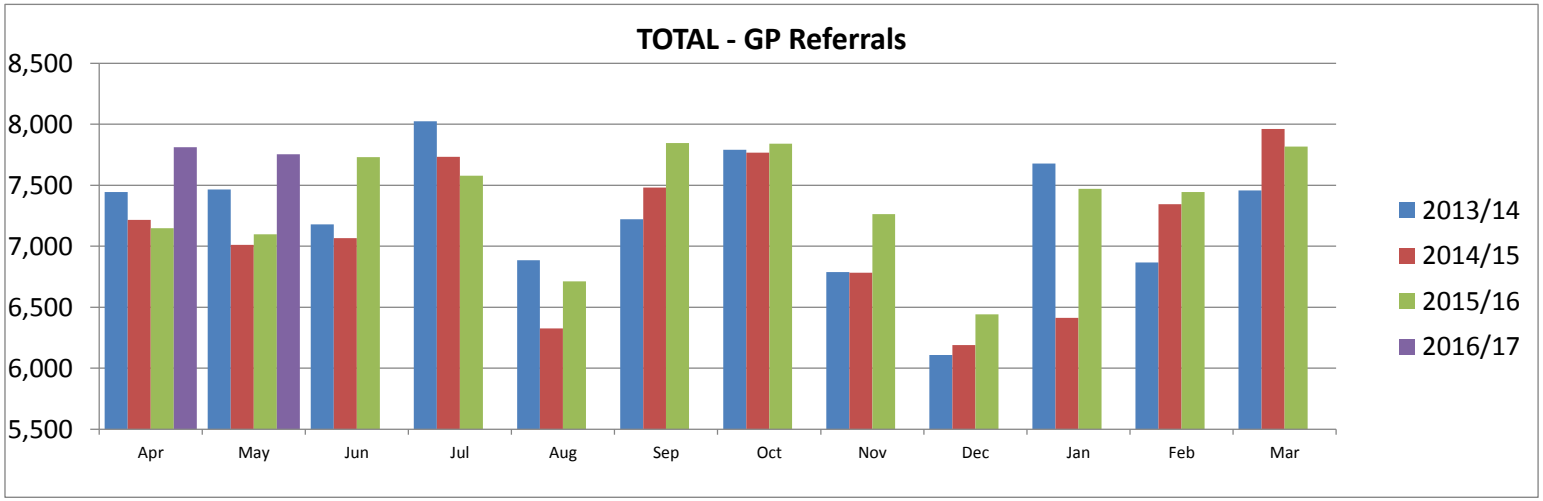




Appendix - Referrals

KEY MESSAGES

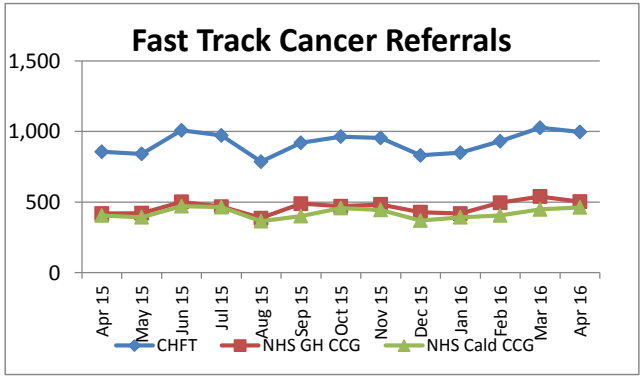
- GP Referrals up 9.1% in May 2016 compared with May 2015.
- With one more working day in May 16 one expects an increase in referrals of 5.3% only.
- YTD there have been 2 more working days compared to April and May 2015 so one would expect this to result in a referral increase of 5.1%.
- Non GP referrals (37% of all referrals) up 11.7% YTD, specialties contributing Trauma and Orthopaedics, Obstetrics, Gynaecology, Oral Surgery, Ophthalmology and Cardiology.
- NHS Calderdale GP referrals have an increase (more than expected) of 10.7% (707) YTD principally due to Orthopaedics 22% (264), ENT 16% (123), Cardiology 36% (90) and Dermatology 23% (106)
- NHS Greater Huddersfield GP referrals increase (in line with expectations) of 4.8% (294) YTD principally due to General Surgery 7% (69), Ophthalmology 9% (49), Gastroenterology 15% (46), Dermatology 12.9% (50) and Cardiology 15% (38)
- YTD there have been notable GP referral increases (above the 5.1% mentioned earlier) for NHS North Kirklees (38%, 162 referrals, numerous practices, Undercliffe in particular, Neurology receiving many extra referrals), NHS Wakefield (59%, 44 referrals, half of the increase from Middlestown practice, Neurology receiving many extra referrals) and particularly NHS Heywood, Middleton and Rochdale (over 400%, 65 referrals, chief rises in Paediatrics, Dermatology and ENT).
- At June's Finance and Performance committee a paper evaluating recent market share movements is to be tabled. This will identify the main specialties that have lost market share in recent years and to which providers the share has moved. An evaluation of the potential income lost through falling market share in the said specialties is also given.

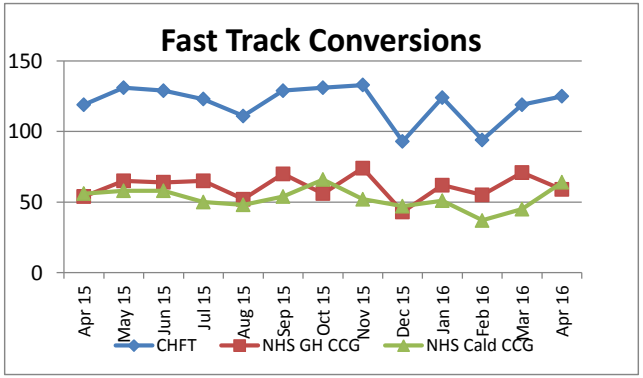


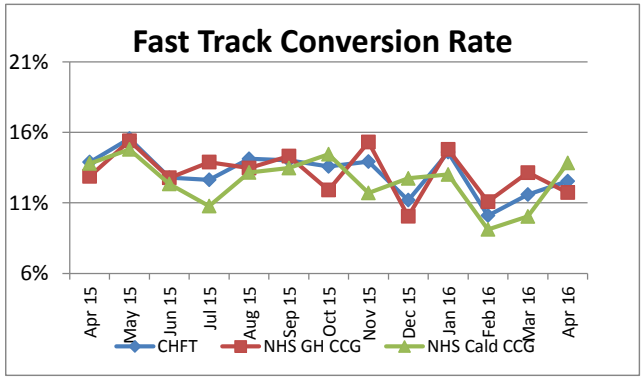
Activity - Key measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	YTD % Change
Fast Track Cancer referrals in month and of those referrals numbers that diagnosed with cancer (conversions)																
NHS CALDERDALE CCG Referrals	5014	392	470	464	365	401	457	444	369	392	406	448	463	**461**	**924**	15.8%
NHS CALDERDALE CCG Conversions	622	58	58	50	48	54	66	52	47	51	37	45	64	**in arrears**	**64**	*14.3%*
NHS CALDERDALE CCG Conversion Rate	12.4%	14.8%	12.3%	10.8%	13.2%	13.5%	14.4%	11.7%	12.7%	13.0%	9.1%	10.0%	13.8%	**in arrears**	**6.9%**	
NHS GREATER HUDDERSFIELD CCG Referrals	5521	422	501	468	386	489	470	483	428	419	496	540	503	**501**	**1004**	19.4%
NHS GREATER HUDDERSFIELD CCG Conversions	731	65	64	65	52	70	56	74	43	62	55	71	59	**in arrears**	**59**	*9.3%*
NHS GREATER HUDDERSFIELD CCG Conversion Rate	13.2%	15.4%	12.8%	13.9%	13.5%	14.3%	11.9%	15.3%	10.0%	14.8%	11.1%	13.1%	11.7%	**in arrears**	**5.9%**	
Other CCG Referrals	410	28	38	41	35	30	37	28	34	39	29	39	31	**18**	**49**	-18.3%
Other CCG Conversions	83	8	7	8	11	5	9	7	3	11	2	3	2	**in arrears**	**2**	*-77.8%*
Other CCG Conversion Rate	20.2%	28.6%	**18.4%**	19.5%	31.4%	16.7%	24.3%	25.0%	8.8%	28.2%	6.9%	7.7%	6.5%	**in arrears**	**4.1%**	
CHFT Fast Track Referrals	10945	842	1009	973	786	920	964	955	831	850	931	1027	997	**980**	**1977**	16.4%
CHFT Fast Track Conversions	1436	131	129	123	111	129	131	133	93	124	94	119	125	**in arrears**	**125**	*5.0%*
CHFT Fast Track Conversion Rate	13.1%	15.6%	12.8%	12.6%	14.1%	14.0%	13.6%	13.9%	11.2%	14.6%	10.1%	11.6%	12.5%	**in arrears**	**6.3%**	
% Change on Previous year																

Note YTD Change for conversions is a month in arrears as latest month will still have conversions to feed through.



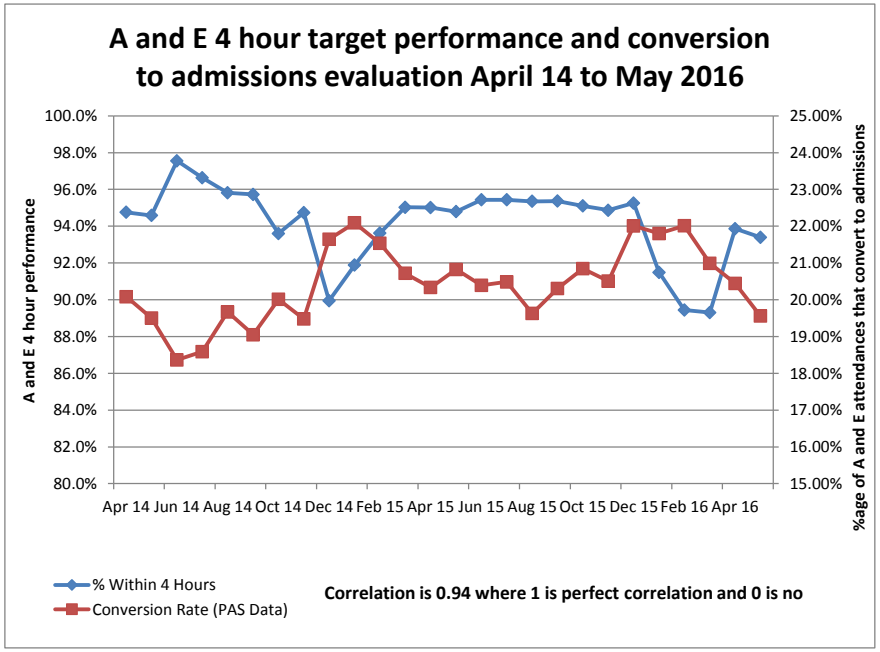




Appendix - A and E Conversion rates and Delayed Transfers

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	YTD % Change
Analysis of A and E activity including conversions to admission																
A and E Attendances	147625	12590	12313	12388	11992	12106	12495	11950	12040	12399	11712	13372	12120	**13588**	**25708**	3.4%
A and E 4 hour Breaches	9030	655	562	565	557	561	611	613	571	1055	1237	1431	743	**897**	**1640**	29.4%
A and E 4 hour performance	93.9%	94.8%	95.4%	95.4%	95.4%	95.4%	95.1%	94.9%	95.3%	91.5%	89.4%	89.3%	93.9%	**93.4%**	**93.6%**	-1.4%
Admissions via Accident and Emergency	30770	2622	2511	2538	2353	2458	2605	2451	2650	2703	2578	2807	2478	**2658**	**5136**	0.4%
% A and E Attendances that convert to admissions	20.8%	20.8%	20.4%	20.5%	19.6%	20.3%	20.8%	20.5%	22.0%	21.8%	22.0%	21.0%	20.4%	**19.6%**	**20.0%**	*-2.9%*

Data Source : A and E Attendances (EDIS), Admissions via A and E (PAS)



Delayed Transfers of Care – Snapshot June 2016	Calderdale	Kirklees	Other	total
Total number of patients on TOC Pathway	85	45	1	131
Patients awaiting assessment by a Social Worker	23	6	1	30
Ongoing assessments inc. SW, Therapy, BIM, Case Conference. MCA, DST	22	22		44
Awaiting 24 hour care, res or nursing	16	11		27
Awaiting Package of Care inc. re-ablement	19	5		24
Awaiting housing	2			2
Awaiting short stay or transitional bed				
Awaiting Intermediate Care Bed	3	1		4

Appendix - Responsive Key Measures

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Target	Threshold
Outpatient Total Waiting List																
GP/GDP sourced referrals	9,014	9,462	9,213	8,978	8,993	9,452	9,533	9,112	8,728	8,921	9,258	9,298	9,505	**9,300**	Not applicable	
Other sourced referrals	8,548	9,060	9,340	9,285	8,994	8,850	8,537	8,428	8,296	8,107	8,389	8,037	8,515	**8,880**	Not applicable	
Total	17,562	18,522	18,553	18,263	17,987	18,302	18,070	17,540	17,024	17,028	17,647	17,335	18,023	**18,180**	Not applicable	
Elective Total Waiting List																
18 week pathway	4,314	4,187	4,363	4,374	4,344	4,418	4,570	4,593	4,573	4,763	4,732	4,794	4,738	**4,842**	Not applicable	
Non 18 week pathway	4,340	4,415	4,551	4,572	4,565	4,640	4,719	4,729	4,792	4,833	4,877	4,956	4,944	**4,976**	Not applicable	
Not on Active List	172	240	216	234	186	192	181	207	170	155	166	153	207	**260**	Not applicable	
Unavailable	274	319	361	370	354	287	227	289	373	231	231	254	238	**293**	Not applicable	
Total	9,100	9,161	9,491	9,550	9,449	9,537	9,697	9,818	9,908	9,982	10,006	**10,157**	10,127	**10,371**	Not applicable	
Referral to Treatment (RTT)																
RTT Total incomplete waiting list	19,390	19,247	19,002	18,981	18,655	18,799	19,525	19,282	19,201	19,355	19,625	19,390	19,337	**19,927**	Not applicable	
RTT Waiting 18 weeks and over (backlog)	833	799	866	845	1052	764	820	758	873	783	825	833	743	**796**	Not applicable	
18 weeks Pathways >=26 weeks open	134	251	246	197	174	137	98	94	126	152	127	139	186	**195**	Not applicable	
RTT Waits over 52 weeks Threshold > zero	0	0	0	0	0	**0**	0	0	0	0	0	0	0	**0**	Not applicable	
% Non-admitted Closed Pathways under 18 weeks	98.47%	98.89%	98.63%	98.23%	98.55%	98.67%	98.48%	98.62%	98.44%	98.32%	98.39%	98.17%	98.42%	**98.49%**	**>=95%**	**95.00**
% Admitted Closed Pathways Under 18 Weeks	91.92%	92.41%	92.67%	92.79%	92.03%	91.64%	90.20%	91.63%	92.04%	92.21%	91.86%	91.96%	92.12%	**92.42%**	**>=90%**	**90.00%**
% Incomplete Pathways <18 Weeks	95.70%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%	96.04%	95.45%	95.95%	95.80%	95.70%	96.16%	**96.01%**	**>=92%**	**92.00%**
18 weeks Pathways >=26 weeks open	139	251	246	197	174	137	98	94	126	152	127	139	186	**195**	**0**	**0**
RTT Waits over 52 weeks Threshold > zero	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0**
% Diagnostic Waiting List Within 6 Weeks	99.54%	99.80%	99.89%	99.93%	99.48%	98.56%	99.82%	99.94%	99.65%	98.48%	99.71%	99.52%	99.91%	**99.86%**	**>=99%**	**99.00%**

RTT KEY MESSAGES:

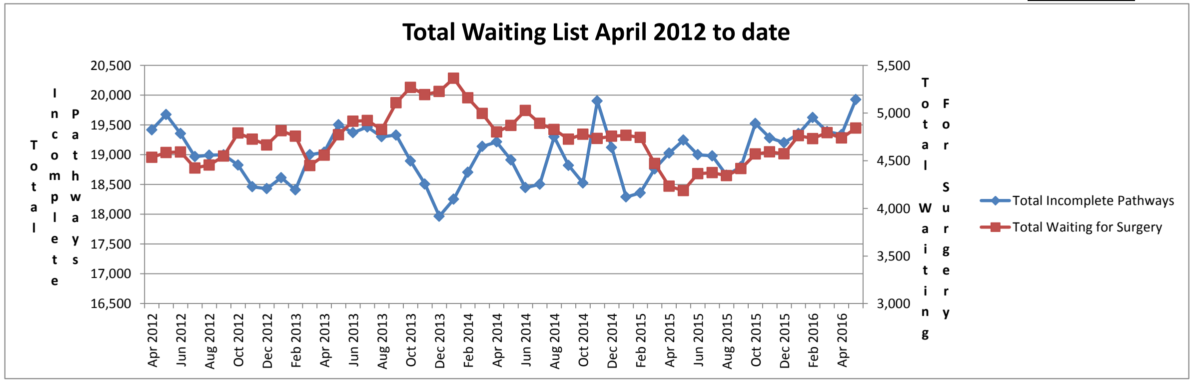
Total number of patients on waiting list (including outpatients, diagnostics, surgery) = 19,927

Total number of patients waiting for surgery = 4,842, this is and increase of 655 compared to the position at end May 2015.

Most notable increases are in the specialties, Ophthalmology, Trauma and Orthopaedics and Gastroenterology

Total number of patients waiting over 18 weeks = 796

Main specialties where highest level of 18+ week waiters:
General Surgery =311 Trauma & Orthopaedics = 163



Appendix - Cancer - By Tumour Group

	15/16	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD	Target	Threshold/ Monthly
62 Day Referral to Treatment																	
Breast	98.75%	100.00%	100.00%	100.00%	100.00%	81.82%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=85%	85.00%
Gynaecology	85.71%	88.89%	100.00%	100.00%	100.00%	50.00%	100.00%	100.00%	84.62%	75.00%	77.78%	70.00%	100.00%	**87.50%**	**94.74%**	>=85%	85.00%
Haematology	91.27%	80.00%	100.00%	85.71%	71.43%	85.71%	100.00%	100.00%	100.00%	100.00%	100.00%	60.00%	100.00%	**83.33%**	**90.91%**	>=85%	85.00%
Head & Neck	74.58%	33.33%	72.73%	75.00%	100.00%	100.00%	71.43%	100.00%	66.67%	66.67%	-	80.00%	100.00%	**42.86%**	**60.00%**	>=85%	85.00%
Lower GI	92.70%	84.62%	100.00%	96.15%	100.00%	100.00%	83.33%	80.00%	84.62%	100.00%	93.33%	100.00%	80.00%	**83.33%**	**81.82%**	>=85%	85.00%
Lung	85.02%	88.24%	75.86%	91.67%	100.00%	83.33%	90.48%	100.00%	85.71%	61.54%	100.00%	92.31%	100.00%	**100.00%**	**100.00%**	>=85%	85.00%
Sarcoma	70.00%	-	-	0.00%	0.00%	50.00%	-	-	-	100.00%	100.00%	100.00%	-	**-**	**-**	>=85%	85.00%
Skin	95.83%	100.00%	92.31%	76.19%	100.00%	95.65%	100.00%	94.44%	90.00%	95.45%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=85%	85.00%
Upper GI	87.97%	84.62%	100.00%	87.50%	100.00%	88.89%	70.59%	100.00%	100.00%	92.86%	57.14%	37.50%	75.00%	**72.73%**	**74.07%**	>=85%	85.00%
Urology	89.60%	100.00%	66.67%	79.41%	85.71%	92.50%	93.75%	88.57%	95.92%	97.06%	96.77%	90.91%	90.70%	**89.47%**	**90.12%**	>=85%	85.00%
Others	95.24%	-	66.67%	100.00%	-	-	100.00%	100.00%	100.00%	66.67%	-	-	-	**100.00%**	**100.00%**	>=85%	85.00%
14 Day Referral to Date First Seen																	
Brain	98.73%	100.00%	80.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**92.86%**	**95.24%**	>=93%	93.00%
Breast	97.81%	100.00%	96.84%	93.17%	98.53%	97.52%	98.32%	98.77%	97.96%	98.43%	99.25%	97.12%	99.22%	**96.02%**	**97.38%**	>=93%	93.00%
Childrens	96.85%	100.00%	100.00%	100.00%	-	100.00%	-	100.00%	-	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	**>=93%**	93.00%
Gynaecology	96.83%	100.00%	97.96%	94.87%	90.67%	97.59%	98.78%	94.95%	91.82%	97.37%	98.99%	100.00%	96.81%	**99.00%**	**97.94%**	>=93%	93.00%
Haematology	97.89%	100.00%	93.75%	90.91%	100.00%	90.48%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.91%	**100.00%**	**94.74%**	>=93%	93.00%
Head & Neck	98.54%	100.00%	98.29%	97.94%	95.08%	100.00%	97.73%	99.12%	98.92%	98.51%	97.96%	100.00%	78.10%	**95.74%**	**86.43%**	>=93%	93.00%
Lower GI	98.98%	99.14%	99.31%	96.83%	98.18%	99.24%	97.44%	98.77%	99.41%	100.00%	100.00%	100.00%	89.93%	**98.09%**	**94.26%**	>=93%	93.00%
Lung	99.14%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	100.00%	91.67%	95.00%	100.00%	100.00%	96.43%	**100.00%**	**98.36%**	>=93%	93.00%
Sarcoma	98.68%	100.00%	100.00%	80.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	91.67%	**100.00%**	**94.44%**	>=93%	93.00%
Skin	93.26%	95.15%	91.32%	93.29%	83.33%	96.61%	100.00%	90.41%	93.67%	100.00%	99.41%	97.58%	98.20%	**99.35%**	**98.67%**	>=93%	93.00%
Testicular	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	93.00%
Upper GI	97.59%	97.10%	98.94%	96.00%	95.18%	95.70%	100.00%	99.02%	98.15%	100.00%	99.00%	98.81%	98.99%	**98.10%**	**98.53%**	>=93%	93.00%
Urology	99.07%	100.00%	98.95%	100.00%	97.00%	100.00%	100.00%	99.08%	100.00%	96.67%	99.07%	99.30%	100.00%	**100.00%**	**100.00%**	>=93%	93.00%

Appendix - Methodology for calculating the performance score

Step 1

- Measures that are RAG rated as **red** score 0 points; amber as 2 points and green as 4 points

Step 2

- Identify which measures are "key" targets for the organisation; they may be CQC or Monitor targets or measures on which the trust is particularly focussing
- Key targets have scores multiplied by a factor of 3
- The proposed key targets are detailed on the next slide

Step 3

- Apply the weighting for the key targets; add up the scores for the measures for that month per domain; divide by the maximum total score possible for that domain; multiply by 100 to get a percentage score

Step 4

- Apply the thresholds for the overall domain to get a RAG rating for each domain
- These have been set as a score less than 50% is **red**, 75% or above is green and in between is amber

Step 5

- Where data is "in arrears" e.g. SHMI, use the score for the previous month for that measure as a proxy

Step 6

- Calculate the overall performance score by adding up the scores for all domains; dividing by the maximum total score possible for all domains; multiply by 100 to get a percentage
- Apply the same thresholds of 50% and 75% to RAG rate the overall score

Appendix - "Key" Targets

The proposed "key" targets are all measures included in CQCs "Intelligent Monitoring" reports for acute trusts or form part of the quarterly monitoring by Monitor. In the new performance score methodology they are weighted more heavily.

Domain	Measure
Safe	• VTE assessments • Never events
Effective	• MRSA • SHMI • HSMR • Emergency readmissions
Caring	• % Complaints closed within target timeframe • Friends and family test
Responsive & Monitor	• Stroke - % of patients admitted directly to the stroke unit within 4 hours • Diagnostics waiting over 6 weeks • Avoidable number of Clostridium difficile cases • A&E 4 hour target • RTT target for incomplete pathways • Cancer standards
Workforce	• Sickness/Absence %
Efficiency & Finance	• Net / surplus deficit

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th June 2016	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 2 - FINANCIAL NARRATIVE - MAY-JUNE 2016 - The Board is asked to approve the Month 1 Financial Narrative - May-June 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Finance and Performance Committee - 28.6.16	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Appendix

Attachment:

FP TRUST FINANCE REPORT Month 2.pdf

EXECUTIVE SUMMARY: Trust Financial Overview as at 31st May 2016 - Month 2

YEAR TO DATE POSITION: M2

	M2 Plan £m	M2 Actual £m	Var £m	
Total Income	**£59.37**	**£59.89**	**£0.53**	
Total Expenditure	**(£60.93)**	**(£61.71)**	**(£0.78)**	
EBITDA	**(£1.57)**	**(£1.82)**	**(£0.25)**	
Non Operating Expenditure	(£4.24)	(£4.05)	£0.19	
Deficit excl. Restructuring	**(£5.81)**	**(£5.87)**	**(£0.06)**	
Restructuring Costs	(£0.00)	£0.00	£0.00	
Surplus / (Deficit)	**(£5.81)**	**(£5.87)**	**(£0.06)**	

YEAR END 2016/17

	Plan £m	Forecast £m	Var £m	
Total Income	**£371.52**	**£374.79**	**£3.27**	
Total Expenditure	**(£361.96)**	**(£366.01)**	**(£4.05)**	
EBITDA	**£9.56**	**£8.77**	**(£0.79)**	
Non Operating Expenditure	(£25.66)	(£24.88)	£0.78	
Deficit excl. Restructuring	**(£16.10)**	**(£16.10)**	**(£0.00)**	
Restructuring Costs	(£0.00)	£0.00	£0.00	
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**	

KEY METRICS

	Year To Date			Year End: Forecast			
	M2 Plan £m	M2 Actual £m	Var £m	Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£5.81)	(£5.87)	(£0.06)	(£16.10)	(£16.10)	(£0.00)	
Capital	£2.52	£2.38	£0.14	£28.22	£28.22	£0.00	
Cash	£1.94	£1.93	(£0.01)	£1.95	£1.91	(£0.04)	
Borrowing	£42.11	£41.93	(£0.18)	£67.87	£67.51	(£0.36)	
CIP	£1.24	£1.26	£0.03	£14.00	£14.00	£0.00	
Financial Sustainability Risk Rating	2	2		2	2		

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 continue 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.

Trust Financial Overview as at 31st May 2016 - Month 2

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

YEAR TO DATE POSITION: M2

CLINICAL ACTIVITY

	M2 Plan	M2 Actual	Var
Elective	1,436	1,233	(203)
Non-Elective	8,592	8,362	(230)
Daycase	6,024	6,249	225
Outpatient	55,355	56,657	1,302
A&E	24,960	25,708	748
OTHER NHS NON-TARIFF	258,073	271,042	12,969
OTHER NHS TARIFF	19,070	20,630	1,560
Total	373,510	389,881	16,371

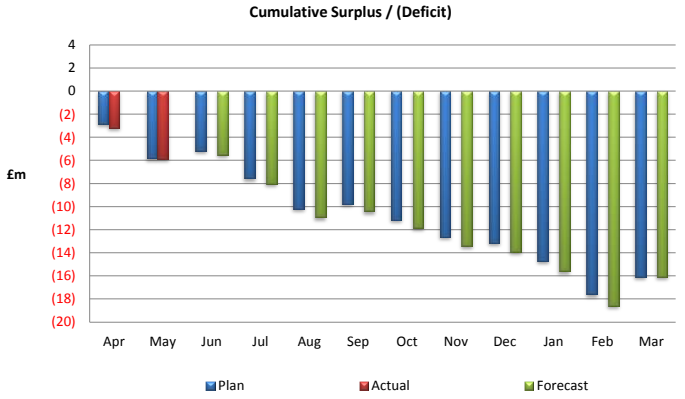
TRUST: INCOME AND EXPENDITURE

	M2 Plan	M2 Actual	Var
	£m	£m	£m
Elective	£3.67	£3.20	(£0.47)
Non Elective	£14.53	£14.63	£0.10
Daycase	£4.30	£4.35	£0.05
Outpatients	£7.08	£7.32	£0.24
A & E	£2.76	£2.85	£0.09
Other-NHS Clinical	£19.39	£20.25	£0.86
CQUIN	£1.10	£1.14	£0.04
Other Income	£6.53	£6.15	(£0.38)
Total Income	**£59.37**	**£59.89**	**£0.53**
Pay	(£40.13)	(£40.95)	(£0.82)
Drug Costs	(£5.89)	(£5.77)	£0.12
Clinical Support	(£5.08)	(£5.18)	(£0.10)
Other Costs	(£7.82)	(£7.81)	£0.01
PFI Costs	(£2.01)	(£2.00)	£0.00
Total Expenditure	**(£60.93)**	**(£61.71)**	**(£0.78)**
EBITDA	**(£1.57)**	**(£1.82)**	**(£0.25)**
Non Operating Expenditure	(£4.24)	(£4.05)	£0.19
Deficit excl. Restructuring	**(£5.81)**	**(£5.87)**	**(£0.06)**
Restructuring Costs	(£0.00)	£0.00	£0.00
Surplus / (Deficit)	**(£5.81)**	**(£5.87)**	**(£0.06)**

DIVISIONS: INCOME AND EXPENDITURE

	M2 Plan	M2 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£2.74	£2.76	£0.03
Medical	£3.86	£3.74	(£0.13)
Families & Specialist Services	(£0.85)	(£1.03)	(£0.18)
Community	£0.80	£0.57	(£0.23)
Estates & Facilities	(£4.48)	(£4.38)	£0.11
Corporate	(£4.03)	(£4.11)	(£0.07)
THIS	£0.07	£0.07	£0.00
PMU	£0.37	£0.31	(£0.06)
Central Inc/Technical Accounts	(£3.55)	(£3.81)	(£0.26)
Reserves	(£0.73)	£0.00	£0.73
Surplus / (Deficit)	**(£5.81)**	**(£5.87)**	**(£0.06)**

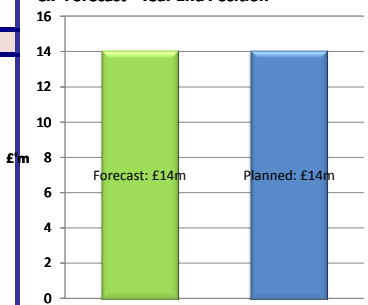
TRUST SURPLUS / (DEFICIT)



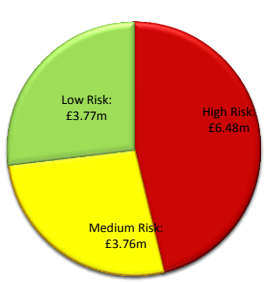
KEY METRICS

	Year To Date			Year End: Forecast			
	M2 Plan	M2 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£5.81)	(£5.87)	(£0.06)	(£16.10)	(£16.10)	(£0.00)	
Capital	£2.52	£2.38	£0.14	£28.22	£28.22	£0.00	
Cash	£1.94	£1.93	(£0.01)	£1.95	£1.91	(£0.04)	
Loans	£42.11	£41.93	(£0.18)	£67.87	£67.51	(£0.36)	
CIP	£1.24	£1.26	£0.03	£14.00	£14.00	£0.00	
	Plan	Actual		Plan	Forecast		
Risk Rating	2	2		2	2		

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14m



Total Forecast £14m

YEAR END 2016/17

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	8,787	8,343	(444)
Non-Elective	51,619	50,861	(757)
Daycase	36,895	37,497	603
Outpatient	338,922	341,669	2,747
A&E	148,571	148,712	141
OTHER NHS NON-TARIFF	1,556,020	1,569,918	13,898
OTHER NHS TARIFF	115,305	118,585	3,281
Total	2,256,117	2,275,586	19,468

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£22.48	£21.68	(£0.79)
Non Elective	£87.09	£87.97	£0.87
Daycase	£26.37	£26.28	(£0.09)
Outpatients	£43.43	£44.20	£0.77
A & E	£16.43	£16.53	£0.10
Other-NHS Clinical	£129.03	£131.85	£2.82
CQUIN	£6.79	£6.95	£0.16
Other Income	£39.90	£39.32	(£0.58)
Total Income	**£371.52**	**£374.79**	**£3.27**
Pay	(£237.12)	(£241.02)	(£3.91)
Drug Costs	(£35.59)	(£35.82)	(£0.24)
Clinical Support	(£30.17)	(£30.53)	(£0.36)
Other Costs	(£47.05)	(£46.62)	£0.42
PFI Costs	(£12.04)	(£12.02)	£0.02
Total Expenditure	**(£361.96)**	**(£366.01)**	**(£4.05)**
EBITDA	**£9.56**	**£8.77**	**(£0.79)**
Non Operating Expenditure	(£25.66)	(£24.88)	£0.78
Deficit excl. Restructuring	**(£16.10)**	**(£16.10)**	**(£0.00)**
Restructuring Costs	(£0.00)	£0.00	£0.00
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**

DIVISIONS: INCOME AND EXPENDITURE

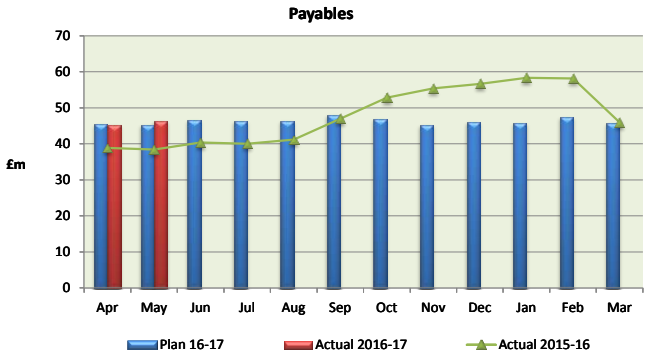
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£19.52	£19.53	£0.00
Medical	£22.07	£22.07	(£0.00)
Families & Specialist Services	(£2.51)	(£2.51)	(£0.00)
Community	£4.86	£4.86	(£0.00)
Estates & Facilities	(£26.69)	(£26.69)	£0.00
Corporate	(£24.04)	(£24.04)	(£0.00)
THIS	£0.47	£0.47	(£0.00)
PMU	£2.62	£2.62	£0.00
Central Inc/Technical Accounts	(£10.02)	(£10.08)	(£0.06)
Reserves	(£2.38)	(£2.33)	£0.05
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**

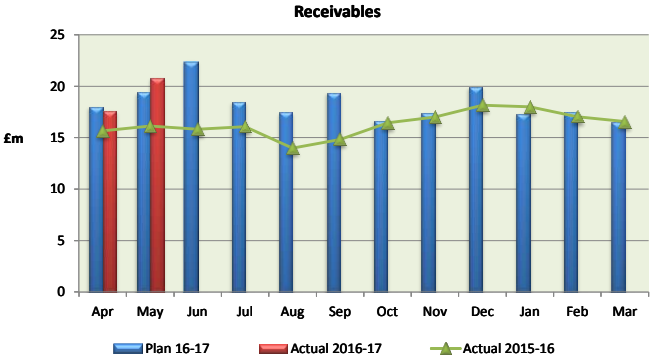
Trust Financial Overview as at 31st May 2016 - Month 2

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

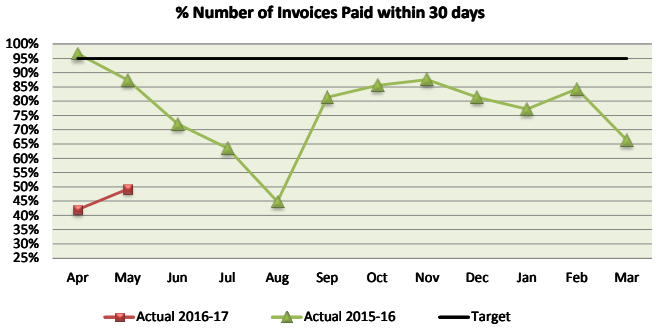
WORKING CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Payables	(£45.30)	(£46.41)	£1.11	
Receivables	£19.41	£20.78	(£1.37)	



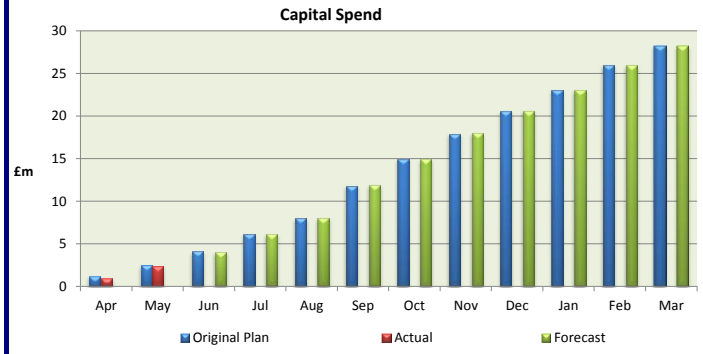


BETTER PAYMENT PRACTICE CODE



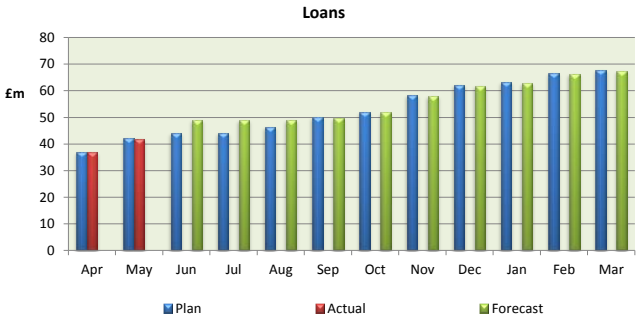
CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Capital	£2.52	£2.38	£0.14	

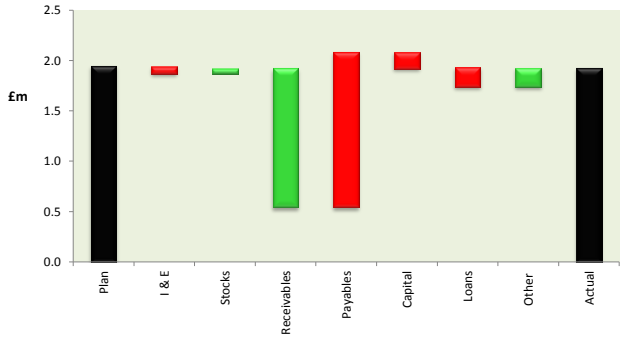


CASH

	M2 Plan £m	M2 Actual £m	Var £m	M2
Cash	£1.94	£1.93	(£0.01)	
Loans	£42.11	£41.93	(£0.18)	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £5.87m versus a planned deficit of £5.81m.
- Elective activity remains behind plan but is offset by higher than planned Outpatient, A&E and Daycase activity.
- Capital expenditure year to date is £2.38m against a planned £2.52m.
- Cash balance is virtually on plan with £1.93m against a planned £1.94m.
- As planned, the Trust borrowed a further £5.8m in month through our Independent Trust Financing Facility (ITFF) Working Capital Facility.
- CIP schemes delivered £1.26m in the year to date against a planned target of £1.24m.
- The Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

SUMMARY FORECAST

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

This position assumes full delivery of the planned £14.0m CIP and recovery of the year to date shortfall in the overall position against plan.

- Cash is forecast very close to plan at £1.91m.
- The Trust cash position relies on the Trust borrowing £37.63m in this financial year to support both Capital and Revenue plans.
- Forecast Capital expenditure is as planned at £28.22m .
- The year end FSRR is forecast to be at level 2 as planned.

RAG KEY: (Excl: Cash)

- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

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

RAG KEY - Cash:

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

ACTIVITY & CAPACITY

CLINICAL ACTIVITY

Activity summary by Point of Delivery

Point of Delivery	Detailed Point of Delivery	In-Month Plan Spells	In-Month Actual Spells	In-Month Spells Var	Year-to-date Plan YTD Spells	Year-to-date Actual YTD Spells	Year-to-date Spells var YTD
DAYCASE	DAYCASE	2,173	2,351	178	4,456	4,614	158
	DAYCASE ENDOSCOPY	765	804	39	1,569	1,635	66
DAYCASE Total		**2,939**	**3,155**	**216**	**6,024**	**6,249**	**225**
ELECTIVE	ELECTIVE	628	539	-89	1,287	1,073	-214
	ELECTIVE ENDOSCOPY	73	67	-6	149	160	11
ELECTIVE Total		**701**	**606**	**-95**	**1,436**	**1,233**	**-203**
NON-ELECTIVE	EMERGENCY SHORT STAY	2,018	2,001	-17	3,975	3,950	-25
	EMERGENCY LONG STAY	1,657	1,578	-79	3,252	3,149	-103
	EMERGENCY THRESHOLD	0	0	0	0	0	0
	NON-ELECTIVE LONG	327	305	-22	644	616	-28
	NON-ELECTIVE SHORT	362	339	-23	720	647	-73
NON-ELECTIVE Total		**4,363**	**4,223**	**-140**	**8,592**	**8,362**	**-230**
A&E	A&E	12,629	13,589	960	24,960	25,708	748
A&E Total		**12,629**	**13,589**	**960**	**24,960**	**25,708**	**748**
OUTPATIENT	OUTPATIENT FIRST	7,499	8,198	699	15,373	16,079	706
	OUTPATIENT PROCEDURE FIRSTS	1,860	2,010	150	3,813	3,983	170
	OUTPATIENT FOLLOW-UP	13,786	14,169	383	28,260	28,308	48
	OUTPATIENT PROCEDURE FOLLOW-UPS	3,858	4,049	191	7,909	8,287	378
OUTPATIENT Total		**27,002**	**28,426**	**1,424**	**55,355**	**56,657**	**1,302**
OTHER NHS TARIFF	CHEMOTHERAPY	597	631	34	1,224	1,246	22
	DIRECT ACCESS & OP	5,415	6,290	875	11,074	12,448	1,374
	MATERNITY PATHWAY	935	912	-23	1,869	1,850	-19
	OTHER NHS TARIFF	2,415	2,478	63	4,903	5,086	183
OTHER NHS TARIFF Total		**9,361**	**10,311**	**950**	**19,070**	**20,630**	**1,560**
OTHER NHS NON-TARIFF	CRITICAL CARE - ADULT	384	562	178	675	857	182
	CRITICAL CARE - NICU	516	545	29	990	1,152	162
	DIAGNOSTIC TESTS & IMAGING	115,815	119,651	3,836	235,221	246,032	10,811
	OUTPATIENTS LOCAL PRICE	3,789	4,357	568	7,767	8,683	916
	PASS THROUGH DEVICES	48	44	-4	96	99	3
	PASS THROUGH HCDS	0	0	0	0	0	0
	REHABILITATION	1,820	2,024	204	3,581	3,953	372
	OTHER NHS NON-TARIFF	4,851	5,313	462	9,743	10,266	523
OTHER NHS NON-TARIFF Total		**127,222**	**132,496**	**5,273**	**258,073**	**271,042**	**12,969**
Grand Total		**184,216**	**192,806**	**8,590**	**373,510**	**389,881**	**16,371**

Overall activity has seen a stronger performance in month 2 and is ahead of plan against all points of delivery with the exception of elective and non-elective inpatients. This is also now the case within the cumulative position.

• Planned day case and elective activity performance is improved at 3.3% (121 spells) above the month 2 plan. This is driven by over-performance within day case activity, with elective activity remaining below plan. The improvement within day case is mainly within Ophthalmology, Gastroenterology and Interventional Radiology. The Ophthalmology position is due to increased capacity with all previously vacant posts now filled with agency, Gastroenterology activity has increased due to additional Waiting List Initiatives (WLI) to deliver demand with Interventional Radiology seeing a shift from elective to day case. 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. Trauma and Orthopaedics (T&O) elective activity has seen stronger performance in month 2 and whilst this has not recovered the shortfall seen in April due to the impact of the Junior Doctors' 48hr Strike and slower than planned retraction of medical patients from T&O beds, this is in line with the May plan.

• Non-elective activity overall is 3.2% (140 admissions) below the month 2 plan which is a continued reduction from April. This continues to be mainly driven by emergency long-stay, across a range of specialties and obstetric/midwifery admissions.

• A&E has seen activity 7.6% (960 attendances) above the month 2 plan which is a significant increase from month 1. This position also represents a significant increase in attendances when compared to May 2015/16.

• Outpatient activity has seen a significant increase across first and follow-ups and is 5.3% (1,424 attendances) above the month 2 plan. The most significant over-performances are within T&O, Dermatology, Gynaecology, Gastroenterology, Rheumatology, ENT and Oral Surgery. The Dermatology position has continued to be driven by the service 'getting ahead' and clearing an ASI backlog prior to a substantive consultant leaving at the end of May. Gastroenterology is due to additional WLI sessions as outlined earlier. Increases in referrals have been seen within T&O, ENT, Ophthalmology and Rheumatology.

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ACTIVITY & CAPACITY (2)

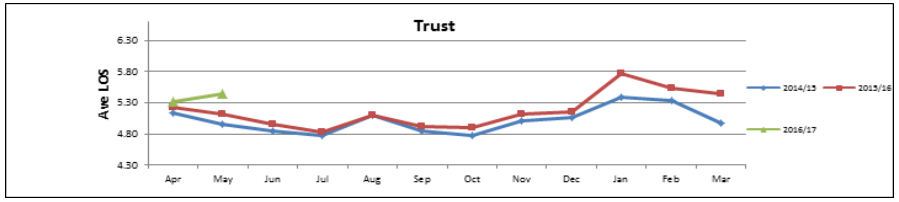
CAPACITY

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										
eds 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. There has been a significant increase in the mobile MRI usage through increased referrals. Ultrasound has also seen an increase in demand, with the requirement of additional agency capacity in order to deliver this.

- Diagnostic testing is 3.3% (3,838 tests) above the month 2 plan which continues to be driven by a large increase within Biochemistry and Haematology.

- Adult Critical Care is 46% (178 bed days) above the month 2 plan. This is solely driven by a long-stay, 6-organ supported patient admitted in November 2015 and discharged from the Trust in May 2016.

- NICU has seen a slowing of the over-performance seen in month 1, with activity 5.6% (29 bed days above the month 2 plan.

- Rehabilitation is 11.2% (204 bed days) above the month 2 plan in line with that seen April, driven by an continued increase within Calderdale due to care home bed capacity pressures.

- Overall Trust level bed numbers are 10 above the month 2 plan which is an increase in the number of beds when compared to April. This is within the Medical bed base, with Surgical and FSS beds in line with plan.

- The average Trust length of stay (LOS) for May was 5.45 days which is an increase from April. 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 decreased, LOS has increased, therefore leading to the increased bed numbers referenced above. Both Surgical and FSS have seen a small decrease in LOS.

INCOME

Summary of Operating Income

Income category	In-Month			Year-to-date		
	Plan Income (£)	Actual Income (£)	Income Variance (£)	Plan (£'m)	Actual (£'m)	Variance (£'m)
NHS Clincal Contract Income	25.04	25.72	0.68	50.10	51.18	1.08
Other-NHS Clinical Income	1.37	1.18	-0.19	2.74	2.57	-0.17
Sub-Total NHS Clinical Income	**26.41**	**26.90**	**0.49**	**52.84**	**53.75**	**0.91**
Other Non-NHS Clincial Income	0.53	0.5	-0.08	1.05	0.98	-0.07
Total Clinical Income	**26.94**	**27.35**	**0.41**	**53.88**	**54.73**	**0.84**
Other Non-Clincial income	2.74	2.6	-0.15	5.48	5.17	-0.32
Total Operating Income	**29.68**	**29.95**	**0.27**	**59.37**	**59.89**	**0.53**

Summary of Clinical Contract Income - by Point of Delivery

Point Of Delivery	In-Month			Year-to-date		
	Plan Income (£)	Actual Income (£)	Income Variance (£)	Plan YTD Income (£)	Actual YTD Income (£)	Variance Income (£)
DAYCASE	2.10	2.20	0.10	4.30	4.35	0.05
ELECTIVE	1.79	1.63	-0.16	3.67	3.20	-0.47
NON-ELECTIVE	7.38	7.45	0.07	14.53	14.63	0.10
A&E	1.40	1.51	0.11	2.76	2.85	0.09
OUTPATIENT	3.45	3.68	0.22	7.08	7.32	0.24
OTHER NHS TARIFF	1.92	1.93	0.01	3.85	3.89	0.04
OTHER NHS NON-TARIFF	6.44	6.74	0.30	12.80	13.78	0.98
CQUIN	0.55	0.58	0.03	1.10	1.14	0.04
Grand Total	**25.04**	**25.72**	**0.68**	**50.10**	**51.18**	**1.08**

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

Commissioner	In-month			Year-to-Date		
	Plan (£'m)	Actual (£'m)	Variance (£'m)	Plan (£'m)	Actual (£'m)	Variance (£'m)
NHS Calderdale CCG	11.24	11.38	0.14	22.51	22.62	0.11
NHS Greater Huddersfield CCG	10.16	10.32	0.16	20.31	20.59	0.28
Other CCG's	1.58	1.74	0.16	3.15	3.42	0.27
NHS England	2.07	2.28	0.21	4.13	4.55	0.42
Total Commissioners	**25.04**	**25.72**	**0.68**	**50.10**	**51.18**	**1.08**

Operating Income

There is a £0.27m favourable variance from the month 2 plan within operating income.

NHS Clinical Income

Within the £0.27m favourable income variance, NHS Clinical income shows a favourable variance of £0.49m. Non-pay spend on pass-through drug and devices is driving clinical income of £0.10m below plan. The remaining £0.59m favourable income variance is mainly due to Clinical Contract PbR income.

The Clinical Contract PbR income position is driven by over-performances within Day case, A&E, Outpatients, Adult Critical Care (in relation to the long-stay 6-organ supported patient), Rehabilitation and Diagnostic testing & imaging. Despite non-elective admissions being below planned levels, the specialty level casemix has lead to a small over-performance in income. 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 2 plan for all of the Trust's Commissioners. The over-performance against the CCG Commissioners is driven by day case, A&E, outpatients, adult critical care and rehabilitation as described above. The over-performance within the NHS England contract is driven by specialist emergency admissions, adult critical care, NICU and Oral Surgery outpatients.

Other income

Overall other income is £0.23m below the planned level for month 2. This is mainly due to continued 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, thereby under-delivering within non-NHS Clinical income but off-setting an 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	10.94	11.38	0.44	21.91	22.62	0.71
NHS Greater Huddersfield CCG	9.87	10.32	0.45	19.73	20.59	0.86
Other CCG's	1.55	1.74	0.20	3.11	3.42	0.32
NHS England	2.20	2.28	0.08	4.41	4.55	0.14
Total Commissioners	**24.56**	**25.72**	**1.16**	**49.15**	**51.18**	**2.03**

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 2 income position represents £1.16m above the month 2 Commissioner Contract value. This is mainly driven by emergency admissions, outpatients, A&E and rehabilitation and adult critical care all above the Commissioner contract value.

Contractual Sanctions

The Commissioner Contract includes all NHS Standard Contract Operational Standards and any applicable financial sanctions. Some of these are included within the Sustainability Transformational Fund (STF) performance trajectories and so will not be subject to 'double jeopardy' within the Commissioner Contract. Month 2 performance has seen 14 ambulance handover breaches, bringing the cumulative value to £6k but due to the link to the STF, this is not reflected within the year-to-date income position.

CQUIN

The performance and income against each CQUIN scheme within the Contract is measured against quarterly targets. At month 2, the Sepsis scheme is flagging as a risk as only 3 out of the 4 Q1 targets will be met, specifically relating to achievement of 90% of patients screened within ED. This element of the CQUIN recognises partial payment of achievement of 50-70% and therefore places £0.02m of Q1 CQUIN funding at risk. The Commissioner Contract includes agreement that the Commissioners will not automatically make a cash adjustment for non-delivery and so no risk of this is currently included within the month 2 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.

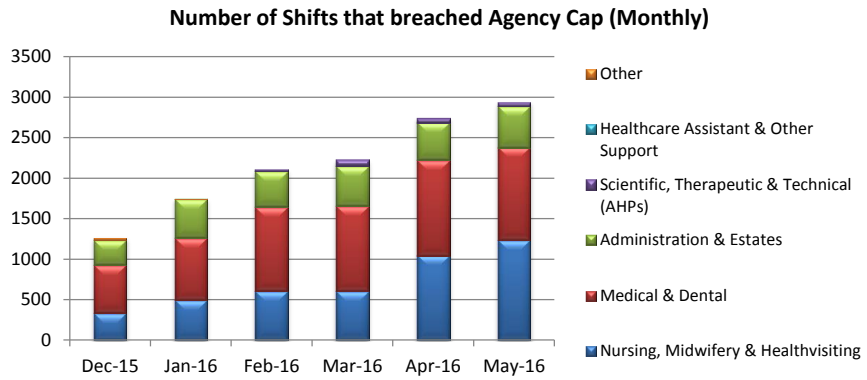
Commissioner Contractual Challenges

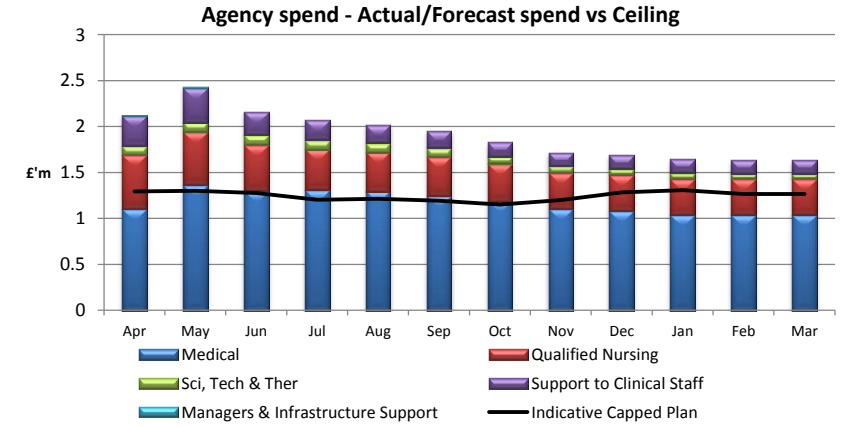
The NHS Standard Contract enables Commissioners to formally make monthly contractual challenges. No challenges have yet been made in relation to 2016/17 and there is currently no risk relating to this included within the year-to-date position.

WORKFORCE

Vacancies

	Sci, Tech &	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	56	71	92	191	80	490
Staff in post (WTE)	611	1,186	509	1,651	1,128	5,085
% Vacancies	8%	6%	15%	10%	7%	9%





For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement. This is in the context of actual expenditure incurred in 2015/16 of £19.93m. The Trust must do all that it can to aim to achieve this target which will be extremely challenging. A simple extrapolation of the year to date agency spend would suggest a potential to spend £27.4m in 2016/17, threatening both compliance with the ceiling but also delivery of the overall control total deficit. Capped hourly rates for agency staff were also introduced by NHSI in 2015/16 which are tightened to lower rates from April 2016 and there is a requirement for all agency staff to be booked through approved procurement frameworks.

Vacancies

In overall terms at the end of Month 2 the Trust was carrying 490 vacancies, a rate of 9% of the total establishment which is static from last month. The highest vacancy rates continue to be in directly patient facing staff groups, medical and nursing staffing at 15% and 10% respectively, which are essential to delivery of activity and maintenance of safe and high quality services. In order to quell the unaffordable use of agency staff recruitment to these posts must be a priority.

Agency rate cap

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

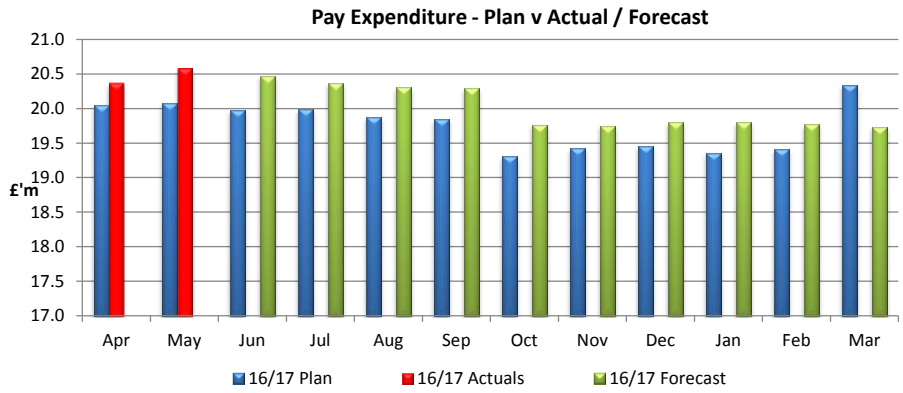
The number of breaches reported in April increased, partly as a result of the reduced cap rate threshold but on a level playing field from April onwards the number of breaches has increased again in May. The number of breaches is exceeding 700 shifts on a weekly basis and the cost in excess of capped rates is above £0.50m per month.

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 2, against a trajectory of £1.30m, actual spend is £2.44m. Divisional forecasts, informed by recent run rates but assuming a level of constraint going forwards based on actions that are being mobilised, project a full year spend of £22.97m illustrated by staff group on the graph opposite.

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. **This provides a significant risk for the Trust.**

EXPENDITURE - PAY



	Pay Expenditure including Agency								
	M2 YTD Budget	M2 YTD Actual							M2 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	7.17	7.06	5.05	1.21		0.20	0.10	0.51	-0.10
Junior Medical	4.55	4.76	3.10	1.26		0.06	0.13	0.21	0.21
Qualified nursing, midwifery and health visiting staff	12.40	12.85	11.12	1.16	0.06		0.40	0.10	0.44
Sci Tech & Ther	4.31	4.52	4.18	0.21	0.03		0.07	0.04	0.21
Support to Nursing staff	3.11	3.59	2.95	0.19	0.29		0.14	0.03	0.48
Support to clinical staff	1.15	1.61	0.98	0.51	0.09		0.01	0.01	0.46
Non Clinical									0.00
Managers and infrastructure support	6.70	6.53	6.29	0.03	0.03		0.12	0.07	-0.18
Any Other Spend	0.04	0.03	0.03						-0.01
Pay Reserves	0.69								-0.69
TRUST TOTAL	**40.13**	**40.95**	**33.70**	**4.57**	**0.49**	**0.26**	**0.97**	**0.96**	**0.82**

Pay costs are £0.50m higher than the planned level in month, up from an adverse variance of £0.32m in Month 1, showing a worsening in run rate which is also illustrated in the increase in absolute expenditure. It should be noted that the £2.0m of contingency reserves are planned against pay in equal instalments across the first six months of the financial year. Two months of this contingency, £0.69m, has been released against the pay position, meaning that the underlying divisional year to date pay overspend was £1.48m.

Whilst the number of beds open in May was slightly above the planned level this is not the primary driver of the additional spend. Rather, it is the carrying of high vacancy levels in clinical staff groups that is causing reliance on agency staffing with the associated premium rates that drives the overspend.

The largest area of overspend by staff group is nursing, the combined overspend against qualified nursing and support to nursing (Healthcare Assistants) is £0.90m in the month. £1.35m was spent on agency staffing in these staff groups across the first two months. The bonus scheme to reward substantive staff for working additional shifts with the aim of avoiding the higher agency premiums has ceased from the end of May and the effectiveness of the escalation protocols for booking agency staffing is being reviewed.

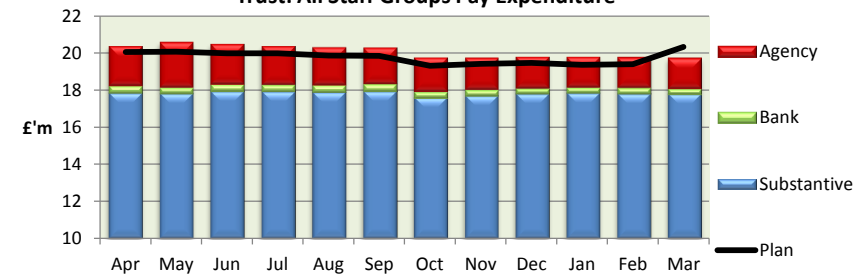
Recruitment difficulties also remain an issue in certain Medical and Surgical specialties for medical staff. This is driving additional costs through the requirement to use agency locum staff in key areas. The overspend against medical staffing at a net £0.11m is lower than the nursing overspend in month as the use of agency is offset in part by these unfilled staffing gaps. The absolute cost of medical agency is however higher at £2.47m in the year to date, against £1.35m spent on nursing agency. There is a balance to be struck in engaging medical staffing between the high cost of employment against the potential income lost through staffing gaps, this assessment is being made on a case by case basis by Divisions.

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 immediate and powerful in order to manage what is one of the most significant risks to delivery of the Trust's financial plan.

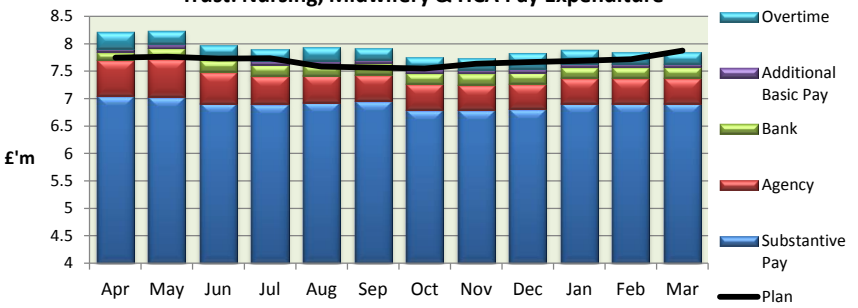
EXPENDITURE - PAY

Actual & Forecast Pay Expenduture

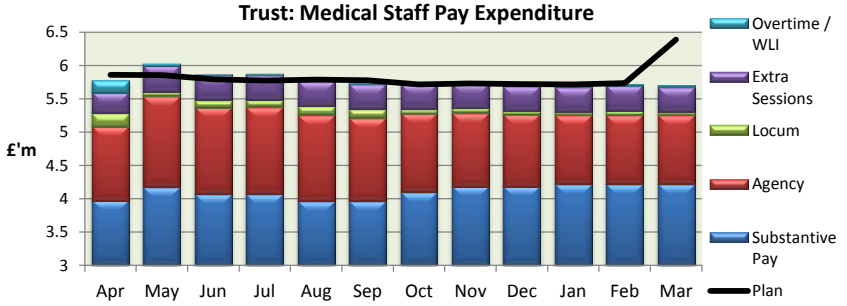
Trust: All Staff Groups Pay Expenditure



Trust: Nursing, Midwifery & HCA Pay Expenditure

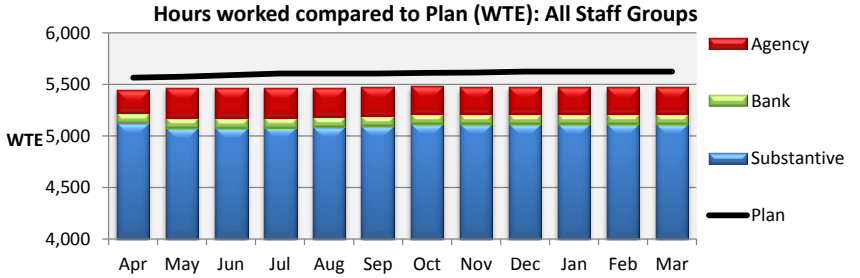


Trust: Medical Staff Pay Expenditure

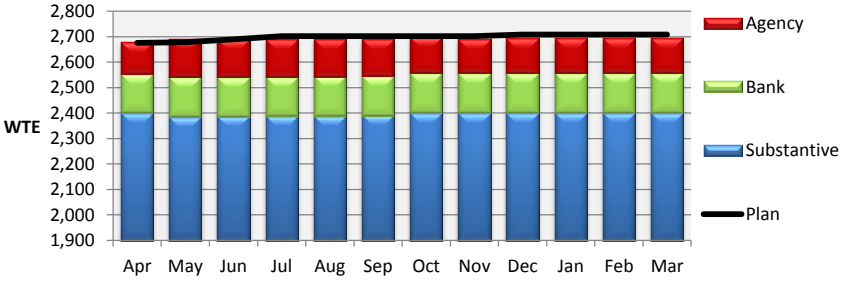


Actual & Forecast Staffing WTE

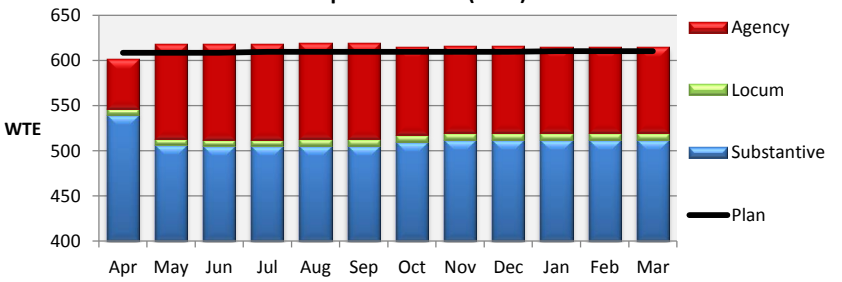
Hours worked compared to Plan (WTE): All Staff Groups



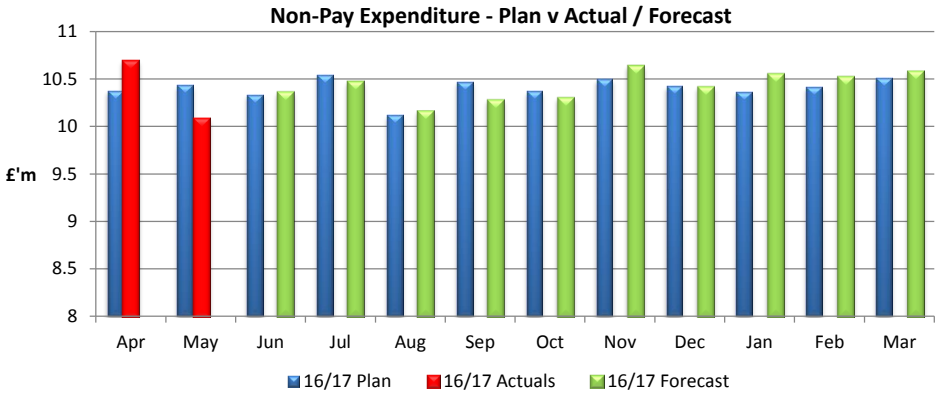
Hours worked compared to Plan (WTE): Nursing, Midwifery & HCA



Hours worked compared to Plan (WTE): Medical Staff



EXPENDITURE - NON PAY



	M2 Plan £m	M2 Actual £m	Var £m	
Drug Costs	(£5.89)	(£5.77)	£0.12	
Clinical Support	(£5.08)	(£5.18)	(£0.10)	
Other Costs	(£7.82)	(£7.81)	£0.01	
PFI Costs	(£2.01)	(£2.00)	£0.00	
Total Operating Expenditure	**(£20.81)**	**(£20.77)**	**£0.04**	
Non Operating Expenditure	(£4.24)	(£4.05)	£0.19	
Restructuring Costs	(£0.00)	£0.00	£0.00	
Total Non Operating Expenditure	**(£4.24)**	**(£4.05)**	**£0.19**	
Total Expenditure	**(£25.05)**	**(£24.82)**	**£0.23**	

Drug costs

Year to date expenditure on drugs was £0.12m below the planned level. Within this, the income and corresponding spend on 'pass through' high cost drugs is £0.21m below plan, this comprises pass through costs from the contracts with the main commissioners as well as the Cancer Drugs Fund and a Hepatitis C drug for which the Trust receives funding directly from NHS England.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £0.08m 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 is 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 reduced from the level seen last month at £0.20m, primarily due to non recurrent benefits within the Estates division of rebates on rates and utilities.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.19m below the planned level.

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

This benefit is supplemented in Month 2 by a £0.06m gain on disposal 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 and none are forecast at present.

SUSTAINABILITY & TRANSFORMATION FUND

Terms and Conditions

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

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

Deliver agreed control total
2016/17 plans were submitted to NHSI in line with their deadlines. The I&E plan is for delivery of the £16.1m control total as set for the Trust by NHSI. The Trust has highlighted to NHSI the level of risk that this plan carries, particularly around the implementation of the new EPR system. At the end of Month 2 the forecast is to deliver the £16.1m planned deficit in line with the control total.

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 c.700 breaches per month against the hourly capped rates. This presents a serious risk of non compliance with the NHSI agency controls and puts receipt of the STF at risk.

As yet the Trust has not received formal approval of the planned capital investment of £28.2m 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 comitted spend; an assessment of essenial versus non essential investments, all of which was required to be cross reference to the Trust's strategies and risk register.

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

Access standards
Whilst the in-month STF trajectory for A&E 4 hour waits has not been achieved (93.4% achieved against STF trajectory of 94%), cumulatively this metric is on track and so no risk to the STF funding is assumed in relation to this. At this stage the Trust is not highlighting any other material risk against performance of the planned trajectories as submitted to Monitor in the course of the first quarter.

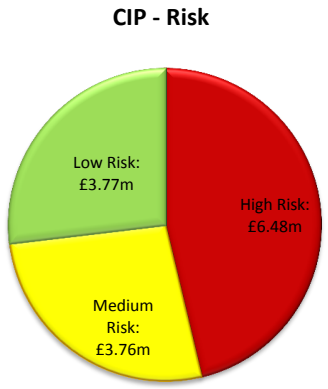
Transformation
The Trust will work with commissioners and develop an integrated five-year plan in line with the national STP timetable. This is very much linked to the work that has already been completed locally to develop the 5 year transformation strategy which the commissioners currently have out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

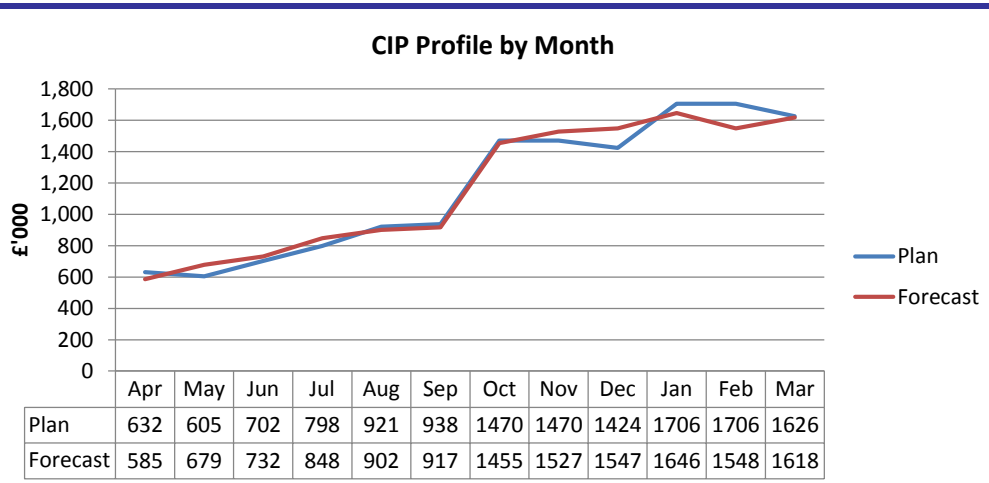
Implementation of the 5 year transformation strategy is dependent upon both the outcome of public consultation and approval of the required funding support from Treasury.

Seven day services
Investment was made in 2016/17 in the Hospital at Night project which will 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	**6.63**	7.96
Drugs	**0.35**	0.30
Blood	**0.04**	0.06
Clinical supplies & services	**1.26**	0.88
Other Costs (excl. depreciation)	**1.11**	1.09
Depreciation on owned assets	**0.60**	0.00
Utilities	**0.17**	0.17
Clinical Income	**3.42**	3.17
Other income	**0.43**	0.38
Grand Total	**14.00**	**14.00**





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	632	605	702	798	921	938	1470	1470	1424	1706	1706	1626
Forecast	585	679	732	848	902	917	1455	1527	1547	1646	1548	1618

In the year to date, £1.26m of CIP has been delivered against a plan of £1.24m.

The delivery of CIP has been profiled based on a combination of known scheme delivery dates but also with sufficient lead and development time for schemes currently at opportunity stage rather than well progressed. Whilst this presents a risk and the in-month CIP challenge increases from £0.61m in month to £1.63m by month 12, full CIP delivery is currently forecast.

CIP Update at 13th June 2016

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

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

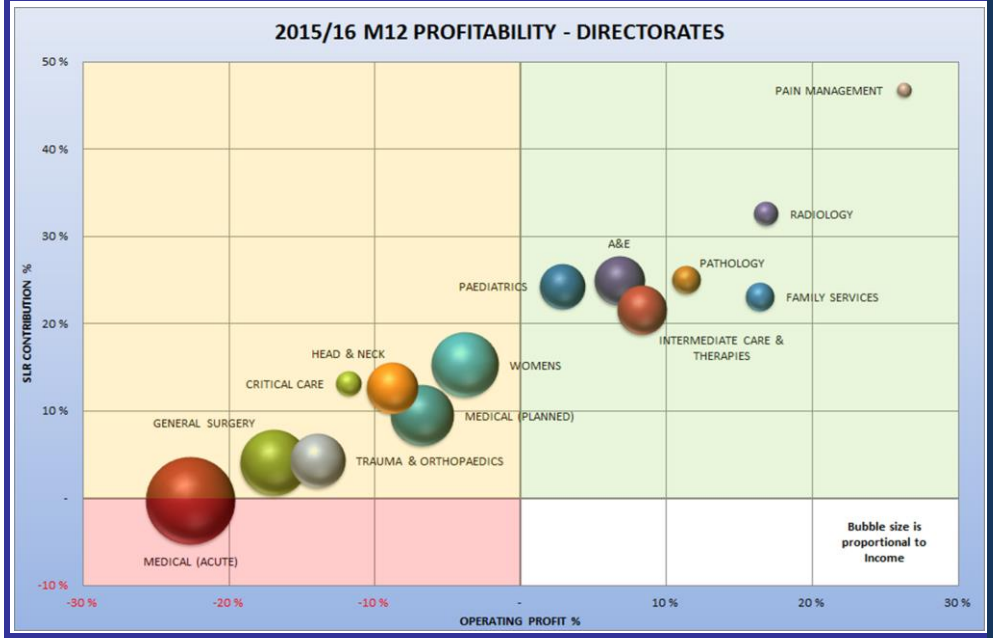
As of mid June, £14m of scheme opportunities have been identified with £12m at Gateway 2 (includes GW2 approved and GW2 ready). A further £0.62m is at Gateway 1 and £0.56m remains as 'ideas in development'. In month, several schemes were not approved at QIA panel and these schemes will be revisited through the governance process as appropriate.

Summary

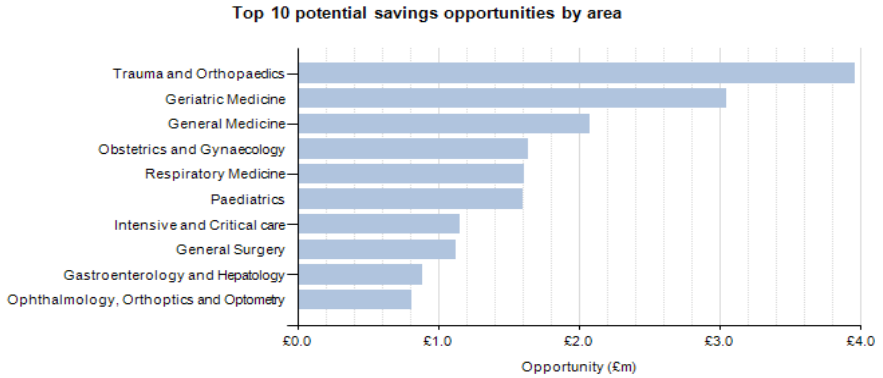
Work is urgently required to develop schemes through to GW 2 but also to ensure that risks of non-delivery are mitigated and schemes are delivered. A further challenge is to increase the value and volume of ideas as delivery of the £14m target within plan will need all current ideas to progress and be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

SERVICE LINE REPORTING

SERVICE LINE REPORTING



CARTER REVIEW



The view opposite illustrates the relative profitability of the Trust's divisions and clinical directorates at a summary level for the full year 2015/16 (revised).

Service Line Reporting (SLR) is a summarised view created by the trust's Patient Level Information & Costing System (PLICS). PLICS uses the patient level information held in the various clinical systems to inform the fair allocation and apportionment of costs, from the financial systems, to the treatment of each individual patient. This level of detail allows us to analyse the key drivers of cost within each service and even identify variability by treatment or clinician.

The Carter Review aims to identify and understand unwarranted variations in the activities and costs of acute trusts. There is a correlation between the areas of suggested focus from the Carter Review and the internally generated SLR information. The detail provided by PLICS has helped to analyse this variation, which has stimulated positive engagement with service managers and clinical leads in a number of areas.

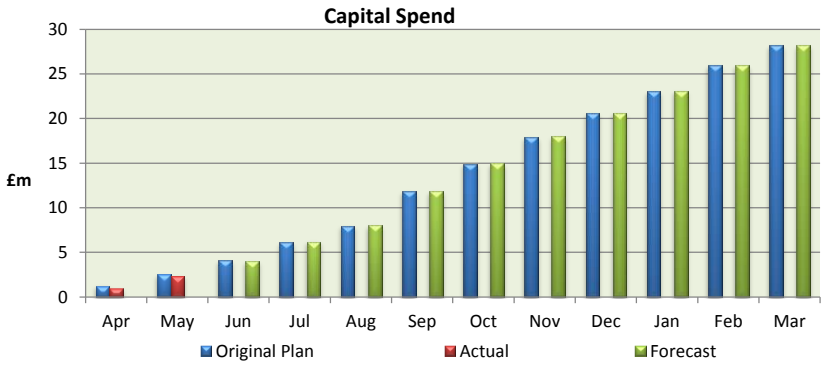
In many cases these service level reviews have identified opportunities for improving costs. These could be simple cost savings (eg. better procurement and standardisation), greater efficiencies (eg. theatre and clinic throughput) or improved patient care/experience (eg. daycases, enhanced recovery, efficient discharge).

Further analysis of service profitability highlights that the largest losses are being made by Geriatric Medicine and Trauma (Non-elective Orthopaedics - mainly hips and knees). Length of stay is a major factor in the cost of care within these services. These opportunities are being pursued at a service level as part of the CIP programme.

CAPITAL

CAPITAL - TOTAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Capital	£2.52	£2.38	£0.14	



CAPITAL - BY SCHEME

	Year To Date			Year End: Forecast		
	M2 Plan	M2 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
Theatre refurbishment	£0.53	£0.50	£0.03	£2.60	£2.60	£0.00
Ward upgrades	£0.04	£0.00	£0.04	£2.40	£2.40	£0.00
Other Estates	£0.11	£0.11	£0.01	£5.97	£5.97	£0.00
Total Estates	**£0.68**	**£0.61**	**£0.07**	**£10.97**	**£10.97**	**£0.00**
Electronic Patient Record	£0.40	£0.41	(£0.01)	£4.74	£4.74	£0.00
Other IT	£1.05	£0.96	£0.09	£2.94	£2.94	£0.00
Total IT	**£1.45**	**£1.37**	**£0.08**	**£7.67**	**£7.67**	**£0.00**
Equipment	£0.15	£0.03	£0.12	£7.22	£7.22	£0.00
PFI Lifecycle	£0.24	£0.24	£0.01	£1.46	£1.46	£0.00
Other	£0.00	£0.14	(£0.14)	£0.91	£0.91	£0.00
Total Other	**£0.39**	**£0.40**	**(£0.01)**	**£9.58**	**£9.58**	**£0.00**
Total Capital	**£2.52**	**£2.38**	**£0.14**	**£28.22**	**£28.22**	**£0.00**

Capital expenditure in the year to date is £2.38m which is £0.14m below the planned level of £2.38m.

Against the Estates element of the total, year to date expenditure is £0.60m against a planned £0.68m. The main area of spend in month was on the continuation of the Theatre refurbishment programme has continued and this is back on track as expected with a year to date spend of £0.50m being £0.03m under the plan of £0.53m, spend on backlog maintenance has continued including the continuation of work to improve privacy and dignity within the radiology department and fire compartmentation work. The Ward refurbishment was planned to commence in May but the plans are currently under review, resulting in being under plan by £0.04m.

IM&T investments total £1.37m against plan of £1.45m. The main areas of spend in month is against Single Sign on, the continuation of the Electronic Patient Record (EPR), and EDMS projects and replacement of PCs and laptops. Other IT spend is under plan by £0.09m in the main due to Wired Network and Security being planned for from May but no business case as yet having been approved.

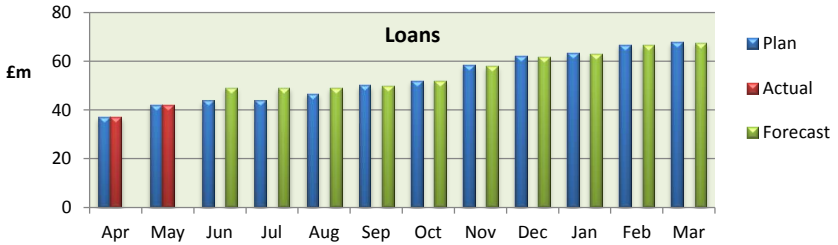
Expenditure on replacement equipment in the year to date is also lower than plan.

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

CASH

CASH & BORROWING

	M2 Plan	M2 Actual	Var	M2
	£m	£m	£m	
Cash	1.94	1.93	(£0.01)	
Loans	£42.11	£41.93	(£0.18)	



CASH FLOW

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	(0.06)
	Non cash flows in operating deficit	(0.15)
	Other working capital movements	0.83
	Sub Total	**0.61**
Investing activities	Capital expenditure	0.14
	Movement in capital creditors	(0.92)
	Sub Total	**(0.78)**
Financing activities	Drawdown of external DoH cash support	0.00
	Other financing activities	0.15
	Sub Total	**0.15**
	Grand Total	**(0.01)**

KEY METRICS

RECEIVABLES:

As at Month 2 16/17 Aged Debt was as follows

Days	30-60	61-90	91-120	121-180	180-360	360+	Total
£m	0.52	0.37	0.41	0.30	0.50	0.48	**2.58**
No Invoices	467	197	188	207	365	511	**1,935**

PAYABLES:

£m	**6.48**	Value of approved invoices not paid at month end
No Invoices	**6,205**	No. of approved invoices not paid at month end

At the end of May 2016 the Trust had a cash balance of £1.93m against a planned position of £1.94m, an adverse variance of £0.01m. The overspend on pay particularly driven by agency staffing drives an immediate outflow of cash above planned levels. This is putting pressure on the Trust's ability to pay other suppliers and has caused a number of suppliers 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.

Operating activities

Operating activities show a favourable £0.61m variance against the plan. The adverse cash impact of the I&E position of £0.21m (£0.06m adverse I&E variance plus £0.15m non-cash flows in operating deficit) offset by favourable working capital variances from plan. The working capital variance demonstrates the holding back of payments to suppliers in order to manage the overall cash position, due to the overspend on agency staffing which converts to cash more swiftly than receipts from commissioners on activity overperformance. This continues to be exacerbated by a number of overdue invoices from other NHS organisations.

Total aged debt based on invoices raised is £2.58m whilst outstanding creditors approved for payment to suppliers stood at £6.48m at month end. The impact of this is seen in the performance against the Better Payment Practice Code, in month 49% of invoices have been paid within 30 days against the 95% target. Payments are expected to catch up in June with the support of cash borrowing. Going forwards, the Trust is also looking to agree earlier cash settlement of activity overtrades with lead commissioners.

Investing activities (Capital)

The favourable cash impact of the £0.14m under spend is offset by a £0.92m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way.

Financing activities

Financing activities show a £0.15m favourable variance from the original plan which is purely a technical movement between current and non current provisions. The £5m capital loan was drawn down from the Independent Trust Financing Facility (ITFF) in April as planned as was £5.77m to support revenue in May.

The total level of net borrowing is lower than planned as the repayment schedule for the capital loan is on a shorter profile than anticipated.

FINANCIAL SUSTAINABILITY RISK RATING

	Plan YTD	Actual YTD
Capital Service Cover		
Revenue Available for Capital Service	(1.59)	(1.82)
Capital Service	3.26	3.45
Capital Service Cover metric	(0.49)	(0.53)
Capital Service Cover rating	1	1
Liquidity		
Working Capital for FSRR	(23.95)	(23.71)
Operating Expenses within EBITDA, Total	(60.93)	(61.71)
Liquidity metric	(23.58)	(23.05)
Liquidity rating	1	1
I&E Margin		
Normalised Surplus/(Deficit)	(5.81)	(5.93)
Adjusted Total Income for FSRR	59.37	59.96
I&E Margin	(9.79%)	(9.89%)
I&E Margin rating	1	1
I&E Margin Variance		
I&E Margin	(9.79%)	(9.79%)
I&E Margin Variance From Plan	0.36%	(0.10%)
I&E Margin Variance From Plan rating	4	3
Overall Financial Sustainability Risk Rating	2	2

Financial Sustainability Risk Rating

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

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

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

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

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

Trust Performance

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

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

As a guide, if the adverse variance from plan (excluding restructuring costs) for the full year were to exceed £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 Monitor and continues to run a deficit, maintaining FSRR level 2 will not in itself change the regulatory implications in terms of the regime that it in place. However, maintaining the Income and Expenditure Margin – Variance from Plan at a level 3 or above is an indicator of performance in itself.

FORECAST

YEAR END 2016/17

	Plan £m	Forecast £m	Var £m
Elective	£22.48	£21.68	(£0.79)
Non Elective	£87.09	£87.97	£0.87
Daycase	£26.37	£26.28	(£0.09)
Outpatients	£43.43	£44.20	£0.77
A & E	£16.43	£16.53	£0.10
Other-NHS Clinical	£129.03	£131.85	£2.82
CQUIN	£6.79	£6.95	£0.16
Other Income	£39.90	£39.32	(£0.58)
Total Income	**£371.52**	**£374.79**	**£3.27**
Pay	(£237.12)	(£241.02)	(£3.91)
Drug Costs	(£35.59)	(£35.82)	(£0.24)
Clinical Support	(£30.17)	(£30.53)	(£0.36)
Other Costs	(£47.05)	(£46.62)	£0.42
PFI Costs	(£12.04)	(£12.02)	£0.02
Total Expenditure	**(£361.96)**	**(£366.01)**	**(£4.05)**
EBITDA	**£9.56**	**£8.77**	**(£0.79)**
Non Operating Expenditure	(£25.66)	(£24.88)	£0.78
Deficit excl. Restructuring	**(£16.10)**	**(£16.10)**	**(£0.00)**
Restructuring Costs	(£0.00)	(£0.00)	(£0.00)
Surplus / (Deficit)	**(£16.10)**	**(£16.10)**	**(£0.00)**

KEY METRICS

	Plan £m	Forecast £m	Var £m
I&E: Surplus / (Deficit)	(£16.10)	(£16.10)	(£0.00)
Capital	£28.22	£28.22	£0.00
Cash	£1.95	£1.91	(£0.04)
Borrowing	£67.87	£67.51	(£0.36)
CIP	£14.00	£14.00	£0.00
Financial Sustainability Risk Rating	2	2	0

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

Electronic Patient Record implementation

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

Agency staffing usage

Recruitment and retention issues in particular are driving a higher agency staffing run rate than the budgeted level. There is a balance to be struck between maintaining safe staffing levels and delivering planned clinical activity at best value.

Planned activity delivery and commissioner affordability

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

In overall terms, contract income is forecast to exceed plan and therefore further exceed the commissioner contracts which are set below the CHFT plan. There is a risk that the funding available in the overall health economy is insufficient to deal with this pressure.

CIP delivery

The full £14m CIP requirement is not yet identified at a sufficiently detailed level to satisfy the Gateway 2 criteria and £6.48m of the overall £14m is flagged as high risk at this stage. The planned CIP profile is significantly weighted towards the latter part of the financial year.

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

Capital expenditure is forecast to be per plan at £28.2m. The forecast net borrowing by year end has reduced as the repayment schedule for the £5m capital loan drawn down in April on a shortened timescale. Total new loans forecast to be drawn down in year remain at £37.63m as planned.

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

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

I&E

At Month 2, the year end forecast position is to deliver the planned £16.1m deficit. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit.

Based on current levels of vacancies and recruitment profiles it is likely to be extremely challenging to significantly reduce agency expenditure whilst striving to maintain safe staffing levels. Recruitment and retention and bed capacity issues bring risk to delivery of elective and daycase activity. Against the £14m CIP target £6.48m remains as high risk. In addition, the new EPR system brings heightened risk of lost productivity through the implementation phase for which the plans do not make any specific financial allowance.

Capital

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

Cash

The Trust is having to manage and prioritise payments to suppliers in order to maintain required cash balances. Further action is being taken to maximise collection of receivables and the profile of cash management is being raised at Divisional level. Confirmation has been received of approval of the loan drawdown for June 2016 at a higher level than originally planned which will allow settlement of a greater number of creditor payments in the short term, whilst all actions are pursued to collect outstanding receivables.

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**

APPENDIX I

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th June 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive and note the updates from Sub Committees and Receipt of Minutes.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the updates from Sub Committees and Receipt of Minutes.
- Quality Committee - minutes of 24.5.16 and verbal update from meeting 28.6.16
- Finance and Performance Committee - minutes of 24.5.16 and verbal update from meeting 28.6.16
- Audit and Risk Committee - minutes of 26.5.16
- Workforce (Well Led) Committee - minutes of 14.6.16

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and note the updates from Sub Committees and Receipt of Minutes.
- Quality Committee - minutes of 24.5.16 and verbal update from meeting 28.6.16
- Finance and Performance Committee - minutes of 24.5.16 and verbal update from meeting 28.6.16
- Audit and Risk Committee - minutes of 26.5.16
- Workforce (Well Led) Committee - minutes of 14.6.16

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES REPORT.pdf

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Quality Committee held on Tuesday 24 May 2016 in the Board Room, Sub Basement, Huddersfield Royal Infirmary

PRESENT

David Anderson	Non-Executive Director /Committee Chair
Helen Barker	Chief Operating Officer
David Birkenhead	Medical Director
Diane Catlow	Associate Nurse Director, Community Division
Mike Culshaw	Clinical Director for Pharmacy
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Tracy Fennell	Associate Nurse Director, Medical Division
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Andrea McCourt	Head of Governance and Risk
Joanne Middleton	Associate Nurse Director, Surgery and Anaesthetic Services
Lynn Moore	Membership Council Representative
Jackie Murphy	Deputy Director of Nursing, Modernisation
Vicky Pickles	Company Secretary
Lindsay Rudge	Acting Director of Nursing
Jan Wilson	Non-Executive Director

IN ATTENDANCE / OBSERVERS

Andrew Haigh	Trust Chairman
Michelle Augustine	Clinical Governance Secretary

ITEM NO	
092/16	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
093/16	**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 Keith Griffiths — Executive Director of Finance Carole Hallam — Senior Nurse Clinical Governance Anne-Marie Henshaw — Associate Nurse Director/Head of Midwifery, FSS Division Dr Julie O'Riordan — Divisional Director, Surgery and Anaesthetic Services Sal Uka — Divisional Director, 7 Day Service/Hospital at Night Bev Walker — Assistant Divisional Director, Medical Division
094/16	**DECLARATIONS OF INTEREST** There were no declarations of interest to note.
095/16	**MINUTES OF THE LAST MEETING** The minutes of the last meeting held on 26 April 2016 were approved as a correct record, subject to the following amendments being made: **Item 73/16 – Update report on mandatory training, essential skills and induction** Q1 (LR): Lindsay Rudge expressed her support for a new system to record training and whether the current system is fit for the future.

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	Item 78/16 – Update report on the action plan following the Kirkup inquiry: final action plan for sign off **OUTCOME:** The Committee did not the sign off the final action plan at the last meeting; however, the plan has been upgraded into the reporting system through the CQC Response Group.
096/16	**ACTION LOG** **Actions due this month** Regulation 28 Cases: The Committee were due to receive an updated report on all four Regulation 28 cases, and it was agreed that one single report should be received at the next meeting summarising all cases. **ACTION** **Action deferred to the next meeting in June 2016.** **Actions going forward** Special measure wards Ward 7BC is no longer in special measures and Ward 5AD has now been stepped down. The Division have requested a further period of enhanced monitoring. **ACTION** **Committee to be updated at the next meeting in June 2016** GI Bleed Service This is due to be reviewed next month; however, the paper will be circulated to the Committee before implementation. **ACTION** **Paper on Interim Acute GI Bleed (AUGIB) Service to be circulated.** Visible Leadership **ACTION** **The due date on the action log to be changed from May 2018 to June 2016.** Emergency Services Report **ACTION**: **The report will be updated at the June meeting.**
PATIENT SAFETY AND QUALITY BOARD (PSQB) DIVISIONAL REPORTS	
097/16	**MEDICAL DIVISION** The Associate Director of Nursing for the Medical Division presented the report to the Committee in full, and the following highlights noted: The report continues to demonstrate good performance across a number of national and local standards. There are, however, some specific areas of focus which require ensuring our performance is in line with expectations: – A&E standard - Division did not deliver against the 95% standard both for the month and for Q4. Most acute trusts continue to experience significant pressure. The division are working with Helen Barker to release pressure on front end. – Stroke – the division is developing an action plan to reach the Sentinel Stroke National Audit Programme (SSNAP) standard 'A' rating, initial trajectory in rating 'c' within 6 months. Both the Transient Ischemic Attack (TIA) and Thrombolysis targets were delivered. A six monthly progress report to be received by the Quality Committee in August 2016. – Friends and Family Test (FFT) - Response rate continues below expected levels, however, significant improvements have been noted in A&E in response to the targeted work in those areas. – Falls – Two harm falls in month - quality improvement lead to be advertised , the falls collaborative meeting is due to restart in June to gain traction around the quality improvement work across the trust. Since the report, there have been six harm falls in the division, all of which went through the serious incidents process.

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	– HSMR/SHMI - is above expected levels. Improvement in coding has been noted within the division; the division continues to undertake mortality review and is currently signed up for an external review of services. Sepsis – the division is confident that there will be an improvement on the target. Two nurse and two medical leads to date have been appointed to facilitate the approach to sepsis within the division. TF will review protocol and how to integrate IT system to work with. The sepsis bundle action plan will be submitted to the Clinical Outcomes Group next month to show how will meet target. – Complaints – 47 closed in May, and three are expected to close in the next fortnight. Weekly assurance meetings continue to take place between the Complaints team in Risk and the division during which a plan for every complaint is agreed. Comments and questions raised by the Committee: Complaints: It was stated that a benchmark across divisions and compared to other Trusts would be beneficial to see. Some local Trusts could be approached nationally and locally. Learning the Lessons on incidents closed in quarter 4 in the division: The division were commended on the paper. Q1 (AH): Hard truths/fill rates: does the data off-set the shortfall in midwife and nurses? A1 (TF): One-to-one usage is attributed to. Work around one-to-one needs revisiting to ensure have governance and having more staff in one-to-one support. A1 (LR): A sub group of the Carter Review Work stream meets every fortnight and looking at high utilised areas and ways to mitigate. Q2 (DB): Is there an action plan for SSNAP data? A2 (TF): This can be circulated if needed. **OUTCOME**: The Committee **RECEIVED** and **NOTED** the content of the report.
098/16	**SURGERY AND ANAESTHETICS DIVISION** The Associate Director of Nursing for Surgery and Anaesthetics presented the report to the Committee in full, and the following highlights were noted: – Fractured Neck of Femur (#NOF) Best Practice Tariff (BPT) - BPT compliance was reported at 85% for Quarter 3; however, improved performance has not been sustained during Quarter 4 despite continued efforts to achieve 85% time to surgery. Please see Appendix 1: Quality report #NOF performance. There is one ongoing complaint regarding delirium. There is a plan for more visibility with this in the division and organisation. Discussion ensued on attempting to balance the capacity for trauma cases, and it was asked how soon the actions will make a difference. It was stated that a change could be seen by July, however, an update from the task and finish group could be provided earlier if needed. **ACTION: Update to be given at next meeting in June.** – Complaints – 43 complaints closed in quarter 4. Response rate continues to show improvement, however some outstanding complaints are still impacting on figures. Assurance that all complaints receive regular updates and are being managed through orange panel meetings. – Complaints analysis and learning – some improvements with closing incidents in time, however, this continues to require close scrutiny. Seven complaints have breached timescale, and there were five mixed sex breaches in January. – Duty of candour – nine orange incidents were reported in quarter 4, all of which required a duty of candour letter to the patient. All letters were sent out within the 10 day time period, giving the division a 100% compliant rate. – Daily safety huddles held every morning, focussing on falls, quality and experience across the division, carried out by matrons and cascaded across the divisional team for information and action.

	– There have been two line infections in quarter 4, both were agreed as unavoidable at orange panel. Learning was identified through investigation and shared with the team. – There have been two post-48 hour clostridium difficile cases: 1 unavoidable case on ward 22 and 1 avoidable case on ward 19. – Staffing levels – nursing review panels have been established to support ward sisters and department leads with roster management – Safety huddles – Support is required to improve the quality of safety huddles across the division. Not as embedded as want to be. Biggest challenge is medical input, need some support from the Improvement Academy. – Appraisals – Performance did not end on plan. Revised process in place from April 2016. Medical staff – 92.77% and non-medical staff – 67.8%. – Orange Panel terms of reference (TOR) – the TOR for the division were presented, and it was suggested that these are shared with other divisions to ensure all are using the same process. – HSMR – Numbers are small, but persistently higher than would expect. **OUTCOME**: The Committee **RECEIVED** and **NOTED** the content of the report.
099/16	**FAMILY AND SPECIALIST SERVICES DIVISION** The Clinical Director for Pharmacy presented the report to the Committee in full, and the following highlights were noted: – Radiology – Red risk - delay in acting upon radiological results. Task and Finish Group established and generic single point of contact being considered. An action plan is being developed and will be reported on in the next quarterly report to Quality Committee. – Pathology suffered a severe hardware failure resulting in loss of the laboratory IT system for five days. The department returned to manual data processing on automated analysers where possible to maintain processing urgent results. This is being investigated as a Serious Incident and will be reported on in next quarterly report to Quality Committee. – Pharmacy **-** Vacancies in senior posts in the Pharmacy stores due to sickness have resulted in inefficiency of this area. A turnaround team has been put in place to maintain safe service provision until new appointees take up post in June and July. The Directorate has addressed three of the majors in the External audit of the HRI Aseptic Unit. The fourth is being addressed through a business case – Maternity - CQC inspection highlighted areas of concern for maternity services across all 5 domains. Further information provided to CQC, and an action plan to address areas for improvement has been approved by CQC and implemented. Quality of response and progress monitored on a weekly basis in Division and a fortnightly basis by Chief Executive. The division have taken this seriously and been a hard-hitting message. Two surgical never events (retained surgical swabs) have been reported in the quarter (DATIX ID 128254 & 129143). Both are currently being investigated by investigators external to the Division, report overdue. Immediate actions taken by the Division as set out in the Risk Register (Risk ID 6646). – Children's Services - Issues with the standards and location of paediatric emergency trolleys were identified during senior staff walk-rounds and as part of the CQC planned visit. Equipment and checking processes were reviewed. 16 new paediatric trolleys have been purchased and top-up consumables for store cupboards cross site are now in place. The Resuscitation Committee will review the current resuscitation policy C-7-2015 to ensure that it reflects that the top part of the paediatric trolley will be checked on a daily basis by a Registered Healthcare Professional. There is now a Lead Paediatric Consultant for Paediatric Resuscitation. Simulation training is being developed across all areas where children may be seen within the organisation. This will be supported on an ongoing basis by in-house APLS instructors. – Update on three-month trial of combined FSS Divisional PSQB: Combined PSQB provided

	limited opportunity for the Board to critically examine complex issues highlighted across the six Directorates and to be assured that quality issues were being sufficiently addressed within other fora. As a result the Division will be reverting to two separate PSQB: a Board for Diagnostic and Therapeutic Services and a Board for Children's, Women's and Outpatient Services from May 2016. – Slot Utilisation - In order to ensure that maximum capacity is utilised, appointment slot utilisation is being monitored. Four additional posts have been funded, dedicated to ensuring that slot utilisation is optimised. Utilisation improvement of 1% per month has been set, with a target of 90% utilisation by March 2016. Current utilisation is above target of 86% at 87.5% and improving. **ACTION: Quality Committee to formally receive a report at the next meeting confirming that no patients came to harm as a result.** – Reduction in Missed Appointments - Last year (2014-15) in the Trust, 36,099 patients failed to attend their outpatient appointment; applying an average outpatient tariff of £127 this equates to £4.5m. This in itself was a reduction on the previous year when 40,880 appointments were missed. As of the end of February 2016 29,652 patients have missed their outpatient appointment. This represents a reduction of 3,529 missed appointments in comparison to the same period in 2014. The Trust has set a target of 7% for first appointment DNA's (Did Not Attend). Year to Date performance is 6.8%. A target of 8% is in place for Follow-Up DNA's, Year to Date performance is at 7.7%. – Always Events Programme – This will now be spread out across the organisation, and the Committee commended the division on work done and completing on time. **OUTCOME**: The Committee **RECEIVED** and **NOTED** the content of the report.
100/16	**COMMUNITY SERVICES DIVISION** The Associate Director of Nursing for Community presented the report to the Committee in full, and the following highlights were noted: – Regular newly formatted divisional Patient Safety and Quality Board (PSQB) meetings take place monthly with a core agenda reflecting the Trust standard terms of reference. Three divisional sub-PSQB committees have been set up covering: therapies, adults and children's services, to enable thorough debate and discussion at service level to take place, this including engagement with front line staff on a rotational basis. The division has developed a compliance register including mapping a gap analysis against the CQC fundamental standards for community services. There is in addition, a strategic level project plan in place covering the implementation of risk, governance, compliance, quality assurance and improvement. – Serious Incident (SI) investigations - thorough root cause analysis and investigation reports are completed for SIs and orange graded incidents. The division is engaged and committed to trend analysis of pressure ulcers (PU) through the Serious Incident / Pressure Ulcer two-weekly panels with the central risk team. – Complaints - The division has developed an SI and complaints tracking tool to ensure that investigations and responses meet internal and external targets. The division currently has one SI and six open complaints – this reflects the work being done within the division by front line staff and managers to resolve complaints before they become formal. – Orange panel meetings – The division has now established an orange weekly panel meeting including engagement of the Tissue Viability Nurse team confirming the level of harm and ensuring incidents can be closed on a timely basis and recording trends and themes to ensure appropriate learning – Prior to the CQC visit in March, the division identified key lines of enquiry and since the inspection have focused on issues arising from the inspection - an action plan is in place and actions are on target for completion, and performance managed via the CQC Response Group. – Safeguarding - The division recently received a safeguarding Children's inspection, reports for which are awaited, however, positive feedback was given. There were some technical issues on how information was shared, but since this was highlighted by the CQC during the inspection, this has now been corrected.

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	– Friends and Family Test (FFT) - The division continues to develop its FFT and is working towards web-based feedback and to be supported by other forms of feedback specifically for the younger and more elderly population. – Therapies, including children's therapies remains on the risk register due to local and national shortages of qualified staff – different models of service provision are being developed and to ensure reflection of future workforce modelling e.g. in line with VANGUARD. – The Health Visiting and Family Nurse Partnership (FNP) services are due to be put to tender with a new service contract in place from April 2017. The Trust is committed to securing the position of preferred provider. **Addendum**: The division have now been informed that the contract will not be put out to tender, and alternative ways of managing patients from both services will need to be sought going forward. Staff from both services have had meetings, been kept involved and informed with a step by step process on support and to understand what will happen in the future. A 10-20% budget reduction is expected, and different ways of working are already being adopted. – Workforce modelling has taken place across district nursing to provide for the first time a workforce model to support current case load. Further work is required to develop acuity tools to ensure capacity can continue to meet current and future demand. It is hoped this work can be replicated across other services within the division with the support of finance. – The division is working with the GP alliance and commissioners to plan around new models of community working using integrated teams and new locality models and several workshops are planned to develop this work. – NICE compliance - The division has established a NICE review group and the following NICE guidance has been assessed with action plans completed as necessary: ∗ Clinical Guideline 88 - Low back pain ∗ Clinical Guideline 142 - Autism in adults ∗ Clinical Guideline 189 – Obesity ∗ NICE Guidance 10 - Violence and aggression These assessments have been submitted to Clinical Effectiveness, Audit and Mortality (CEAM) Group. The process of review continues on a rolling programme with reporting to divisional PSQB meeting. – Mandatory Training – Appraisal dates are booked until the end of the year. Last year's compliance was good. – Sickness – currently at 3.7% across adult services. Work done on long- and short-term sickness - trend is stress and anxiety. – Focussing on incidents as orange panel group is now in place. There has been an increase in line infections, and investigations done so far are inconclusive and undertaking training with the Central Venous Access Device (CVAD) team. Comments and questions raised by the Committee: Q1 (JW): How does communication take place between district nurses and homecare? A1 (DC): Records are kept in homes and available on SystmOne. Early morning huddle meetings also take place to identify what has taken place during the night, and how to share information across services. Communication in patient's homes is also recorded on SystmOne and now trialling summary sheet which can be updated. **OUTCOME**: The Committee **RECEIVED** and **NOTED** the content of the report.

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101/16	**ESTATES AND FACILITIES DIVISION** The Director of Planning, Performance, Estates and Facilities presented the report to the Committee in full, and the following highlights were noted: – The division is exploring a reduce, re-cycle and re-use philosophy for management of waste equipment / furniture, and now collecting and repairing beds and mattresses to ensure they are not unnecessarily hired. – There has been an improvement in patient meals, and now focussing on staff meals. – CRH "Bring me food" initiative launched in January 2016 with positive feedback. Take up has been good and will be rolled out wider. This involves a member of catering staff visiting areas or accepting a ring down from staff or parents, carers to have food delivered to the Ward. Service currently available Monday to Friday 7.30am until 2:00pm. – Incidents – one of the highest numbers within division were slips trips and falls (18% in total). Patient hoists and slings inspected as per the requirements of Lifting Operations and Lifting Equipment (LOLER) regulations. – Porters receiving training on how to move bariatric patients – Catering teams introducing picture menus for patients with dementia and trays for finger food. – HRI fruit and vegetable stall increased to two days per week in January 2016 and will increase to three days per week from May 2016. CRH fruit and vegetable stall will commence mid-June 2016 – Security – new Local Security Management Specialist (LSMS). Will have detailed action plan to work against. – Mandatory Training and appraisals – Division seem to have good success, and this was replicated by the FSS division who had equal success. It was suggested that the technique is shared throughout the Trust through PSQB meetings. Questions raised by the Committee: Q1 (AH): Is there sufficient staffing for security cross-site? A1 (LH): Currently have two staff cross-site during the day, and one staff member at night at CRH and one staff member at night at HRI. **OUTCOME**: The Committee **RECEIVED** and **NOTED** the content of the report.
CQC RESPONSE	
102/16	**CQC REPORT** Lindsay Rudge, Associate Director of Nursing, presented the report which provides a summary of actions being progressed by the CQC Response Group, in advance of receiving the final CQC report. The CQC Response Group is now established and meets every two weeks and chaired by the Chief Executive. The Group is responsible monitoring progress with action plans developed in response to commissioned Independent Service Reviews, and the result required of the action plans is to implement new practices and attitudes into the Trust in order for them to become part of the culture, and embedded into the governance structure, not actions in response to the CQC. The meeting focusses on three sections within the action plan: – Issues raised with the Trust by the CQC lead inspector - These are recognised as high level concerns and covers: Maternity, Clinical Decisions Unit, Acute Upper Gastro-intestinal Bleed Pathway, Middle Management Development, Patient Flow, Documentation and Outpatient Services

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	– Trust wide themes - These are areas of concern anticipated to feature in report, but not issues directly fed back in the inspection team feedback. These were either known about before the inspection and more progress is still required or were picked up from soft intelligence during the inspection. – Divisional plans - These are predominantly smaller and/or single issues that will be picked up through Divisional improvement work. A process is being put in place to ensure there is robust evidence available to demonstrate: – The action has been completed – The action has achieved the intended impact – There is evidence of ongoing monitoring where appropriate – Any identified risks are captured on the risk register The Committee stated that assurance needs to be in place whereby work undertaken by the Response Group is not already being done elsewhere. **OUTCOME:** The Committee **NOTED** the approach being taken to address any issues and deliver and monitor the action plan and also gain assurance that the intended impact is being achieved.
ITEMS TO RECEIVE AND NOTE	
103/16	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** • Learning from five divisions to be shared • Fractured Neck of Femur action plan was discussed in detail by the Quality, and the plan will return next month for update on outliers • New models of care in Community, and Family Nurse Partnership (FNP) tender
104/16 **ACTION:**	**QUALITY COMMITTEE WORKPLAN 2016/17** **OUTCOME:** The Committee **RECEIVED** the Work Plan for 2016/17 and were asked to **NOTE** the reports required for the next meeting on 28 June 2016 That all papers required for the next meeting on 28th June 2016 are submitted to Michelle Augustine for circulation by **Monday, 20th June 2016**
105/16	**ANY OTHER BUSINESS** Serious Incident Review Group Andrea McCourt gave a summary of the first meeting of the Serious Incident Review Group, which will spotlight on orange incidents, and have divisional ownership and sign-off. The Quality Directorate will co-ordinate the meeting and ensure that learning is shared at Patient Safety and Quality Board meetings.
DATE AND TIME OF NEXT MEETING	
Tuesday 28 June 2016 2:00 - 5:00 pm Boardroom Sub-Basement, Huddersfield Royal Infirmary	

MINUTES APPROVED:

APPENDIX A
APPENDIX 1

Calderdale and Huddersfield NHS
NHS Foundation Trust

QUALITY COMMITTEE

PAPER TITLE: Quality report #NOF performance	**REPORTING AUTHOR:** J Middleton 21st May 2016
DATE OF MEETING: 24th May 2016	**SPONSORING DIRECTOR:** L Rudge
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To note
PREVIOUS FORUMS: Divisional PSQB	

EXECUTIVE SUMMARY:
(inc. Purpose/Background/Overview/Issue/Next Steps)

FRACTURE NECK OF FEMUR and BEST PRACTICE TARIF

* Best Practice
* In April 2011 the Department of Health introduced a best practice tariff (BPT) for hip fractures as a financial incentive to improve care, which was updated in 2012 to include cognitive screening.

The best practice standards are: -

* 1) The time to surgery is within **36 hours** from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia.
* 2) Admitted under the **joint care** of a consultant geriatrician and a consultant orthopaedic surgeon.
* 3) Admitted using an **assessment protocol** agreed by geriatric medicine, orthopaedic surgery and anaesthesia.
* 4) Assessed by a **geriatrician within 72 hours** of admission.
* 5) Post-operative geriatrician-directed **multi-professional rehabilitation** team.
* 6) Fracture prevention assessments (**falls and bone health**).
* 7) Two Abbreviated **Mental Health Tests** (AMT) to be performed and all the scores recorded in the National Hip Fracture Database with the first test carried out prior to surgery and the second post-surgery but within the same spell.

The orthopaedic service has failed to consistently deliver the first requirement of best practice guidance (getting patients to theatre in 36 hours). Other patients who need trauma operations are waiting too long, and when they are being prioritised surgeon availability becomes a consideration rather than just clinical need.

NOF Performance 2015 – 2016

Across England 74.9% of patients were operated on within 36 hours following #NOF, West Yorkshire average is 69.1%, CHFT was 62.4% (performance in the latter half of 2015-16 was 77%).

Comparison from NHFD report

Hull	550 #NOF	90 hrs theatre	ratio=6.1
Pinderfields	600 #NOF	96 hrs theatre	ratio=6.25
Bradford	330 #NOF	60 hrs theatre	ratio=5.5
Calderdale	**510 #NOF**	**49 hrs theatre**	**ratio 10.4**

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Performance against all elements of BPT :

Table 1:

Fragility Hip Fracture Best Practice Tariff Report

Date of issue - 23 May 16

YTD APRIL 2015 - MARCH 2016	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total YTD 15/16	%	Total YTD 14/15	% Var 15/16 & 14/15
BPT Components Achieved																
a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia.	33	28	33	26	24	25	31	32	43	29	35	19	356	69.4%	303	17.5%
a) % Time to surgery within 36 Hours	71.7%	56.5%	76.7%	66.7%	61.5%	55.6%	72.1%	76.2%	86.0%	70.7%	72.9%	61.3%	69.4%		62.1%	11.8%
(b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon.	45	42	43	39	39	44	43	41	50	41	48	31	506	98.6%	458	10.5%
% admitted under the joint care of a consultant geriatrician	97.8%	91.3%	100.0%	100.0%	100.0%	97.8%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%	98.6%		93.9%	
(c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia.	46	46	42	39	39	45	42	42	50	41	48	29	509	99.2%	462	10.2%
% admitted using an assessment protocol	100.0%	100.0%	97.7%	100.0%	100.0%	100.0%	97.7%	100.0%	100.0%	100.0%	100.0%	93.5%	99.2%		94.7%	
(d) assessed by a geriatrician in the perioperative period (within 72 hours of admission).	43	38	41	39	38	39	39	39	50	37	44	31	478	93.2%	397	20.4%
% assessed by a geriatrician within 72 hours	93.5%	82.6%	95.3%	100.0%	97.4%	86.7%	90.7%	92.9%	100.0%	90.2%	91.7%	100.0%	93.2%		81.4%	
(e) postoperative geriatrician-directed multi-professional rehabilitation team	38	42	40	38	38	43	40	39	47	40	47	29	479	93.4%	401	19.5%
% MDT	82.6%	91.3%	93.0%	97.4%	92.3%	95.6%	93.0%	92.9%	94.0%	97.6%	97.9%	93.5%	93.4%		82.2%	
(f i) fracture prevention assessments (Falls)	38	37	38	36	32	43	39	35	46	20	9	1	374	72.9%	344	8.7%
% falls assessment	82.6%	80.4%	88.4%	92.3%	82.1%	95.6%	90.7%	83.3%	92.0%	48.8%	18.8%	3.2%	72.9%		70.5%	
(f ii) fracture prevention assessments (Bone health)	46	43	43	37	37	42	42	40	45	20	9	1	405	78.9%	430	-5.8%
% Bone Health	100.0%	93.5%	100.0%	94.9%	94.9%	93.3%	97.7%	95.2%	90.0%	48.8%	18.8%	3.2%	78.9%		88.1%	
(g i) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Pre-Op	43	42	42	39	37	45	43	42	50	41	48	31	503	98.1%	458	9.8%
% AMT test Pre-Op	93.5%	91.3%	97.7%	100.0%	94.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%		93.9%	
(g ii) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Post-Op	42	39	39	38	38	43	41	39	46	41	48	29	479	93.4%	354	35.3%
% AMT test Post-Op	91.3%	84.8%	90.7%	97.4%	92.3%	95.6%	95.3%	92.9%	92.0%	100.0%	95.8%	93.5%	93.4%		72.5%	
(g i & ii) The number of patients who had both Pre Op and Post Op AMT test scores	40	37	39	38	34	43	41	39	46	41	48	29	473	92.2%	337	40.4%
% who had AMT test Pre and Post Op	87.0%	80.4%	90.7%	97.4%	87.2%	95.6%	95.3%	92.9%	92.0%	100.0%	95.8%	93.5%	92.2%		69.1%	

NOTE: Activity based on discharge date and patients over 60 years.

Month assigned by Trust Discharge Date

Figure 1

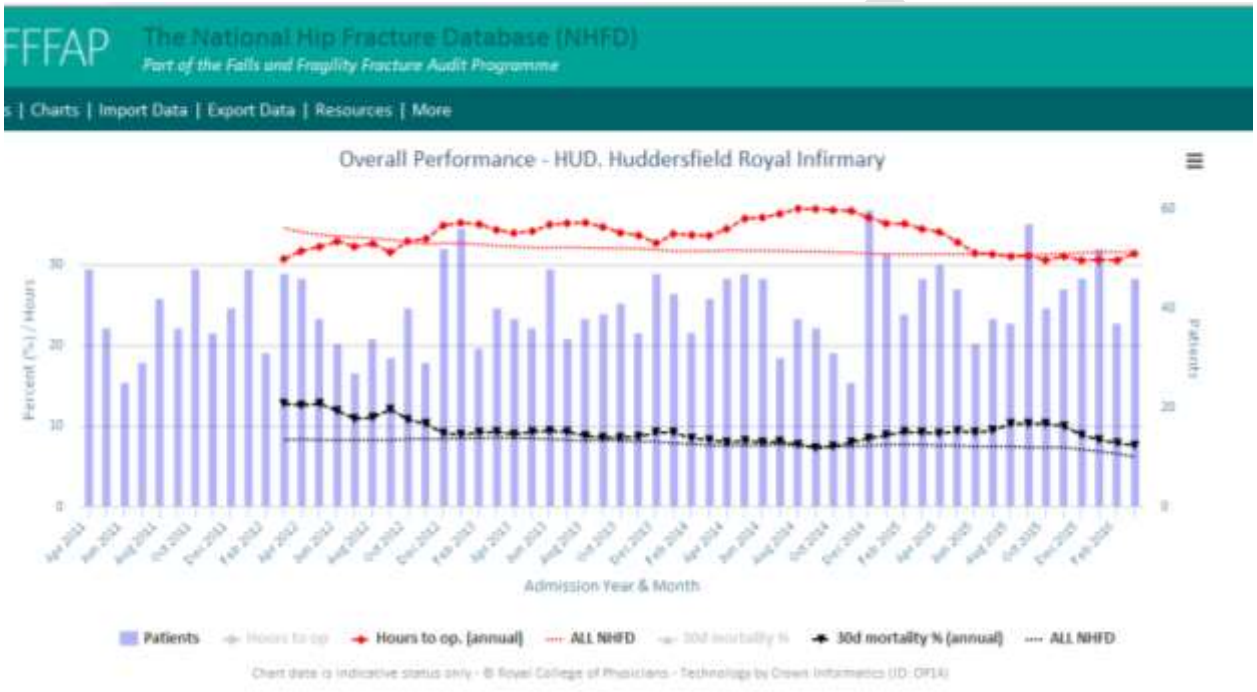
APPENDIX A

Quality Impact :

CHFT Fracture Neck of Femur 30 Day Mortality Rate - Jan 2015 to March 2016

Table 2

Month	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total Patients:	51	39	46	49	44	33	38	37	57	40	44	46	52	37	46
30 Day Mortality (last updated 29 Apr 2016):	6	5	2	2	6	1	4	5	4	4	3	2	3	3	1
% Mortality	11.8%	12.8%	4.3%	4.1%	13.6%	3.0%	10.5%	13.5%	7.0%	10.0%	6.8%	4.3%	5.8%	8.1%	2.2%



Data taken from the National Hip Fracture Database which is published annually.

No correlation seen with mortality associated with time to theatre.

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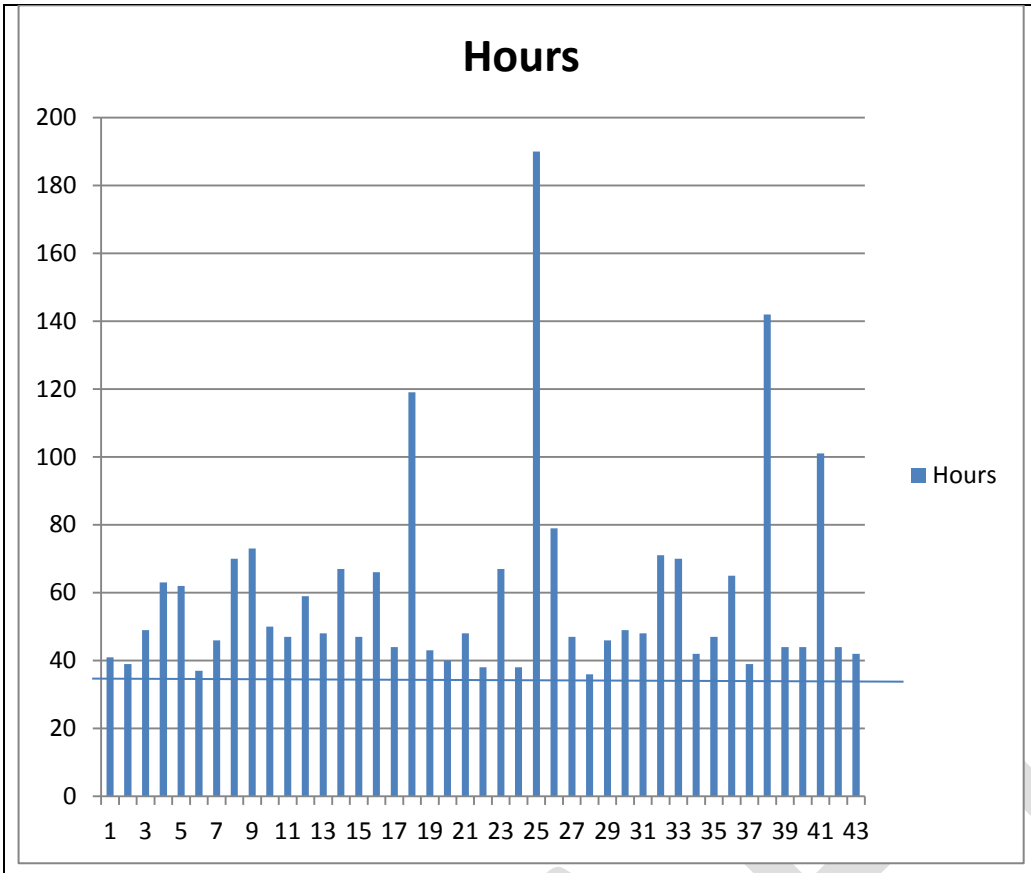

Table 2 : Patients with #NOF who have breached 36 hours actual time to theatre Jan – April 2016
NB : 43 patients breached out of a total of 150 patients for this period.

A root cause analysis is undertaken for each patient that has breached however these focus on the reason for breach and do not measure the impact from a quality and experience perspective.

67% of the patient breaches were due to organisational reasons with the remaining patients breaching for clinical reasons.

The 4 longest breaches experienced were between 100 – 190 hours due to:

1) Patient required THR
2) Patient required MRI to determine if there mets in the femur (to determine type of fixation)
3) Patient required MRI to determine if mets in acetabulum this was positive so resulted in further delay as required THR
4) Patient was admitted as a collapse was severely compromised on 99% optiflow on admission had orthogeri and anaesthetic input daily to optimise but took several days to get to a point were suitable for theatre

Complaints :
Formal complaints associated with a delay to theatre are low _ it is thought this is probably due to the nature of this vulnerable patient group as well as the support offered to patients awaiting surgery from the trauma team. This is difficult to evidence due to the quality of RCAs and monitoring however there is some correlation with improvements in other elements of BPT that may be impacting on this.

Since January 2016 there has been one formal complaint received regarding a lady with dementia whose surgery was cancelled twice.
She unfortunately developed a delirium and her operation was performed at 48 hours.
This investigation into this complaint is ongoing and the learning will be shared with the orthopaedic team and wider divisional team.

A more recent complaint has also been received for a lady with a #NOF that was repaired within timescale but identified nursing issues with EOL care.

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Incidents:
For the period of March 2015 – March 2016 there have been 424 incidents reported by ward 19 and 20. Of these 5 incidents were classed as orange and 3 were classed as red. All red incidents were related to cat 3+4 pressure ulcers none of which were acquired by patients awaiting surgery for a #NOF.

This does not capture those patients with #NOF that were outlied onto surgical wards due to lack of capacity in trauma beds.

Performance against Nursing Quality Indicators for wards 19 + 20:
Data related to quality outcomes is not differentiated for this group of patients.

Improvements have been made across both areas around the number of harm falls. Falls without harm have improved but work is ongoing to ensure falls bundles are embedded into practice with level of assurance that all elements are being performed.

The improvement academy will be facilitating further work to improve the quality of safety huddles that are conducted on both areas from the end of June 2016.

Conclusion :

Action plan in place with GM for orthopaedics and trauma lead working with Matron for trauma and orthopaedics:

- Desired Result (Clear explanation of the desired standard)
    - For no patient to have to wait longer than 36 hours for an operation following #NOF due to organisational delays
    - For all other trauma operations to be carried out within an appropriate timescale
    - Capture the impact on quality and experience for every patient who experiences a delay in time to theatre
- Reality (Explanation as to why we are off track)
    - Insufficient time in trauma theatre
    - Conflicting priorities mean patients wait too long for their operation
    - The ratio of #NOF patient to scheduled theatre time is low compared to the region.
    - Experience of patients who breach waiting times is not measured
    - Current RCAs measure outcome of breach not impact.
    - Trauma coordinator cover is not provided consistently over a 7 day period due to lack of cover for unplanned absence and some annual leave
    - There is a lack of visibility outside the trauma team of cases awaiting theatre
- Response (Action plan including timescales)

Task and finish approach established to :

Book all fallow laminar lists	May 2016
Specialist trauma to go onto elective lists	May 2016
Monday afternoon hand trauma list in day surgery	June 2016
Second and third case slots on trauma list reserved for #NOF	May 2016
Increase timetabled trauma theatre time and job plan surgeons to it.	June 2016
Consider the risk of trauma operating on elective income	June 2016
Consider the risk increased trauma operating on 18 week performance	June 2016
Consider the impact of increased trauma operating on touch time reporting	June 2016
Revise RCA template to measure quality metrics	June 2016
Improve visibility of patients who are on the trauma list across the organisation	July 2016
Work with site commanders to provide improved cover over 7 day period in the absence of a trauma coordinator	July 2016

FINANCIAL IMPLICATIONS OF THIS REPORT:
Improvements are required in order to meet all elements of Best practice tariff.

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RECOMMENDATION: Progress against the improvement plan will be reported at the request of the Quality Committee.
APPENDIX ATTACHED: NO

Minutes of the Finance & Performance Committee held on Tuesday 24 May 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
David Birkenhead	Medical Director (In part)
Keith Griffiths	Director of Finance
Lesley Hill	Director of Planning, Performance and Esates & Facilities
Richard Hopkin	Non-Executitve Director
Phil Oldfield	Non-Executive Director - Chair
Owen Williams	Chief Executive (In part)
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Stuart Baron	Assistant Director of Finance
Gary Boothby	Deputy Director of Finance
Andrew Haigh	Chair
Brian Moore	Membership Councillor
Andrea McCourt	Head of Governance & Risk (In part)
Lindsay Rudge	Acting Director of Nursing (In part)
Betty Sewell	PA (Minutes)

ITEM

080/16 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed Andrea McCourt to the meeting.

081/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Mandy Griffin – Acting Director of Health Informatics Services
Victoria Pickles – Company Secretary

082/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

083/16 MINUTES OF THE MEETINGS HELD 26 APRIL 2016

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

084/16 MATTERS ARISING AND ACTION LOG

The Chief Executive asked the Chief Operating Officer to update the Committee with regard to the latest position in relation to the scale back of the A&E trajectory. It was noted that we submitted the trajectory which was discussed at Board of Directors but this was declined by NHS Improvement (Monitor). Our trajectory has been re-submitted and the re-submission will go back to Board. CCG's have acknowledged our position and NHSI have accepted our revised STF trajectory for Quarter 1 of 93% for April and May and 94% for June.

069/16: Authorisation process for agency/locum staff – The Chief Operating Officer confirmed that a paper had gone to WEB, some re-drafting of the Standard Operating Procedures is required and the paper will come back to Finance & Performance next month.

072/15: CHNST/NHSLA - Learnings from claims – The Head of Governance & Risk presented a paper to the Committee which outlined work being undertaken within the Divisions. Meetings have taken place with NHSLA's Safety Lead for the North of England with Divisions which helped to highlight the areas of focus. The report included a Scorecard which had been shared with Clinical and Divisional Directors. It was noted that the profile of claims has been raised within the Trust and work continues to progress shared learnings.

The Chief Executive commented that the presentation was a clear and easy way of representing the issues and suggested that this information should be placed on the WEB agenda. Owen also flagged that due to the nature of some claims we should appreciate the clinical sensitivity of these issues.

Andrea confirmed trends are being monitored across the board and delayed diagnosis is the top theme, but that the increase is both local and national. It was agreed that opportunities to share learnings with other Trusts should be initiated.

ACTIONS:
To arrange for CNST to be included on the WEB agenda – **LR/AMcC**
To investigate opportunities for shared learning with other Trusts - **OW**

029/16: SAFER Patient Flow Programme Update – The Chief Operating Officer presented a paper to demonstrate the progress achieved through the SAFER patient Flow Programme and the PMO to release the predicted CIP. The programme is structured in three work streams which in turn have different components which have been broken down into the priority areas.

The key areas for each of the work streams and themes were received by the Committee.

It was noted that most of the content of the report would be more appropriate for the Quality Committee and it was confirmed that a slightly different report would be going to that Committee next month.

It was also noted that Karen Barnett, Assistant Divisional Director for Community Services is our programme board member for Vanguard and we are hoping to get momentum from our partners to drive some of this work through. The challenge for the Trust is to get involved in conversations with local authorities and out of hospital providers. Early conversations with Locala have taken place.

The Director of Finance recognised the number of issues that sit outside the Trust but internally there are things that could be done and to sit this report alongside a comprehensive workforce strategy is key. It was agreed that this item should be placed on the Workforce Well-led Committee agenda and the Quality Committee.

In terms of governance it was confirmed that a Programme Board has been set up and SRG (Systems Resilience Group) are being updated, it will also be discussed at Turnaround Executive and a separate dashboard has been established which is tracking the forecast around CIP.

The Chief Operating Officer gave assurance that a member of Workforce would be asked to join the Programme Board, it was noted that the 7 Day Working will be linked into this work. It was agreed that there should be a connection with this report and the clinical ownership of the Carter opportunities.

ACTION : To ensure this work is linked to the Workforce Strategy and update in September - **HB**

FINANCE AND PERFORMANCE

085/16 MONTH 1 FINANCE REPORT

The Deputy Director of Finance introduced the new style report which is being replicated at Divisional Performance meetings. The financial position stands at a deficit of £3.16m which is £300k behind plan as at Month 1. It was noted that whilst Income is in a favourable position, activity is down.

Activity & Capacity

The majority of the points of delivery after one month are below plan, some can be linked to the Junior Drs Strike and other challenges linked to elective beds. The delay of 8 days for Medicine to handover beds back to Surgery has had an impact on activity. Additionally, within the Surgical workforce there are gaps and, therefore, are struggling to deliver their capacity which is impacting on income. It was noted that the average length of stay was higher in April than planned.

Income

The favourable income position of £390k was supported by one-off gains and without these we would continue to see under-performance going forward, the challenge is to get back to plan. It was noted that weekly meetings are taking place with regard to activity looking at the knowledge portal which includes a forward look.

It was also noted that going forward a table will be prepared showing performance against our plan and against the Commissioner's plan.

Workforce

Workforce is key to delivering activity and expenditure pressures, vacancies were highlighted across the different staff groups, it showed 14% of the medical posts were vacant in month. The table also highlighted some of the other challenges around agency, the number of breaches are monitored on a weekly basis and most of the shift breaches relate to ceiling breaches rather than framework breaches. One of the challenges in accepting the STF was to reduce the total agency spend to £14.95m and at Month 1 we are significantly off-plan, this excludes any EPR agency staff. The Divisions have been tasked with a revised plan but this will be a major challenge.

Discussions took place with regard to nursing vacancies and it was noted that March is a particular month where there is a big turnover of nursing staff, however, we have

an intake of 60 nurses in September but recruitment can take time and it was acknowledged that the slow recruitment rate means that we can lose out. It was agreed that it would be helpful to track vacancy changes and approved business cases which have not been recruited to, the Acting Director of Nursing referenced a paper which would be discussed at Board regarding Hard Truths.

The Deputy Director of Finance confirmed that in future months a breakdown of the gaps would be presented and to note that the pay bill is increasing month on month and that this trajectory needs to be included to show that this is the case.

The Director of Finance referenced the previous paper presented by Helen Barker where we have between 15% and 9% vacancies, also substantive staff could be on study/annual leave or absent due to sickness. Absenteeism from front-line staff affects patient flow and clinical decision making and to have open discussions and visibility with regard to the pressures we face is necessary. Everything is driven by the Workforce Strategy and we need to find a different solution to help with recruitment.

It was noted that the Workforce Strategy will take time to be developed, a short-term solution is required and there could be 'hot-spots' which we could target, it was acknowledged that there is no quick fix. It was confirmed that a paper will be going to WEB and the output of those discussions would be share at the next meeting. It was recognised that the Board would require assurance of a short term plan as well as a long term plan detailing how we address the underlying workforce position.

The Acting Director of Nursing reported that an options paper will be made available within the next few weeks which is looking at 'hot-spots' and how we can create a different skill-mix using the banding system.

It was also noted that international recruitment is being looked at to source medical staff.

ACTION: To provide a report outlining the nursing options looking at hot spots and how we could create a different skill mix using the banding system to present at the next Committee meeting - **LR**

Pay

A £320k pay pressure was reported and nursing is driving this pressure, even with actions being progressed, the use of agency staff ranks as one of the main risks to delivery of the Trust's financial plan. It was noted that the release of reserves in month has supressed the scale of the pressure. Non-pay spend will continue to be monitored closely.

STF

The schedule detailed the terms of conditions for the funding and where we are against those measures. The key area called out was the £16.1m control total, we are forecasting delivery but there is significant risk noting that the control total excludes the challenges called out with regard to EPR. Another condition relates to the agency ceiling and this will not be delivered unless we reduce agency spend.

CIP
The CIP profile by month highlights the plan which peaks in February 2017, we are on track with the programme but it is heavily 'back-ended'. The challenge is to develop and progress schemes to Gateway 2 this month. The Director of Transformation and Partnerships reported that £14.4m has been identified and half of that amount sits at Gateway 2 there is £3m at Gateway 1 pushing into Gateway 2 and £2m sitting at the 'ideas' stage. A number of deadlines have slipped and discussions have taken place at Turnaround Executive, more importantly we need to identify schemes above £14m. Each clinical division are undertaking work around areas identified by the Carter Review, in addition, Surgical and Anaesthetics will have a Star Chamber tomorrow. It was confirmed that a clear message has been communicated Trust wide around the PMO process. It was acknowledged that a different rigour which has eliminated schemes with too higher risk has been introduced as well as increasing the proportion of 'cost out' schemes as opposed to 'income' schemes. On a weekly basis a considerable amount of work is taking place with additions and removals from the programme.

Capital
The Trust is working to a capital plan of £28.2m which was underspent as at Month 1.

Cash
The Deputy Director of Finance described the cash position which is linked to organisational challenges already discussed and the whole environment needs to become more cash focussed. At Month 1 the Trust had a cash balance of £1.94m but to achieve this we only paid 42% of our suppliers against the Better Payment Practice Code target of 95%.

The Cash Committee meets monthly and includes representation from clinical areas, discussions have taken place with regard to looking at stocks, how and when we raise invoices and the quality of information provided when we raise invoices. A communications strategy has been discussed as a way of raising awareness and to get engagement with regard to the cash position. An external independent view has not been committed to, but a peer to peer review is taking place.

The members of the Finance & Performance Committee feel assured that the Finance Department are in control of the cash position and are committed to communicating the message Trust wide.

Discussions took place with regard to the renegotiation of payment terms with some suppliers and the effect of paying agencies weekly which includes payment of NI Contributions and superannuation. It was recognised that renegotiation would depend on the type of suppliers, these will be reviewed and conversations will take place.

With regard to cash receipts, a number of actions came out of the last Cash Committee, one was to request from Divisions the prompt raising of invoices which should include all supporting information to avoid any challenge from the customer. The Divisions will also provide their aged debt analysis at their Divisional

Performance meeting to raise awareness.

Risks
The following risks where highlighted:-

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

The Chair summarised the financial position as follows:-

- Challenging month
- Big risks ahead and it would be harder as we progress throughout the year
- Challenges with regard to agency
- Cash - to look at renegotiating some of the larger contracts
- Debt position acknowledged

STRATEGIC ITEMS

086/16 TURNAROUND PROGRAMME UPDATE

The Director of Transformation and Partnership reiterated what had been covered in previous discussions that schemes at Gateway 1 are being pushed to Gateway 2. Star Chambers are being held and the Carter Report will come back to the Committee in June.

087/16 & 088/16 EPR FINANCIAL IMPACT REPORT & HIGHLIGHT REPORT

The Assistant Director of Finance (SB) provided an overview of the financial implications should the Trust experience a delay with the EPR implementation.

The current project position is currently 9 weeks behind the initial schedule giving a go-live date of 8 October 2016, this date has still to be agreed and finalised. As a result of this delay, Cerner have communicated their intent to issue a delay notice letter to the Trust, at this point in time, the Trust is not accepting this liability and have requested further detail with regard to reasons for the delay.

An overview of the financial positon of the EPR project to 30 April was included in the papers. The key headlines being the Pay Costs – the project incurred £77k in additional costs driven by additional overtime for contractors and the EPR Team have been challenged to bring back to standard operating hours per week. The report included the key cost variables which were outlined by key cost categories with an explanation of how each of the costs varies over time. The contract between the Trust (CHFT & Bradford) and Cerner makes provision for Cerner to reasonably recover their costs if they are unable to deploy resources elsewhere in the event of delay. The current monthly charge for staff on the project is c£160k per month.

The benefits of the EPR business case were called out and any delay with the project will inevitably delay the return in investment. The benefit realisation is being

managed through the Project Management Offices.

It was noted that EPR is utilising cash as part of our capital plan and also as part of our income expenditure plan, any additional costs will have an adverse impact on the Trust's cash position and our I&E position.

With regard to the operational impact of the EPR deployment, the Trust has set up an EPR Operations Group which is led by the Chief Operating Officer. An operational plan is being developed to cover the go-live period.

The key actions with regard to the project were outlined and noted by the Committee.

The standard Highlight Report was referenced which reiterates the overview of the programme along with the financial position to date and forecast spend.

The Director of Finance acknowledged the complexity of the project and that the whole programme affects capital plans and cash. The programme to date is now at budget for capital and revenue and it is likely that the EPR Transformation Meetings will continue to surface issues, therefore, along with the potential contractual situation with Cerner for which there is no provision, will push us into a more pressured environment in addition to the operational impact. Taking everything into account the Trust will have to consider increasing the capital provision and firm up the I&E position for 16/17. Keith went on to say that this is a project that we can implement once and it is important that we share our plans with the regulator once we have visibility of the operational plan, the position with Cerner is clearer and a go-live date is confirmed..

The Chief Executive updated the Committee with the latest position regarding the go live date. A conference call had taken place between ourselves and Bradford and from that conversation the preference would be to have a dual launch date of the 19th November, this would effectively mean it would push us a month on and costs will have to be factored into this decision. There are reservations from our point of view which will be discussed at the Transformation Board and the Trust Board.

The Chair summarised discussions as follows:-

- The financial plan assumes a start date of 8 October which has slipped.
- Potentially a dual go-live of the 19 November with additional running costs and additional risk which will be required to be managed.
- The go-live date will be decided upon at the next Transformation Board, subject to risks being mitigated. An update will then go to the Trust Board in June.

The Chief Executive added that there has been a shift across both organisations where people want to see this happen and, therefore, we do need to start focusing on the launch date of 19th November 2016.

ACTION: To provide a further update following the next key stage phase – **MG/SB**

GOVERNANCE

089/16 INTEGRATED PERFORMANCE REPORT

It was confirmed that the IPR had been tabled to triangulate issues with quality and the Finance & Performance Committee, the report will be discussed fully at the Quality Committee to be held later today. #NoF Best Practice Guidance and Stroke Performance were called out as areas to note and the Chair of the Committee also noted A&E Targets and Waiting Times and how these link to the financial implications.

The Carter dashboard will be included into the standard monthly IPR.

090/16 MONTH 1 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 April 2016 for submission to NHS Improvement.

The Committee noted the contents.

091/16 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.

092/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES

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

- EPR – a further report next meeting
- Agency
- Underlying financial position in relation to cash, EPR, trading and capital
- Workforce
- Public sponsorship for the Patient Flow report

093/16 ANY OTHER BUSINESS

No items were raised and the meeting was closed.

DATE AND TIME OF NEXT MEETING

Tuesday 28 June 2016, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

Calderdale and Huddersfield NHS
NHS Foundation Trust

APPENDIX A

Minutes of the Audit and Risk Committee Meeting held on Thursday 26 May 2016 in Acre Mill, 3rd Floor commencing at 10:45pm

Prof Peter Roberts	Chair, Non-Executive
Richard Heaton	Non-Executive Director
Phil Oldfield	Non-Executive Director

IN ATTENDANCE

Gary Boothby	Deputy Director of Finance
Jillian Burrows	Senior Manager, KPMG
Michael George	Internal Audit Manager
Keith Griffiths	Executive Director of Finance
Helen Kemp-Taylor	Head of Internal Audit
Andrea McCourt	Head of Governance and Risk
Peter Middleton	Membership Councillor
Clare Partridge	External Audit
Victoria Pickles	Company Secretary
Zoe Quarmby	Assistant Director of Finance (Observer)
Aimee Church	HFMA (Observer)
Andrew Haigh	CHFT Chairman (Observer)
Sophie Rowe	HFMA (Observer)
Natalie Whitehead	Internal Audit In-turn (Observer)
Kathy Bray	Board Secretary (minutes)

Item

030/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Adele Jowett, Local Counter Fraud Specialist

031/16 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

032/16 MINUTES OF THE MEETING HELD ON 20 APRIL 2016

The minutes of the meeting were approved as a correct record, subject to the correction to the spelling of Jillian Burrows name on page 5.

033/16 ACTION LOG AND MATTERS ARISING

23/15 – Review of Waiving of Standing Orders – PWC Engagement Work - It was agreed that this item would be included on the agenda for the next Audit and Risk Committee.
ACTION: ARC Agenda item – 21.7.16
STATUS: Open

40/15g – External Audit – Payroll Report – It was noted that the end of year ISA260 external audit report included the payroll audit report.
STATUS: Closed

54/15 – Review of Standing Financial Instructions/Scheme of Delegation – The Company Secretary advised that a meeting had been arranged with the Deputy Director of Finance to finalise these documents and they would be presented to the July ARC Meeting.
ACTION: ARC Agenda item – 21.7.16
STATUS: Open

58/15a – Review of Outstanding Internal Audit Recommendations – It was noted that since the inception of review meetings, performance had improved. It was agreed that this item would

be included on the Work Plan and leads would be invited to attend as slippage on issues occurred. This would be monitored by Internal Audit and the Company Secretary.
STATUS: Closed

70/15 – Clinical Audit and IA Reports – Peter Middleton asked if this item could be brought to the next Membership Council Meeting for information. The Company Secretary reported that the review of clinical audit and internal audit plans had been undertaken and discussed at the last Weekly Executive Board meeting. The Company Secretary was happy for this to be taken to the Membership Council meeting on the 6 July 2016.
ACTION: Agenda item – MC – 6.7.16
STATUS: Closed

72/15 – Review of Risk Management System – It was noted that Internal Audit were undertaking work to understand the rise in Clinical Negligence Costs and a paper was being presented to the Finance and Performance Committee in August 2016.
STATUS: Closed

06/16 – ARC Induction Programme – It was noted that Internal Audit had now shared their induction pack with the Audit and Risk Committee.
STATUS: Closed

034/16

ANNUAL ACCOUNTS

The Committee reviewed the documents required in order to recommend signing off the Annual Report and Accounts. Apologies were received for the late circulation of some of these documents. Discussion took place regarding each document:-

a. Going Concern – The Deputy Director of Finance presented the report. The Committee considered the evidence presented and agreed that the Trust should be considered as a going concern and that the accounts for the period 31 March 2016 were prepared on that basis.

b. Audited Annual Accounts and Financial Statement - it was noted that the financial position was consistent with the performance statistics previously submitted to NHS Improvement/Monitor. It was noted that no material changes had been made following audit. All present received and accepted the document subject to the amendment to the 'print area' which would rectify the textual errors.

c. Draft Letter of Representation – The document, prepared in-line with guidance, was received, noted and approved.

d. Annual Governance Statement – The Company Secretary reported that this document had been prepared following the prescribed format in the guidance.

Minor amendments had been included following receipt of KPMG findings in relation to the Quality Report audit recommendation around the 18 weeks for patients on incomplete Pathways and A/E maximum waiting time of four hours from arrival to admission/transfer/ Discharge Audit. It was noted that these had been included in the final document.

e. Annual Report - The Company Secretary presented the Annual Report. It was noted that there was some repetition throughout the document and this was driven by the fact that the sections of this Annual Report required to be stand-alone documents. Following minor typing errors the document would be submitted for artwork to be undertaken before it is laid before Parliament on the 24 June 2016 and submitted to the Board/MC Annual General Meeting on the 15 September 2016.

Peter Middleton asked that actual mortality statistics are also included in the Quality Report and the Company Secretary agreed to ensure that this request is included.
ACTION: Company Secretary

Internal and External Audit representatives asked that it be placed on record that in their opinion the narrative had been very well presented and thanks were given to the Company Secretary.

f. Head of Internal Audit Opinion – The Head of Internal Audit presented the report which provided an Internal Audit Opinion on the effectiveness of the system of internal control at the Trust for the year ended 31 March 2016.

The document included a total of 33 reports which had been issued during 2015/16. Of these, 10 had been issued with a "limited assurance" opinion. It was noted that the Audit and Risk Committee had received and discussed details of these audits throughout the year. It was noted that the on-going audit work around Payroll continued to be monitored.

The Chair reiterated the process available to the Audit and Risk Committee to invite leads to attend Audit and Risk Committees where slippage in deadlines occurred regarding the implementation of recommendations.

g. Year-end Report and Long Form External Audit (ISA260) - The Engagement Lead for KPMG asked that these two items be discussed together. External Auditors advised that the final set of accounts had been checked and the ISA260 had been issued which would be signed-off at the end of the meeting. The content of both reports were discussed.

It was noted that External Audit had issued an unqualified audit opinion on both the Accounts and Quality Report.

The key findings from their work on the quality accounts were noted. This included the two national priority indicators:-

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge.

Detailed testing on the indicators concluded that external audit were able to give a clean limited assurance opinion on the Accident and Emergency four hour waiting time indicator.

However, a limited assurance opinion on the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways was not possible due to issues with accuracy of data and the fact that the Trust may be over performing. As a result of this issue External Audit were unable to give limited assurance on the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways indicator included in the Quality Report for the year en 31 March 2016.

The overall opinion on the quality indicators was therefore that a qualified limited assurance opinion had been issued on the quality accounts.

With regard to the Use of Resources, it was concluded that the Trust had adequate arrangements to secure economy, efficiency and effectiveness.

OUTCOME: The Committee agreed that the Annual Account documents to be forwarded to Monitor as required and agreed that they would be recommended to the Board to approve.

35/16 QUALITY REPORT

a. Quality Account
The Company Secretary advised that the Quality Account was a requirement of NHS Improvement/Monitor and is reported separately as well as being included within the Annual Repo The document had been prepared with the engagement of the public and Membership Councillors with regard to the choice of indicators and had also received feedback from partners. The document had been reviewed by External Audit and following inclusion of the recommendations made in the ISA260 (above) this document would be progressed.

b. External Audit Assurance on the Trust's Quality Report
As discussed earlier in the meeting, subject to the recommendations made by external audit, it was confirmed that there were no significant concerns regarding this document.

OUTCOME: The Committee agreed the Quality report for recommendation to the Board for approval.

36/16 REPORT ON WHISTLEBLOWING AND OTHER EXPRESSIONS OF INTEREST
The Company Secretary reported that one case had been reported and this was being Investigated. Further details would be brought to the July Audit and Risk Committee.
OUTCOME: ARC Agenda item – July 2016

37/16 INFORMATION TO RECEIVE
The following information was received and noted:-
a. Quality Committee Minutes – 29.3.16, 26.4.16
b. Risk & Compliance Group Minutes – 13.4.16
c. THIS Management Board – 16.4.16

38/16 ANY OTHER BUSINESS
There was no other business to note.

39/16 MATTERS TO CASCADE TO BOARD

- **Annual Accounts and Reports documents – recommended to the Board of Directors**
- **Quality Report – recommended to the Board of Directors**
- **Whistleblowing – investigation ongoing – update to next ARC Meeting**
- **Internal Audit – include in MC Agenda – 6 July 2016.**

DATE AND TIME OF NEXT MEETING
Thursday 21 July 2016 at 10.45 am – EPR Large Meeting Room, Acre House.

REVIEW OF MEETING
All present were content with the issues covered and the depth of discussion.

Thanks were given to members for reviewing the large amount of papers at short notice.

/KB/ARC-26.5.16(4)
1.6.16

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Tuesday 14 June 2016, 3.00 pm – 4.00 pm in Discussion Room 3, Learning and Development Centre, Huddersfield Royal Infirmary.

PRESENT:	
Helen Barker	Chief Operating Officer
Gary Boothby	Deputy Director of Finance
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Jackie Green	Interim Director of Workforce and Organisational Development
Karen Heaton	Non-Executive Director
Anne-Marie Henshaw	Associate Director of Nursing, Families and Specialist Services
Ashwin Verma	Divisional Director, Medical
Jan Wilson	Non-Executive Director (Chair)
IN ATTENDANCE:	
Juliette Cosgrove (for Brendan Brown and David Birkenhead)	Assistant Director for Quality
Simon Duree	Staff Side Chair
Tracy Fennell	Associate Director of Nursing, Medical
Azizen Khan	Assistant Director of Human Resources
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development

44/16	**WELCOME AND INTRODUCTIONS:** The Chair welcomed members to the meeting.
45/16	**APOLOGIES FOR ABSENCE:** David Birkenhead, Executive Medical Director Brendan Brown, Executive Director of Nursing Rosemary Hedges, Membership Councillor Andy Lockey, Director of Medical Education Phil Oldfield, Non-Executive Director, (Deputy Chair) Victoria Pickles, Company Secretary
46/16	**DECLARATION OF INTERESTS:** No declarations of interest were received.
47/16	**MINUTES OF MEETING HELD ON 21 APRIL 2016:** The minutes of the meeting held on 21 April 2016 were approved as a true record.

48/16	**ACTION LOG (items due this month)** Terms of Reference To be resubmitted to the June 2016 Board of Directors for approval. **Action:** VP The Committee noted the following actions were outstanding:- Identify a Medical Director deputy. **ACTION:** DB Identify a Clinical Director to participate as a member of the Committee. **ACTION:** DB Sub-group structure Identify reporting arrangements for equality and diversity. **ACTION:** VP Board Assurance Framework/Corporate Risk Register Test the role of the Committee in ensuring the Board Assurance Framework / Corporate Risk Register is appropriately maintained. **ACTION:** PO/JW/JE/VP Education and Training Restructure Please see agenda item 60/16. Visible Leadership: Process and Outcome of First Visits To identify dates for reports to be received by the Committee. **ACTION:** VP Human Resources Management Group Group to be convened. JE to discuss with IW. **ACTION:** JE Workforce (Well Led) Committee Work Plan 2016 / 2017 Identify dates for visible leadership reports to be received by the Committee **ACTION:** VP Visible leadership updates to be incorporated into the work plan. **ACTION:** SL CQC Inspection Update LR to provide the Committee with an update once the final CQC report is received. **ACTION**: LR
	MATTERS ARISING / MAIN AGENDA ITEMS
49/16	**CARE OF THE ACUTELY ILL PATIENT:** JC reported that the Care of the Acutely Ill Patient had been set up in response to the Trust's concerns regarding its mortality statistics. Quality of care is also a concern for the Trust in respect of respiratory disease, stroke and frailty. The Trust has commissioned an independent review of these. JC informed the Committee that

	mortality review has been introduced into Consultant job plans and bundles of patient care packages are being standardised. **ACTION:** DB to produce a quarterly report on workforce issues arising from the Care of the Acutely Ill Patient work **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.
50/16	**WORKFORCE STRATEGY:** JG presented the framework for the development of the Trust's 5 year Workforce Strategy. Key themes of the strategy are:- Simplifying system and structures Raising people management capacity Building greater engagement Creating an engaged inclusive environment Improving leadership capability JG outlined what the WTE reduction over the next 5 years means and the need to reshape the workforce to build a workforce for the future. JG explained that adopting a systematic approach across the Trust to workforce development and change is critical to the success of the strategy. **ACTION:** IW to provide updates on the Workforce Strategy to the Committee **OUTCOME:** The Committee **RECEIVED** and **NOTED** the presentation.
51/16	**2015 STAFF SURVEY ACTION PLAN:** JE reported the Staff Survey Action Plan had been submitted to and approved at the May 2016 Board of Directors meeting. The Committee was informed that there are common themes identified in the Staff Survey Action Plan and the Workforce Race Equality Scheme (see agenda item 54/16) Action Plan. That being the case, the Chief Executive has requested that the two action plans be combined. The combined action plan is to be submitted to the Executive Board at its 16 June 2016 meeting. It is anticipated this will move very swiftly to the implementation phase with actions being refined as implementation rolls out. Progress against actions will be reported to the Executive Board and an update provided to the Committee at its meetings. The Board of Directors is to receive an update at its September meeting. **ACTION:** JE to provide Combined Action Plan to the August 2016 Committee meeting **ACTION:** SL to include progress report as a standard item in the Committee workplan **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.

52/16	**HEALTH AND WELLBEING CQUIN:** JE reported that a national CQUIN for improving NHS staff health and wellbeing has been introduced for 2016/2017. The CQUIN is in 3 parts:- • Introduction of health and wellbeing initiatives (physical activity, access to physiotherapy services and mental health /wellbeing) – 1a • Healthy food for NHS staff, visitors and patients – 1b • Improving the uptake of flu vaccinations for front line staff – 1c JE reported these indicators comprise 0.75% of the total value of the CQUIN scheme. The value of the CQUIN is c£1.8m. JE reported good progress in identifying and implementing actions to deliver activity in order to secure the CQUIN income. An action plan has been developed for submission to the CCGs in relation to 1a. This is required by 30 June 2016. A submission to DH in relation to 1b is being collated and will be ready by the 30 June 2016 deadline. The Committee was informed that there was risk in delivering the 75% flu vaccine target to secure the full value of the CQUIN payment for this element. A flu vaccine steering group has been established to design a robust action plan for the campaign. AV suggested linking in with the EPR trainers as a means of targeting staff. **ACTION:** JE to share action plans and an update with the Committee at its next meeting **ACTION:** SL to include a quarterly progress report in the workplan. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
53/16	**REVIEW OF WORKFORCE IT PROGRAMMES:** These items were deferred to the next meeting. • **Electronic Staff Record (ESR)** **ACTION**: CW - deferred to August 2016 meeting • **E-Rostering** **ACTION:** LR – deferred to August 2016 meeting
54/16	**WORKFORCE RACE EQUALITY SCHEME (WRES):** AK provided a summary of the WRES and the development of an action plan in response to colleague feedback from focus groups held in the first quarter of this calendar year. A paper and the action plan were submitted to the Executive Board and Board of Directors in May 2016. The action plan was approved by the Board of Directors. JE advised the WRES Action Plan is to be combined with the Staff Survey Action Plan (please see agenda item 51/16). **ACTION**: please see agenda item 51/16 **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.

55/16	**INTEGRATED PERFORMANCE REPORT - WORKFORCE:** The report was shared with the Committee ahead of the meeting. Discussion took place regarding the timeline for the report - the production of the report should align to the Committee meeting dates to ensure that Divisional commentary is included. **ACTION:** HB/JE to align the production of the report and Committee dates **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
56/16	**FINANCE AND PERFORMANCE REPORT - WORKFORCE:** GB highlighted the high level of vacancies particularly in relation to Consultant and nursing posts. April 2016 data showed almost 500 (9%) vacancies across the organisation. £2.13m had been spent on agency staffing. The Committee was advised that May 2016 data is showing an increase in costs of agency staffing to £2.5m. It was noted that vacancies are a significant element of the reason for continuing high agency costs. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
57/16	**NHS IMPROVEMENT AGENCY CONTROL TARGET COMPLIANCE:** JE reported that the NHSI diagnostic tool for agency spend has been adopted to identify compliance with agency spend rules and to determine an action plan. Progress against the actions will be reported monthly to the Executive Board. The Trust has a trajectory to measure month on month performance against its agency spend control target of £14.95m for 2016/2017. In support of this, Divisions are producing and presenting plans to deliver their proportion of the control target. The plans will be reviewed at the June Divisional Performance Meetings. **ACTION:** HB to provide an update to the Committee **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
58/16	**CQC INSPECTION UPDATE:** JC advised the draft CQC report is expected to be received at the end of July/early August 2016. Work is progressing/action plans are being developed in respect of issues that the CQC made the Trust aware of at the end of its inspection. This work is being monitored by a CQC response group chaired by the Chief Executive which meets every two weeks. **ACTION:** BB/LR to bring final report to Committee **OUTCOME**: The Committee **RECEIVED** and **NOTED** the upate.
59/16	**REPORT FROM COLLEAGUE ENGAGEMENT, HEALTH AND WELLBEING GROUP:** JE advised the 2016/2017 staff FFT was launched on 13 June 2016.

	As part of the on-going work within the IIP standard an online staff questionnaire will be used in 2016, 2017 and 2018. A sample survey will be used in July 2016 in Medical, Estates and Facilities and Corporate function areas. It was noted that Divisional representation was poor at the June 2016 meeting. Discussion with members is to be progressed. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
60/16	**REPORT FROM EDUCATION AND LEARNING GROUP:** JE reported an Education and Learning Group (ELG) workshop had been held on 10 May 2016. The workshop developed a vision for education and learning in the Trust 'To deliver high quality patient care through a multi-disciplinary learning environment offering opportunities for all employees to take personal responsibility to develop as a competent, capable and compassionate colleagues and teams.' Priority areas for action were also identified. The group is scheduled to meet monthly and at its next meeting on 22 June 2016 will focus attention on progressing the priority areas as well as putting in place arrangements for drafting a strategy document and an associated work plan. **OUTCOME**: The Committee **RECEIVED** and **NOTED** the report.
61/16	**REPORT FROM MEDICAL WORKFORCE GROUP:** The notes of the May 2016 group were shared with the Committee. JE stated it is important that groups reported to the Committee design their meeting and reporting arrangements to ensure an up to date flow of information about activity through to the Committee. **OUTCOME**: The Committee **RECEIVED** and **NOTED** the meeting notes.
62/16	**REPORT FROM NURSING WORKFORCE GROUP:** JC highlighted the key points of the report:- • Increase in nursing vacancies – further international recruitment is being considered • Concerns regarding retention of nurses • Work is progressing in terms of rotas and bridging gaps. SD advised that staff side have raised recruitment/retention as an agenda item at the June 2016 Staff Management Partnership Forum. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
63/16	**BOARD ASSURANCE FRAMEWORK:** This item was deferred to the next Committee meeting.

64/16	**CORPORATE RISK REGISTER:** JC advised the 3 risks have not shifted position. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
65/16	**REVIEW OF COMMITTEE:** The group agreed to meet monthly from August 2016. It was noted that KH will act as Chair. JW and PO will continue as Non-Executive Director members of the Committee. It was suggested that monthly meetings will allow for improved agenda prioritisation and for more balanced reporting from Committee sub-groups. **ACTION:** SL to arrange monthly meetings
66/16	**WORKFORCE (WELL LED) COMMITTEE WORK PLAN 2016/2017:** The Committee workplan was shared for information. This will be updated. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the workplan.
67/16	**ANY OTHER BUSINESS:** There was no other business identified.
68/16	**MATTERS FOR ESCALATION:** There were no matters identified for escalation to the Board of Directors
DATE AND TIME OF NEXT MEETING: Monday 15 August 2016, 3.00 pm – 5.00 pm, Discussion Room 2, Learning and Development Centre, Huddersfield Royal Infirmary	