Table of Contents

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 29 September 2016 from 1:30 pm

Venue: Boardroom, Huddersfield Royal Infirmary HD3 3EA

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Brian Moore, Public Elected MC	Chair	**VERBAL**	**Note**
2	**Apologies for absence:** **Dr D Anderson, Non-Executive Director** **Mr Keith Griffiths, Executive Director of Finance (Mr Gary Boothby, Deputy Director of Finance attending)**	Chair	**VERBAL**	**Note**
3	**Declaration of interests**	All	**VERBAL**	**Receive**
4	**Minutes of the previous meeting** held on 28 July 2016	Chair	**APP A**	**Approve**
5	**Matters arising and review of the Action Log** a. 125/16 – Staff Survey Action Plan – Updated report	Chair Chief Executive	**APP B** ***APP C TO FOLLOW***	**Review** **Receive**
6	**Patient/Staff Story:** **" Maternity Services"** Presented by Anne-Marie Henshaw, Head of Midwifery and Gail Wright, Deputy Head of Midwifery	Chair	**Presentation**	**Note**
7	**Chairman's Report** a. Chair/CE Provider Meeting – 21.9.16 b. Joint BOD/MC Annual General Meeting – 15.9.16	Chair	**VERBAL**	**Note**
8	**Chief Executive's Report:**	Chief Executive	**VERBAL**	**Note**
Transforming and improving patient care				
9	Right Care, Right Time, Right Place - Consultation	Director of Transformation	**VERBAL**	**Note**

		and Partnerships		
Keeping the base safe				
10	Risk Register	Executive Director of Nursing	**APP D**	**Approve**
11	Board Assurance Framework Update	Company Secretary	**APP E**	**Approve**
12	EPRR Assurance Process - 2016/17 (Emergency Preparedness Resilience Response)	Executive Director of Planning, Performance and Estates	**APP F**	**Approve**
13	Quarterly Quality Report – Q1	Executive Director of Nursing	**APP G**	**Approve**
14	CQC Report and Next Steps	Chief Executive	**APP H**	**Approve**
15	Governance Report:- a. Review of Meeting Dates b. Board Workplan c. Use of Trust Seal d. Attendance Register e. Declaration of Interests Register - BOD f. NHS Improvement – Feedback from Q1 submission		**APP I**	**Approve**
16	Single Oversight Framework	Company Secretary	**APP J**	**Approve**
17	Safeguarding Update – Adults and Children	Executive Director of Nursing	**APP K**	**Approve**
18	Integrated Performance Report - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Finance	Chief Operating Officer “ Director of Nursing Director of Nursing Executive Medical Director Executive Director of Finance	**APP L**	**Approve**

Financial Sustainability				
19	Month 4/5 – 2016 – Financial Narrative	Deputy Director of Finance	**APP M**	**Approve**
A workforce for the future – no items				
20	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 26.7.16, 23.8.16 and verbal update from meeting 27.9.16 ▪ Finance and Performance Committee – minutes of 26.7.16, 23.8.16 and verbal update from meeting 27.9.16 ▪ Audit and Risk Committee – minutes from meeting 21.7.16 ▪ Membership Council Draft Minutes – 6.7.16 ▪ Nomination and Remuneration Committee (Membership Council) Minutes – 21.7.16		**APP N**	**Receive**
Date and time of next meeting Thursday 3 November 2016 commencing at 9.00 am **Venue: Board Room, Sub-Basement, Huddersfield Royal Infirmary HD3 3EA**				

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).*

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th September 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 28.7.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 28 July 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 28 July 2016.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 28 July 2016.

Appendix

Attachment:

FINAL BOD MINS - PUBLIC - 28.07.16.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 28 July 2016 in the Board Room, Huddersfield Royal Infirmary.

PRESENT

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

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Director of The Health Informatics Service
Victoria Pickles	Company Secretary
Dr Steven Cleasby	NHS Calderdale Clinical Commissioning Group Governing Body GP (for item 6 – Patient Story)
Alison Wilson	General Manager, Estates and Facilities (for item 6 – Patient Story)
Chris Bentley	Matron, Estates and Facilities (for item 6 – Patient Story)

OBSERVERS

Brian Moore	Membership Councillor
Kate Wileman	Membership Councillor

114/16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

115/16 APOLOGIES FOR ABSENCE

Apologies were received from:

Dr Linda Patterson Non-Executive Director

116/16 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

117/16 MINUTES OF THE MEETING HELD ON 30 JUNE 2016

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

118/16 MATTERS ARISING FROM THE MINUTES / ACTION LOG

109/16 INTEGRATED PERFORMANCE REPORT – BOD MEETING DATES

The Chairman explained that Board meetings would be moving to the morning of the first Thursday in the month with effect from 3 November 2016.

119/16 PATIENT / STAFF STORY

Dr Stephen Cleasby introduced a presentation on 'Improving Hospital Food'. He explained that the Food for Life Partnership, funded by the Big Lottery had been

commissioned by Public Health Teams in 11 local authorities to work in schools, early years settings, care homes and, in 2014, NHS acute hospitals. Calderdale and Huddersfield NHS Foundation Trust was one of three NHS Trusts nationally which had helped to develop an approach to food in hospitals for patients, staff and visitors and the hospital leaders framework. This Trust had also piloted a CQUIN on nutrition and food.

Alison Wilson described the work with HealthWatch to get patient feedback on the quality of food which had identified concerns around temperature, choice and appearance. This led to a focus on three key areas: patient food experience; catering quality and community and partnership. She explained that the Trust had introduced homemade soups on both sites; lighter options for patients; snack platters; as well as more choice for soft foods at Calderdale to reflect the concerns raised on that site. Work was also done with wards to ensure that they have a detailed menu list and that staff know the range of menus that are available.

Christine Bentley confirmed that the Trust had achieved the first CQUIN and for 2016 will be completing the second CQUIN which includes improved health options and improved vending facilities. The Trust would also be continuing the pathfinder work focusing on:

- Growing project into Community settings in Calderdale
- Implementation of food and hydration strategy
- Shared learning workshops with other Trusts
- Training and support for staff

A question was asked about reflecting cultural diversity in menus. Christine Bentley responded that the Trust offers a range of menus including Caribbean and other specialised menus which offer a number of diverse choices.

The Executive Director of Nursing reported that he had been aware of this work on food and nutrition prior to joining the Trust. He congratulated the team on the progress made and asked what was planned next. Dr Cleasby explained that the work would continue with Food for Life and would like to explore wider community co-operatives to supply food to the Trust. Christine Bentley commented that the Trust was looking at discharge packs for patients working with the Trust's fruit and vegetable suppliers. Alison Wilson added that a fruit and vegetable stall would be set up at Calderdale Royal Hospital, to match the one at Huddersfield Royal Infirmary and that there would be a 'go-see' to Trusts that have done work around the presentation of food.

The Chairman thanked Dr Cleasby and the CCG for their support and the Trust colleagues for their implementation and leadership in this work.

120/16 CHAIRMAN'S REPORT

120/16 (1) Board to Board with Mid Yorkshire Hospitals NHS Trust

The Chairman reported on the meeting held with board members from Mid Yorkshire Hospitals Trust which had covered a number of areas of collaborative working including estates and fertility services. The meeting had also been an opportunity for the Trust to share the experience of implementing the Electronic Patient Record (EPR) and the Programme Management Office arrangements. Both Trusts recognised the value of continuing to work together.

120/16 (2) NHS Providers Governance, Sustainability and Improvement workshop

The Chairman gave feedback from his attendance at the NHS Providers' workshop. He explained that there was a need to ensure that governance and leadership is progressing at the same pace as the wider Sustainability and Transformation Plan (STP) process. He reported that there had been some concerns expressed by the

Chairs of Trusts around the governance processes associated with the development of STPs and that this was being reviewed nationally.

OUTCOME: The Board **NOTED** the update from the Chairman.

121/16 CHIEF EXECUTIVE'S REPORT

Sustainability and Transformation Plan

The Chief Executive gave feedback on development of the STP. He explained that the group consists of representatives of Acute Trusts, Mental Health Trusts, Clinical Commissioning Groups (CCGs) and local authorities, led by Rob Webster Chief Executive of South West Yorkshire Partnership Foundation Trust, working to meet the deadlines of NHS Improvement and NHS England to produce the STP. The West Yorkshire STP covers six districts including Harrogate which all have their own local plans. The areas of overlap form the wider West Yorkshire plan. There had also been a meeting with the leads from the national Arm's Length Bodies to discuss the progress in developing the STP. This had demonstrated that more work would be required on the plan prior to the deadline for completion in September. The plans are intended to close both the quality and financial gaps across the system.

The Board recognised that this work is complex and is moving at speed and there was a need to ensure that the Board was properly engaged in the development of the plan. It was agreed to provide a further update at the meeting in September.

ACTION: OW / AB

OUTCOME: The Board **NOTED** the progress with the development of the STP and **AGREED** to receive an update at the next meeting in September.

122/16 CONSULTATION UPDATE

The Director of Transformation and Partnerships informed the Board that the formal public consultation had concluded in June and that independent analysis of the findings from consultation would be shared with the Clinical Commissioning Groups and Joint Overview and Scrutiny Committee in August. The JOSC is due to meet in September to consider these findings and also the evidence collected through their own engagement events.

The Director of Transformation and Partnerships also reported that a petition addressed to Calderdale and Huddersfield NHS Foundation Trust had been received containing 160 signatures and that this had been shared with the Board in line with Standing Order 2.7. The petition had been included in the consultation feedback.

OUTCOME: The Board **NOTED** the update on the consultation process and **RECEIVED** the petition.

123/16 BOARD ASSURANCE FRAMEWORK

The Company Secretary presented the 2016/17 Board Assurance Framework (BAF) and highlighted that it had been updated to reflect the 2016/17 1 Year Plan approved by the Board in May.

It was noted that a new risk has been identified and included on the BAF:
- Failure to maintain a cash flow position

Two risks were recommended for closure:
1. Failure to deliver a robust financial and Cost improvement plan (CIP) for 2016/17
It is recommended that this risk be closed and a new risk be identified to address the financial and CIP planning process for 17/18 and beyond
2. The Trust is unable to grow due to inability to increase clinical income opportunities

It is recommended that this risk be closed and a new risk be developed to reflect the Sustainability and Transformation Plan work and the wider West Yorkshire discussions

The Company Secretary also recommended that the BAF be updated and reviewed more frequently reflecting the pace of change in the NHS.

ACTION: VP

OUTCOME: The Board **APPROVED** the recommended changes to the BAF and **AGREED** to receive a further version at the meeting in September.

124/16 RISK REGISTER

The Executive Director of Nursing reported on the risks scoring 15 or above within the organisation. These were:-

6131 (20): Progression of service reconfiguration impact on quality and safety
2827 (20): Over-reliance on middle grade doctors in A&E
4783 (20): Outlier on mortality levels
6345 (20): Staffing risk, nursing and medical
6503 (20): Delivery of Electronic Patient Record Programme
6658 (20): Patient flow
6721 (20): Non delivery of 2016/17 financial plan
6722 (20): Cash flow risk
6732 (20): Cost improvement delivery

Risks with increased score
There were none with an increased score.

Risks With Reduced Score
There were none with an increased score.

New and closed risks
There were no new or closed risks.

The Board discussed the commitment to £28M of capital. The Executive Director of Finance reported that this had been discussed and confirmed with NHS Improvement at the Progress Review Meeting on 19 July.

Prof Peter Roberts asked that the internal audit reports with limited assurance and those with outstanding recommendations be considered for inclusion on the risk register. It was also recognised that, along with the BAF, the risk register should be regularly reviewed to reflect the changing environment within the NHS and it was agreed to review the risk register in August and share with members of the Audit and Risk Committee.

ACTION: BB

OUTCOME: The Board **RECEIVED** and **APPROVED** the corporate risk register.

125/16 WORKFORCE RACE EQUALITY STANDARD

The Chief Executive presented the setting out the Trust position against the Workforce Race Equality Standard (WRES) for 2016 and highlighted the work to ensure that those from black and minority ethnic (BME) background have parity of opportunity. Recognise the clear understanding that the diversity of workforce and leadership has an impact on the quality of care to diverse populations.

The Chief Executive reminded the Board that the Trust had developed its WRES action plan after hearing directly from BME colleagues about their experience of

working in the Trust and what they identified as key areas for improvement. The action plan was approved by the Board of Directors in May 2016 and is now incorporated into a combined WRES/staff survey action plan which is monitored by Executive Board.

There was recognition that the nine indicators that make up the WRES are nationally set and represent the journey the NHS is on to make improvements for colleagues from a BME background. Karen Heaton commented that these miss an opportunity to strengthen grievance procedures and how these support staff to be able to highlight concerns.

The Board asked that the action plan be shared with the local CCGs for a view.

ACTION: OW

Clarification was also sought on whether the number of staff include agency. The Chief Executive responded that agency staff were probably not included in the figures and that this would be clarified in the updated report.

ACTION: OW

OUTCOME: The Board **APPROVED** the publication of the WRES baseline workforce data report.

126/16 CARE OF THE ACUTELY ILL PATIENT

The Executive Medical Director reported on progress against the work to improve quality of care and to address the Trust's HSMR and SHMI. He explained that although mortality remains a concern, there has been a reduction in the HSMR and progress made against all themes within the care of the acutely ill patient programme. Compliance against the care bundles was improving steadily and this work will be supported by the implementation of the EPR.

OUTCOME: The Board **RECEIVED** the report.

127/16 DIRECTOR OF INFECTION PREVENTION AND CONTROL QUARTERLY REPORT

The Executive Medical Director presented the Director of Infection, Prevention and Control (DIPC) report for the first quarter of 2016/17. There have been 6 cases of D Difficile, 3 avoidable and 3 unavoidable, against an agreed ceiling of 21 cases. It was noted that there has been a small increase in cases nationally. The Executive Medical Director explained that C Difficile is usually associated with elderly patients and antibiotic usage. The work on identifying sepsis means that there is an increase in antibiotic usage and this may be having an impact on the number of C Difficile cases.

The Executive Medical Director highlighted the positive performance in relation to low numbers of MSSA, good compliance with hand hygiene and an improvement in ANTT competence assessment. There had also been three positive cases of Zika virus in patients that had recently returned from a Zika area. The Executive Medical Director clarified that Zika virus is transmitted only through mosquito bites or sexually transmitted and that there was a very low public health risk.

OUTCOME: The Board **RECEIVED** the report.

128/16 DIRECTION OF INFECTION, PREVENTION AND CONTROL ANNUAL REPORT

The Executive Medical Director presented the DIPC Annual Report which provides information about the infection prevention and control arrangements and activity during the period April 2015 to March 2016, with an assessment of performance against national targets for the year. The report demonstrated the good work done throughout the year, with relatively low numbers of infections across the Trust.

OUTCOME: The Board **RECEIVED** the report and thank the Infection Control team for their work.

129/16 INTEGRATED PERFORMANCE REPORT

The Chairman explained that the Board was now receiving a six-page summary Integrated Performance Report (IPR), although the full document will be accessible by all board members and be available on the Trust website. The Board sub-committees will be doing detailed scrutiny of the relevant sections of the IPR and will escalate any areas of concern to the Board.

The Chief Operating Officer highlighted the key points of operational performance for June:

- The Trust complied fully with the NHS Improvement targets with the exception of the Emergency Care 4 hour wait time. June's position saw 95.07% of patients seen within 4 hours, the best position for a number of months. This gave an overall position for Q1 of 94.1%.
- A&E attendances remain high. This is not unique to the Trust as the position is replicated across Yorkshire and the Humber.
- The conversion rate of patients seen in A&E who require admission is falling which would suggest that patients are attending A&E who could be appropriately cared for in other settings. As a result there are plans to communicate messages to the public on the use of urgent and emergency services.
- Some additional beds have been opened. These have been managed alongside maintaining a reduction in the use of agency staffing through centralising the flexible workforce team and increasing the hours that the team operate into evening and at weekends.
- Performance against 12 of indicators on the Carter dashboard is improving. Performance deteriorated against five of the indicators, two of which have deteriorated for the 2nd month running. A deep-dive will be undertaken into these two areas.

The Executive Director of Nursing reported performance against the safe and caring domains:

- Performance has dipped in relation to falls and pressure ulcers, although there has been some improvement in the medicine directorate. There continues to be focused work in these two areas. Priority is the care we deliver.
- There has been an improvement in the quality of complaints responses and a backlog of over 70 complaints has been cleared. Performance in complaints response timescales remains challenging.
- The Trust is performing well on Friends and Family Test scores both in terms of the response rates and the percentage that would recommend the Trust.

The Executive Medical Director highlighted the key areas of performance in the effective domain as:

- The Trust remains on track for rates of hospital infection with no avoidable cases in June.
- The Trust is slightly above the ceiling target for perinatal deaths. All perinatal deaths are logged as an incident and fully investigated, which has not identified any trends.
- Remain an outlier in SHMI but HSMR is starting to fall. Mortality reviews are continuing with around 50% of hospital deaths reviewed, which has not identified any trends but will identify learning.
- The percentage of patients with a fractured neck of femur being treated within 36 hours of admission remains a challenge. 18 of 24 people received an operation within 36 hours. There were 3 clinical breaches and 3 organisational breaches. Root cause analysis is undertaken on all breaches and work continues to improve performance against this standard.

David Anderson, Chair of the Quality Committee confirmed that all these areas had been discussed in detail at the Committee's meeting earlier in the week and further assurance was being sought on the work being done to address these areas.

Discussion took place on the numbers of falls. The Executive Director of Nursing explained that it was reflective of the demographic of the patients being seen in hospital, and the number of patients who have been in hospital for longer than is required from a medical perspective. He added that good practice had been sought from other Trusts to see what can improve this position and that the Trust is looking at open visiting as it helps in observing patients.

The Chief Operating Officer described the work being done to look at those patients who have been in the hospital for 100 days plus to see what else can be done to facilitate their discharge into an appropriate setting. She reported that a new Assistant Divisional Director for Medicine had taken up post and that the discharge and social work teams were now co-located on both sites to support this work.

The Board discussed what has impacted on the achievement of the A&E standard. The Chief Operating Officer explained that there had been an increase in demand with an evening surge and that with two separate A&E departments the Trust has less resilience to cope with surges in demand, particularly in an evening.

Workforce

The Chief Operating Officer provided an overview of performance against the workforce targets:

- Sickness absence rates continue to fall, demonstrating the impact of the Absence Management team.
- More return to work interviews being undertaken and a leaver interview process would be rolled out.
- Completion of mandatory training will be challenging with the requirements for training for the EPR and its roll out. As a result the mandatory training matrix will be adjusted to reflect priority areas for 2016//17.
- There remain a high number of vacancies. Some of this impacted upon by a number of business cases that have been agreed and these staff are not yet in post.

OUTCOME: The Board **RECEIVED** the Integrated Board Report and **NOTED** the key areas of performance for June.

130/16 MONTH 3 FINANCIAL NARRATIVE

Finance

The Executive Director of Finance reported the key financial performance areas:

- Financial position stands at a deficit of £5.02m, a favourable variance of £0.15m from the planned £5.17m. The Trust is forecasting achievement of the control total of £16m. This does not include any accounting for the impact of EPR.
- The Trust has seen a strong performance against the clinical activity contract, driven primarily through non elective, A&E and outpatients.
- This has resulted in a pay overspend as there continues to be a heavy reliance upon agency staffing. Total agency spend in month was £2.3m, a slight fall on last month but above the NHS Improvement trajectory.
- The impact of this operational position is as follows at headline level:
- EBITDA of £1.11m, an adverse variance of £0.10m from the plan.
- Delivery of CIP of £2.47m against the planned level of £1.78m.
- Contingency reserves of £0.75m have been released against pressures.
- Capital expenditure of £3.67m, this is below the planned level of £4.10m.

- A cash balance of £1.94m in line with the planned level of £1.91m, supported by borrowing.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.
- Theatre utilisation has stabilised around 83% with room for further improvement due to insufficiently filled lists and large number of patient cancellations.

The Executive Director of Finance also highlighted that the national approach to financial delivery is escalating resulting in the requirement to respond to information requests from the centre at short notice. He pointed out that there is a risk that there could be further revision of the control total.

Phil Oldfield, Chair of the Finance and Performance Committee confirmed that the committee had undertaken detailed scrutiny of the financial position at its meeting earlier in the week. He pointed out that there is a planned reduction in beds in Q2 with a financial impact. He explained that the cash position is particularly challenging meaning that payment of suppliers within the better payment practice code timescales is difficult but is being well managed by the finance team. The Chief Executive added that this was a similar position to other Trusts nationally.

The Executive Director of Finance reminded the Board that the requirements of the Sustainability and Transformation Fund had been published with 70% based on achievement of the Trust's control total and 30% dependent on achievement of performance trajectories.

The Chair asked whether more than £14m of CIPs had been identified. The Chief Executive responsed that the gateway process for CIPs tests schemes and doesn't allow through ones that would not deliver, therefore more than £14m had been considered. He added that work had started on looking at further opportunities for efficiencies both in year and over the next five years.

The Executive Director of Finance highlighted that the Trust had over-performed against our contract in both elective and non-elective activity and CCGs may start to look at what can be done to contain this activity going forward. He informed the Board that NHS Improvement had announced that there would be a requirement to agree a two-year contract this year.

OUTCOME: The Board **APPROVED** the Month 3 financial narrative and **NOTED** the continued financial challenges.

131/16 MEDICAL REVALIDATION ANNUAL REPORT

The Executive Medical Director reported on the progress of the Trust's management of medical appraisal and revalidation since the introduction of revalidation in December 2012 and highlighted the following points:

- As at 31st March 2016, 309 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust.
- In the 2015/16 revalidation year (1st April 2015 – 31st March 2016) 94 non training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC). There were 92 positive recommendations and two deferral recommendations to enable them to collect more data.
- Based on headcount, 93.5% of non-training grade appraisals were completed and submitted in the appraisal year. 5.5% of non-training grade medical staff were not required to complete an appraisal (due to recently joining the Trust, maternity leave etc.).

The Executive Medical Director explained that there was a lot of work going around the quality of the appraisal process alongside the revalidation process. He clarified that agency medical staff are revalidated through their agency and have to be

revalidated in order to work.

The Board asked that the next annual report include an update on those that are delayed.

ACTION: DB

OUTCOME: The Board **RECEIVED** the revalidation annual report.

132/16 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The Board received an update from each of the sub-committees that had met in the previous month.

Quality Committee

The Chair of the Quality Committee reported the items discussed at the meeting held on 26.7.16:

- A review in detail of the quality aspects of the IBR
- Learning from a mock paediatric resuscitation exercise
- Review of the implementation of NICE guidance. Good progress had been made with some still partially implemented.
- An update on the draft CQC report and the next steps
- A report on the recent serious incidents and the learning from these.
- Receipt of the quarterly quality report
- The need for a push on mandatory training.

OUTCOME: The Board **RECEIVED** the update and **the minutes of the meeting held on 28.6.16.**

Finance and Performance Committee

The Chair of the Finance and Performance Committee reported the items discussed at the meeting held on 26.7.16:

- The development of the CIPs up to 2020/21which would report back in October
- Approval of the reference costs submission
- A review of the financial risks and agreement that the risk ratings remain valid.
- Discussion on the deteriorating position in relation to harm and whether this had any links to the Trust's financial position.

OUTCOME: The Board **RECEIVED** the update and **the minutes of the meeting held on 28.6.16.**

Audit and Risk Committee

The Chair of the Audit and Risk Committee reported the items discussed at the meeting held on 21.7.16:

- Continued compliance with regulatory reporting
- Approval of the amendments to the Standing Orders and the revised authorised limits in the Standing Financial Instructions
- Approval of the job description for the Chair of the Audit and Risk Committee
- The outstanding internal audit recommendations relating to payroll and maternity
- Three limited assurance internal audit reports
- The newly merged internal audit service
- Approval of the Annual Reports for Internal Audit, Counter Fraud and the Quality Committee
- The current live counter fraud investigations

OUTCOME: The Board **RECEIVED** the update.

133/16 DATE AND TIME OF NEXT MEETING

Thursday 15 September 2016 - Joint Board / Membership Council Annual General

Meeting, 6pm Lecture Theatre, Calderdale Royal Hospital.

Thursday 29 September 2016 – Board of Directors' meeting, Boardroom, Huddersfield Royal Infirmary.

The Chair closed the public meeting at 3:40pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th September 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - 1 SEPTEMBER 2016 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 September 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 September 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 September 2016

Appendix

Attachment:

ACTION LOG - BOD - PUBLIC - As at 1 SEPT 2016(2).pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 September 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT** Update on pilot to be brought in February 2016.	COO	**25.2.16** Report received. Likely implementation to be July 2016.	29.9.16		
25/16a 25.2.16	**IMPLEMENTING THE FORWARD VIEW** Following discussion it was agreed that a paper would be prepared for the Board once the footprint levels/Trust's role had been finalised	DoF/DTP	**26.5.16** Director of Transformation and Partnerships advised that plans were being developed. Agreed that input would be brought to the September BOD Meeting (Private).	29.9.16 (Private Agenda)		
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	Initial review of information across all Quality metrics complete. Refreshed presentation of Quarterly quality report to commence in September 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		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 September 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
106/16 30.6.16	**RISK REGISTER – IMPACT OF RECENT REFERENDUM** The question of whether the long term effects of the results of the EU referendum had any implications such as staff recruitment/vacancies and increased drug costs were required to be included on the Risk Register in the future. The Chief Executive acknowledged that the Trust was alert to the issues, would monitor the situation and once the Trust was fully aware of the issues would escalate as appropriate. The Board agreed that this position should be reviewed again in November 2016 and any material risk included in the Risk Register.			? Nov 2016		
109/16 30.6.16	**INTEGRATED PERFORMANCE REPORT – BOD MEETING DATES** Discussion was taking place regarding the timeline for completion of the report and whether it was possible to move the key committee meetings to the 1st week in the month.	Chair/Co Sec/Board Sec		28.7.16		28.7.16
109/16 30.6.16	**IPB – TARGETS** The Chairman asked whether the setting of targets for pressure ulcers and falls should be reviewed in the future. It was noted that the Executive Director of	Exec DoN	Initial review of information across all Quality metrics complete. Action correlates to Board Action 33/16 (25.2.16)	29.9.16		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 September 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
	Nursing was undertaking work in this area and further information would be brought to the Board after the review had been undertaken.					
121/16 28.7.16	**SUSTAINABILITY AND TRANSFORMATION PLAN** The Board recognised that this work is complex and is moving at speed and there was a need to ensure that the Board was properly engaged in the development of the plan. It was agreed to provide a further update at the meeting in September.	OW/AB		29.9.16 (Private agenda)		
124/16 28.7.16	**RISK REGISTER** Prof Peter Roberts asked that the internal audit reports with limited assurance and those with outstanding recommendations be considered for inclusion on the risk register. It was also recognised that, along with the BAF, the risk register should be regularly reviewed to reflect the changing environment within the NHS and it was agreed to review the risk register in August and share with members of the Audit and Risk Committee.	BB	**Action Complete.** Company Secretary and Assistant Director of Quality have reviewed Risk Register. Items to be escalated if necessary			18.8.16
125/16 28.7.16	**WORKFORCE RACE EQUALITY STANDARD**		**a. Action Complete** The Board asked that the action plan be shared with the local			18.8.16

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 September 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
	a. The Board asked that the action plan be shared with the local CCGs for a view. b. Clarification was also sought on whether the number of staff include agency. The Chief Executive responded that agency staff were probably not included in the figures and that this would be clarified in the updated report.	OW OW	CCGs for a view. I can confirm that our action plan has been shared with the CCG and that we have also asked to see their actions to see if there are any opportunities for shared learning and working together. **b. Action Complete** Clarification was sought on whether the number of staff include agency. The numbers within the report do not include agency staff. The RES requires that we assess data related to permanent staff to be able to provide comparable data year on year.			

APPENDIX C

Calderdale and Huddersfield NHS
NHS Foundation Trust

BOARD OF DIRECTORS

PAPER TITLE: STAFF SURVEY ACTION PLAN PROGRESS REPORT	**REPORTING AUTHOR:** JASON EDDLESTON, DEPUTY DIRECTOR OF WORKFORCE AND OD
DATE OF MEETING: 29 SEPTEMBER 2016	**SPONSORING DIRECTOR:** OWEN WILLIAMS, CHIEF EXECUTIVE
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial sustainability	**ACTIONS REQUESTED:** • To note

PREVIOUS FORUMS:
Updates on progress have been shared with the Executive Board.

EXECUTIVE SUMMARY:
The paper provides an update from Director leads on progress implementing the Workforce Race Equality Scheme (WRES) and staff survey action plan. The progress template describes actions taken and RAG rates the status of each action area. The RAG ratings are determined by the respective action lead. The current status of the overall plan (25 actions) is as follows:-

1. On track – delivered (green)	**9**
2. On track - not yet delivered (amber / green)	**5**
3. Off track – with plan (amber / red)	**11**
4. Off track – no plan in place (red)	**0**

FINANCIAL IMPLICATIONS OF THIS REPORT:
None

RECOMMENDATION:
The Board of Directors is asked to note the content of the progress update.

APPENDIX ATTACHED: YES

This page has been left blank

STAFF SURVEY ACTION PLAN PROGRESS REPORTING TEMPLATE	
Start date:	**June 2016**
Latest update:	**29 September 2016**
Lead Manager:	**Jason Eddleston, Deputy Director of Workforce and Organisational Development**
Lead Director:	**Owen Williams, Chief Executive**
Monitoring Committee:	**Executive Board / Workforce (Well Led) Committee**
Date signed off as complete	

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

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
	COLLEAGUE HEALTH AND WELLBEING				
2	**Create a robust health and wellbeing strategy** Test draft colleague health and wellbeing strategy and calendar of events (2016 Year of Health and Wellbeing) with staff survey focus group and 1:1 interview participants Produce health and wellbeing handbook and roadshow calendar Design communications plan to maintain visibility of events Identify role models/champions for work life balance and increase existing network of 50 workplace wellbeing champions to 100	Ian Warren / Karen Heaton	30 September 2016		**September update** Strategy shared for comment using a structured approach with WRES and staff survey focus group and 1:1 interview participants. No negative responses received. Working with Calderdale MBC and West Yorkshire Police to inform the Trust's approach. NHS staff health and wellbeing CQUIN healthy initiatives action plan drafted and submitted to CCGs. Action plan including measures agreed with CCGs. Focus on delivery from 30 June 2016. Link to colleague mental health support (see action 1).

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
					2016 events programme in place. To be enhanced through development and incorporation of activity plan designed for delivery of the NHS staff health and wellbeing CQUIN. Current events programme to be tested with focus group and 1:1 interview participants. No negative responses received. Health and wellbeing handbook to be drafted by 31 October 2016. Communication plan for activities launched by 31 October 2016.
3	**Offer health and wellbeing benefits** Explore the direct provision and external partnership provision of physical and mental health & wellbeing relaxation and exercise classes on site. Explore the direct provision and/or external partnership provision of gym facilities Explore the opportunities for improved provision for rest facilities, use of outdoor spaces, provision of changing rooms and showers Provide healthy food options Effectively communicate provision across the Trust	Lesley Hill / David Anderson	30 September 2016		**<u>September update</u>** Received quotes for an on-site gym, and currently in the process of getting further discounts with gyms local to the two hospitals. Healthy vending tender about to go to the market. Funding has been identified for further benches and tables for the sites. These are currently being purchased.

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
TALENT MANAGEMENT / LEADERSHIP AND MANAGEMENT DEVELOPMENT					
5	**Set out clear guidelines on flexible working for managers and staff including consideration of meetings ban at certain times, email / phone off times (not expected to be available 24/7)** Clarify flexible working options with case study examples and staff / manager stories Create and deliver workshops for senior managers on changing the culture of the Trust about working evenings and weekends and review use of email communication	Lesley Hill	31 July 2016		**<u>September update</u>** Working on the communication plan to raise awareness of the open events about long hours and flexible working. Events will be in October. A plan will be developed following the October events, and a further change management plan will be developed at this point.
6	**Improve access to personal and professional development opportunities** Enhance the quality of appraisals Offer 'go see' opportunities (internal and external) for all staff Identify clear career progression routes Design a comprehensive leadership and management development programme Create structured development programmes for all clinical and non-clinical colleagues	Ian Warren / Peter Roberts	31 August 2016		**<u>September update</u>** Workforce Strategy in development and to be discussed with Directors in October 2016. NHS Employers identified as a potential partner for external audit of appraisal quality. Contact made and proposal received. Chief Executive pursuing. Draft leadership and management development programme designed to support new organisational structures by Head of Workforce Development. Structured learning pathways for all staff groups / pay bands to be incorporated into the model. Paper formatted

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
	Use coaching circles as a learning and development tool Offer mentoring and coaching programmes for all staff Explore the options for protected learning and development time Preceptors given protected time to support new starters				with Directors meeting on 28 September 2016. Education and Learning Group scoping work priorities.
7	**Introduce standards for line managers** Design performance/management standards/competencies for managers at every level in the Trust Utilise standards/competencies to recruit and select to manager posts Prepare guidance for managers on tools to use to strengthen team working	Helen Barker / Phil Oldfield	31 August 2016		**<u>September update</u>** WTGR breakthrough events held linking work from Task and Finish group to front line staff and managers across all Divisions/corporate teams. Proposals for 2016 / 2017 and 2017 onwards developed and reviewed by Chief Operating Officer, Non-Executive Lead and Director of Workforce and OD. Ready to be shared at EB, date currently being confirmed in October. Commenced discussions with University and OD experts on incorporation into leadership development and succession planning opportunities.

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
8	**Strengthen the provision of equality and diversity training to include cultural awareness training and valuing different perspectives** Review current programmes available through the West Yorkshire Equality and Diversity network Review and develop the existing Embracing Diversity training programme (to include cultural awareness in how we treat patients including taking steps to understand patients diverse needs and adjusting services to suit those needs, and how to challenge on issues of equality and diversity through authentic speech)	Lesley Hill / Jan Wilson	30 September 2016		**September update** Revised training is being developed.
10	**Increase BME representation in senior roles** Improve our recruitment processes including having a BME person as a panel member for Band 7 and senior management appointments	Mandy Griffin / Karen Heaton	30 September 2016		**September update** Meeting was held in July to plan next step and agree what information was required in order to make a recommendation including:- • the pool of staff available to include a BME representative on interview panels • recruitment training and how includes the diversity elements. • what should the target be • how do current HR policies facilitate this • what is already available from other organisations that do this well. Next meeting will take place in September.

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
11	**Support BME colleagues in their career progression** Provide mentoring and coaching for anyone who wants to get on and who feels that an E&D issue may be holding them back including support to navigate training and development pathways and opportunities for job shadowing	David Birkenhead / David Anderson	30 September 2016		BME Mentorship group established and meeting. Innov8 to be contacted to scope out an offer of support for training for Mentors. Once complete will recruit potential mentors. Focus group for BME staff led by OW has occurred, Exploration with BDCT and other health care providers who have implemented a BME mentoring service. Explored the use of My E Coach as a potential resource. Mentoring service to be hosted by Organisational Development.
12	**Provide a career pathway for BME colleagues** Develop a comprehensive programme for Bands 3 / 4 (Administrative staff) and Band 5 / 6 (Clinical staff) to support them in career progression / promotion	Ian Warren / Karen Heaton	31 December 2016		**<u>September update</u>** Workforce Strategy in development and to be discussed with Directors in October 2016. WTGR breakthrough events held linking work from Task and Finish group to front line staff and managers across all Divisions/corporate teams. Proposals for 2016 / 2017 and 2017 onwards developed and reviewed by Chief Operating Officer, Non-Executive Lead and Director of

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
					Workforce and OD. Ready to be shared at EB in October 2016. Commenced discussions with University and OD experts on incorporation into leadership development and succession planning opportunities.
COMMUNICATION, INFORMATION AND FEEDBACK					
15	**Implement a clear trust-wide communications strategy** Revise the current internal communications plan to describe requirements at corporate, divisional and directorate level	Brendan Brown / Richard Hopkin	31 July 2016		**<u>September update</u>** Links to action on Team Briefing. Survey on internal communications completed. 1000+ responses from across all staff groups. Responses analysed and draft findings shared with divisions and team brief group. Short paper on learning from other Trusts put together and being reviewed at Colleague Engagement Group. Require draft workforce strategy to support final plan development.
18	**Incorporate BME focus group outcomes / actions in the Trust's workforce strategy** The work from the BME focus groups and in particular the action plan will be integrated into the broader workforce strategy	Owen Williams / Karen Heaton	30 September 2016		**<u>September update</u>** To be incorporated in the Workforce Strategy.

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
19	**Increase staff appetite for use of IT – use to empower and engage and inform** Put conferencing systems into community settings/meeting rooms to increase use of webinars and limit travel between sites Video Big Brief/TV screens for briefings/communication Scope what IT is required to make us more efficient and implement employee and manager self-serve Open up access to internet cafés on Trust sites Scope use of the Electronic Staff Record (ESR) to its full potential and explore alternatives to the Oracle Learning Management system in ESR	Mandy Griffin	30 September 2016		**<u>September update</u>** An initial meeting to look at the capability of delivering the actions has now taken place with THIS colleagues. The plan to delivery is now being developed. 2 more meetings have taken place and the following those meeting it was agreed that:- • a group has been formed to review how we communicate how existing technology can be used for video conferencing, Big Briefs as well as using solutions like Webinar and Jabba • the ESR related actions will be taken to the ESR project board • guest wireless is already available so the plan to advertise and market like an internet café is being developed.
20	**Communicate standards for behaviour / use of language** Set out clear and helpful guidelines spelling out acceptable/unacceptable behaviour and language	Lesley Hill / Karen Heaton	31 October 2016		**<u>September update</u>** A CHFT leaflet has been produced with a draft proposal for CHFT behaviours and will be shared across the Trust for feedback. Once this has been released, will incorporate comments and feedback into a CHFT behaviours rollout.

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
21	**Support colleagues raising concerns in relation to discrimination and racism** Create a safe and effective pathway for dealing with issues of discrimination and racism	Mandy Griffin / Richard Hopkin	31 October 2016		**September update** • the team agreed to create a BME support website with links to how issues can be dealt with • create a telephone messaging process to deal with issues safely • review/amend raising concerns policy to develop the visibility of the BME process • create a support group and process for developing this group through learning from other trusts • consider events for marketing the website/telephone process and broader communication (Trust newsletter) • review raising concern data • develop measures/KPIs for monitoring effectiveness. The next meeting will take place in September 2016.
22	**Establish a profile in the Trust for E&D issues** Create processes to monitor progress and measure the effectiveness of the steps we are taking including an ongoing forum like focus groups or listening groups to monitor issues around equality and diversity, share experiences and identify solutions	Mandy Griffin / Karen Heaton	31 October 2016		**September update** A meeting was held in July where a discussion took place around • surveys online • virtual listening forums • quarterly/ 6 monthly focus groups • sustainable forums • social groups and best practices from other organisations.

REF	ACTION	LEAD	DEADLINE	RAG	PROGRESS
					• the BME Network. A second meeting is being arranged to ensure recommendation is made within proposed deadline of 31 October 2016.
REWARD AND RECOGNITION					
24	**Have a new must-do which is to 'smile and be respectful' and use 'please and thank you'** Add the 'must-do' value to those the Trust already has in place and communicate	David Birkenhead	30 June 2016		See action 14

COMPLETED ACTIONS					
	COLLEAGUE HEALTH AND WELLBEING				
1	**Provide more colleague mental health support** Review mindfulness pilot programme and establish future plan	Brendan Brown / David Anderson	30 June 2016		**September update** Action remains on track to deliver. Three facilitated courses of 6 weeks (1.5 hours/week) delivered to date with positive feedback from attendees - reviewed and plan to progress and continue to offer 6 week programmes for colleagues wishing to learn and practice the 'how to' of mindfulness. In addition, in the process of launching weekly 'mindful hubs' which meet same time and

	Working in partnership with chaplaincy to support mental wellbeing retreat days and events Review managing stress training for managers and staff				place over the summer for all those who have previously attended the course and wish to continue to receive support, time and place to practice mindfulness. First retreat day held 12 July with 12 participants. Free to colleagues, supported by charitable funds but at present attended in participant's own time. The day incorporates sessions on resilience (Based on Robertson Cooper), self-awareness (Myers Briggs), Creative time, Mindfulness taster. Outcome to be evaluated but it is hoped this will become a regular event Currently 3 offers; • Managing stress for managers (½ day based on 5 steps to risk assessment and introducing HSE management standards) Facilitated by OH / Psychology services • Stress Health Matters (1 day for all staff – recognising and self-managing stress)Facilitated by OH /Psychology services •Mental Health First Aid (MHFA) facilitated by external provider Each programme evaluates well by participants but attendances are not high A refresh of the 2 'stress' courses is underway to redesign the offer; informed by collecting feedback and views of key stakeholders and participants and to complement other mental health programmes and reflect the current / future CHFT culture.

	Review and develop mental health first aid training programme				An increased presence of MHFA programme available (the most recent course in June 16 more than doubled attendees to 16) Programme evaluation underway.
TALENT MANAGEMENT / LEADERSHIP AND MANAGEMENT DEVELOPMENT					
4	**Recruit to values/behaviours and use these to hold colleagues to account** Extend 'recruit to values' programme to all staff groups	Anna Basford / Keith Griffiths	31 July 2016		**September Update** Meetings and workshops (involving representation from all Divisions) have taken place to scope the work required and learning of where this is already implemented in relation to recruitment of nursing staff. The aim is to roll out the use of the Recruit to Values tools to wider staff groups – including managers and administration staff, doctors, therapists and estates and facilities staff. Actions have now been agreed to enable the Trust to roll out values based recruitment across all staff groups with effect from 31 October 2016.
9	**Implement changes to internal processes to improve recruitment to posts** Refine vacancy control mechanisms Implement StepChange recruitment process recommendations	Ian Warren	30 September 2016		**September update** Learning from early weeks of refreshed vacancy control process identified and incorporated into the process. Guidance reissued in September 2016. Process for early contact with leavers and relaunch of leaver survey approved at Executive Board on 28 July 2016.

					'Quick win' actions from StepChange analysis implemented (for example, improved vacancy control process, refinement of pre-employment check process and dedicated / named divisional resourcing leads in place). Recruitment Manager to be appointed in October 2016. Service Improvement Lead to be appointed in October 2016.
13	**Improve direct engagement with BME colleagues** Set up a BME Network led by the CEO to oversee the implementation of these actions	Owen Williams	30 June 2016		**<u>September update</u>** The first meetings of the Colleague Engagement Network and BME Staff Network were well attended and a workplan is being agreed by each of the groups. The Networks have been established from the colleagues involved in the earlier focus groups.
14	**Everyone use the "Hello my name is …" campaign** Implement an everyday behaviour campaign to develop working practice	David Birkenhead	30 June 2016		Raised awareness through Trust Communications. Include in Big Brief. Placed a screen saver. Redesigned Trust ID badges to include the logo and written an agreement to the principles for all new starters which they will be asked to sign. Awaiting for new NHS logo design information.

COMMUNICATION, INFORMATION AND FEEDBACK					
16	**Review delivery of team brief to include time for improved communication by managers talking to staff face-to-face and listening to their concerns and recommendations** Revise team brief policy and re-introduce team brief training for all line managers across the Trust building in these principles. Implement a corporate framework for listening groups/drop in sessions	Helen Barker	31 July 2016		**<u>September update</u>** Weekly Task and Finish group established with a cross section of staff Internal communications survey completed with 1000+ responses from all staff groups. Responses analysed and initial findings shared with divisions and group. WTGR groups taking place in September led by Catherine Riley with feedback at end of month. Divisions testing 15-1 and Breakfast meeting approaches. Link to internal communications work around introduction of weekly email. Options for developing learning and skills development for line managers around communication and engagement of staff completed for presentation to Web. Formal proposals to be presented to EB, date to be confirmed.

17	**Communicate the outcome of the BME focus group work** Design a communication plan to share key messages from focus groups across the Trust	Lesley Hill / Jan Wilson	31 July 2016		**September update** Key messages to be agreed and will be incorporated into usual communication channels.
REWARD AND RECOGNITION					
23	**Promote the use of thank you messages/cards** Revise design and ensure supply available across all teams with short guidance note	Keith Griffiths	31 May 2016		**September update** Thank you cards fully rolled out and in use. Communication campaign to be developed and launched.
25	**Enhance 'Celebrate Success' opportunities** Develop plan to embed celebrating success across divisions	Lesley Hill	30 June 2016		**September update** Action complete.

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 29th September 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Corporate Risk Register - This paper presents to the Board the corporate risk register as at September 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 on 13 September 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 September 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, risk 6841, relating to operational readiness for the Electronic Patient Record.

The risk relating to junior doctor industrial action is currently on the risk register at a score of 12 and will be reviewed once the national situation is clearer. The risk will be represented in October 2016 if the risk score is increased.

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 Corporate Risk Register are being appropriately managed
ii. Approve the current risks on the risk register.
iii. Advise on any further risk treatment required

Appendix

Attachment:

Corporate Risk Register - September combined.pdf

CORPORATE RISK REGISTER REPORT

Risks as at 19 September 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 6345 (20): Staffing risk, nursing and medical 6503(20): Delivery of Electronic Patient Record Programme 6721 (20): Non delivery of 2016/17 financial plan 6722 (20): Cash flow risk
RISKS WITH INCREASED SCORE
There are no risks with increased risk scores.
RISKS WITH REDUCED SCORE
4783 (16): Outlier on mortality levels, reduced from score of 20 due to progress with understanding the cause of mortality. 6658 (16): Patient flow risk reduced from score of 20 due to progress with discharge planning. 6723 (12): Cost improvement delivery risk score reduced from 20 and now managed within divisional risk register.
NEW RISKS
1 new risk has been added to the Corporate Risk Register in September 2016, risk 6841 EPR operational readiness risk.
CLOSED RISKS
None

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

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	April 2016	May 2016	June 2016	July 2016	September 2016
		Strategic Risks						
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme - transformation	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=	↓16
2827	Developing Our workforce	Over –reliance on middle grade doctors in A&E	Medical Director (DB)	20=	=20	=20	=20	=20
6841	Keeping the Base Safe	Not being able to go live with the Electronic Patient Record – operational readiness	Chief Operating Officer (HB)	-	-	-	-	15!
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	↑20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	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	Director of Workforce and OD	16=	=16	=16	=16	=16
6694	Keeping the base safe	Divisional Governance arrangements	Director of Nursing (BB)	16=	=16	=16	=16	=16
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	-	!15	=15	=15	=15
6753	Keeping the base safe	Inappropriate access to person identifiable information	Director of THIS (MG)	-	-	-	16!	=16

		Financial Risks						
6721	Financial sustainability	Non delivery of 2016/17 financial plan	Director of Finance (KG)	-	!20	=20	=20	=20
6722	Financial sustainability	Cash flow risk	Director of Finance (KG)	-	!15	20↑	=20	=20
6723	Financial sustainability	Capital programme	Director of Finance (KG)	-	!20	=20	=20	↓16
		Performance and Regulation Risks						
6658	Keeping the base safe	Inefficient patient flow	Chief Operating Officer (HB)	20=	=20	=20	=20	↓16
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	Director of Workforce (IW)	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), Director of Workforce (IW)	20=	=20	=20		=20

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

Trust Risk Profile as at 19 September 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	= 6345 Staffing risk, nursing and medical = 6131 service reconfiguration	
Likely (4)				↓4783 Outlier on morality levels ↓ 6 6 5 8 Inefficient patient flow = 6300 Clinical, operational and estates risks outcome = 6594 Radiology risk/ diagnostic tests = 6596 Serious Incident investigations = 6598 Essential Skills Training Data =6694: Divisional governance arrangements = 6753 Inappropraite access to patient identifiable data = 6723 capital programme =5806 Urgent estate work not completed	= 2827 Over reliance on middle grade doctors in A&E = 6503 Non delivery of EPR programme =6721 Not delivering 2016/17 financial plan
Possible (3)					= 6299 Medical Device failure levels =6722 Cash Flow risk ! 6814 EPR operational readiness
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

SEPTEMBER 2016
CORPORATE RISK REGISTER

Risk No	Div	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6131	Corporate	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. A change in consultant recruitment process (that commenced during January 2016) will reduce time to appointment. **September 2016 update:** Consultation complete, CCG and Scrutiny considering the outcome. CCG decision on next steps timetabled to be made public on 20 October 2016	Oct-2016	Oct-2016	WEB	Anna Basford	Catherine Riley
2827	Medical	Apr-2011	Developing our workforce	There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff.	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time July 2016 Update: No appropriate applications from overseas consultant recruitment. Senior clinical fellow (consultant level) commences 1st August. Advert out to attempt further MG recruitment **September 2016 Update:** 2 Substantive consultants have resigned. Senior Clinical fellow appointed to Consultant level position. Currently 10 on consultant rota. One additional Specialty Doctor has been recruited	Sep-2016	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

6345	Trustwide	Jul-2015	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas - lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties (A&E, Ophthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology, Gynaecology/Urology Oncology, Acute Oncology Service) - over-reliance on middle grade doctors meaning less specialist input - dual site working and impact on medical staffing rotas - lack of workforce planning / operational management process and information to manage medical staffing gaps - lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - 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	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment. -revised approvals process for medical staffing to reduce delays in commencing recruitment. -HR resource to manage medical workforce issues. - Exit interviews for Consultants being conducted. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements Therapy Staffing - posts designed to be as flexible as possible - review of skill mix and development of Assistant Practitioners. - flexible working - aim to increase availability of flexible work force through additional resources / bank staff	Medical Staffing Lack of: - workforce plan / strategy for medical staff identifying level of workforce required - dedicated resource to develop workforce model for medical staffing - centralised medical staffing roster (currently divisional) / workforce planning for medical staff - system /process to identify, record and manage gaps in planned medical staffing, particularly for junior doctors - measure to quantify how staffing gaps increase clinical risk for patients Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) July Update - Nurse Staffing · Targeted recruitment for substantive Registered Nursing and Midwifery workforce underway. This is currently focused on local recruitment from graduate programmes and overseas recruitment · Liaison with staff who have recently left the Trust to commence, to ascertain reasons for leaving, and encourage return to the Trust · Specific recruitment to bank, night and weekend posts to commence · Focus on retention of existing staff underway and revisited with Ward leaders · Branded recruitment process under development, promoting CHFT as an exemplar employer · Development programmes for Ward Managers and Matrons to commence from September 2016 · Standard Operating procedure for use and authorisation of temporary nursing staff launched · Full workforce review of ward nursing establishments undertaken by Chief Nurse office July 2016 **September 2016 Update** Medical Staffing - international recruitment via specialist recruitment agency for hard to fill Consultant level posts continues but to date this has not been succesful. Nurse staffing • Targeted recruitment continues with increased focus of recruitment from graduating nurses & midwifes from local HEI's • Continued EU recruitment programme • Specific job advert now continually running advertising the Trusts commitment to flexible working contracts & shift patterns • Focused recruitment event planned for October 2016 to attract potential staff, show case the organisation & promote current vacancies • Standard operating procedure now in place for use & authorisation of temporary nursing staff. • Specific recruitment continues to the flexible workforce • Branded recruitment and advertising process under development – promoting CHFT as an exemplar place to work	Aug-2016	Nov-2016	WLG	David Birkenhead, Brendan Brown, Ian Warren	Lindsay Rudge, Jason Eddleston & Claire Wilson

6503	Corporate	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 Risk &Compliance group via the Cerner Portal if required, any escalations from transformation group will be brought to Risk &Compliance Group by the programme leads July Update: Dual go live with BTHFT communicated trust wide for the 19 November 2016. ST2 (System Testing) finished early July, IT1 (Integration Testing) completes this week (15th July). Feedback evidences that CHFT are in a good position both technically and operationally. There is a second risk being drafted around Operational Readiness/Engagement to help manage that aspect. No change to score. **September 2016 Update:** Upon review, and in order to ensure patient safety, a decision has been made to plan for a launch/go-live next year, this plan will also include the decision to separate the go-live. This decision will allow more time to engage and train staff, deliver the technical solutions that will support EPR and more thoroughly test the system and its data. This will help to mitigate some of the contributory factors outlined in this risk. Octobers update will be able to include some new indicative timescales and mitigation plans.	Oct-2016	Sep-2017	RC	Mandy Griffin	Mandy Griffin
6721	Corporate	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	**September 2016 update:** At Month 5, 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. Divisional financial recovery plans and additional savings plans must be implemented to ensure delivery of the Trust's forecast financial position. A fine balance must be struck to drive the necessary reductions in agency expenditure whilst striving to maintain safe staffing levels and deliver standards and access targets. The Trust is currently spending on agency staffing at a rate which would breach the NHSI ceiling level of £14.95m. The Trust has a level of assurance from NHSI that this will not hinder receipt of the STF if the control total is delivered. Against the £14m CIP target the risk profile has been reviewed and £1.96m of schemes remain as high risk. The CIP risk is increased by the planned profile of delivery which is heavily weighted to the latter part of the year. In addition, the new EPR system brings heightened risk of lost productivity through the implementation phase for which the plans do not make any specific financial allowance. The new Junior Doctors contract, strike action and the costs of addressing CQC recommendations may also bring additional unplanned pressure .	Sep-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

6722	Corporate	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 **September 2016 update:** Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments and compensate for delays in the flow of Strategic Transformation Fund cash (which is outside of the Trust's control). Further action is being taken to maximise collection of receivables and the profile of cash management is being raised at Divisional level and agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner. Cash continues to be a high risk due to the knock on impact of I&E risks and the fine balance required in managing working capital. Borrowing remains at the higher interest rate.	Sep-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer
4783	Corporate	Aug-2011	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	2 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine and Complex Medicine which will give guidance on areas of further improvement. Action plans for these areas being developed based on preliminary report findings. Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. August reviews of July deaths (using new process) compliance 70% - highest since Feb'15 Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised Aug 2015 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Final reports from Royal College of Physicians awaited (expected June 2016) Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Mortality case notes review may not pick up all factors relating to preventability Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. To be completed by Dec 15 Care bundles not reliably commenced and completed	20 4 x 5	16 4 x 4	12 4 x 3	To complete the work in progress. CQUINS to be monitored by the Trust External review of data with assistance from Prof Mohammed (Bradford) August 2016 The CQC inspection report referenced the wokr ongoing within the organisation in relation to mortality and has said that we must continue with the work that we are doing to reducate avoidable mortality. We have received the fianl report from the Respiratory ISR and wil commence a plan to deliver the actions. **September 2016 update:** A new mortality review process will be implemented which will lead to a consultant led review into each death. Progress continues to be made with the management of sepsis and a lead nurse has commenced in post.	Oct-2016	Mar-2017	COB	David Birkenhead	Juliette Cosgrove

6723	Corporate	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	**September 2016 update:** As yet formal approval of the planned capital investment of £28.2m has not been received but no negative feedback has been received from NHSI on this programme following a comprehensive deep dive return that was submitted in June and as such the Trust is proceeding with its capital plans.	Sep-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer
5806	Estates & Facilities	May-2015	Keeping the base safe	There is a risk that the urgent Estates schemes (see below) cannot be undertaken due to insufficient resources, resulting in a poor patient experience, possible ward closures and harm caused by slips, trips and falls. Flooring: in ICU at HRI, Ward 19, CCU CRH Windows: Ward 6 at HRI and all elevations of the hospital, A&E Resus Theatres / Environment ; HRI Main, DSU and Theatre 6 and CRH Theatres HRI road surfaces, pipework, second water main, aseptic unit improvements Staff Residences Saville Court and Dryclough Close Properties (fire and utilities compliance). Trust wide roofs Air Handling Units Medical Gas Plant Structural Medical Air Plant Electrics upgrade of local distribution boards. Plant room refurbishment Facet Survey – Physical condition Ward upgrade programme ICU nurse call and draeger ponta beams	Each of the risks above has an entry on the risk register and details actions for managing the risk Due to lack of capital monies focus is on monitoring, maintaining and repairing where appropriate. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities.	Unable to deliver all the actions in the Independent Advisors action plan due to lack of monies.	16 4 x 4	16 4 x 4	6 3 x 2	August 2016 Capital programme to be agreed. Quote obtain for a wireless nurse call system in ICU **September 2016 Update** The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so	Oct-2016	Mar-2017	RC	Lesley Hill	Paul Gilling / Chris Davies

6658	Medical	Mar-2016	Keeping the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	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. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20 4 x 5	16 4 x 4	9 3 x 3	July Update Safer patient flow programme fully operational with clear governance arrangements including monthly reporting to WEB to ensure full organisational awareness and ownership. Process to cross check patients with a long wait in A&E and outliers within the mortality review process. As per the bed plan a further 14 bed reduction on the HRI site which, with current demand is requiring more focused patient flow team input **September 2016 Update** Single transfer of care list in place and finalised with agency partners meaning that there is consistent prioritisation of discharge planning. Integrated the discharge and social care teams on both sites. New process in SAS and Medicine for matron reviews every morning identifying and actioning discharge planning. Associate Director in place focusing on urgent care and safer flow. Active participants in the NHS I Improvement Programme for Emergency Care.	Oct-2016	Apr-2017	BOD	COO Helen Barker	Bev Walker
6753	Corporate	Jun-2016	Keeping the base safe	The Risk of:- Inappropriate access to PID and CHFT Organisational data on some Trust PC's. This risk is increased by the inability to audit access either pre or post any incident. Due to :-Data being saved under Web-station log ins on communal PCs and associated network drives (wards etc) Resulting in:-Breach of confidentiality of patient or staff internally and organisational risk from a CHFT data breach.	- Only trust staff can access the PCs under the web-station login - Only PC's that are a member of a specified group will allow the use of web-station login - Policy mandates that no Data (especially PID) to be saved to local drives - Reduction of generic logons where possible (low impact) - Sophos encryption of disk drives for encrypted local disk data	- Process to wipe the local drive on web-station PCs daily (Begin Comms after audit) - Removal of generic logons through roll out of single sign-on/VDI (Oct 2016) - Password for web-station does not change (currently set in 2010) every 3 months as per other user accounts - Ability to save information to shared network drives associated with web-station account. This information is accessible by all who use the account. - Not all PC's have Sophos Encryption installed (Ongoing)	16 4 x 4	16 4 x 4	4 4 x 1	Clarity around the extent of the problem through audit of PCs and network saved data - End of July 2016 Understand potential completion dates for SSO and VDI - October 2016 July Update: Work is continuing with the Audit of the situation/PC's, once complete short term mitigation can be put in place to reduce the score while we are waiting for SSO/VDI to be implemented in October. **September 2016 Update** Short term - Unprotected PC's have been encrypted. Longer term - SSO/VDI hardware is in place, Configuration is underway, Ward 3 at CRH will be the initial test area in October. Roll out will commence in November.	Oct-2016	Dec-2016	RC	Mandy Griffin	Rob Birkett

6594	Family & Specialist Services	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 July update - agreed new process will go-live from 25th July. Cross-divisional involvement in developing and implementing this process - to be reviewed in August to ensure fully successful. Risk expected to reduce at this stage. **September2016 update** Process described in place and working well. First audit of process to be completed in October - if audit is satisfactory and provides assurance of process, this risk will be reduced in line with this	Oct-2016	Oct-2016	RC	David Birkenhead	Rob Aitchison/ADDs
6596	Corporate	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	1. Capacity - recruitment taken place for dedicated investigation resource in Governance and risk team - final stages of recruitment process being completed 1. Ongoing delivery of Effective Investigation Training Course (1 day, monthly) 2. Greater identification and sharing of learning from each SI, sharing within PSQBs and across division through reporting and SI review group August update Reports still not always meeting the deadline and we still need to train more investigators. Those that are conducting investigations are getting more support from the Risk Management Team. One report was noted by the CCG as excellent. **September 2016 update** The CQC in their published report stated that we must train more investigators in the use of RCA tools and techniques, a plan is in place to deliver the required actions.	Oct-2016	Dec-2016	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove

6300	Trustwide	May-2015	Keeping the base safe	As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services.	- 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 as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being 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, has been conducted	The inspection report has shown us to be in the "requires improvement" category An action plan is being developed but not yet approved	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 August update The final report shows that we require improvement but with lots of areas of good practice. action plans are being developed to meet the required improvement. **September 2016 update** Governance arrangement for the oversight of the improvement plan are being approved by the Trust Board in September. A Quality Summit is planned for October. The Trust is confident that most actions are achievable in the short to medium term but still has some actions that will require service transformation.	Oct-2016	Mar-2017	WEB	Brendan Brown	Juliette Cosgrove
6694	Trustwide	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 Action plan in place to deliver improvements	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 August update Scoping work continues. Variable quality of reports to the Quality Committee but some reached an excellent standard. **September 2016 update** The CQC issued a requirement notice to ensure that divisional governance arrangement continue to be improved. A plan is in place to deliver the improvements.	Oct-2016	Dec-2016	QC	Director of Nursing Brendan Brown	Juliette Cosgrove

6598	Corporate	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. Further essential skills subjects are been identified and added to the list with increasing frequency. This obviously not only extends the period of time the roll out project will take but also leads to a re-prioritisation exercise around establishing which are the key priority essential skills to focus on first.	There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject (the project timeline extends until February 2017). Compliance measurement will be enabled as each TA is set although this is a lengthy process within the confines of the current Learning Management System. The business plan to commission an alternate learning management system has been approved therefore the tendering process is underway. The Education and Learning Group (ELG) has recently been established and any new requests for addition to the essential skills list need to be approved by this group which should help apply some control to the content of the list.	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.	16 4 x 4	16 4 x 4	12 4 x 3	August Update As a result of repeated reference to the lack of MCA/DoLS and FGM training in the recent CQC report, these are now priority essential skills. Work underway to agree the target audience and enrol staff onto the relevant e-learning packages. This will of course delay the progress with other essential skills. **September 2016 Update** Essential Skills emphasis is currently on aspects identified within the CQC report, mostly in relation to maternity. These are now priority actions which has led to delays in the progress of other planned essential skills work. 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.	Sep-2016	Dec-2016	NA	Director of Workforce	Pamela Wood

6715	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 to allow and act on findings in real time The discharge documentation is under going review Fluid balance is being reviewed, the evidence base is being examined by the Deputy 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. August Update The documentation sub group continues to meet and the audit of fluid balance charts has been completed, the results are currently being analysed with a view to share the learning. Attendance at the group has been poor, the chair is currently reviewing representation. The newly formed falls collaborative will now lead the work on falls with the lead nurse feeding back to the documentation group. 3 wards have attended Weekly Executive Broad to share their improvement/action plans; progress against plans is being monitored by the divisions. **September 2016 Update** The work described above continues with the documentation sub-group meeting regularly to work on improvement. Last months CRAS audits demonstrated overall improvement. 27 medical record audits took place which demonstrated sustained improvement in recording co-morbidity, however compliance in annotating the record remains poor;; performance management is being addressed through divisional PSQB's. The Matrons audits demonstrate a low return in medicine at HRI. Further work is required to ensure care plans are personalised; this is being led through the Associate Nurse Directors. The overall CRAS audit shows sustained improvement in infection control and patient experience. Falls documentation remains an issue, however the falls collaborative are currently scoping the documentation therefore performance is unlikely to improve until change occurs.	Feb-2017	Mar-2017	QC	Brendan Brown	Jackie Murphy

6841	Corporate	Sep-2016	Keeping the base safe	Risk of not being able to go live with the Electronic Patient Record due to : *Pre Go-live* Lack of operational readiness: unable to extend clinics, inability to maintain safe patient flow. Workforce not yet trained and confident in the EPR system, unable to be released for training and lack of basic IT skills as not currently required within staff role. Worsening staffing levels (see risk 6345), vacancies, sickness and staff leaving to work in Trusts with non EPR systems. Lack of colleague ownership and engagement for the EPR at all levels of the organisation. Potential un-availability of suitable IT equipment in all areas of the Hospitals that need access to EPR. *CUT OVER* Lack of clear processes documented, communicated & resourced in order to carry out paper monitoring of patients through the go-live period. Productivity & efficiency may reduce as colleagues defer to paper systems. *POST GO LIVE* Inability to use the system effectively once the extended support mechanisms start to reduce following Early Live Support. Lack of confidence of the system due to any quality &/or performance issues. Efficiency & productivity may reduce due to inexperience of using the system Inability to report against regulatory standards. Resulting in reputational damage arising from inability to go live with the EPR , financial impact, impact at every point of patient care (appointments, patient flow, records, MDT s, payment) and continued use of paper records which can impact on	Pre go-live - A robust governance structure is in place to support the implementation of the EPR, including EPR specific risk register reviewed at weekly EPR meeting. - Weekly EPR operational board with direct escalation to WEB (and sponsoring group) - 90/60/30 day plans will aid control - 1:1 consultant plan Cut over: - Strong cut over plan with a developed support structure for BAU post ELS. - Command and control arrangements for cut over (Gold, Silver, Bronze) Post go-live: - gap	1. Training – need to monitor uptake of EPR training (EPR team and divisions by mid-September 2016) 2. Need to identify capacity and activity gaps through divisional operational readiness reporting 3. Number of EPR Friends/effectiveness of EPR friends.	15 5 x 3	15 5 x 3	10 5 x 2	Engagement and operational readiness sign off closer to go live date via operational readiness checklist and EPR passport. Closely monitor progress around training and staff feedback following the sessions. Further work with the divisions to clearly communicate the operational groups expectations and measure progress through the divisions reporting back to the ops group.	Oct-2016	Sep-2017	RC	Helen Barker	Mandy Griffin

6299	Trustwide	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. **September 2016 update** High Risk devices with scheduled PM's now at 89.5% across the trust, Breakdown KPI's now developed showing HRI and Acre Mill at 97.78%, CRH at 82.1% and Community at 84.74%. Bank staff still supporting PPM scheduling. (73.9% of inventory now scheduled, 20.4% devices not needed to be on schedules representing 94.3% of inventory scheduled). Temporary admin support still in place to continue with database updates. Work continues to validate data this is a continuing process.	Oct-2016	Mar-2017	DB	Lesley Hill	V Wotherspoon

6693	Corporate	Mar-2016	Keeping the base safe	Risk Of: Failure to comply with the Monitor cap rules. Due to: Bed capacity – The Trust has opened a significant number of additional beds in response to service pressures requiring safe staffing levels. No. of vacancies in the workforce – The Trust has a high number of vacancies across its workforce resulting in the requirement to engage agency staff (including national shortages). Resulting in: High usage of externally sourced agency workers, utilising agency that breaches the cap rate and in circumstances uses off-framework agencies. Regulator sanction – The Trust receiving a regulatory sanction given the number of breaches the Trust currently reports against the Monitor agency cap. Safety risk – The Trust is unable to fill vacant posts (Medical, Nursing, AHP, A&C) resulting in the risk of patient safety, quality and care.	The Trust collects weekly information on the number of breaches of the Monitor cap and reports this through to Monitor. Assurance via Finance and Performance and Well- led Group The Trust has performed a number of challenge sessions to review all existing long term breaches of the Monitor cap. Following this one-off exercise the Trust has sought to integrate this review/challenge into the existing Divisional Business Meetings. An exercise has been carried out to write a letter to all agencies (across all staff groups) requiring agencies to comply with the Monitor cap imposed. Nursing - The Trust has a centralised escalation process in place for the authorisation of requests to secure agency workers for Nursing staff (qualified and non-qualified), through to Nursing Director. The Trust has rich information on the Nursing workforce, covering bank, overtime and agency as a monitoring tool for spend/bookings. Medical – Divisional authorisation of requests to secure agency workers/locums AHP's – Divisional authorisation of requests to secure agency workers Admin & Clerical – Divisional authorisation of requests to secure agency workers	Reportable breaches are currently signed off at Director level though the Trust could further raise the awareness and action by including this information within a report to the Executive Board. Robust escalation and management information for all non-Nursing staff groups. Routine divisional review of agency spend.	15 3 x 5	15 3 x 5	9 3 x 3	A further paper to the Weekly Executive Board that requests gaps in controls are addressed and requests a directive from the Exec Board about absolute compliance with the agency cap and framework compliance guidance. Implementation of a Trust wide management system for all temporary workforce groups (rolled out from the existing system for locums). Manage a safe bed reduction plan from the Trust's current position. Recruit to all vacant posts across all workforce groups. Implement the EPR and reduce the Trust's reliance on agency staff. **September 2016 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 vacanciessigned and activity plans being finalised. Business case for further international recruitment for nursing posts drafted Expanded role of the flexible workforce office to lead on all bank and agency procurement being explored and costed '. Brookson' agency engagement model for medical and nursing, A&C and other staff groups adopted with timetable for implementation to be finalised A business case to recruit additional HCA to reduce current agency reliance is to be drafted A nursing business case that offers revised nursing skill mix is to be developed. Scope and develop the internal bank for medical staff Consolidate and expand bank worker numbers for nursing and AHPs	Aug-2016	Sep-2016	WLG	Ian Warren,	Mark Borrington, Project Manager

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th September 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: BOARD ASSURANCE FRAMEWORK - The Board is asked to approve the update to the Board Assurance Framework	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

-

Main Body

Purpose:

As agreed at the Board meeting in July, the Board Assurance Framework has been reviewed to assess whether there is any amendment required to the Trust's strategic risks as a result of the changing NHS landscape and the challenges facing the Trust.

Background/Overview:

Please see attached

The Issue:

There was a request to consider whether a risk should be added relating to the development of the Sustainability and Transformation Plans. The Company Secretary met with the Chief Executive and it was agreed that at this point there were no strategic risks identified but that STP would be reflected in risk 2/2016 'Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (STP, EPR, CIP, and service reconfiguration)'.

There have been no new risks and no closed risks.

While the risk scoring remains the same there have been some adjustment made to the assurances and the actions have been updated to reflect the current position. References to the corporate risk register have also been updated.

Next Steps:

It is recommended that the BAF remain under review and be brought to the Board in November following the submission of the STP and the decision by the Clinical Commissioning Group Governing Bodies as to whether to progress the service reconfiguration proposals.

Recommendations:

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

Appendix

Attachment:

BAF update for Board September 2016.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2016/17

Contents:

compassionate care

REF	RISK DESCRIPTION	Current score	Lead	Link to RR
Transforming and improving patient care				
001	Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI.	20 =	DB	4783 6313 2827 6596
002	Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (EPR, CIP, CQC preparation and service reconfiguration) while keeping the base safe	20 =	OW	6346
003	Faliure to progress service reconfiguration caused by an inability to agree a way forward across health and social care partners	20 =	AB	6131 2827 4783
004	Inability to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	12 =	DB	
005	Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care	15 =	MG	6503 6841
006	Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust	9 =	BB	
Keeping the base safe				
007	Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety	15 =	BB	6300 6694 6594 6596 6299 6598 6829 6299 6715 6234 6300
008	Failure to implement robust governance systems and processes across the Trust	12 =	OW	6694
009	The Trust does not deliver the necessary improvements required to achieve full compliance with Monitor	20 =	OW	4706 6693
010	Failure to achieve local and national performance targets	16 =	HB	6658
011	Failure to maintain current estate and equipment and to develop future estates model to provide high quality patient care	16 =	LH	6300 6299 5806 6723
A workforce fit for the future				
012	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop collegues.	20 =	BB / DB	6345 6497 6723
013	Failure to attract and develop appropriate clinical leadership across the Trust.	16 =	DB	
014	Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites.	12 =	JE	
Financial sustainability				
015	Failure to deliver the financial forecast position for 2016/17 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity	15=	KG	6721 6828 6723 6822 6721
017	Failure to progress and agree a five year strategic turnaround plan across the local health economy	15 =	AB	6131 2827 4783
019	Failure to maintain a cash flow	20 NEW	AB	6722

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

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
1.1516	Quality Committee	Executive Medical Director	**Risk** Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI. **Impact** - Inaccurate reporting of preventable deaths - Increased regulatory scrutiny as become CQC outlier - Inability to learn lessons - Increased risk of litigation and negative publicity. - Possible increase in complaints and litigation	• Safety thermometer in use on wards • Safety huddles being implemented • Mortality review process redesigned and rolled out with clinical leads appointed to address the gaps in capacity / capability to undertake reviews • Tighter process in place in relation to SI reporting and investigation • Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) • Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan • Mortality dashboard analyses data to specific areas • Monitoring key coding indicators and actions in place to track coding issues • Nervecentre roll out across the Trust • Ongoing work to improve the care of frail patients • Implementation of care bundles • Mortality reviews in respiratory and stroke not showing any themes • Three level 2 reviewers trained • Work with GP lead on post-discharge deaths within 30 days	<u>First line</u> Mortality dashboard in divisions Mortality reviews provide themes to improve standards of care Coding review putting Trust in upper quartile for some areas Mortality Surveillance Group established <u>Second line</u> Care of the Acutely Ill patient report to Board PSQB reports to Quality Committee Mortality review updates to Quality Committee <u>Third line</u> HSMR has fallen to 109.6. Predicting modest further reductions Independent review of cases by Professor Mohammed	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. Mortality reviews not yet undertaken consistently. Carried out for 40% of all deaths. Job plans for 2017/18 will include requirement to undertake mortality reviews	• SHMI position remains high	**Initial** 5x4 = 20	**Current** 5x4 = 20	**Target** 4x4 = 16

Action	**Mort**	**Lead**
Recruitment to Hospital @ Night team underway. To be completed	Complete	
Awaiting review of mortality review guidance to implement process further	November	JC
Phase 1 roll out of Hospital @ Night	October	SU
Post-discharge deaths wtihin 30 days work being carried out	December	DB
Job plans for 2017/18 being developed	March	DB

Links to risk register:
Risk 4783 - Outlier on Mortality
Risk 2827 - Clinical decision making in A&E
Risk 6313 - Inability to progress service transformation
Risk 6596 - SI reporting

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
2.1516	Board of Directors	Chief Executive	**Risk** Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (STP, EPR, CIP, and service reconfiguration) **Impact** - Delivery of safe clinical care - Financial sustainability - Low staff morale. - Viability and competitiveness of Trust is compromised	• Programme Management Office established to manage schemes •Turnaround governance arrangements in place including weekly Turnaround Executive • Joint EPR governance arrangements in place with BTHT • Moderisation WEB and report to F&P Committee / Board on progress with delivery of EPR • Full board complement in place • WYAAT meetings • Risk reporting and review arrangements • Hospital Programme Board • Partnership Board with CCGs	First line Modernisation WEB held every 6 weeks CIP plan on track for 16/17 EPR implementation programme Fortnightly CQC steering group Second line Integrated Board Report EPR report to Finance and Performance Committee / Board Turnaround Executive scrutiny weekly Monthly report on turnaround to Finance and Performance Committee Board approval of 5 Year Strategic Plan Third line PRM meetings with Monitor demonstrate progress Well Led Governance Review showed some areas of good practice EPR Gateway assurance report	EPR continues to be risk with training timetable to be fully implemented and go-live still to be determined	CQC assessment of requires improvement	Initial 4x4 = 16	Current 4x5 = 20	Target 3x3 = 9
Action					**Timescales**			**Lead**		
Implementation plan for CQC actions					December			BB		
Links to risk register: Risk 6346 - Capacity and capability to deliver service transformation										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
3.1516	Board of Directors	Director of Transformation and Partnerships	**Risk** Faliure to progress service reconfiguration caused by inability to agree way forward across health and social care partners **Impact** - Delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance; Compliance with Paediatric Standards; Compliance with Critical Care Standards; Speciality level review in Medicine - Unable to meeting 7 day standards - Inabilty to recruit and retain workforce in particular medical workforce (increased reliance on Middle Grades and Locums) - Potential loss of service to other areas	• Participation in Hospital Services Board by key senior staff. 20/1/16 CCGs made the decision to commence public consultation on the future configuration of hospital services. • CCGs and NHS England representatives included in roundtable discussion with Monitor • There is an agreed consensus between the CCGs and the Trust on the preferred clinical model.This has been reviewed and endorsed by Yorkshire and Humber Clinical Senate. • Monitor support for development of 5 Year Strategic plan approved by the Trust Board and updated to take account of 16/17 planning guidance. • ED business continuity plan developed • Additional consultant posts agreed for ED • Interim actions to mitigate known clinical risks • Nurse led service managing Paediatrics • Critical care still being managed on both sites • Frequent hospital to hospital transfers to ensure access to correct specialties	<u>First line</u> Vanguard work in Calderdale showing an impact <u>Second line</u> 5 Year plan progress report to Finance & Performance Committee and Board Urgent Care Board and System Resilience Group in place <u>Third line</u> Recent Trauma review shows positive position for CHFT PRM meeting with Monitor tracks progress	• Difficulty in recruiting Consultants, Middle Grade and longer term locums • Estate limitations inhibit the present way of working • Consultant rotas cannot always be filled to sustain services on both sites	• High use of locums • High sickness rates among staff	5x5 = 25	4x5 = 20	3x5 = 15

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

Links to risk register:
Risk 6131 - large scale service change
BAF risk 3.1516

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
4.1516	Quality Committee	Executive Medical Director	**Risk** Inability to deliver appropriate services over seven days resulting in poor patient experience, greater length of stay and reduced quality of care. **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Working group set up and workshop held with senior colleagues to develop plan • Perfect week learning shared • Governance systems and performance indicators in place • Part of the West Yorkshire early implementers • Capacity brought in to support programme • New gastro rota implemented	First line Improvement in performance against some key indicators including pre 12 o'clock discharge and reduction in outliers Second line Integrated Board report Benchmarked against four key Keogh standards Paper received at WEB Third line Independent review of mortality cases by Professor Mohammed Visit from NHS Improvement Medical Director gave positive feedback	• Gap analysis and action plan to be followed up • National consultant contract negotiations outcomes awaited • Capacity to deliver 7 day service action plan • Medicine action plan to be implemented • Hospital @ Night Phase 1 roll out to take place	• Included within new Single Oversight Framework. Need to understand metric measured and impact on Trust • Scope for futher implementation limited without service reconfiguration or additional investment	**Initial** 4x3 = 12	**Current** 4x3 = 12	**Target** 2x3 = 6
Action					**Timescales**			**Lead**		
7 day service action plan to be finalised Hospital @ Night phase 1 roll out					~~October / November~~ April September			SU SU		
Links to risk register: No corporate (>15) risks										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
5.1516	Finance and Performance Committee	Interim Director of The Health Informatics Service	**Risk** Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care **Impact** - Inability to realise the benefits - Non delivery of improvements in clinical outcomes - inability to realise return on investment or financial value for money	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Financial appraisal and selection of preferred supplier that included full benefits realisation and implementation plan. • Modernisation Programme Management and Governance structure to manage the implementation and roll-out of the EPR system within the Trust-wide IT Modernisation Programme. • A detailed project plan and timelines has been agreed with Cerner (EPR Provider) and Bradford for the roll-out of the EPR. • Current state gap analysis completed • Go live date planned for 19 Bovember	<u>First line</u> Regular reporting showing progress against plan CHFT has met exit criteria for the majority of areas <u>Second line</u> Joint Transformation Board with BTHT meets on a monthly basis chaired at Chief Executive level. Assurance Board that includes Non-Executive directors. Report to Finance and Performance Committee <u>Third line</u> 2nd Gateway assurance report Monthly update to NHS Improvement as part of PRM reporting arrangements	• Training plan to be fully described and populated		Initial 3x5 = 15	Current 3x5 = 15	Target 1x5 = 5
Action					**Timescales**			**Lead**		
Communications and Engagement plan to be implemented Training plan to be completed and delivered					Ongoing starting in September September			MG MG		
Links to risk register: Risk 6503 - Non delivery of EPR Risk 6841 - EPR go-live										

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

Action	**Timescales**	**Lead**
Membership Strategy review to be completed	September	RM
Awaiting outcome of CQC report to identify any further action to be taken	Complete - no actions identified in report	RM

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

TRUST GOAL: 2 KEEPING THE BASE SAFE

Ref	OWNER Board committee	OWNER Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING Initial	RATING Current	RATING Target
7.1516	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale	• Quality governance arrangements revised and strengthened • Revised SI investigation and escalation process in place • Improved risk management arrangements • Weekly CQC Steering Group in place overseeing self assessment of compliance with CQC domains and delivery of 90 day plans • Use of e-rostering in place. • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures • Leadership walkrounds implemented • Policies reviewed	<u>First line</u> Staffing levels reported to WEB CQC Steering Group reports Clinical audit plan reviewed Assessment of compliance with NICE guidance <u>Second line</u> Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs in Integrated Board Report. PSQB reports to Quality Committee CQC Action plan progress reported to Quality Committee DIPC report to Board Care of the Acutely Ill Patient plan report to Board Slight improvement in HSMR Vacancy and agency use reporting <u>Third line</u> CQC report showed requires improvement; no inadequate areas in line with Trust's self-assessment Quality Account reviewed by External Auditors and stakeholder bodies Well Led Governance review Independent assurance on clinical audit strategy	• Mandatory training compliance • CQC report identified a number of areas requiring action both at Trust-wide and divisional level including medicines management, complaints handling, mandatory training and staffing levels. • Operational priorities impacting on capacity • Standard of serious incident investigations needs to be improved • Estate issues identified • Scale of change and pace impacting on staff morale and engagement • Not fully compliant with NICE guidance where appropriate	• CQC assessed the Trust as requires improvement • National Clinical Advisory Team recommendations not fully addressed • Staff FFT response to recommendation as a place to work and place to be cared for declining • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements	3x5 = 15	3x5 = 15	2x5 = 10

Action	Timescales	Lead
CQC response action plan to be implemented	March	BB

Links to risk register:

Risk 6694 - Divisional governance
Risk 6594 - Radiology
Risk 6596 - SIs
Risk 6598 - Essential Skills
Risk 6829 - Pharmacy
Risk 6299 - Medical devices
Risk 6715 - Documentation
Risk 6234 - Mandatory training
Risk 6300 - CQC

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
8.1516	Board of Directors	Chief Executive	**Risk** Failure to implement robust governance systems and processes across the Trust **Impact** - Potential to affect the quality of patient care. - Reputational damage - Risk of regulatory action - Learning opportunities missed	• Quality governance review undertakend and implemented • Review of Board level sub-committees • Improved board level risk management reporting arrangements • PMO in place and improved governance in relation to CIP planning • Performance Management Framework approved and being implemented	First line Divisional governance arrangements in place with Executive attendance Improved PSQB reporting Self assessment undertaken against Board Governance Assurance Framework template Maintaining compliance against financial plan including CIP for 16/17 Second line Well Led Governance Review action plan delivered and monitored by the Board Third line PRM meeting with Monitor showing progress Well Led Governance Review identified no red flags Partnership Board meeting with CCGs	• Risk management arrangements to be strengthened at divsional level and below • Mandatory training and appraisal compliance not yet showing improvement	• Assessment of divisional governance to align to Well Led Governance review • CQC assessment as requires improvement including some areas linked to well led such as divisional governance arrangements • CIP profile for 16/17 back-loaded which may prove challenge towards the end of the year	**Initial** 3x4 = 12	**Current** 3x4 = 12	**Target** 2x4= 9

Action	**Timescales**	**Lead**
Well Led Governance review action plan to be implemented	~~September~~ COMPLETE	AH / VP
CQC response implementation plan to be delivered	March	BB
Performance management framework implementation update to be brought to the Board	September	HB

Links to risk register:
Risk 6694 Divisional governance

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

Action	**Timescales**	**Lead**
Well Led Governance Review action plan to be implemented	~~September~~ COMPLETE	AH / VP
Development of 16/17 CIP schemes to be completed	~~September~~ October	AB
Awaiting outcome of CQC report to identify any further actions to be addressed	~~August~~RECEIVED	BB
CQC response implementation plan to be delivered	March	BB
Assessment of impact of Single Oversight Framework to be presented to Board	October	VP / KG / HB

Links to risk register:
Risk 4706 - Financial plans
Risk 6693 - Agency cap

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
10.1516	Finance and Performance Committee	Chief Operating Officer	**Risk** Failure to achieve local and national performance targets and levels required for STF **Impact** - Poor quality of care and treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders - STF withheld and financial issues	• Strengthened performance monitoring and management arrangements • Bed modelling work and additional investment made in to bed capacity • Theatre productivity work and Theatres perfect week • New patient flow programme • CQUINS compliance monitored by Quality directorate • Bronze, silver and gold command arrangements and escalation process • External expertise brought in to support the patient flow work • System-wide gold commanders meeting in place • Regular forum in place between Operations and THIS to strengthen information flows and reporting • Head of Performance in place • Assistant Director for SAFER appointed	First line Weekly performance review with divisions. Divisional board and PSQB reviews of performance with executive attendance Activity reporting discussed at WEB Intergrated Board report focus of one WEB each month for detailed scrutiny wtih wider representation from divisions 'Deep dive' discussions into areas of under performance Appointment slot issues action plan has resulted in reduced ASIs Work begun to develop more intuitive dashboard Second line Enhanced Integrated Board Report discussed at Quality Committee and Board Finance and Performance Committee monthly report on activity Report on compliance with best practice tariff Third line Urgent Care and Planned Care Boards and System Resilience group	• System responsiveness • Appointment slot issues backlog still to be addressed in three key areas • Delivery of activity remains behind plan and action plans do not set out full recovery • Achievement of 4 hour emergency care standard requires micro-management. • Gap in external reporting sign off process. • Demand increased by 4.4%	• A number of indicators remain off track including A&E target in Q2; non-reportable delayed discharges. • Lack of certainty around SRG funding for 16/17 winter period • Lack of robust system surge plans.	4x4 = 16	4x4 = 16	2x3 = 6

Action	**Timescales**	**Lead**
Continued work on SAFER programme	Ongoing	HB
Particpation in NHS I improvement events related to patient flow	Ongoing	HB
Assessment against Single Oversight Framework to be undertaken	October	VP / HB / KG

Links to risk register:
Risk 6658 - Patient flow

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

Action	**Timescales**	**Lead**
Implement actions from PAMS assessment	March	LH

Links to risk register:
Risk 6300 - estates risk
Risk 5806 - estates schemes
Risk 6299 - medical devices
Risk 6723 - capital

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING Initial	Current	Target
12.1516	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop collegues. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff	• Weekly nurse staffing escalation reports • Ongoing multifacted recruitment programme in place, including international recruitment; • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure • ED business continuity plan in place; • Vacancy Control Panel in place; • E-roster system in place. • Framework for identifying 'at riak' wards which are under resourced or under performing in place. • Risk assessments in place • Nursing recruitment and retention strategy in place	First line Staffing levels, training and education compliance and development reported to WEB Divisional business meetings and PSQBs consider staffing levels as part of standard agenda IBR shows slight decrease in sickness levels, and reduction in agency spend Trust wide review of Ward Nurse staffing levels completed by DoN July 2016 Weekly meeting on agency spend Second line Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs embedded in Integrated Board Report. PSQB reports to Quality Committee Third Line Plans discussed with NHS I	Current hotspots are: Emergency Care; Radiology; Hisotpathology; vascular surgery; opthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; therapies; clinical administration Clear workforce strategy / plan required Recruitment and retention strategy for medical and therapy staffing required Continued spend on locums and agency remains above the NHS I cap leading to financial pressures in year.	• Not yet clear of the impact of agency figures on the new Single Oversight Framework assessment • Need clear workforce plan • Need recruitment and retention strategy for medical and therapy	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
Workforce strategy for medical staff to be developed	December	DB
Implementing revised guidance on safer staffing	November	BB
Improved reporting on planned and actual staff in post	COMPLETE	IW
Assessment against single oversight framework to be undertaken	October	VP / HB / KG

Links to risk register:
Risk 6345 - overall staffing risk
Risk 6497 - Nurse staffing
Risk 2827 - Middle grade staffing

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
13.1516	Quality Committee	Executive Medical Director	**Risk** Failure to attract and develop appropriate clinical leadership across the Trust. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities	• Devolved clinical structure • Work together get results programme in place • Positive feedback from Junior doctors on medical training • Performance appraisal based around behaviours • Coaching circles process • All CIP schemes have clinical lead • Development of new roles across professional groups • Good revalidation compliance • Performance Management Framework agreed including job description for clinical leads.	<u>First line</u> Established escalation framework to prioritise action to address week areas Clinicians leading of transformation programmes e.g. cardio /respiratory Engaged leaders toolkit in place Clinical lead particpation in star chamber approach Job planning framework approved <u>Second line</u> Integrated Board Report Revalidation report to board <u>Third line</u> IIP Accreditation Internal Audit report and Turnaround Director report on PMO arrangements and inclusion of clinicians and Quality Imapact Assessment processes in governance arrangements.	• Education proposal not yet finalised • OD plan for medical workforce to be developed • Divisional structures including time for clinical leadership to be finalised	• Assessment of divisional governance to align to Well Led Governance review • Acquire independent assessment of clinical leadership arrangements • Staff FFT / Survey results deteriorating • Appraisal compliance away from target	4x4 = 16	4x4 = 16	3x3 = 9

Action	**Timescales**	**Lead**
Job planning arrangements to be agreed and implemented	~~September~~	DB
Divisional structures work to be completed	March	HB
OD plan for medical workforce to be developed	March	IW
Education proposal to be reviewed and implemented	December	IW
Restructure of medical director's office to be completed	December	DB

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

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

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

Links to risk register:
Risk 6828 - PMU
Risk 6822 - Sepsis CQUIN
Risk 6723 - Capital
Risk 6721 - Financial plans

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY

Ref	OWNER		RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE &	GAPS IN CONTROL	GAPS IN ASSURANCE	RATING		
								Initial	Current	Target
17.1516	Board of Directors	Director of Transformation and Partnerships	**Risk** Failure to progress and agree a five year strategic plan across the local health economy **Impact** - financial sustainability - viability of certain services - inability to compete or collaborate with other WY acute trusts	• PRM process • Roundtable discussions introduced including Monitor, CCGs and NHS England • EY appointed to develop 5 year plan. 5 Year Strategic Plan completed at end December 2015 and updated in January 2016 to take account of 16/17 planning guidance. Plan approved by Trust Board in January 2016. • Public consultation completed	First line WEB assessment of direction of travel Second line Board scrutiny and approval of 5 Year Plan. Hospital Services Programme Board discussions to ensure plan aligned with local health economy plans - this has enabled CCGs in January to confirm decision to commence public consultation on future configuration of hospital services. Third line PRM meetings with NHS Improvement and Roundtable discussions with CCGs. NHS I oversight of strategy development process. NHSE assurance of CCG processes and readiness to commence public consultation. Third party assurance of consultation process.		• The Five Year Strategic Plan has been agreed and submitted to NHS Improvement. An application has been made to DH for the required external funding support. However no confirmation on funding yet received. • Public consultation completed 21 June 2016. Findings from consultation were published 25 August 2016. CCGs are undertaking process of deliberation that includes receiving a report from Joint OSC in September. CCG decision scheduled for 20 October 2016.	4x5 = 20	3x5 = 15	2x5 = 10

Action	Timescales	Lead

Links to risk register:
Risk 6131 - mortality standards
Risk 2827 - clinical decision making in A&E
Risk 4783 - Service reconfiguration

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY

Ref	OWNER		RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE &	GAPS IN CONTROL	GAPS IN ASSURANCE	RATING		
								Initial	Current	Target
19.1617	Board of Directors	Director of Finance	**Risk** Failure to maintain a cash flow position so that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash. resulting in external scrutiny, significant reputational damage and possible inability to function as going concern **Impact** - financial sustainability - external scrutiny - reputational damage - ability to continue as a going concern	* Agreed £5m capital loan from Independent Trust Financing Facility received in April 2016 * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from Monitor * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Working capital loan facility in place (at 3.5% interest rate) for £13.1 m to support cash in advance of progression of revenue support loan (at 1.5% interest rate) * Profile of cash management is being raised at Divisional level * Agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner.	First line WEB financial performance report Cash Management Committee Second line Finance and Performance Committee reports Third line Bi-monthly PRM with NHS Improvement	Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Cash continues to be a high risk due to the knock on impact of I&E risks and the fine balance required in managing working capital	Distressed cash support through "Revenue Support Loan" not yet formally approved by NHS Improvement	5x3 = 15	5x4=20	5x3=15

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

Links to risks register:
Risk 6722- Cash management

ACRONYM LIST

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

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
BB	Brendan Brown, Director of Nursing
DB	David Birkenhead, Executive Medical Director
HB	Helen Barker, Associate Director of Operations
JC	Juliette Cosgrove, Assistant Director of Quality
KG	Keith Griffiths, Executive Director of Finance
MG	Mandy Griffin, Interim Director of the Health Informatics Service
LH	Lesley Hill, Executive Director of Planning, Estates and Facilities
RM	Ruth Mason, Associate Director of Engagement and Inclusion
VP	Victoria Pickles, Company Secretary
SU	Sal Uka, Consultant Paediatrician and 7 day services clinical lead
IW	Ian Warren, Executive Director of Workforce and Organisational Development
OW	Owen Williams, Chief Executive
ALL	All board members

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Ian Kilroy, Trust Resilience and Security Management Specialist
Date: Thursday, 29th September 2016	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: NHS ENGLAND EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) NATIONAL STANDARDS ANNUAL SUBMISSION-Oct 2016 - Annual requirement to self assess against national standards for emergency preparedness and business continuity	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Estates & Facilities Quality safety Board. WEB	
Governance Requirements: The Trust is a category 1 responder, as identified, within the Civil Contingencies Act with statutory obligations. The self review process is fed into the NHS England Emergency Preparedness, Resilience and Response compliance programme. There are CQC and national contract elements compliance requirements as well	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of the supporting papers is to enable the Trust to self-assess against NHS national standards for emergency preparedness and business continuity. Highlight areas of work required benchmarked against national standards and consolidate a resilience footprint across the wider health resilience economy. Supporting information details are the Core Standards self-review document. Statement of Compliance against the core standards and an agreed action improvement plan to develop the current profile to agreed standards.

Main Body

Purpose:

The paper and all identified work programmes to mitigate areas of work required is to be supported and agreed by the Trust board

Background/Overview:

Background - EPRR Standards V4 have developed progressively to self-review changing aspects of EPRR landscape. CHFT has routinely complied with the direction for submission. Overview, analysis and assessment of this year's standards against current EPRR portfolio practice is that there are significant pieces of work required. The compliance level would be Substantial with the caveat of fully implementing the associated improvement plan

The Issue:

Issues relating to a number of specialised Incident Response Plans requiring development or extensive review. Training needs analysis associated with crisis and emergency management training for management layers in the Trust. Exercising of plans to be formalised and applying a risk based approach to testing Trust owned plans to demonstrate compliance with categorised responder status under the statutory guidance of the Civil Contingencies Act 2004 and NHS England Guidance

Next Steps:

Next steps to implement the improvement plan and embed the EPRR process within core business activity

Recommendations:

The Board is requested to acknowledge the position statement. Agree to the proposed action plan. Fully support the implementation of the work programme and continuing programme of raising awareness of the EPRR agenda at CHFT

Appendix

Attachment:

COMBINED EPRR ASSURANCE FRAMEWORK ATTACHMENTS.pdf

NHS England Core Standards for Emergency preparedness, resilience and response

v4.0

The EPRR Core Standards spreadsheet has 7 tabs:

Introduction - this tab,. outlining the content of the other 6 tabs and version control history

EPRR Core Standards tab - with core standards nos 1 - 37 (green tab)

Business Continuity tab:- with deep dive questions to support the review of business continutiy planning for EPRR Assurance 2016-17 (blue tab) with a focus on organisational fuel use and supply.

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and NHS ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard (NHS Ambulance Services only): designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards (NHS Ambulance Services only): designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V4.0. The following changes have been made :

- Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab
- Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Updated the requirements for primary care to more accurately reflect where they sit in the health economy
- update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to supporting PHE in the collection of

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	Action to be taken	Lead	Timescale
Governance																				
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.		**Demonstrate this through quarterly AEO/EPRR Manager meetings and out turn reports.**		
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y			**Annual Work programme developed to reflect gap analysis. Supporting document explains timescales.**		
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y			**EPRR & BCM Policy indicate expectations and approach**		
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y			**As required and upon the direction of the AEO and in liaison with EPRR Manager. An analysis of a significant event needs to be defined. Additionally, a Security and Resilience Group requires establishment and implementation. Annual report and exercise reports require development, as required**		
Duty to assess risk																				
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed		**EPRR risk assessment profile requires setting on the DATIX system and recurrent management appraisal of threat levels. Principally present as part of the GAP analysis and continuing development of the risk profile. Significant and identified risks of severe weather, staff absense, denial of access, fuel shortage, IT & Communications, Utilities Failure, Major Incident Response, supply chain, COMAH, Flooding, Surge & Escalation and reference to the WY Community Risk Register requires periodic**	**EPRR Manager**	

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	Action to be taken	Lead	Timescale
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	• associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Attendance at LRF, LHRP, Health Sub and Local Authority EP Groups established. WYAT ERP and NPAG further demonstartes enagement with wider EPRR community**		
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**See above. Subsequently action is as required.**		
Duty to maintain plans – emergency plans and business continuity plans																				
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.				
		corporate and service level Business Continuity (aligned to current nationally recognised BC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y					Y				**Requires development. Plan out of date**	**EPRR Manager**	
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Requires development. Plan out of date**	**EPRR Manager**	
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y			**Requires development. No obvious plan in place**	**EPRR Manager**	
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y				Y			**Requires development. No obvious plan in place**	**EPRR Manager**	
		Mass Casualties	Y	Y	Y			Y		Y	Y				Y			**Requires development. Plan out of date**	**EPRR Manager**	
		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Requires development. No obvious plan in place**	**EPRR Manager**	
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y					
		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y			**Requires development. No obvious plan in place**	**EPRR Manager**	
		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y			**Requires development. No obvious plan in place**	**EPRR Manager**	
		Lockdown	Y	Y	Y			Y	Y					Y	Y			**Requires development. No obvious plan in place**	**EPRR Manager**	
		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y			**Maybe satisfied by JERP for HRI & CRH, but no overarching plan**	**EPRR Manager**	
		Excess Deaths/ Mass Fatalities	Y	Y	Y					Y	Y				Y			**Requires development. No obvious plan in place**	**EPRR Manager**	
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y															

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	Action to be taken	Lead	Timescale
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y															
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors		**Pre-requisite plans are out of date and/or require comprehensive update**	**EPRR Manager**	
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.		**Major Incident Plan in place and comprehensive review of complete EPRR function being commissioned**		
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**As part of the BCM process functions have been identified with associated BIA process, BCP plan writing and implementation**		
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y			Y	Y									**In line with Major Incident Planning principles. Requires minor development**	**EPRR Manager**	
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Specifiy who has been consulted on the relevant documents/ plans etc.				
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
Command and Control (C2)																				

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	Action to be taken	Lead	Timescale
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.				
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y		Y	Y	Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.		**No formal training presently delivered. Enquiring about SLiC, TLiC, NDM, Dynamic E-Learning Package**	**EPRR Manager**	
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.		**Form part of the current Major Incident Plan**		
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Decision Log available**		
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y					
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y													**YAS HART Team, PHE or WY Police. In addition, EPRR Manager.**		
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y															
Duty to communicate with the public																				

Core standard		Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	Action to be taken	Lead	Timescale
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies		Discuss with Communications Office		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	Action to be taken	Lead	Timescale
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.				
Information Sharing – mandatory requirements																				
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) /				
Co-operation																				
25	Organisations actively participate in or are represented		Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area				
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y					
27	Arrangements include how mutu	NB: mutual aid agreements are wid	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y					
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y					Y	Y				Y					
29	Arrangements outline the procedure for responding to incidents which affect two				Y						Y				Y					
30	Arrangements demonstrate how organisations support NHS	Examples include completing of SITREPs, cascading of	Y	Y	Y			Y	Y			Y		Y						
31	Plans define how links will be made between NHS England,										Y									
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months									Y	Y									
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y			Y	Y	Y		Y			Y			EPRR Manager attends	EPRR Manager	
Training And Exercising																				

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	Action to be taken	Lead	Timescale
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years		**Needs development**	**EPRR Manager**	
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Needs development**	**EPRR Manager**	
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y	Y	Y	Y	Y			Y			**Op Malady - Mers CoV Exercise**		
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y		Y	Y	Y	Y	Y	Y			Y					

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core	Action to be taken	Lead	Timescale
2015 Deep Dive																				
DD1	Organisation has undertaken a Business Impact Assesment	• The organisation has undertaken a risk based Business Impact Assessment of services it delivers, taking into account the resouces required against staffing, premises, information and information systems, supplies and suppliers • The organisation has identified interdependencies within its own services and with other NHS organisations and 3rd party providers • Risks identified thought the Business Impact Assessment are present on the organisations Corporate Risk Register	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• updated Business Imact Assessment • corporate risk register		**Details of the critical functions need to map across to EPRR risk profile. A comprehensive programme of BCM commenced during 2014. Yorkshire Ambulance Service Business Continuity Manager, has provided a Service Level Agreement for approximately 2 years. Policy statement developed, training delivered to management team, board approval sought and programme of information gathering commenced. 50+ BIA are in the process of development or completion.**		
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolorable Peroiods of disruption for these	• The organisaiton has identified their Critical Functions through the Business Impact Assesment. • Maximum Tolerable Periods of Disruption have been set for all organisaional functions - including the Critical Functions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity plan explicitly details the Critical Functions • Business Continuity plan explicitly outlines all organisations functions and the maximum torlerable period of disrution		**Risk analysis of critical functions requires further confirmatory work. Transference onto the corporate risk register requires completion, review and periodic testing. Interdependencies analysis requires development. 3rd party providers requires development**		
DD3	There is a plan in place for the organisation to follow to maintain critical functions and restore other functions following a disruptive event.	• The organisation has an up to date plan which has been approved by its Board/Governing Body that will support staff to maintain critical functions and restore lost functions • The plan outlines roles and responsibilities for key staff and includes how a disrutive event will be communicated both internally and externally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• an organisation wide Business Continuity plan that has been updated in the last 12 months and agreed the Board/Governing Body		**BC Policy governs this activity**		
DD4	Within the plan there are arrangements in place to manage a shortage of road fuel and heating fuel	• The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• detail within the plan that explicitly makes reference to shortage of fuel and its impact of the business.		**Requires development**	**EPRR Manager**	
DD5	The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this .	EPRR Framework 2015 requirement, page 17	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Review current tenders and contracts terms and conditions. Review National Supply Chain / NHS Standard terms and conditions. Review National terms and conditions, Crown Commercial Services to ensure adequate existing and future coverage. Review critical strategic contracts (e.g. laundry, food, decontamination, waste, IT, acute medical supplies, pharmacology etc)**		
DD6	Review of Critical Services Fuel Requirement Data Collection Programme (F1:F18)	Please complete the data collection below - this data set does not count towards the RAG score for the organisations. Please provide any additional information in the “Other comments” free text box.	Y	Y		Y	Y	Y	Y						Y	• NHS Ambulance Trusts have already provided this information in a national collection in May 2016.				

Fuel Demand Summary

When providing information on the fuel requirements for both business as usual and to operate a critical service please ensure the supply and demand balances whereby:

Total Daily fuel use (F1) = own bunkered fuel use (F5) + any 3rd party bunkered fuel use (F6) + any forecourt fuel use (F9)

Section 1: Business as Usual Demand

		Petrol	Diesel	Other (inc LPG, Kerosene
F1	How much fuel do you use daily when providing a business as usual service? (litres)	None	235 litres for fleet vehicles	See below

Section 2: Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene
F2	Do you hold bunkered fuel (Yes/No) If no go to F6			Yes
F3	What is the total bunkered fuel capacity? (litres)			x
F4	On average, what volume of bunkered fuel do you hold? (litres)			x
F5	Do you use your own bunkered fuel when providing a If no go to F6			
F6	Do you access a 3rd party or another service's bunkered If no go to F8			
F7	If you have answered "Yes" to F6 or have bilateral supply agreements to operate a business as usual service, please			

1) What happens if I have mutual aid agreements with another Critical Service provider to utilise their bunkered stock, do I need to record the bunkered stock or will they?
DECC is requesting that the supplier records the bunkered stock holdings and the user records the demand. As the user of these bunkered fuels in this instance, please record the use of these stocks under the section referring to access to third party bunkered stock.

2) Should we assume that in the build up to an emergency our bunkered stocks would be full, as we would be prioritising deliveries and therefore the days' stock held calculations should be based on full capacity and not average daily stock holdings?
The prioritisation of supply will be dependent on the facts of any fuel shortage scenario, and will be a decision taken at the time. Data provided in the template should provide DECC with a sufficient evidence base to make decisions based on capacity and BAU bunkered stocks. Therefore please fill out the template as requested, providing notes where you think that

Section 3: Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene
F8	Do you use forecourts to operate a business as usual service? (Yes/No) If no go to F10		Yes	
F9	What is the average daily forecourt fuel use to operate a business as usual service? (litres)		235.25 litres	ERROR - Forecourt Fuel Volume Used more than total daily fuel use (Q.7)

Critical Service Operation Only

Please refer to question 4 of the guidance notes for further information on how to identify the fuel requirements of a critical service.
During an emergency it is expected that organisations will not be operating as normal and will only be delivering those essential services that are Critical.
Low fuel consumption alternatives should also be explored as part of the Critical Service identification process. For example, if there is the possibility that a
The below section refers to the fuel requirements to deliver a Critical Service only.

Section 4: Critical Service Demand

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F10	How much fuel would you use daily if you were providing a critical service? (litres)		235.25	

Section 5: Critical Service Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F11	Do you have access to either your own or 3rd party bunkered fuel if you were providing a critical service (either from general access or mut If no go to F14			Yes
F12	What volume of your own bunkered fuel would you use daily if you were providing a critical service? (litres)			x ERROR - Bunkered fuel use
F13	What volume of 3rd party or another service bunkered fuel (either from general access or mutual supply agreements) would you use daily			x ERROR - Bunkered fuel use
F14	If you have answered "Yes" to F13 or have bilateral supply agreements to operate a critical service, please provide a description of any If no go to F15			

Section 6: Critical Service Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F15	Will you need access to Designated Filling Stations (DFS) if you were providing a critical service? (Yes/No) If no go to F17		Yes	
F16	What volume of fuel would you use daily from Designated Filling Stations (DFS) if you were providing a critical service? (litres)		N/K	ERROR - DFS Fuel use higher than total critical fuel demand (Q.16)

Critical Service Operation Only

F17 To ensure that there are adequate Designated Filling Stations* (DFS) to meet the demands of all critical users , please detail in the table below the number of
A Designated Filling Station (DFS) is a retail filling station with the purpose of only supplying road fuel for critical use only. The DFS list will be compiled to provide

Vehicles	Number of Vehicles required to operate a critical service		
	Petrol	Diesel	Other (inc LPG)
With NHS Logo	50	12	0
Without NHS Logo	50	12	0
Private vehicles	N/K	N/K	0

Gas oil - Yes

120,000 litres

75,000 litres

No

No

As above

8,571 litres daily

None

Total	100	24												
F18	If you have answered "Yes" to question 2 (Do you hold bunkered fuel?) please detail which company primarily supplies your bunkered fuel and where known which local													

Who primarliy supplies your bunkered fuel? Please Select from drop down list:	If other or multiple suppliers please state:	Which Terminal is your bunkered fuel supplied from? Please Select from drop down list:	If other please state:	Average Number of Deliveries per Month
Other	BOC	Unknown		

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness											
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control		**Plan out of date**	**EPRR Manager**	
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump		**See above**	**EPRR Manager**	
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)				
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements		**To invoke a periodic check through clinical lead for HRI/CRH**	**EPRR Manager**	
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness				
	Decontamination Equipment											
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))				
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y							
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y							
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y							
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y							
	Training											

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	Core standard	Clarifying information						Evidence of assurance				
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y					Trust follows national guidance. Locally amongst WYAT Resilience Leads it is felt that urgent clarification from NHS England on training validation required through YAS for CBRNe Trainer(s) credentials and resilience in the team	EPRR Manager	
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme				
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		Y		Y					See point 48	EPRR Manager	
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y					

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (tuisiness continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organisations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organisations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organisations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments.			Y													
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.	• Organisations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organisations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organisations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month.			Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.	• Organisations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y													
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

Outputs - EPRR Strategic overview (Plan of the plan)

Crisis/Emergency Management

SLiC for Directors on call
Directors on Call portfolio
TLiC for SMOC
NDM for Operational Managers
E-learning Package/TNA
Loggists Training
Profiled testing and exercising regime

Business Continuity

Risk profile on the corporate risk register
Completion of BCM for high risk areas
Exercise a programme of audits for high risk
Test proportion of BCP's for high risk

Incident Response Plan development

EPRR/BCM Policy
Pandemic Flu
REAP
Severe Weather
Fuel Disruption
Utilities
Lock down
Evacuation
Mass Casualties/Fatalities
Hazardous Material/CBRNe

Strategic Command & Control

Critical Incident Plan
Major Incident Plan
On call approach
Incident Co-ordination Centres
Security Resilience Governance Group

areas

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Improvement Plan 2016/17

Organisation: Calderdale & Huddersfield NHS Foundation Trust

Plan owner: Lesley Hill, Accountable Emergency Officer & Ian Kilroy, Emergency Preparedness Manager

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	8 of the prerequisite plans are out of date and/or require comprehensive update	Plan/Policy writing – requires review or introduction • CBRNe/HAZMAT • Severe Weather • Pandemic Flu • Fuel Supply disruption • Surge & Escalation • Lockdown • Evacuation • Mass casualties/fatalities Commissioned external consultant to work on the direction of the AEO/EPRR Manager to address plan writing required	April 2017
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	8 of the prerequisite plans are out of date, require development and/or require comprehensive update	See above	April 2017
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	No formal training presently delivered. Unclear how many Directors/SMOC have recently received any recognised training for competencies reasons. Enquiring and developing SLiC, TLiC, NDM, Dynamic E-learning package for identified staff	Develop training analysis in line with Chief Operating Officer, Accountable Emergency Officer and Head of Learning & Development Commission a provider to deliver to identified group. Forecast to develop TNA with L&OD for all management levels appropriate to accountability and authority	June 2017
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to	Needs development	Enquiring about SLiC, TLiC, NDM, Dynamic E-Learning training needs analysis. Forecast to develop TNA with L&OD for all management	April 2017

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Improvement Plan 2016/17

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
	deliver the response to emergencies and business continuity incidents		levels	
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	Needs development in line with plan writing programme	Not at this time due to plan writing requirement. Engagement with external partner exercises will be facilitated	April 2017
Business Continuity - Deep Dive				
DD4	The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel.	Review current plan that is out of date	Review and update plan	April 2017
Hazardous Material - CBRNe				
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Review current plan that is out of date	Review and update plan	April 2017
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	See point 38.	See point 38	April 2017
50	The organisation has sufficient number of trained de-contamination trainers to fully support it's staff HAZMAT/ CBRN training programme.	Increase resource. Presently weak resilience in this capacity	Discussions with YAS and NHS England to develop systems resilience	April 2017

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2016-17

STATEMENT OF COMPLIANCE

Calderdale & Huddersfield NHS Foundation Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR (v4.0).

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating **Substantial** compliance against the EPRR Core Standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address **one to five** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address **six to ten** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address **11 or more** core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**[1]	Standards rated as **Amber**[2]	Standards rated as **Green**[3]
33	0	5	28
Acute providers: **46** Specialist providers: **44** Community providers: **43** Mental health providers: **41** CCGs: **38**	[1] *Not complied with and not in an EPRR work plan for the next 12 months*	[2] *Not complied with but evidence of progress and in an EPRR work plan for the next 12 months*	[3] *Fully complied with*

Where areas require further action, this is detailed in the attached *EPRR Core Standards Improvement Plan* and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting *Date signed*

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th September 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: QUARTERLY QUALITY REPORT - Q1 - The Board is asked to receive and approve the Q1 Quarterly Quality Report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and approve the Q1 Quarterly Quality Report.

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 Q1 Quarterly Quality Report.

Appendix

Attachment:

Q1 Quality Report 16-17 FINAL for BOD (2).pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Calderdale & Huddersfield Foundation Trust
Q1 Quality Report
2016-17

Subject:	Q1 2016-2017 Quality Report
Prepared by:	Juliette Cosgrove – Assistant Director of Quality Andrea McCourt - Head of Governance and Risk Lisa Fox – Information Manager
Sponsored by:	Brendan Brown - Director of Nursing
Presented by:	Brendan Brown - Director of Nursing
Purpose of paper	Discussion requested by Trust Board Regular Reporting For Information / Awareness
Key points for Trust Board members	The report is structured into the five Care Quality Standards domains, with each section having a summary providing an overview of compliance with each indicator and highlights. During this quarter, all CQUIN, Quality Account and Contract requirements were achieved, with the exceptions noted below: Highlights: **SAFETY:** • Falls prevention lead now in place – falls prevention now part of a wider piece of work on reducing harm • Safety huddle work supported by Improvement Academy on wards H19 and CRH ward 6bc • Record keeping – 92% compliance with CRAS audit standards, though variability across wards • Medicines management – self administration medication collaborative established to support patients in managing their medication from home in hospital and supporting poster campaign • Maternity – maternity action plan now in place **EFFECTIVE:** • **Mortality** – The latest SHMI shows the Trust to have a SHMI of 113 which is classified as 'above expected'. key priority areas identified are the reliability of clinical care for respiratory, stroke and elderly patients, recognising and responding to deteriorating patients and timely antibiotics for patients with sepsis.

	• **Care Bundle implementation** – some improvement noted in compliance with asthma bundle and acute kidney infection bundle • **Reducing Hospital Acquired Infection** – 0 cases MRSA bacteraemia since Q2 2015/16 • **Hospital at Night** - achievement of Hospital at Night Programme CQUIN for Q1 • **End of Life** – integrated workplan being developed for end of life care • **Stroke** – improvements in stroke pathway delivery • **EXPERIENCE:** • **Improving the Patient Experience** – 4 quality improvement projects in development: - children's voice - effective care on a busy surgical ward - maternity patient experience - developing new measures of feedback for community services • **National Adult In Patient Survey 2015** – some improvement / positive results in relation to availability of hand wash gels and cleanliness of hospital toilets and bathrooms • **Improving Hospital Nutrition** – positive feedback from PLACE inspections of patient food at CRH and HRI **RESPONSIVE:** • **Incidents, complaints, claims** – improvements in sharing of learning from adverse events via Patient Safety Quality Boards and Quality Committee and with divisions for claims • **Appointment Slot Issues** – improvement in the number of referrals awaiting appointment **WELL - LED:** • **Safe Staffing** – Roster efficiency tool introduced to support safe staffing levels and roster efficiency approval for overseas recruitment campaign for nursing staff • **Sickness and absence** – improved position • **7 Day service** – progress in General Surgery towards a more Consultant delivered 7 day service.

Table of Contents

APPENDIX G

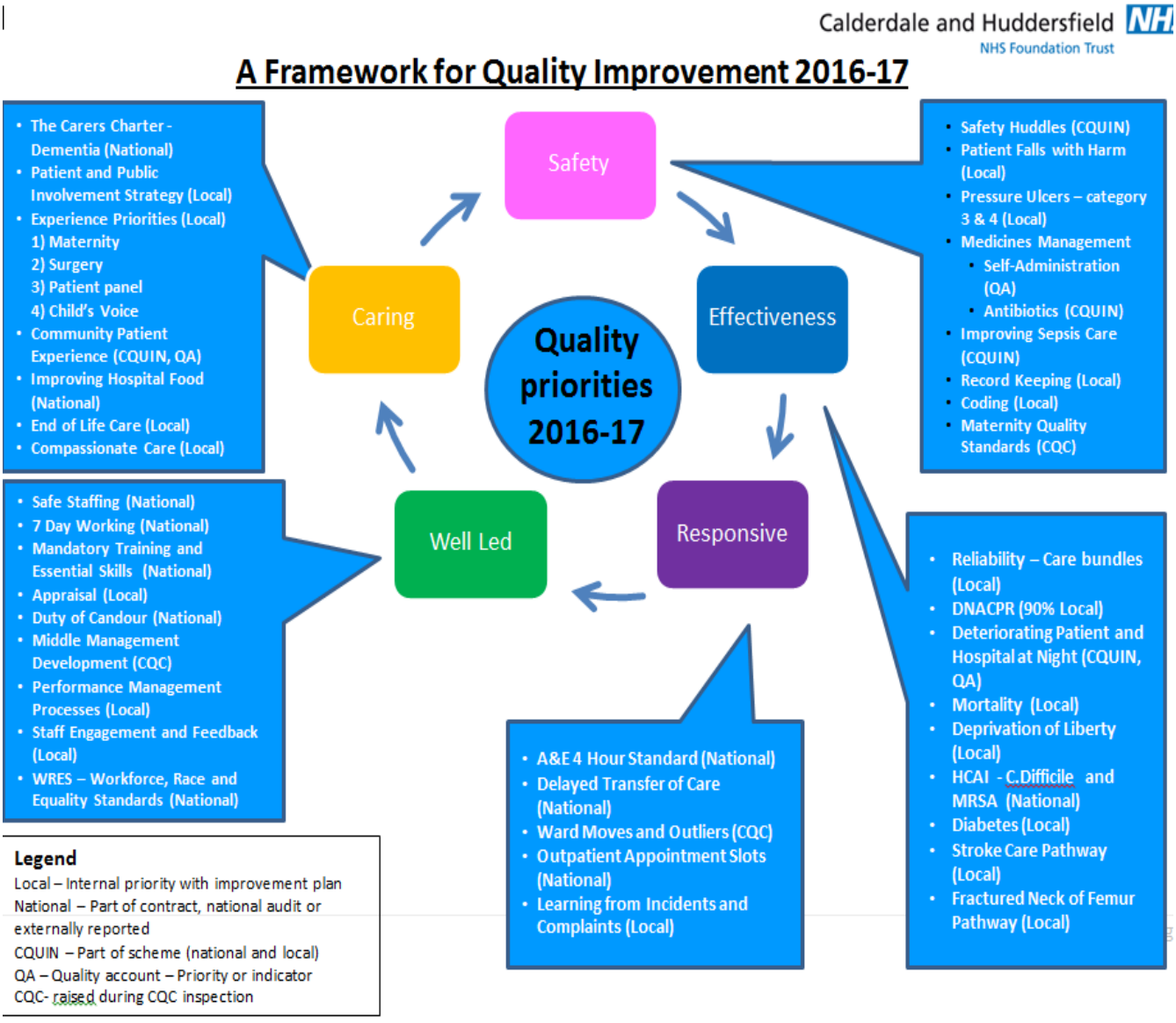
Introduction

This quarterly quality report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance during each quarter of 2016-2017 within Calderdale and Huddersfield NHS Foundation Trust (the Trust).

Each year the Trust works with the commissioners to agree what should be included in the local contract including CQUIN priorities. These cover key clinical priorities and build upon our strategic aims.

The Care Quality Commission Intelligent Monitoring reports also provide a framework for determining quality priorities.

From all these sources the following diagram shows the Trust key priorities for 2016-17, these have been broken down into the 5 key CQC domains



Summary of Key Performance Frameworks:

2016/17 Quality Account:

There are three Quality Account priorities for 2016/17. These are listed below and further detail regarding progress can be found on the page number indicated

Domain	Focus/Priority	More Details
Safety	Reducing Falls through the implementation of Safety Huddles	Pg 12
Effectiveness	Implementation of Hospital at Night to reduce mortality	Pg 39
Experience	Improving Patient Experience in the Community	Pg 51

2016/17 CQUINS:

There are seven CQUIN areas for 2016/17. These are listed below and further detail regarding progress can be found on the page number indicated. The information contained in the performance box provides a quick overview of target attainment during the most recent quarter, where applicable.

	Indicator Name	Q1 Achievement	Page
1a	Staff Well Being – Services	Y	-
1b	Staff Well Being – HFFSB	Y	-
1c	Staff Well Being – Flu Vaccination	N/A	**N/A**
2a1	Sepsis Screening – Emergency Admissions	Partial - 66%	**Pg. 22**
2a2	Sepsis Antibiotics – Emergency Admissions	Y	**Pg. 22**
2b1	Sepsis Screening – Inpatient Admissions	Y	**Pg. 22**
2b2	Sepsis Antibiotics – Inpatient Admissions	Y	**Pg. 22**
3a	Anti-Microbial Resistance	Y	**Pg. 18**
3b	Antibiotic Review	Y	**Pg. 18**
4	Safety Huddle Implementation	Y	**Pg. 12**
5	Self-Administration of Medicines	Y	**Pg. 18**
6	Hospital at Night	Y	**Pg. 39**
7	Community Patient Experience	Y	**Pg. 51**

Domain One – Patient Safety: People are protected from abusive and avoidable harm.

Patient Safety Compliance Summary

Indicator 2015-16	Compliance
1.1 Reducing patient falls with harm	Reporting only
1.2 Introducing Safety Huddles	Reporting only
1.3 Reducing pressure ulcers	Achieved
1.4 Improving Medicine Management (CQUIN)	Partial
1.5 Improving Sepsis Care (CQUIN)	Reporting only
1.6 Record Keeping	Reporting only
1.7 Maternity Quality Standards	Reporting only
1.8 Coding	Reporting only

1.1 Reducing patient falls with harm

Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England. The National Patient Safety Agency (2011) report 'Essential care after an inpatient fall' states that each year around 282,000 patient falls are reported in hospitals and mental health units. A significant minority result in death, severe or moderate injury. (including approximately 840 neck of femur fractures, 30, head injuries and 550 other fractures). Falls impact on the quality of life through pain, loss of confidence, loss of independence and increased mortality. Falls are estimated to cost the NHS more than £ 2.3 billion per year.

The National Institute for Clinical Excellence (NICE) – Guideline 161 (2013) 'Implementing Fall Safe' provides recommendations for the management and prevention of inpatient falls. CHFT has responded to these recommendations implementing 6 key actions.

- Commencement of a falls lead nurse within the trust to provide traction and drive project work.
- Roll out of safety huddles. Improve engagement with teams
- Review of equipment.
- Review of documentation supporting falls prevention and management that is compliant with guidelines.
- A communication and training strategy including reviews and learning
- Ensure following an in-patient fall patients get the best care to prevent harm and repeat falls.

The target for falls prevention for 2016/17 is to move away from the trajectory of a 10% reduction in falls that cause harm, this is because we know that as patients become more frail and elderly we will see an increase in falls in this group of patients and we know falls will happen.

The focus will continue to be on preventing falls but this will become a larger piece of work focusing on quality of care for patients. Falls will, therefore, become part of a larger project

of reducing harm led by the Deputy Director of Nursing; this project will be a strategic piece of work which will focus on the overarching basic principles of care encompassing, safety, dignity, patient experience and reducing harm.

Current Performance

Since December 2015 up end of March 2016 there were 823 falls in total across the trust. The trust has reported a total of 315 falls throughout the first 2 months of the first quarter for 2016, the table below illustrates a breakdown by Division.

	Quarter 4 2015/16			Quarter 1 2016/17		
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD
Surgery	26	23	30	23	36	138
Medicine	158	133	124	126	121	662
FSS	7	5	2	3	6	23
Total	191	161	156	152	163	823

Falls with harm

Since December 2015 up to the end of March 2016 there were 32 harm falls across the trust, a breakdown by division can be seen in the table below. The Trust has reported 13 harm falls throughout the first 2 months of the first quarter for 2016. This shows that for harm falls the Trust has had a much higher than predicted amount of harms falls.
and is on course for the 10% reduction trajectory.

The first 2 months of quarter 1 in 2016/17 have seen 13 harms falls. This is a steep increase in falls compared to the first 2 months of quarter 1 in 2015/16 where 4 harm falls were reported – this is an increase of 9 harm falls on the previous year and exceeds the planned trajectory.

	Quarter 4 2015/16			Quarter 1 2016/17		
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD
Surgery	1	-	-	-	-	1
Medicine	3	3	2	6	7	21
FSS	-	-	-	-	-	-
Total	4	3	3	6	7	32

The national Audit Falls and fragility Audit of inpatient falls (2015) reported the national average rate of falls per 1000 occupied bed dates (1000 OBDs) as a range of 0.82 -19.20, the mean being 5.6 for acute hospitals. CHFT reports at 8.42 (Per 1000 OBDs). The national reported range for falls resulting in harm was noted as 0.01 –2.00 (Per 1000 OBDs) – CHFT is reported at 0.09 (per 1000 OBDs).

The newly appointed falls lead will continue to drive and work to an action plan to look at the following actions:

- Improving the quality of assessments and intervention for patients at risk of falls
- Improve multidisciplinary working with regard to the assessment and management of patients at risk of falls

- Educate and empower ward staff to make small but effective innovation and change through the implementation of a falls quality improvement collaborative
- Introduce and monitor compliance with a Falls Investigation Prompt sheet to compliment the CHFT RCA investigation tool developed by Effective Investigation Group (to improve quality of RCA).
- Support and monitor actions that were agreed at the CHFT first Harm Summit on 10th November 2015 , such as falls mapping, improving safety huddles, a review of footwear that is available for patients at CHFT and embedding bedside handover.
- Review the Falls Prevention bundle following first National In-patient Falls Audit recommendations.
- Undertake a falls mapping exercise in areas of high incidence (see appendix 3) to further understand what additional measures can be put in place to aid prevention.
- Review the falls prevention strategy, with recommendations to shape the improvement work plan for 16/17.
- Consider high risk patients presenting with a dementia and how environmental factors can support a reduction in falls
- Consider trail of falls bracelets for high risk patients
- Development of a falls policy / protocol to include post fall guidance
- Engage in a multidisciplinary approach to manage falls, including medication reviews, medical reviews.
- Initiation of safety huddle CQUIN to drive a reduction in number of falls

Falls Lead actions to date

- Alterations of existing falls assessment risk tool ongoing as a paper item until it can be merged into EPR.
- Work commenced with EPR to ensure Falls programme and assessment/care plans embedded.
- Formation of Task & Finish group to work on documentation in conjunction with revised documentation group. Falls now a regular agenda item on the fortnightly meetings of this group.
- Commenced work with Improvement Academy and identified that wards H19 and CRH6BC as the first two wards to be supported and monitored on safety huddles.
- Engaged support from senior clinicians on both of the above wards to support safety huddles.
- Receiving all orange and red incidents directly from Datix team and taking lead on identified cases to ensure all learning opportunities are taken forward.
- Taken responsibility for all Trust training on falls in the new starter induction days including medical teams.

Plans for Q2 and Q3

- Risk assessments of all patients presenting with a fall over the age of 65 and those from age 50-64 with an underlying condition as recommended in NICE Guidance 2015 on first 2 wards identified for the Safety Huddle initiative and those areas that are already performing these successfully.
- Review Trust Falls Policy and amend as required.
- Create Post Falls Policy either within or in conjunction of the above.

- Providing access to Knowledge Portal for wards to link directly to Datix on a daily basis to identify trends relating to falls and see what is happening in real time.
- Investigate problems with falls alarms failures due to a reported 21 incidents of green and yellow classification having been identified from January to June 2016, and enquire as to any possible alternatives.
- Review and embed changes to existing Falls Prevention and Risk Management Care Plan on repository as past review date and currently written from a tissue viability perspective.
- Network with other Trust Falls Lead nurses where improvements and innovation has proved helpful in reducing falls and bring back learning.
- Work with Nerve Centre to get Lying and Standing BP within 6 hours of admission to any ward where the patient has met the criteria for high falls risk as recommended in national falls audit.
- Liaise with Improvement Academy around more suitable icons for patient bed PIPA boards to reduce clutter and improve conformity.
- Work with A&E staff to ensure correct falls risk assessment is undertaken and appropriate referral to community services is completed in a timely way. Also to ensure that place of fall is recorded correctly as either patients home; NH/RH or Intermediate Care bed as current data is proving unreliable. (Joint work with Community).
- Community team to liaise with GP's to determine why patients are coming to A&E with falls and what alternative actions there might be for some of these patients to reduce unplanned admissions.
- Embed falls investigation prompt sheet into Datix (adapted format from Improvement Academy Fishbone diagram) to improve learning from incidents such as trends in ward transfers, medications, AHP reports and recommendations around mobility for nursing team; times of day; days of the week; ages of patients; co-morbidities; staffing levels; dependency levels etc.
- Review of available footwear for patients at risk of falling
- Work with Dementia team to ensure all recommendations are complied with at ward level.

1.2 Reducing Harm: Safety Huddles

Background:

Estimates suggest that approximately 5–10% of hospitalised patients in high-income countries experience harm and about one third of these harmful events are preventable.

The local, national and international patient safety initiatives that have been designed over the last decade have almost all failed to demonstrate significant impact. Reducing harm across a hospital requires behavioural change at a ward team level.

National programmes have piloted the use of the patient safety huddles and demonstrated a reduction in the number of falls, an increase in overall staff morale and improved teamwork.

These quality indicators are linked to financial CQUIN to improve care, reduce harm and prevent deterioration on inpatient wards.

Current Performance

NHS Trusts have developed and piloted 'patient safety huddles' to help reduce patient harm. The huddles are led by the most senior clinician and take place at a regular time each day for 10–15 minutes. They provide a non-judgemental, no-fear space in the daily workflow of ward staff. Team members develop confidence to speak up and jointly act on any safety concerns they have. They become a vehicle for ward teams to continually learn and improve.

These are presently happening in around 90 % of medical and surgical wards across both sites at CHFT, however the quality and consistency has been recognised as variable.

In response 14 wards with high numbers of patient harms have been targeted as part of a quality CQUIN to measure the effectiveness of introduction of an effective multidisciplinary safety huddles.

However it has been recognised falls and falls with harm have been identified as a significant risk for the Trust hence the requirement to embed quality safety huddles across all medical and surgical wards with the ongoing support of the national Improvement Academy and the Trust's Falls Quality Improvement Lead.

- Work has started with the Improvement Acacdemy in supporting wards H19 and 6BC at CRH on their daily safety huddles.
- Data is being collated from the previous 12 months to provide a baseline measurement.
- Ward based re-training is booked for the w/c 25th July on Falls Alarms with the company representative and medical devices staff.
- Double sided rubberised strip socks have been requested from Procurement for all wards and training will be provided at ward level.
- BP measurements are to be taken for all patients within 6 hours of admission as per recommendations of the last National Audit of Inpatient Falls.
- Work has started on documentation to ensure that Falls bundles meet the same recommendation

A robust action plan has been developed and remains on track to ensure all medical and surgical wards have effective multidisciplinary safety huddles in place by the end of Quarter 4. Progress and actions against plan will be monitored via the CQUINs performance group.

1.3 Reducing Pressure Ulcers

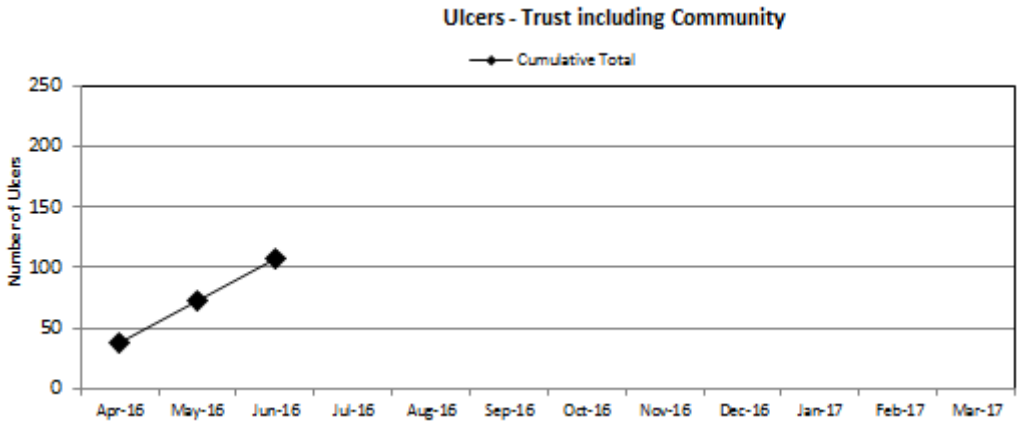
Aims and Objectives of Work

Pressure ulcer prevention is an important measure of the quality of care provided to patients. Pressure ulcers are largely preventable and their prevention is included in domain 5 of the Department of Health's NHS Outcomes Framework 2014/15 (NICE CG, 179). They can have a significant impact on patient's wellbeing and quality of life.

The pressure ulcer prevention and reduction programme is being overseen by the Safeguarding committee and Patient Safety Group which receives regular progress reports

Reduction, correct management and timely referral of other wounds include dehisced surgical wounds, burns, fungating wounds, moisture lesions and leg ulcers.

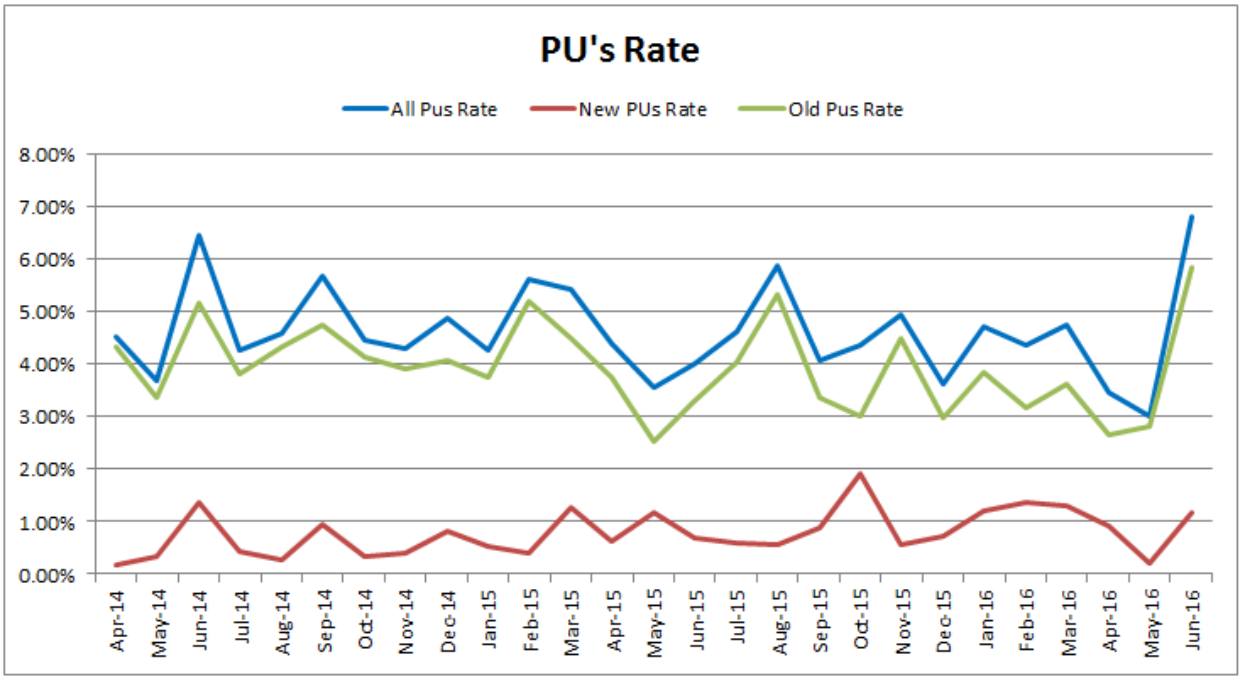
Hospital acquired pressure ulcer trajectory



Safety Thermometer

Pressure ulceration is one of the harms measured as part of the Safety Thermometer. The measure includes old pressure ulcers (pre-existing & occurring within 3 days of admission) and newly developed pressure ulcers.

When benchmarked against national data (obtained from HSCIC) CHFT rate for all pressure ulcers is above the national average of 4.46% for Q1 at 4.60% but below the national rate of 0.95% for new pressure ulcers at 0.86%.



Completed actions in Q3

- Ongoing clinical support and training is being provided by the equipment co-ordinator to wards to ensure appropriate use of pressure relieving equipment, Figures are variable between wards due to however, to date no wards have achieved required training & competency assessment for this equipment.

- All severe (category 3 and 4s) CHFT acquired pressure ulcer investigations now have Senior Nursing approval at the completion stage. The process is being reviewed as the previous process was not robust. Tissue viability, risk and safeguarding teams are developing a process to apply to primary and secondary care, which will ensure clear pathways to CQC notifications, Safeguarding concerns and STEIS. The new approach which will involve a panel review of pressure ulcers to ascertain if harm was avoidable and whether harm was caused, this will be evidenced by a root cause analysis process.
- This will allow better identification of learning from incidents.
- A review of all pressure ulcers in quarters 1, 2 and 3 is being undertaken following identification of reporting of pressure ulcers that are not attributable to CHFT.
- 4 editions of the Pressure Ulcer Newsletter have been published and circulated across CHFT. This will involve partnership working across primary and secondary care settings.
- Tissue Viability team have commenced validation of severe pressure ulcers although the timeliness of this continues to present a challenge due to clinical demand. –the expectation is that all category 3 and 4 pressure ulcers are reviewed by a Tissue Viability nurse within 24 hours. Going forward this will be measured as a key performance indicator for senior specialist clinical review
- The Tissue Viability team are providing training to new RGNs, HCAs and apprentices on pressure ulcer prevention as part of the Trust induction plan and continue to support a commissioned programme of education in community.
- The team are reviewing e training and education modules to support wider access to training and education tools available.

Improvement Plan:

Communication

Smarter ways of working utilising technology to be more efficient. Systm1 referrals to commence supported by IT. Development of wound assessment and management documentation. Electronical referrals commenced to provide audit trail and efficiency.
Database produced to audit and manage caseload

EPR

Progressive work continues in development of tissue viability documentation in EPR in partnership with Bradford.

Equipment

To understand current process and identify improvements for provision of equipment.
Equipment co-ordinator to ensure patients on correct equipment
New equipment to be explored in relation to cost savings.
Investment in equipment to reduce heel pressure ulcers commenced at beginning of 2016, pressure ulcer reporting via datix will provide assurance for reduction.

Medicine management and formulary
Member of Area Prescribing Committee to influence change regarding wound management dressings, to consider cost effectiveness and evidence based products. To write a wound policy to ensure setting a standard for other wounds.

Link nurse champions
To continue with supporting and educating TV link nurses to empower them to prevent and manage pressure ulcers. To explore a competency framework to ensure a standardised approach.

Partnership working
Network building with North East tissue viability group
Safeguarding links established and work being undertaken to ensure openness and transparency
Infection Control: to discuss merging of TV and Infection control link nurses
Falls Nurse: to ensure partnership working with safety huddles
Workforce and development team: ensure close working partnership and promotion of training days
Medical devices: ensure understanding of roles and working together

Education
To consider different ways of offering education to staff to promote flexible learning e.g. eLearning or webinars to include primary and secondary care settings and care homes.

To ensure TVN are updated to new and current developments in the wound care field partnership working continues with companies and also to develop links with university. Presently due to lack of resources staff are not able to attend university courses for self-development.

Quality and safety
Due to a reactive service, staff capacity is not able to focus on Category 2 pressure ulcer reduction. If more resources were available this would be achieved through the visibility of the TV team on the ward, equipment education and moving and handling education.
Corporate patient leaflet to be developed as presently the one utilised is not CHFT.

Community plan

- Pressure area training should be delivered to all community teams.
    - Monthly training sessions are being delivered to community nursing staff. Non-nursing teams have also been invited to attend. Training includes pressure ulcer prevention and management.
- Concerns with care agencies or care staff should be escalated in a consistent and timely way, process established with safeguarding to attend triangulation meetings
- React to red training pack was sent to care homes by CCG; no implementation was offered to care homes at time. For introduction and embedding of the R”R tool is required
- Equipment co-ordinator to support primary and secondary care
- Pressure ulcer panel streamlined to be consistent with central panel

Supervision

To embed supervision in the TV team to ensure reflective practice

Tissue Viability Service

The Tissue Viability team is a nurse-led service that provides expert advice and support to patients and colleagues across the health economy. The team provides clinical advice, assessment and treatment as well as training on a range of topics, such as pressure ulcer prevention and equipment use and the monitoring of pressure relieving equipment within the hospitals.

The Tissue Viability team has continued to provide training on pressure ulcer prevention & management, wound care and leg ulcer management. However, due to resource issues, half of the planned sessions have not taken place. The team has supported training for apprentices and new nursing recruits and will review the delivery of training to allow wider access via e training modules and tools.

Within the TV team all nurses hold the prescribing qualification; work is progressing with the prescribing lead to ensure this skill is used in primary care

1.4 Medicines management

Aims and Objectives of Work

Effective medicine management ensures that patients receive the correct medicine at the correct time which in turn expedites their return to good health, reduces the time spent in hospital, and prevents unnecessary hospital readmissions. Nationally the transfer of information about patients' medicines continues to be a significant risk to patient safety. Between 30 – 70% of patients can have either an error or an unintentional change to their medication when their care is transferred (Royal Pharmaceutical Society July 2011).

Performance is driven by The Medication Safety Group, established in November 2014, and overseen by the Patient Safety Group.

Q1 Performance: Missed Doses:

The Trust wide missed doses audit monitors intentional and unintentional missed doses (see table below for overview of the differences) with a focus on blanks, ticks and crosses which are in breach of policy as outlined in section 12 of the Medicine Code (Preparation & Administration of Medicines) and documentation on Prescription Chart & Administration Records.

Intentional missed doses	Unintentional missed doses
✓ Omitted at nurses discretion ✓ Prescriber requested omission ✓ Pharmacist/ Healthcare professional requested omission ✓ Patient refused	✓ Patient away from ward ✓ Patient could not take/ receive dose ✓ Dose not available ✓ Nil by mouth ✓ Blanks, Ticks, Crosses

The last missed doses audits were undertaken week commencing 11th January and 25th April 2016. These were one month later than usual for Q3 and Q4. This was because Q1 and Q2 data collection had to be delayed because the Pre-Registration Pharmacists who collect the data had only come into post and had to receive training to enable them to collect the data.

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
For all missed doses	13.37%	17.26%	15.29%	16.54%
Intentional missed doses	5.57%	8.50%	7.58%	7.01%
Unintentional missed doses	7.80%	8.68%	7.71%	9.54%
Blanks	216	268	223	246
Ticks/crosses etc	32	45	36	125

Performance increased in Q3 but slipped in Q4 with unintentional missed doses at 9.54%. The next Trust wide missed doses audit will take place July/August 2016 when the new Pre-registration Pharmacists are in post. Data will be collected for one 24 hour period in order to establish the number of intentionally missed and unintentionally missed doses.

In order to endeavour to get back on track and improve performance results continue to be fed back to all Ward Managers/Matrons, the Nursing and Midwifery Practice Group and to the Nursing and Midwifery Committee.

There is an ongoing campaign to encourage patients to bring all their medicines and diabetes related equipment into hospital with them so they can manage their medicines if they are able and reduce the number of missed/delayed doses. Work continues with the Yorkshire Ambulance Service and other regional NHS Trusts. The plan is for a targeted approach to encouraging this practice. This would include the use of a 'sealable green medication bag' (that is currently being used for medicines when a patient is transferred or discharged) that would be used by ambulance staff when they bring patients form home to a Medical Assessment Unit, Surgical Assessment Unit, Accident and Emergency, Coronary Care.

Wards continue to be encouraged to check prescription chart and administration records on each shift change/handover to check documentation and ensure doses have not been missed. It also gives the opportunity to 'challenge' colleagues. Identifying missed doses and raising any concerns with the nurse in charge is also part of the mock CQC medicines management audits. These audits are used to populate individual ward/departmental action plans for improvement.

There is now a Self-administration Collaborative and self-administration will be spread. It is anticipated that delays and missed doses will reduce in areas offering and encouraging self-administration. Currently staff on Ward 17 and 12 HRI and 8AB CRH have been re-trained in the self-administration of medicines.

In the future, EPR will allow CHFT to run missed/delayed dose reports at any point so missed/delayed doses, good practice and practice in need of improvement can be identified and acted upon quickly.

Self-administration Collaborative

It is important that patients who successfully manage their medication in community are also supported to manage this whilst in hospital. This reduces the risk of issues such as missed and can reduce the length of patients alongside encouraging their independence.
In Quarter 1 Ward 17 at HRI has been the ward used for the CQUIN. Baseline collections and improvement work has also taken place on the following wards.

HRI: Wards – 22, 12, 10, 6, 3, 15
CRH: Wards – 5C, 6BC, 9, 8AB, 8D, CCU

The work stream is led by clinical lead Rob Moisey who continues to be supported by other clinical, nursing and pharmacy colleagues. Project support is provided by the Clinical Governance Support Unit and the Health Informatics Service.

Self Admin CQUIN % Compliance							
Month/Week	Patients Audited	Is the level written on the drug chart %	Is there a self-administering form in the notes %	Is a 7 stated in the prescription sheet %	No of patients willing and able to self care %	No achieved	% Achieved
Apr-16	**23**	**100%**	**96%**	**13%**	**17%**	**3**	**75%**
08/04/2016	22	100%	32%	18%	18%	4	100%
15/04/2016	24	100%	96%	8%	8%	2	100%
28/04/2016	23	100%	96%	13%	17%	3	75%
May-16	**24**	**83%**	**88%**	**8%**	**8%**	**2**	**100%**
05-May-16	24	100%	96%	8%	8%	2	100%
19-May-16	24	96%	88%	13%	13%	3	100%
26-May-16	24	83%	88%	8%	8%	2	100%
Jun-16	**23**	**96%**	**91%**	**9%**	**9%**	**2**	**100%**
16-Jun-16	23	78%	87%	9%	9%	2	100%
30-Jun-16	23	96%	91%	9%	9%	2	100%

Training ward staff

As each new ward become involved in the collaborative, nursing staff undertake a program of training in the elements of self-administration and self-management and the use of associated documentation. Training sessions are arranged on all the wards for Nursing/Midwifery staff and the sessions are delivered in the main by the Specialist Nurse Medicines Management, remaining staff are trained by the Ward Manager. The Specialist Nurse Medicines Management maintains contact with wards after self-care has been launched and ward staff are made aware to contact her should any problems arise of if any clarification is required.

It has been acknowledged by the Collaborative and the Nursing and Midwifery Committee that the training of ward staff in self-management self-administration of medicines can no longer be sustained using this approach due to the workload of the Specialist Nurse, Medicines Management and capacity to release ward staff for training. Due to the latter training has been delayed on 4C CRH and Ward 11 HRI. 4C CRH will offer and encourage the self-management of diabetes and self-administration of medicines from December 30th in line with meeting the end of Q3 deadline but Ward 11 HRI will miss this slightly offering the self-management of diabetes and self-administration of medicines from January 18th.

Campaign

There is an ongoing campaign to encourage patients to bring all their medicines and equipment into hospital with them so they can manage their medicines if they are able and reduce the number of missed/delayed doses. Work has now spread to the Yorkshire Ambulance Service and other regional NHS Trusts. The plan is for a targeted approach to encouraging this practice. This would include the use of a 'sealable green medication bag' (that is currently being used for medicines when a patient is transferred or discharged) that would be used by ambulance staff when they bring patients form home to a Medical Assessment Unit, Surgical Assessment Unit, Accident and Emergency, Coronary Care.

Patient information

Work is being done on the collaborative wards to ensure that patients receive a self-administration leaflet.


Diabetes self-administration information for inpatients


Patient/Carer/Parental Administration of Medicines

Patient questionnaire

A questionnaire has been developed and introduced in Q1 in order to obtain feedback from patients about their experiences managing their medication and/or self-administering their medicines (see below).

Q2 Improvement Plan:

- Two more wards have been identifed as the next to be brought into the CQUIN in Q2 and a training programme is now in place for these wards.
- Continue to complete the questionnaire with patients managing their medication and/or self-administering their medicines.
- Continue to share progress at the Joint Sisters meeting, nursing and midwifery practice group and Nursing and Midwifery Committee

CQUINS – Antimicrobial

Reduction in antibiotic consumption/1000 admissions

Baseline data has been submitted to Public Health England. The CQUINS looks for a 1% reduction in a number of antibiotics against consumption in 13/14. Internal monitoring indicates this will be challenging.

Empiric review of antibiotic prescriptions

As part of good antimicrobial stewardship it would be expected that a review of an antibiotic should take place within 72 hours (by day 4) of starting (day 1). This review would include documented evidence of either:

- Stop
- IV to PO switch
- Change antibiotic
- Continue
- OPAT

This information can be documented within the medical notes, on the medication chart or electronically

Monthly audit to be undertaken by pharmacists:

- Minimum 50 antibiotic prescriptions from a representative sample across wards and sites in the Trust
- Sampling criteria:
  - 12 wards – up to 6 antibiotic prescriptions
  - CRH – children's ward (3bcd), 2a, 4c, 5a, 6c, 8a
  - HRI – 10, 11, 15, 17, 21, ITU
  - Random sampling by bed numbers (start at bed 1, bed 2 etc until reached 6 antibiotic prescriptions per ward) on one day per month

	Apr 16	May 16	Jun 16	Q1 total
Total number prescriptions	50	56	49	155
Number reviews documented within 72 hours	36	54	46	136
%	72%	96%	94%	88%

The CQUIN Q1 target was 25% which was exceeded. The Q2 target is 50% and the Trust is not envisaging any risk in meeting the target.

1.5 Improving Sepsis Care

Aims and Objectives of Work:

Sepsis is a complex disease process associated with multiple pathologies, and high mortality rates. Sepsis causes about 37,000 deaths per year in the United Kingdom alone, as such accounting for more deaths than lung cancer alone, or breast and bowel cancer combined (Survive Sepsis, 2010).

Early identification and intervention improves both morbidity and mortality from sepsis. The UK Sepsis Trust, working with Health Education England (HEE) has produced a number of clinical tools to support consistent recognition and response across primary and secondary care.

In 2016/17 a national CQUIN continues and now aims to have:

- 90% of emergency admissions, and inpatients, being screen for sepsis where appropriate.

- 90% by Quarter 4 those patients who have been identified as Septic having received antibiotics within an hour of admission.

Q1 Performance:

- Sepsis Screening has been incorporated into the triage processes in both the Emergency Department, which will have a significant impact on the % of patient undergoing a screening for sepsis.

- The Sepsis Improvement group continues the work of the previous year and now includes representation from children directorate

- Regional wide network group have been coordinated to share learning and best practice.

APPENDIX G

Performance:

2A Timely identification and treatment of sepsis in emergency departments
A1 Screening

	Quarter 1									Q1		
	Apr-16			May-16			Jun-16					
	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total
Number of patients who met the criteria for sepsis screening and were screened for sepsis	24	0	24	13	7	20	39	11	50	76	18	94
The total number of patients who met the criteria for sepsis screening according to the agreed local protocol	50	0	50	35	15	50	39	11	50	124	26	150
% Eligible patients screened for Sepsis	48%	-	48%	37%	47%	40%	100%	100%	100%	61%	69%	63%
Target	90.0%											

A2 - Initiation of treatment and 3 day review

	Quarter 1									Q1		
	Apr-16			May-16			Jun-16					
	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour	13	0	13	6	0	6	2	0	2	21	0	21
Number of patients (in sample) with severe red flag or septic shock who received a review after 3 days	10	0	10	7	0	7	2	1	3	19	1	20
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour and a review after 3 days	10	0	10	6	0	6	2	0	2	18	0	18
Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV antibiotics < 1 hr	14	0	14	11	0	11	2	1	3	27	1	28
% Patients with severe red flag or septic shock that received Iv antibiotics < 1 hour.	71%	-	71%	55%	-	55%	100%	0%	67%	67%	0%	64%
Target	Baseline											

2A Timely identification and treatment of sepsis in acute in-patient settings
B1 - Screening

	Quarter 1									Q1		
	Apr-16			May-16			Jun-16					
	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total
Number of patients who met the criteria for sepsis screening and were screened for sepsis	4	0	4	4	0	4				8	0	8
The total number of patients who met the criteria for sepsis screening according to the agreed local protocol	43	4	47	36	4	40				79	8	87
% Eligible patients screened for Sepsis	9%	0%	9%	11%	0%	10%	-	-	-	10%	0%	9%
Target	Baseline											

B2 - Initiation of treatment and 3 day review

	Quarter 1									Q1		
	Apr-16			May-16			Jun-16					
	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 90 mins	0	1	1	2	2	4				2	3	5
Number of patients (in sample) with severe red flag or septic shock who received a review after 3 days	1	2	3	3	5	8				4	7	11
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 90 mins and a review after 3 days	0	1	1	2	3	5		1	1	2	5	7
Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV antibiotics < 90	2	2	4	3	5	8		3	3	5	10	15
% Patients with severe red flag or septic shock that received Iv antibiotics < 90 mins	0%	50%	25%	67%	60%	63%	-	33%	33%	40%	50%	47%
Target	Baseline											

Improvement plans for 16/17:

- Introduction of a new Matron for Sepsis to support improvement work throughout he Trust. Due to start end of July.
- Develop clarity around processes to evidence that a sepsis screen has taken place when an inpatient scores high NEWS. At present clinical judgements are being made in this patient cohort, however there is not a robust mechanisms to enable this decision making to be noted
- To review the recommendations in the recent release of NICE guidance on sepsis and assess impact and application of guidelines.
- Roll out Paediatrics screening tool as appropriate.

1.6 Improving Record Keeping

In 2013 the Trust prioritised improvement to our clinical records and documentation. A clinical lead for records was appointed and an in-depth review of governance took place, along with a complete revision and review of clinical documentation and awareness raising of professional standards. The intended result was to ensure a high quality record that is patient centred, involves the multidisciplinary team, involves the patient and tells the patient story.

The Clinical Records Management Board was established and remains in place to ensure improvement in the quality of clinical records is maintained. The group governs the process for agreeing new documentation, overseas performance, enables the transition to digital records and has oversight of information governance issues.

Quality of the record and record keeping is monitored through data collected using the Clinical Record Audit Standard (CRAS) tool. Monthly audits have been carried out since April 2013, covering 12 standards with 23 individual elements assessed. A RAG rated system is used to highlight those teams achieving the 95% target required to be compliant with the documentation against the 107 individual questions. Further audit has been developed to provide assurance regarding patient involvement, MDT working and effective communication and handover and where necessary this is actioned to assist in behavioural and cultural change.

The audits are primarily performed by Matrons, Sisters and colleagues from the audit department; although, a therapy and medical audit are in place and can be utilised by teams. All of the results are performance managed through the Divisional Patient Safety and Quality Boards with areas identified that require further focused work and action/ improvement plans implemented and managed.

Current Performance

Current performance demonstrates an overall Trust compliance of the CRAS audit at 91.9% against the 107 questions within the 12 standards. However, there are areas that are consistently problematic across a high number of wards and departments, measuring less than 80% compliance consistently in the following areas-:

- Discharge/ Transfer
- Falls
- Fluid Balance
- Medication Charts
- Accessibility and Quality of the Notes

The best performing wards in May were 17, 12 and CDU at HRI and 2CD and 8D at CRH. The worst performing wards were 11, 22 and 15 at HRI and 6BC and 7BC at CRH.

Improvement Plans for 2016/17

Transformational change is underway with the vision that the Electronic Patient Record (EPR) will enable the safest, most efficient and patient-centred organisation in the NHS. CHFT jointly procured with Bradford Teaching Hospitals NHS Foundation Trust (BHTFT) the Cerner Millennium EPR to empower the Trust to work more effectively, so patients benefit

from improved quality and experience specifically through having an accurate, timely, high quality patient record. It will be implemented fully in A&E and all inpatient wards including paediatrics, outpatients, community, and virtual wards.

In the meantime wards and departments continue to develop specific action plans tailored to their results that are monitored through Divisional Patient Safety Quality Boards.

However, it is recognised that sustaining improvement has proven difficult in some elements; therefore, a focus on specific areas for improvement has been re- energised. With the support of the Deputy Director of Nursing (DDON), the, matrons and sisters in Band 6 development roles across the Trust are reinstating the Documentation Improvement Group. This group will lead on a number of improvements that have proved difficult to change and will be supported through action learning and coaching circles facilitated by DDON and the Professor of Nursing. Best evidence demonstrating peer review has been implemented and best and worst performing wards are buddying in order to learn from each other.

The evidence base for falls documentation and recording of fluid balance has been reviewed. A lead nurse for falls has recently been appointed and identified documentation as a priority for improvement. The Discharge Matron and Discharge Team are also reviewing the discharge documentation along with the Multi-Disciplinary Team ensure it is appropriate without being onerous.

All work is linking with the EPR work streams to ensure there is a consistent approach.

1.7 Maternity

Background

The CQC pre report action plan for maternity, an update was presented to the CQC response group on the 22nd June which identified the following aims:

- Improved Outcomes for women

- Reduction in PPH
- Reduction in third degree tears
- No never events
- Delays in Induction Occur only for Clinical reasons

- Positive Patient Experience feedback from women
- Positive staff feedback(engagement events, staff survey)

Q1 Developments

- Maternity Patient Experience group has met and agreed terms of reference and a work plan is being developed. Assistance from a member of the Maternity Services Liaison Committee has been agreed to support maternity patient experience actions. Reviewing the feedback from Meet the Midwife and weekly roundings

- A Maternity dashboard has been signed off. The draft was reviewed at maternity forum with good feedback from the forum members.

  The Trust has commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to undertake an invited service review of maternity services. The review will take place 26 to 28 July.

- Training reviewed and agreed for third and fourth degree tears, flyer going out to staff with all dates.

- A Maternity action plan is place following the CQC visit and focuses on the following:

  - Ensure compliance with CHFT guidance on monitoring fetal growth
  - Reduce the rates of PPH
  - Ensure learning from themes and trends in lower harm Incidents
  - Improve the experience of patients using the service
  - Reduce the numbers of third & fourth degree tears
  - Provide assurance of safe management of shoulder dystocia
  - Review service to ensure adequate service provision to avoid delays in induction of labour, augmentation or acceleration
  - Set key outcome measures to monitor performance and identify risk to performance delivery
  - Review the access to theatres in and out of hours to ensure that we are compliant with the Royal College of Anaesthetists Standards for Obstetric Units and NICE guidelines for Caesarean Section
  - Effective governance and risk management arrangements for the division
  - Workforce engagement plan

Improvements for 16/17

- RCOG invited service review which is due to take place in Q2.
- Further staff engagement events planned
- Compliance with training for third and fourth degree tears to be reported

1.8 Improving Clinical Coding

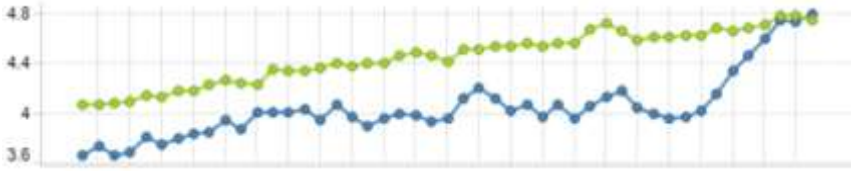
Background

Clinical Coding is used to classify the diagnosis and treatment of every admitted patient. The system relies on the expertise of clinical coders, who extract data from documentation used to record clinical information. The quality (accuracy and completeness) of the documentation is also crucial to the quality of the coded data. CHFT performance against clinical coding KPI's (% Sign & Symptom, Depth of Coding and Average Charlson Score) were below the national average for the Trust and at specialty level. By improving the performance for each KPI's it would result in a positive impact on HSMR/SHMI. CHFT's aim is to be in the national upper quartile for the 3 coding KPI's and this is reliant on the documentation and the quantity and quality of the coders extracting the data.

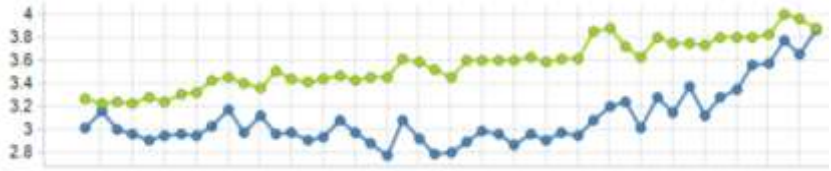
Current Performance

There has been significant improvement in all coding KPI's within the last quarter and 12 months as a result of increased clinical engagement, improvements to clinical documentation to aid the clinical coding process, vacancies filled within the coding team and improved use of data to identify areas for improvement. All 3 of the clinical coding KPI's show a positive improvement as demonstrated in the graphs below.

Depth of Coding Apr 2012 – Feb 2016



Average Charlson Score Apr 2012 – Feb 2016



% Sign & Symptom Apr 2012 – Feb 2016

Source: HED. CHFT – Blue Line; National Average – Green Line

However there is considerable variation at a specialty level as shown in table below.

Coding KPI's by Specialty – June 2016

Treatment function	Episodes	Average co-morbidity score	Average diagnoses	% signs and symptoms
100 - General Surgery	1,676	2.72	4.70	9.37%
101 - Urology	433	2.98	4.96	9.70%
107 - Vascular Surgery	46	11.78	9.96	0.00%
110 - Trauma & Orthopaedics	631	2.24	4.51	0.32%
120 - ENT	247	1.28	3.20	9.31%
130 - Ophthalmology	800	1.41	3.47	0.00%
140 - Oral Surgery	139	1.00	2.26	0.00%
160 - Plastic Surgery	114	1.07	2.19	0.00%
191 - Pain Management	216	1.91	3.24	9.26%
Surgical Division Total	**4,302**	**2.30**	**4.22**	**5.67%**
180 - Accident & Emergency	341	5.01	6.60	28.15%
300 - General Medicine	2,368	7.08	7.28	19.89%
301 - Gastroenterology	569	4.00	4.71	8.08%
303 - Clinical haematology	350	3.16	3.85	0.57%
306 - Hepatology	37	13.97	9.57	5.41%
314 - Rehabilitation service	67	9.00	11.15	0.00%
320 - Cardiology	412	6.18	7.67	17.72%
328 - Stroke Medicine	89	7.66	9.28	11.24%
340 - Respiratory medicine	141	7.48	7.89	7.80%
370 - Medical Oncology	568	9.27	4.98	0.18%
400 - Neurology	9	0.00	1.22	0.00%
410 - Rheumatology	85	1.20	3.00	0.00%
430 - Geriatric Medicine	228	13.50	11.28	10.09%
Medical Division Total	**5,264**	**6.78**	**6.72**	**13.97%**
420 - Paediatrics	1,133	0.13	2.11	10.77%
501 - Obstetrics	576	0.31	4.09	0.00%
502 - Gynaecology	296	0.84	3.84	6.42%
560 - Midwifery service	173	0.28	2.84	0.00%
811 - Interventional Radiology	60	5.75	5.02	13.33%
FSS Division Total	**2,238**	**0.43**	**2.99**	**6.65%**
CHFT TOTAL	**11,804**	**3.95**	**5.10**	**9.6%**

Source: Standard Activity, Knowledge Portal. Red = Lower Quartile, Amber = Interquartile and Green = Upper Quartile

Improvement plans for 2016/17

- 4 out of 5 clinicians with PA for coding identified which will assist with specific coding improvements particularly 'lost' co-morbidities, further improvement in documentation used for coding and education/engagement sessions for clinical staff.
- 6 trainees recruited and will commence training leaving 2.5wte vacancies that will continue to be advertised as a rolling advert with the plan that if no suitable applicants by autumn/winter 2 additional trainees will be recruited. Additional capacity will allow more time for coding and for clinical engagement to improve documentation.
- Roll out of 3M Encoder which will assist with the coding process especially for coding trainees.
- Roll out of Cerner Millennium - Cerner Millennium will 'pull-through' conditions documented in the LTC/Problem section of Millennium into clerking in section. Emphasis to be given in clinical training for this section of Millennium to be completed ASAP after go-live with all important co-morbidities (that impact on patient care, HSMR or SHMI).
- Continue to work with wards and Specialist Palliative Care (SPC) teams regards importance of documenting SPC input and continue with the check process to ensure SPC involvement in care is not missed.

- Develop specialty specific coding awareness presentations for clinical teams
- Continue to identify and work with areas/specialties where coding quality improvements are required.

Domain Two – Effective: Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Effectiveness compliance summary

Indicator	Compliance
2.1 Reducing Mortality	Partial Compliance
2.2 Improving Reliability – Implementing Care Bundles	Reporting Only
2.3 Improving the Management of Fracture Neck of Femur	Reporting Only
2.4 Improving Diabetic Care	Reporting Only
2.5 Reducing Hospital Acquired Infections (Contract)	Achieved
2.6 Hospital at Night (CQUIN)	Achieved
2.7 Deteriorating Patient	Reporting Only
2.8 Improving End of Life Care	Achieved
2.9 Deprivation of Liberty (DOLs)	Reporting Only
2.10 Conditions of Interest – Stroke	Reporting Only

Highlights:

Mortality – key priority areas identified are the reliability of clinical care for respiratory, stroke and elderly patients, recognising and responding to deteriorating patients and timely antibiotics for patients with sepsis.

Care Bundle implementation – some improvement noted in compliance with asthma bundle and acute kidney infection bundle

Reducing Hospital Acquired Infection – 0 cases MRSA bacteraemia since Q2 2015/16

Hospital at Night - achievement of Hospital at Night Programme CQUIN for Q1

End of Life – integrated workplan being developed for end of life care

Stroke – improvements in stroke pathway delivery
e

2.1 Learning from Mortality

The main outcome measure is the Summary Hospital Mortality Index (SHMI) calculated by the Health and Social Care Information Centre (HSCIC). The SHMI is the ratio between the actual number of patients who die within 30 days of discharge from the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the local patients.

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100).

The Trust aims to:

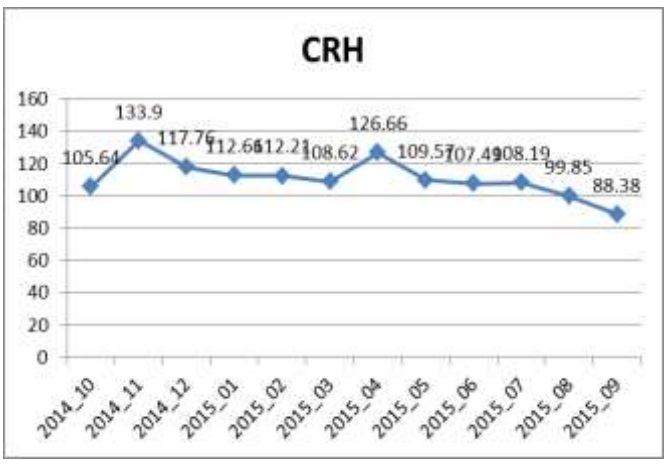
- Reduce the SHMI to 100
- To review 100% of all in hospital deaths each month

SHMI update

Data has been released in May for SHMI incorporating performance data up to **September 15**

- Looking at the rolling 12 month SHMI (October 14 – September 15), the score is **113.88**. This is a declining position from 111.00 (from the previous rolling 12 month period of (July 14 – June 15)

- The site breakdown shows HRI at 116.19 and CRH 111.21. The graphs below show the month on month SHMI for HRI and CRH.

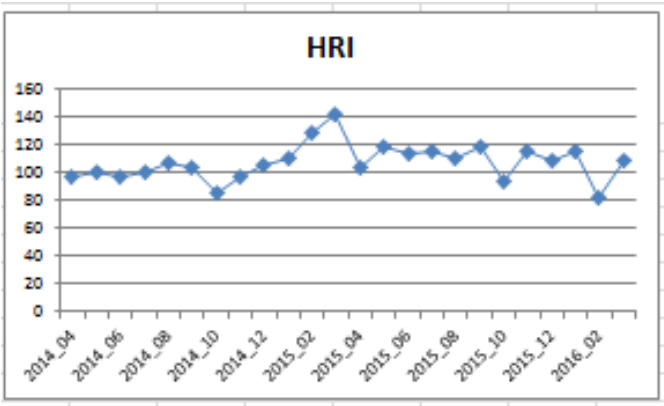


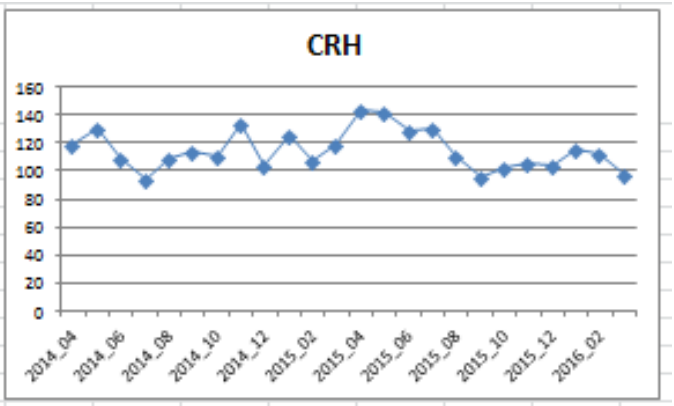
HMSR update

Data has been released in **June** for HSMR incorporating performance data up to **March 2016.**

- Looking at the rolling 12 month HSMR (April 15 – March 16), the score is **111.62**. This is a notable improvement from 114 (from the previous rolling 12 month period of March 15 – Feb 16)

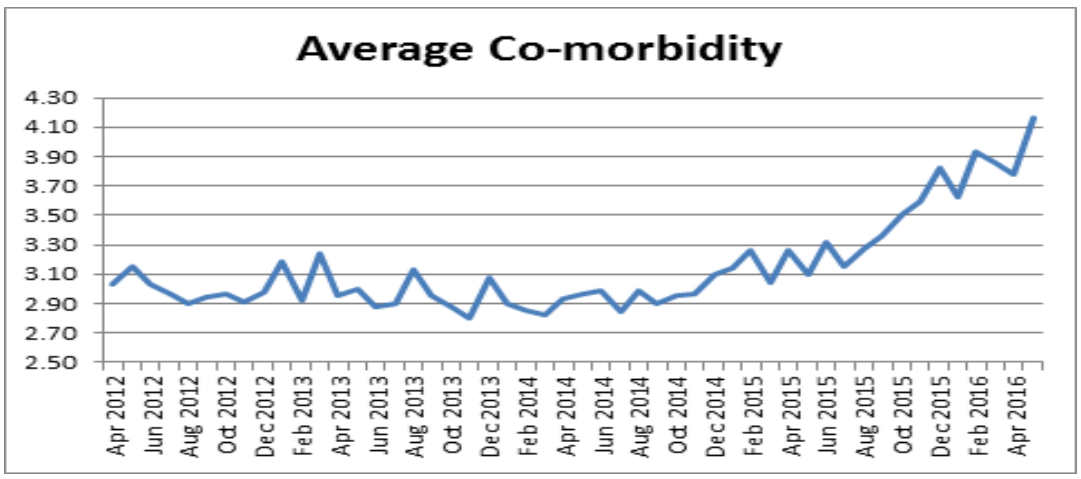
- The site breakdown for the same period shows HRI at 108.00 and CRH at 115.00. The graphs below show the month on month HSMR for HRI and CRH.





Improvement in Key Coding Indicators

There has been significant improvement in documentation and coding of the co-morbidities that affect HSMR/SHMI as seen in the chart below however there is further work is required to achieve national upper quartile performance in all specialities.



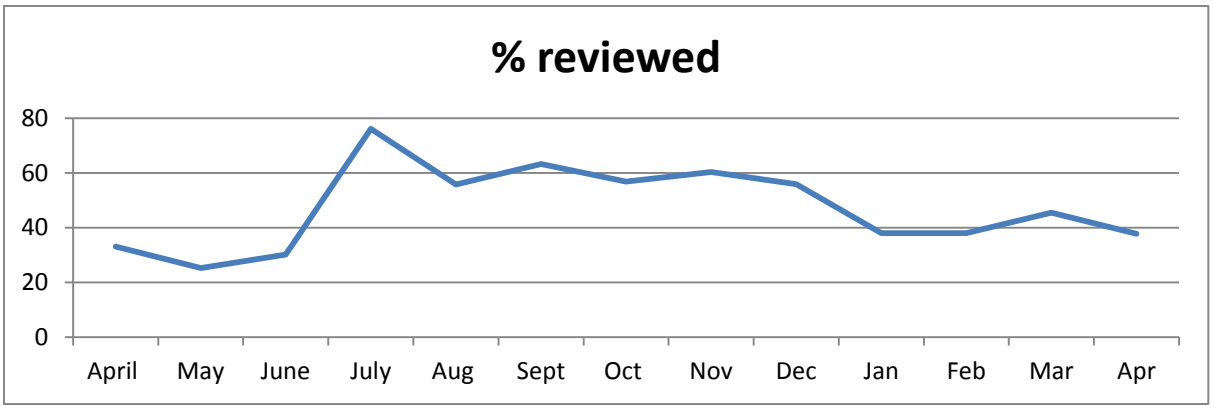
Internal Mortality Review Process

Mortality cases are reviewed internally using a two level process with the aim to review 100% cases at first level. These reviews are performed by a team of 'mortality reviewers' using a standard tool with a number of 'screening' questions to assess whether there were any preventability factors. The preventability is scored using the Hogan score of preventability on a scale of 1 to 6 as described below.

1. Definitely not preventable.
2. Slight evidence for preventability.
3. Possibly preventable but not very likely, less than 50–50 but close call.
4. Probably preventable, more than 50-50 but close call.
5. Strong evidence for preventability.
6. Definitely preventable.

In addition, the 1st level reviewers can provide some free text that captures useful information on preventability and provide a score of the care provided. All cases assessed as Hogan 3 or above are sent for a second level review with the purpose to provide a more in-depth review of the patients care and management to understand where the gaps have occurred. Performance of the first level reviews had improved in the last 6 months of 2015 but has now declined. The chart below shows the % of mortality cases reviewed each month. The decline has been due to many

of the senior nurses who perform the mortality reviews being required to manage other priorities in the Trust including maintaining safe staffing levels and patient flow.

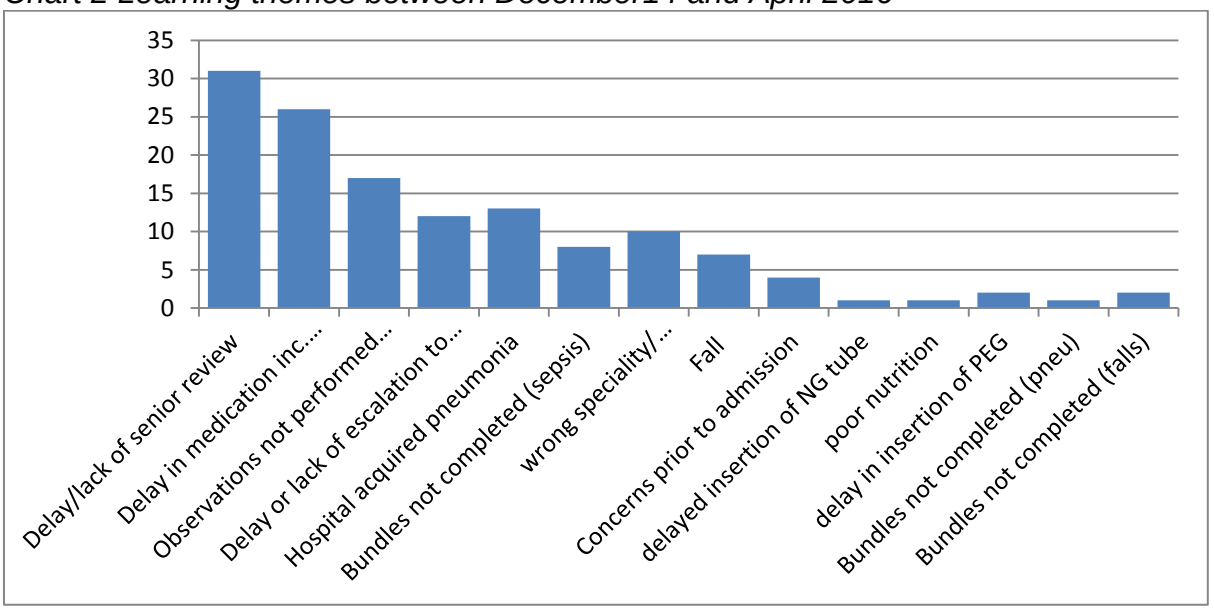


The second level reviews are currently performed by 3 senior doctors who were appointed in January using a standardised tool. Of the cases identified for second level review since April 2015, 40 second level reviews have been performed, prioritising on the more recent cases and the Hogan 4 and 5 cases. Of these, 23 cases were reassessed as a lower preventability score including both Hogan 5 cases. 13 remained the same score and 4 were scored higher on second level review.

Learning from mortality reviews

Once the reviews have been performed, the data is added to the Knowledge Portal. In addition, data is being analysed on a monthly basis using the key learning themes from cases assessed as Hogan 2 and the more in-depth details gathered from the Hogan 3-5 cases. The 'Learning from Mortality Reviews' reports is shared with the reviewers, members of the Clinical Effectiveness and Mortality Group, Clinical Outcomes Group and Divisional Patient Safety and Quality Boards.

Chart 2 Learning themes between December14 and April 2016



The top themes from the reviews are aligned to various improvement work streams as identified below.

Top themes	Improvement work
1. Delay/lack of medical review	Included in the 7 day working and hospital @ night – Deteriorating Patient work stream
2. Delayed medications, mainly antibiotics	Included in the Medication Safety Group and highlighted at the Nursing and Midwifery Committee
3. Observations not performed as policy	Included in the deteriorating patient work stream and since the implementation of Nerve Centre last year there has been a marked improvement
4. Delay or lack of escalation of NEWS	
5. Incomplete bundles	Included in the Reliability theme of the CAIP
6. Fluid balance recording	Included in the CRAS audit action plan with matron led improvement work on documentation
7. Hospital acquired pneumonia (including aspiration pneumonia)	Include in the HCAI action plan

Mortality Alerting Conditions

The Trust is showing as an outlier in mortality for two diagnostic groups; Acute Cerebrovascular Disease (ACD) and Pneumonia. An in depth review of 15 ACD has been carried out with the main learning themes being poor documentation at clerking, co-morbidity capture, Stroke Pathway, DNA CPR and Care of Dying Pathway. Also, issues with NG feeding, including aspiration pneumonia and delays in PEG insertion.

An in depth review of 30 Pneumonia cases have been commissioned from the inaugural meeting of the Mortality Surveillance Group and is currently underway.

Improvement work

From the various information sources it would suggest that there are a number of complexities that effect the currently Trust's mortality position. However from the information, key priorities can be identified that would lead us to improve patient outcomes and thus improve the mortality position.

The key priority areas are identified below and are aligned with the work streams within the 'Care of the Acutely Ill Patient', divisional action plans and sepsis improvement programmes.

1. Reliability of clinical care, particularly with respiratory patients and stroke patients ensuring that all elements of the evidence based pathways and bundles are met
2. Reliability of clinical care with the elderly, particularly frail patients, ensuring these patients are provided regular senior review on a daily basis
3. Recognising and responding to deteriorating patients
4. Timely antibiotics for treating patients with sepsis

2.2 Improving Reliability – Implementing Care Bundles

Aims and Objectives of Work

Improvement theory suggests that care bundles allow clinical teams to focus their efforts on a small number of measurable strategies aimed at improving specified outcomes (BTS/NHSI; 2012). Protocol-based care also enables staff to quickly see what action should be taken, when and by whom. They allow practice to be standardised and reduce variation in the treatment of patients. They are also an important tool in improving the quality of care, as variance from the agreed care pathway can be measured easily, allowing systemic factors that inhibit provision of best care to be identified

There are five conditions identified within the Care of the Acutely Ill (CAIP) work stream where evidence-based care bundles have been developed to improve patient outcomes. These are;

- Asthma
- Acute Kidney Injury (AKI)
- Sepsis
- Chronic Obstructive Pulmonary Disease (COPD)
- Community Acquired Pneumonia (CAP)

These care bundles have been included in the medical clerking documentation and compliance is measured monthly by members of the audit team with a target compliance of 95%.

Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Asthma - Bundle Started	95%	87%	100%	100%										95%
Asthma - Bundle Completed	95%	46%	50%	42%										43%
AKI - Bundle Started	95%	58%	62%	79%										68%
AKI - Bundle Completed	95%	39%	38%	48%										43%
Sepsis - Bundle Started	95%	88%	91%	86%										88%
Sepsis - Bundle Completed	95%	41%	45%	39%										42%
COPD - Bundle Started	95%	43%	65%	77%										61%
COPD - Bundle Completed	95%	85%	33%	48%										53%
Pneumonia - Bundle Started	95%	40%	23%	43%										36%
Pneumonia - Bundle Completed	95%	67%	20%	77%										75%

Asthma

There has been very good compliance with commencing the Asthma care bundle with overall compliance to the end of Q1 being 95%. However, compliance with completing all the elements was only 43%

Acute Kidney Injury

There has been month on month improvement during the last quarter for both commencing the AKI bundle and completing all the elements but overall compliance is still a long way from the target at 68% and 46% (year to date) respectively.

Sepsis

The monthly compliance of commencing the sepsis bundle remains fairly static at 88% overall compliance to date but the ongoing completion remains at 42% overall compliance

Chronic Obstructive Pulmonary Disease

Improved compliance on commencing the COPD bundle has been achieved each month but has deteriorated for the completion of all the elements since April. Overall compliance year to date is 61% and 53% respectively.

Community acquired Pneumonia (CAP)

There has been a variable compliance with both the commencing of the CAP and completing all the elements with a noted better compliance for completing all the elements. Overall compliance from April is 36% for commencing the bundle and 75% for completing all the elements.

Improvement work

Each of the care bundles have now been incorporated in the medical clerking documentation to prompt the commencement of the appropriate bundle. This has probably contributed the improvement noted in some of the bundles and has allowed retrospective audit to take place. The sepsis and AKI bundles are also incorporated into the surgical clerking documentation from July 2016.

Future Plans

1. To gain a better understanding of why there is better compliance with some elements of each bundle and why we fail to comply or document other elements of the bundles.
2. Identify a clinical lead for each of the bundles and to see how this work may fit with existing workstreams such as the ‘care of the frail patient’ and ‘plan for every patient’ workstreams.
3. Meet with the EPR team to understand how the elements of each of the bundles will fit within the new EPR

2.3 Improving Management of Fracture Neck of Femur

Introduction:
The Best Practice Tariff (BPT) was introduced in 2010. It aims to act as a financial incentive for hospitals to optimize management of patients with neck of femur (NOF) fractures.
Where all the factors associated with best practice have been delivered a supplement of just over £1300 is added to the tariff.

We expect to receive between 450 and 500 patients who have sustained a fractured NOF each year.

Aims and Objectives of Work:

Seven factors were identified by NICE and require inputting into the National Hip Fracture Database (NHFD). Each of these factors relates to either patient experience or outcome.
The first of the factors relates to getting patients to theatre within 36 hours of admission, this target was set to ensure no patient ever spent more than one night in a hospital bed with a broken hip.

We set the ambition to get to 85% for all components in October last year. For all aspects of the BPT standards we have achieved this ambition with the exception of time to theatre. The reasons for this are:

- A high percentage of patients who are clinically not fit
- There is not always a hip surgeon available within 36 hours for patients who require total hip replacement
- Theatre capacity, there are sometimes patients with conditions other that #NOF who need to be operating on first.

Q1:

Performance for individual components Q1

		(Last year)
• Time to theatre	69%	(70%)
• Admitted under joint care	99%	(96%)
• Admitted using appropriate assessment protocol	100%	(99%)
• Assessed by a geriatrician within 72 hours	98%	(90%)
• Post-op geriatric MDT	96%	(88%)
• Falls assessment	99%	(84%)
• Bone health assessment	99%	(99%)
• Pre and post op AMT	95%	(86%)

66% of patients got all components of BPT (best practice tariff).

The service continues to utilise elective theatre space where necessary to carry out procedures in the necessary timescales and is now successfully carrying out total hip replacements at HRI when patients need them.

Fallow lists are being identified further in advance; we are currently booking vacant lists to the end of August in order to inject extra capacity.

The Directorate monitors the mean wait times on a monthly basis for patients who were delayed due to organisational reasons; this has not exceeded 48 hours.

The nursing teams on the wards continue to focus on every single component of best practice guidance, taking responsibility for making sure each patient gets each component where possible.

In June the Orthogeriatric service suffered some unexpected sickness, but the team were supported by the medical Division to be able to deliver the necessary components of care.
The Directorate has updated the RCA form to compare outcomes and quality of experience between patients receiving their operations before and after the 36-hour target.

Improvement Plans:

The team is shadow reporting all patients so they can be audited and practice changed to ensure all patients receive the 2 new components that we expect to be included in BPT.
Ongoing participation in the PERFECTED research study (Peri-operative Enhanced Recovery hip Fracture Care of patients with Dementia). This is a National Institute for Health Research (NIHR) funded Applied Research Programme aiming to improve hospital care for patients with Dementia who break their hip. The Directorate is getting positive feedback from the research team that

changes and recommendations are being embraced. The research project has been a very positive experience for all involved.

The directorate has been supported by THIS to develop a tool which provides information on the historic patterns of trauma and the activity over the year, to allow the service to calculate the amount of trauma operating capacity it needs to be able to provide a consistent service, which delivers patients to theatre in a class leading timescale. The capacity needed will be available from autumn when the theatre refurbishment at HRI is complete and theatre 6 is available.

2.4 Improving Diabetic Care

Aims and Objectives of Work

People with diabetes admitted to hospital benefit most when they are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin (NICE quality standard).

A programme of work is underway to improve care of the diabetic patient and aligns with the self-administration of medicines CQUIN as discussed in the Medicine Management section.

2.5 Reducing Hospital Acquired Infections

Aims and Objectives of Work

The Trust is committed to providing a safe environment for patients including preventing healthcare associated infections (HCAI). Although significant reductions in HCAI have been made over the past few years, it is recognised that continued focus and effort is required to sustain the changes that have been successful in reducing our HCAI rate and ensure that we do not exceed the targets set for HCAI as detailed below.

In 2016/17 the Trust aims are to:

- Have 0 Trust assigned MRSA bacteraemias
- Have no more than 21 Clostridium difficile (Post 48-hour admission) infections
- Improve on the previous year's outturn of MSSA Bacteraemias, i.e. 9
- Improve on the previous year's outturn of E.Coli infections, i.e. 25
- Screen more than 95% of all elective in-patients for MRSA

Current Performance
Performance at the end of Q1:

Indicator	Q1 Performance	On Track?
Meeting the MRSA bacteraemia (Trust assigned)	0	On Track
Meeting the C-diff target (Post 48 hours)	6	Over Trajectory
MSSA Bacteraemias	2	On Track
E-coli rates	5	On Track

MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemia:
There have been no further cases of MRSA bacteraemia since Q2 of 2015/16. The main action identified from the last case was improvement work with ANTT (aseptic non-touch technique). The Infection Prevention and Control Team have trained an additional 80 ANTT assessors, and will implement a new e-learning package for junior medical staff from August 2016.

MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemia:
There have been 2 reported cases in Q1. These cases have not been linked. MSSA screening has commenced for patients with central venous access devices and patients undergoing vascular fistula formation. These are subject to case note review and any lessons fed into the Trust HCAI Action Plan.

E.coli bacteraemia:
There have been 5 post admission cases in Q1. These are subject to case note review and any lessons fed into the Trust HCAI Action Plan.

There is no national reduction target set for E. coli bacteraemia, however the Trust has set an internal target to not exceed the out-turn of cases (25) in 2015/16. This may be challenging to achieve as a review of all of last year's cases did not reveal many common areas for action. 4 were related to long term urinary catheters. Lessons from a former catheter project nurse are incorporated in the trust HCAI action plan to support the reduction in the use of urinary catheters.

***Clostridium difficile* (*C. difficile*):**
There have been 6 post admission C. difficile cases in Q1.
3 of the 6 cases have been agreed as avoidable following the RCA meetings. Of the 3 cases agreed as avoidable the following key learning opportunities were identified: appropriate timeliness of stool specimens, clear documentation on normal bowel habits and when specimens have been taken and prompt isolation of patients with loose stools.

Improvement Plans for 2016/17

The Trust recognises the challenge to meet the target for *C.difficile* cases (external target). There is a comprehensive programme and action plan to reduce healthcare associated infections, the following actions are included within the action plan:

- The PIIP (Preventing Infection, Improving Prescribing) Group has been established, but attendance has been poor with 2 meetings being cancelled in quarter 1. This will report to the Infection Control Committee (ICC). In addition, the Divisions will be requested to provide information on their performance on reducing HCAI, particularly on the progress of their action plans with quarterly reporting to the ICC.
- The IPCT are leading an audit of Aseptic Non-touch Technique (ANTT) practice across the Trust.
- Work has been done to improve the timeliness of isolation of patients with suspected infective diarrhoea with support from the ADNs and matrons. MAU have been given 'read only' access to ICNet to give them access to the information required to make appropriate isolation decisions.
- Enhanced surveillance of surgical site infection is currently underway in orthopaedics
- Surveillance of cases of Hospital Acquired Pneumonia is currently underway to try to establish a benchmark for some improvement work

2.6 Hospital at Night

Background

Patient care is generally described as delivered 'in-hours' - Monday-Friday 8am-5pm - or 'out-of-hours', evening, nights and weekends, including public holidays. This out-of-hours proportion accounts for over 70% of care time, with significantly reduced staffing across all healthcare professional groups. Increasing patient acuity and dependency means there are multiple demands on senior nurses and medical staff working out of hours.

Hospital at Night (H@N) is a set of national standards for how clinical care is delivered out-of-hours, with medical staff working together across specialty or division to share workload that is coordinated, usually by a senior nurse, to ensure prioritization and patient safety.

Current Performance

At CHFT, medical and senior nursing staff are available variably across the out-of-hours period to support wards and clinical areas. There is currently no tracking system to identify tasks required or prioritisation, clinical night staff are dependent of ward staff bleeping them with individual tasks. Current staffing only accounts for clinical support/coordination overnight, leaving weekend/bank holiday days and evenings uncovered.

Improvement plans for 2016/17

As part of the Nervecentre system purchased through the Nursing Technology fund, H@N Task management has been scoped and is currently undergoing testing and debugging. This system uses the mobile/web application for Nervecentre to request tasks for clinical care outside the competencies of ward based staff, which will then be co-ordinated using mobile technology across all available clinical staff. The technology will allow the coordinator to see individual workloads and allocate as patients require.

The system requires clinical coordination for the full out-of-hours period. A group of band 6 nurses have been recruited and with the current night sister team will form the new Clinical Coordinator Team. All of these staff will be trained to co-ordinate this workflow. In addition a new team of band 3 clinical support workers have been recruited who have extended clinical skills and will be able to act as a supplement to the current night team.

A proposal has been submitted to go-live with the Hospital@Night system in September at Calderdale and in October in Huddersfield. However, the scope of the current hospital at night project is limited to the introduction of this electronic task management system and clinical

coordination. There will be a WTGR breakthrough event on the 5 August to look at a broader vision of all out of hours hospital care namely the HOOP – Hospital Out Of hours Programme. The aim is to transform both clinical and operational responses out of hours to deliver better patient experience by reducing delays in moving patients from our EDs and responding to tasks in a more timely manner, improve patient outcomes by recognising and responding to our sickest patients, contribute to achieving our ED performance and improving the experience of our staff out of hours. The break through event will lead to a project plan for improvement reporting to the Safer Programme Board.

2.7 Deteriorating Patients

Background
It is clear that whilst in hospital there is a risk of patients deteriorating which will undoubtedly affect their outcome. A recent (12 July 2016) patient safety alert from NHSI describes that 26% of preventable deaths arises from 'inadequate monitoring' for both adults and children. It advocates the use of EWS (Early Warning Scores) to identify deteriorating patients.

Current Performance
At CHFT EWS are in place throughout the organisation. With the introduction of Nervecentre all observations are electronic using hand-held devices in all inpatient areas. If a patient's EWS is abnormal then the system prompts the nurse to either repeat observations sooner and/or manually escalate the patient to a doctor. For adult patients who score a NEWS of 7 or more are automatically escalated to outreach during the hours of 8am and 8pm every day. Hospital at night will respond to these escalations as described above.

DPG (Deteriorating Patient Group) has re-formed after the initial implementation of Nervecentre.

At present the plan is to consolidate and review the data available through Nervecentre but also look at themes identified from mortality reviews, cardiac arrests and clinical incidents to inform a specific action plan for improvement. There is also a plan to audit responses to patients who score a NEWS of 7 or more both in and out of hours to better understand where improvement(s) can be made.

Improvement plans for 2016/17
The plan for improvement is yet to be confirmed. However, it is anticipated that learning from mortality reviews, cardiac arrests, clinical incidents and the planned audit of patients with a NEWS score of 7 or more will provide the areas that are in need for improvement. One area that has already been highlighted is the timeliness of observations. Discussions are already in place with senior nursing colleagues to develop an improvement plan. Thus the actions to NHSI's alert are already underway and the action plan will be shared with NHSI by January 2017. The DPG action plan is expected to be confirmed by Q3.

2.8 End of Life Care inc DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)

The quality of end of life care delivered within CHFT remains an important priority. The recent CQC visit identified the fact that while there are elements of excellent practice, there is a need to fully embed its position within the organisation. There has also been a downturn in performance results in the National Care of the Dying Audit for hospitals.

There is now a plan to re-establish the End of Life Care Collaborative with a much broader base of input from senior medical and nursing staff. This coincides with the creation of a year long secondment post to scope end of life care provision and education across CHFT.

Three main documents are being pulled together to create a workplan to improve end of life care, with primary goals, secondary drivers and measureable outcomes. It is imperative that there are better mechanisms in place to report progress, failings and potential developments.

The main goals are:

- Identification of people in the last 12 months of life and communication with these patients and those important to them.
- Co-ordination of care particularly for people with complex needs and vulnerabilities.
- Timely and equitable access to high quality care including 24/7 support.
- Care in the last hours and days of life which delivers the 5 priorities of care for the dying patient.

Identification of the last year of life:
It is recognised that there is a need for better training in advanced communication skills and in the recognition of the last 12 months of life. Three further study days founded by Health Education for Yorkshire and the Humber (One Chance to Get it Right) remain, with education delivered by a joint team of professionals from Kirkwood Hospice and CHFT.

It is imperative that more senior doctors attend these study days. It is clear that there continues to be reluctance to make appropriate and timely decisions regarding cardiopulmonary resuscitation and enhanced levels of mandatory training may address this problem. Making part of the region-wide DNACPR video mandatory as part of basic life support training would be helpful. Roll-out of and training in tools such as the SPICT (Supportive and Palliative Care Indicators Tool) should also be encouraged.

Co-ordination of care:
It is recognised that there is a need for clearer decision-making regarding treatment plans by senior clinicians with better communication within and between teams. The use of safety huddles should be explored with respect to end of life care decisions and all efforts made to enhance the quality of clinical handover. It is identified that there is a need for a robust supported discharge pathway for those patients approaching the end of life and better monitoring of Fast Track applications is needed. The Electronic Palliative Care Co-ordination System (EPaCCS) has been proven in other areas of the country to increase the likelihood of patients dying in their place of preference and in avoiding unnecessary hospital admissions for patients at the end of life. Implementation of EPaCCS should be considered following introduction of the Electronic Patient Record.

Timely access to high quality care:
There has been a temporary cessation of clear categorisation of complaints at the end of life, but if we are to respond to these issues, continued surveillance will be required.
The creation of a central syringe driver pool should go some way towards alleviating the lengthy delays in accessing this important piece of equipment for patients at the end of life. Negotiations and planning continues to implement a 9-5, 7 day-a-week service for the specialist palliative care nursing service within CHFT. Further workforce planning and investment in the service will be required if high quality care is to be delivered at weekends without compromising the existing service through the week. There is now a well-established process for recording Level 1 advice given by the Specialist Palliative Care Team to patients on wards across the Trust, which has gone some way to correcting inaccuracies in the appropriate coding of patients' multiple co-morbidities at the end of life. This will continue along with continued support from the coding

team. Following full implementation of the Electronic Patient Record, it is hoped that a more accurate picture of specialist palliative care involvement will be possible.

Care in the last hours and days of life:
Training in the use of the Individualised Care of the Dying Document (ICODD) continues, but it is evident that there continues to be some reluctance or reticence on the part of some clinicians to use this document to support people in the last days of life. Currently the use of the ICODD across hospital wards is falling slightly to approximately 35% usage in the month of May 2016; reasons for this are unknown. There is a need to understand the number of anticipated deaths in our hospital wards of which 100% should be supported by the ICODD. An audit of all deaths in a 4 week period will allow us to identify the magnitude of this task. This measure will remain critical for review and improvement and undoubtedly further education will be required.

Regular audit of practice will be required and this Trust is committed to taking part in the National Care of the Dying Audit for Hospitals including accessing feedback from bereaved relatives. Following the publication of this year's results, which showed a reduction in performance across many parameters, it is clear that we will continue to need to improve the services that we deliver to patients and their families and that this will require to be done in co-operation with our partner organisations. Other audits planned for the forthcoming year include a specific audit of bereaved relatives of patients who were seen by the Hospital Specialist Palliative Care Team, along with a wider audit of clinical nurse specialist activity within the Trust. There will also be continued audit of compliance of DNACPR decisions.

2.9 Safeguarding Patients/ Mental Capacity Act and Deprivation of Liberty Safeguards

Aims and Objectives of Work

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009).The legal framework provided by the MCA 2005 is supported by the MCA Code of Practice, which provides guidance and information about how the Act works in practice. The Code has statutory force which means staff who work with and/or care for adults who may lack capacity to make particular decisions have a legal duty to have regard to relevant guidance in the Code.

The DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 or the European Convention on Human Rights (ECHR) in a hospital or care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where Deprivation of Liberty appears to be unavoidable, in a person's own best interests.

The specific aims for the work are to:

(i) To ensure all patients who are deprived of their liberty have in place a legal Safeguard that authorises CHFT to detain the patient, whether it be under the DoLS, the Mental Health Act 1983 (amended 2007), or the Mental Capacity Act 2005.
(ii) Provide assurance that CHFT are compliant with all aspects of the MCA 2005 and DoLS 2009.

Historical Data and Analysis
Historically there have been in totality:

In 2014

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

In 2015

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

In 2016 (up to 31.3.16)

Number of DoLS applications 94
Data is now captured quarterly and reports are shared at the Safeguarding Committee meeting.

The MCA came into effect in 2007 followed by the DOLS on the 1st April 2009. The DoLS apply to vulnerable people aged 18 or over who have a mental health disorder including dementia, who are in hospital or a care home and who do not have the mental capacity to make decisions about their care or treatment. Those providing the care should consider all options, which may involve restricting the person's freedom, and should provide care in the least restrictive way possible. However, if all alternatives have been explored and the hospital believes it is necessary to deprive a person of their liberty in order to care for them safely, they must get permission to do this by following processes known as the Deprivation of Liberty Safeguards; and they have been designed to ensure that a person's loss of their liberty is lawful and that they are protected. A ruling from the UK Supreme Court in March 2014 has given a new 'acid test' for deprivation of liberty:

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

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

There have been two MCA/DoLS audits last year (2015-2016) and improvement plans were developed to address issues identified and we continue to raise awareness in this area. Increased staff awareness has resulted in increased authorisations.

(i) Q1 Progress.

From April to June 2016 there have been 93 urgent authorisations in total made to both Kirklees and Calderdale Metropolitan Councils regarding patients who are deprived of their liberty whilst being cared for as inpatients. CHFT can grant itself an urgent authorisation for up to a period of 14 days whilst the Local Authority determines whether or not to authorise the deprivation of liberty.

From these urgent authorisations made 17 urgent authorisations progressed and the standard authorisation was authorised under the DoLS. Whilst this may appear to be small numbers, 49 of the authorisations were cancelled by the Trust; because the patient was discharged, they had died, it was more appropriate for the Mental Health Act to be used as the legal authorisation, or they regained capacity and therefore it was not lawful to continue with the deprivation of liberty. So for the time the authorisation was in place it was appropriate under the legislation. A small number of the urgent authorisations have lapsed. This occurs when the Local Authority do not complete all their assessments within 14 days of the urgent authorisation being applied. Unfortunately CHFT do not have any influence over the assessment timescales and Local Authority processes for managing this. In these cases the Safeguarding Team continues to

monitor the patient to ensure that the deprivation is still valid, the patient still lacks capacity, all restrictions in place remain least restrictive whilst ensuring the patient remains safe on the wards, and that there are no objections to the DoL. These numbers have not yet been captured and further work is progressing to build this into the database.

All DoL applications are recorded and kept centrally within the Safeguarding Team records. A comprehensive database captures all contacts and records the outcomes of applications made. The CQC are notified of all DoLS authorisations and outcomes. This is in line with the requirements of the legislation. All patients who are subject to an urgent or standard authorisation are monitored by the team.

ii) Assurance and Audit

Since CHFT was inspected in March 2016 there is still some uncertainty with staff regarding the Interaction between DoLS and MCA Legislation leading to delays in obtaining a timely Deprivation of Liberty and notification to the Safeguarding Team for advice and support. To ensure that CHFT are acting in accordance with MCA and DoLS Act legislation and compliant with statutory responsibilities further advice and support is being considered from a legal perspective in utilising the standard authorisation process without applying for an urgent authorisation. Legal clarity will be sought before further discussion.

Twice yearly audits to identify any gaps and good practice in relation to MCA DoLS are planned for July and December this year. In 2015 two audits were undertaken within CHFT which comparatively identified areas where patients were more likely to be who met the 'acid test' criteria for a DoL, and showed an increase in knowledge and awareness at the 2nd audit by a significant increase in the number of authorisations granted.

iii) Training

A significant piece of work has taken place to review all staff groups within CHFT and the level of safeguarding training that they are required to complete in line with the Intercollegiate document for Safeguarding Children and the draft intercollegiate document for Safeguarding Adults. These new figures and compliance reflect the increased numbers of staff that are required to complete a higher level of training. MCA and DoLS is delivered as part of levels 2 and 3 Safeguarding Adults training.

Level 1 training figures have remained static at 81% compliance and have increased since quarter 3 2015-16 (72.6%). This is delivered by an eLearning package.

Level 2 has increased from 61% to 64% (adults) and from 63 to 65 % (children). This is now delivered by a new eLearning package launched in February 2016.

Level 3 Adults – is a new data capture since the allocation of Level 3 to particular staff groups, and has increased from 13% to 22%. A training strategy to target this group of staff is required. This training is delivered face to face

Level 3 Children has increased from 33% to 53% during this quarter. This training is delivered face to face.

Other work has included;

- Continued work and updating the Trusts Intranet Safeguarding pages which include MCA and DoLS to facilitate easier and up to date information.

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

- The safeguarding team have worked with the Risk Department to ensure that the CQC are aware and notified of all DoLS authorisations which includes outcomes.

- Improved information capturing by collaborative working with the health informatics team in developing a safeguarding dashboard to include DoLS and Mental Health Act statistics.

Improvement Plans for 2016/17

- The Safeguarding Policies and Procedures for Children and Adults are currently being reviewed and updated in line with The Care Act 2014, Working Together 2015, and the Intercollegiate Document for Children 2014. The new Mental Capacity and Deprivation of Liberty Policy will be introduced with updated referral processes and pathways.
- The Safeguarding Team are now co-located within the same offices as Calderdale Local Authority Adult Health and Social Care Team. This is in line with the true spirit of the Care Act 2014.

- Priorities for 2016 will include compliance with The Mental Health Act (1983). This includes: securing honorary contracts to enable Mental Health Liaison Psychiatrists to act as Responsible Clinicians for CHFT detained patients, writing a Mental Health Act policy for CHFT to include roles and responsibilities processes and training strategies, finalising a service level agreement for the Mental Health Liaison Team service and servicing of Mental Health Act papers by SWYPT, training for Duty Matrons and Site Commanders on the receipt and scrutiny of mental health act papers, and understanding the role of security and use of restrictive interventions to enable appropriate detention of patients under the Act.

- To Develop MCA DoLS as part of essential skills training; MCA DoLS training is ongoing within level 2 and level 3 safeguarding adults. Separate MCA/DoLS training can be facilitated and delivered to staff in more detail that requires enhanced skills in MCA and DoLS.

- Develop a strategy to ensure all Matrons attend multiagency MCA DoLS training and Safeguarding children and adults training; External MCA/DOLS training dates circulated to all matrons.

2.10 Conditions of Interest – Stroke

Aims and Objectives of Work

Strokes affects between 174 and 216 people per 100,000 population in the UK each year (Mant et al 2004), and accounts for 11% of all deaths in England and Wales. It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years (Mohan et al 2011). By focusing in improvement in stroke care, patient outcomes can be vastly improved,

The Trust has the following aims to strengthen and improve stroke services

- Reduce stroke mortality to a SHMI of less than 100,
- Improve functional outcomes for patients
- Reduce the length of stay by 20%
- Improve overall SSNAP score to “A”

To do this we will:

- Ensure all stroke patients are admitted directly to a stroke bed
- Ensure all patients received 45 minutes of therapy 5 times a week
- Ensure all appropriate patients receive thrombolysis within 60 minutes of arriving at hospital

Current Performance

The end of Q1 has seen significant improvement in key areas:

- SNAPP data showed that the service had moved from a D to a B rating.
- Improvements noted in all indicators although ongoing work to achieve full compliance still continues.
- 90% stay on stroke ward now at 87.50%
- This is the an improvement in month
- 68.75% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival. An improvement of 18.75% in month.

Future actions for 16/17:

A full report will be presented in the Q2 report.

Domain Three – Experience (Caring): Staff involve and treat people with compassion, kindness, dignity and respect

Patient experience compliance summary

Indicator	Compliance
3.1 Dementia	Reporting only
3.2 Improving the Inpatient Experience	Reporting only
3.3 Improving the Community Experience (CQUIN)	Achieved
3.4 Improving Hospital Nutrition	Reporting only
3.5 Improving End of Life Care	Reporting only

Highlights:

Improving the Patient Experience – 4 quality improvement projects in development:

- children's voice
- effective care on a busy surgical ward
- maternity patient experience
- developing new measures of feedback for community services

National Adult In Patient Survey 2015 – some improvement / positive results in relation to availability of hand wash gels and cleanliness of hospital toilets and bathrooms

Improving Hospital Nutrition – positive feedback from PLACE inspections of patient food at CRH and HRI

3.1 Dementia

The Trust is currently redeveloping its dementia strategy and fuller report on this will be received in the Q2 report.

3.2 Improving the Inpatient Experience

1. Aims and Objectives of Work

Measuring patient experience is essential in order to assess the delivery of the Trust's vision**:** ***Together we will deliver outstanding compassionate care to the communities we serve*** along with the strategic goal of: ***Transforming and improving patient care.***

Analysis of patient feedback helps us to better understand our patients' expectations, their experience and their satisfaction. For example their views of the environment in which their care and treatment was delivered, whether they were kept informed, whether they treated with respect and dignity and how their interactions with staff made them feel.

It is important when we measure patient experience, that patients are also given the opportunity to tell us how we can make it better. This may often be about the small things as well as any large system changes.

The primary method of measuring the patient experience in the trust is through the Friends and Family test (FFT) which is now well established across all inpatient and day case, as well as in the A&E and outpatient departments areas, maternity services and across community services.

2. Local Quality Improvement Projects

This year four quality improvement projects have been identified, which will use FFT and other feedback data to direct the aspects of improvement. For each of these improvement priorities, there will be an objective to build into the project plan an element of service user involvement.

All projects are currently in their infancy and will be scoped to run over the next 12 months, an initial outline for each is detailed below.

2.1 Children's voice

Staff working with children and young people are looking for innovative ways of increasing the opportunities to involve children and young people in their healthcare and also in how services are designed and delivered.

Methods have been used previously, e.g. young people included on recruitment panels, the 15 step challenge; however these tended to be a one off initiatives. The aim of this approach will be to establish a more robust arrangement, enabling more sustainable activities to be put in place.

The first step will be 'a go see' exercise to find out what other Trusts have achieved, examples identified are:

- Wye Valley NHS Trust's 'Voice of the Child' with 12 young people known as CHIPS (Children in Hospital Improvement Partner Service) working as you ambassadors to help improve hospital services
- Blackpool Teaching Hospital NHS Trust 'Victoria's Voice' which aims to make it easier for children and young people to get involved in the trusts services and have a say in how things work for children and young people
- Addenbrooke's Hospital's 'ACTIVE' project which is a children and young people's board made up of children and young people who have been patients, some who are thinking about working in a medical career and others who are just interested and want to make a difference.

2.2 Effective communication on a busy surgical ward.

Surveys of patients' views have revealed that patients are not always aware of their plan of care, with communication not always being as good as it could be. This project will further explore how communication takes place between the multidisciplinary team and how key information such as a patient's clinical condition, the treatment plan, and expected outcomes is shared with patients / relatives.

This work will commence on a general surgical ward which receives post-surgery patients, where there can be as many as 11 ward rounds taking place each day. It is not possible for the nursing staff to chaperone each of these rounds and this can have a detrimental impact on communication with nursing staff relying on the medical records to get updates regarding plans of care. Support from the Yorkshire & Humber Improvement Academy has been secured to help take this project forward. A culture survey will be the first step to explore potential barriers, followed by a focus group to identify interventions. Testing these with both staff and patients will be an important element of this project.

2.3 Maternity patient experience work

The Maternity Patient Experience Group has revised its terms of reference and membership and has a new workplan in place. A key element of the plan is a workshop - Putting the

Patient First: Customer Care and Communication Skills in the NHS. This is delivered by the NHS National Performance and Advisory Group.

Four half day sessions will be run during August and September that will include a focus on:

- Understanding the impact of your own behaviour on others
- How to handle challenging situations and people
- Effective communication techniques
- Understanding and managing patient expectations
- Identifying how and why perceptions are formed
- Proactive versus reactive behaviour
- Demonstrating a positive attitude
- Taking ownership

The workshop is designed to look at an individual's attitudes and behaviours and how they impact on the provision of service to both service users and colleagues.

2.4 Community CQUIN - Introducing new measures of feedback.

Patient feedback in the Community only has one formal mechanism, the Friends and Family Test, which doesn't always provide the detail required to really understand the issues of those areas which may be in need of improvement. A number of informal methods are used but the information is not easy to triangulate with our quality improvement process. As part of this CQUIN the Trust aims to develop some specific feedback tools / questionnaires to enable assurance / measurement of the services.

3. Other patient experience feedback

National surveys are another key source of patient feedback. During quarter 1 2016, there have been 2 surveys published with the following high-level messages:

3.1 National survey of adult inpatients 2015

Each year all acute and specialist NHS Trusts participate in a survey of adult inpatients. This year the survey was sent to 1220 patients discharged from a CRH or HRI inpatient ward in July 2015, of these 552 responded, giving a response rate of 45%

Patients were asked about their experience of:

- The Emergency /A&E department
- Waiting list and planned admissions
- Waiting to get a bed on a ward
- Doctors and nurses
- Care and treatment
- Operations and procedures
- Leaving hospital

Results of the survey were published on Wednesday 8th June 2016 . Scores for each question are out of 10, a higher score is better. Trust scores of each question in the survey are also compared with the range of results from all other Trusts that took part. An analysis technique called the 'expected range' is used to determine whether a Trust performs 'about the same', 'better' or 'worse' than other Trusts. This analysis is based on a rigorous statistical analysis and therefore any scores outside the expected range means it performs significantly better / worse than what would be expected and unlikely to have occurred by chance.

CHFT were reported as scoring about the same for all but 2 of the questions. The Trust was reported as scoring better than the majority of other Trusts for the questions:

- Were hand-wash gels available for patients and visitors to use? Scoring 9.8
- Were you given enough privacy when being examined or treated on the ward? Scoring 9.7

The Trust was also noted to have made a statistically significant increase since last year in the scores for 2 of the questions:

- Were you given enough privacy when being examined or treated in the A&E department? Scoring 9.1
- How clean were the toilets and bathrooms that you used in hospital? Scoring 9.0

The results will be further analysed by the Trust's Health Informatics team, including a review of any comments supplied by patients. This will be reviewed by the Patient Experience and Caring Group who will be responsible for identifying any improvement work required.

3.2 National Cancer Patient Experience Survey - 2015 Results

A survey of cancer patients is carried out each year with results published at both a overarching level as well as for each tumour site. These results are analysed to assess comparative performance, based on a calculation of "expected ranges". This means that Trusts are flagged as outliers only if there is statistical evidence that their scores deviate (positively or negatively) from the range of scores that would be expected for Trusts of the same size.
At the overarching level the Trust scored outside the expected range in 3 questions.

- *Negatively for 2 questions:*
  - Q17 Patient given the name of the CNS who would support them through their treatment. Trust score = 84%. Expected range = 86% to 94%
  - Q22 Hospital staff gave information on getting financial help. Trust score = 47%. Expected range = 47% to 63%
- *Positively for 1 question:*
  - Overall the administration of the care was very good / good. Trust score = 93%. Expected range = 85% to 92%

The Trust's lead cancer nurse is now working with each cancer team to develop individual plans based on their results.

3.3 National surveys being carried out during 2016

Three further surveys will be conducted this year:

- National inpatient survey
- Children and young people's survey
- Accident and emergency survey

3.3 Improving the Community Experience

This work is being progressed as part of the CQUIN program and a full report in to the design and development of the community patient survey tool will be received in Q2.

3.4 Improving Hospital Nutrition

Aims and Objectives of Work

Nutrition for patient's staff and the public is still classed as a priority for CHFT, following on from the ground work done in 15/16 as part of the CQUIN scheme.

With support from Food for Life who are funded by Calderdale CCG we will continue to:

- Develop and progress a Whole Hospital Food For Life Approach in six key areas: leadership for a health promoting setting, catering quality, patient experience, staff health and wellbeing, retail and vending and community and partners. This is highlighted in the Trust Food and Drink Strategy
- Integrate CQUIN objectives into a wider Whole Hospital approach to food through the introduction of the National Health and Wellbeing CQUIN .
- Increase level of integration and partnership working with other local services and stakeholders through our contacts with food for Life .
- Create opportunities to share learning and best practice between CHFT, partners and other NHS Trusts.

Nutrition including the Health and Wellbeing CQUIN will continue to be monitored and reported each quarter at the Food for life Hospital Leaders steering group with representation from the CCG, Public health, CHFT and Food for Life

Patient Satisfaction:
Patient satisfaction is currently measured by the distribution of a questionnaire to inpatients. This has been reviewed and due to the length of the questionnaire will be discontinued over the next few months but will be replaced with 3 key questions taken from the national PLACE inspection and will be integrated within an Estates and Facilities questionnaire. This is currently with the Membership Council to review.

On 27th June at HRI in partnership with Appetito a food tasting event was held in the main entrance. Some of the feedback is highlighted below

- You should be very proud of the food you serve.
- All the soups are delicious.
- All the items are very fresh and nice I enjoyed the food thanks for the lunch.
- A lovely menu.
- Hospital food this is brilliant.

Although a lot of partnership work has been undertaken with CHF and its partners (ISS/ Engie/Anglia Crown/Burlodge) the meal delivery system in place at CRH continues at times to be problematic.

ISS are working with CHFT around delivering an improved meal delivery service in line with CHFT maintaining the current contract we have with ISS. A Go See event is scheduled on the 17th August to Derby where the system is in place including senior Estates and Facilities staff ,matrons and dietetic staff.

PLACE 2016
The PLACE inspections took place at HRI on 27th and 28th April 2016 and for CRH on 10th May 2016 and Friday the 20th May 2016 .

HRI
The inspection teams undertook food tasting on ward 17, 19 and 20 the service was observed and showed full interaction between nursing and catering teams. Patients were complimentary about the food received and were in happy in general with the menu content. At the end of the service, the food was tasted by the inspection team and this was approximately 20 minutes after

the meal trolley had arrived on each ward. On ward 19 it was noted the day room being used for meal times and there was excellent interaction between the staff and patients. It was noted by the inspection team the quality/taste and temperature of food was of a very good/good standard along with the service. The only food tasted which raised a concern was jelly which was sugar free and a pasta dish. Both were marked as poor as both lacked flavour.

CRH

The inspection teams undertook food tasting and service delivery on wards 1d /4c which is the standard plated service and ward 3abcd paediatrics which offers a bulk service.

Patients on these wards were complimentary about the food received and were happy in general about the menu content. At the end of the service to patients, the food was tasted by the inspection team.

The inspection team were complimentary with the menu options for the children's ward. They could choose off a normal children's menu offering fish fingers/chicken nuggets or from the standard menu offering more traditional pasta dishes/vegetables/fish etc.

The only food tasted which raised concerns were:

- Cheese and tomatoes quiche which scored acceptable for texture. Taste was very good
- Roast potatoes on one ward scored acceptable on taste and acceptable on texture
- Cheese pasty acceptable on taste and acceptable on texture. Was a little dry
- Sausages score acceptable on texture as the skin appeared a little tough
- Carrots scored poor on taste on one ward by one half of inspection team but on the other ward scored very good

All food scored high on temperature

Food Waste

CHFT achieved our CQUIN for 2015/2016 by reducing food waste overall by 1%

On May 24th a workshop was held at CHFT looking at reducing waste . This was organised by Food for Life

Vending Facilities

The tender specification for Vending is nearing completion and it is in line with the National CQUIN for 206/2017 which is "healthy food for NHS staff, visitors and patient based on the Public Health report "Sugar Reduction"

Partnership working with Food for Life:

Calderdale CCG have funded the Soil Association Food for Life (FFL) for the next 2 years .FFL are continuing to use their expertise in supporting CHFT in improving the food experience for staff, visitors and patients. As FFL link into other NHS organisations CHFT have attended and also hosted a workshop at CRH . The workshop attend at South Warwickshire NHS Foundation Trust was called "Making the most of Volunteers to Support Food Activities". The event was attended by Matron Chris Bentley and Renee Comerford Practice Learning Facilitator who presented the work on Prevention of Delirium and the role of the student volunteers in Nutrition . The workshop hosted by CHFT "Engaging ward level staff around Food" was well attended by CHFT staff and other Trusts

Nutrition and Hydration Strategy:
The strategy will be reviewed by CHFT Communication team to ensure the strategy is written in line with our branding
It has been shared at the Nursing and Midwifery Committee/Nutritional Steering Group and Patient Experience Group

Fruit and Veg stall:
The fruit and Veg stall at HRI continues to be a success. It is now available for 3 days a week. Due to partnership working with Calderdale Public Health/CHFT Catalyst (SPC) and the local markets the CRH Food and Veg stall has been agreed initially as a Pilot for one day a week. The Trust is awaiting confirmation of a start day but planned for the end of July 2016

Food for Life Catering Mark:
In December last year ISS achieved their Bronze Catering mark in retail this was re accredited in February 2016 and have retained the Bronze standard. ISS continuing to work towards achieving the silver standard over 2016 /2017

Incredible Edible/Rooting and Fruiting :

Trees for Wellbeing is a project run by Rooting and Fruiting, a Social Enterprise. Their vision is to create abundance in our local area; green spaces that are great for residents and local habitats, and that can support happy, healthy and connected communities.

They aim to help fulfil this vision by working with people from all walks of life to establish permanent food landscapes. They are interested in how green spaces, particularly trees, reduce preventable illnesses and help people to get well quickly.

Trees for wellbeing have been funded to create a series of small food forests within Calderdale Royal hospital. These are edible gardens, which model natural woodlands. They include a range of trees, shrubs, creeping and climbing plants, and even mushrooms. These plants work together to provide a flourishing environment for everyone to enjoy.

They are working with the hospital staff especially OT, patients, visitors and neighbours of the hospital to have a say in how these are designed and developed. As well as providing advice and hands-on workshops on planting techniques and maintenance to those involved, and will be working with people to care for, develop and benefit from these beautiful and abundant gardens. The launch event is planned for the 28th July

MUST (Malnutrition Universal Screening Tool) Compliance:

From April 2016 the Trust is taking part in the BAPEN (British Association Of Parenteral and Enteral Nutrition) national audit on a quarterly basis which includes the monitoring of the MUST tool. This is so CHFT can benchmark themselves against other organisations. The latest audit was completed in June of this year and we are still awaiting the results. The results and relevant action plans from the divisions will be managed through the Nutritional Steering Committee which was re-established in June 2016 chaired by Joanne Middleton ADN for surgery

Domain Four – Responsive: Services are organised so that they meet people's needs

Indicator	Compliance
4.1 Learning from Incidents, Claims and Complaints	Reporting only
4.2 Appointment Slot Issues	Reporting only
4.3 Patient Flow and the SAFER programme	Reporting only

Highlights:

Incidents, complaints, claims – improvements in sharing of learning from adverse events via Patient Safety Quality Boards and Quality Committee and with divisions for claims

Appointment Slot Issues – improvement in the number of referrals awaiting appointment

4.1 Incidents, Complaints and Claims

Incidents

Key messages:

- 1.9% reduction in CHFT incidents recorded in Q12016/17 compared to Q1 2015/16
- Suspected falls is the top reported incident in Q1, as in the last quarter
- Medical Division is the highest reporter of incidents in Q1 (43.1% all incidents) by division
- Labour Delivery recovery Post Natal Unit is the highest reporting department (215 incidents)
- 13 Serious Incidents (Sis) Q1, 1 of which is a pressure ulcer
- 1 never event in Q1

1.1 Numbers of Incidents

For the period 1 April 2016 to 30 June 2016 a total of 2,593 incidents were reported by CHFT members of staff. Of these, 1120 43.1% were reported by the Medical Division.
The table below shows that the number of incidents report has decreased by 49 incidents (1.8%)

1.2 Incidents by Divisions:

The tables below show that the number of incidents reported in Quarter 1 per Division, with the Medical Division reporting 43.1% of total incidents

Incidents Reported by Division	Q4 2015-2016	Q1 2016-2017
Community Division	125	78
Corporate Division	8	5
Estates and Facilities	29	37
Families and Specialist Services	677	798
Huddersfield Pharmacy Specials	1	1

Medical Division	1203	1120
Surgical & Anaesthetics Services Division	599	554
Totals:	**2642**	**2593**

In Community the likely reason for a fall in the number of incidents reported is the transfer of a number of community services on the Huddersfield site being transferred , under contract transfer, to Locala Provider services . this will need to be monitored in future quarters to test this

A positive reporting culture remains in the Trust despite the reduction in the number of incidents reported. The incidents reported by the community division have reduced by 47 (37%). This is as a result of a change in the coding of incidents that occur in nursing homes which have previously been reported as CHT incidents and now are more accurately reported as non CHT incidents.

2 . CHFT Incidents

2.1Top Incident Categories

The top 20 reported incidents for Quarter 1 are given below with suspected fall being the top incident category reported, accounting for just under a third of incidents. This is consistent with quarter 4 of 20151/6.

There has been a change in the approach to coding during Q1, with staff coding incidents from mid May 2016. The incident team is currently reviewing what impact this is having on the reporting of incident categories.

Top 20 Incident categories Q1 2016/17

Top 20 Q4 15-16		Top 20 Q1 16-17	
Slips, trips, falls and collisions	547	**Slips, trips, falls and collisions**	523
Administration or supply of a medicine from a clinical area	193	**Administration or supply of a medicine from a clinical area**	161
Patient's case notes or records	140	**Pressure sore / decubitus ulcer**	132
Lack of/delayed availability of facilities/equipment/supplies	128	**Connected with the management of operations / treatment**	103
Connected with the management of operations / treatment	125	**Adverse events that affect staffing levels**	96
Adverse events that affect staffing levels	123	**Transfer**	81
Transfer	102	**Accident caused by some other means**	76
Pressure sore / decubitus ulcer	98	**Lack of/delayed availability of facilities/equipment/supplies**	75
Discharge	96	**Discharge**	72
Accident caused by some other means	73	**Patient's case notes or records**	71
Abuse etc of Staff by patients	69	**Other**	66
Infection control	67	**Communication between staff, teams or departments**	61
Communication between staff, teams or departments	64	**Abuse etc of Staff by patients**	58
Medical device/equipment	61	**Transfusion of Blood related problem**	49
Administration of assessment	53	**Appointment**	48
Appointment	44	**Medical device/equipment**	45
Labour or delivery – other	43	**Labour or delivery – other**	44
Preparation of medicines / dispensing in pharmacy	37	**Security incident related to Personal property**	44

Admission	34		**Admission**	42
Possible delay or failure to Monitor	34		**Medication error during the prescription process**	41
Totals:	2131		**Totals:**	1888

FALLS

Falls remains the highest incident category reported, with 523 incidents reported in Q1 2016/17, a slight reduction from 541 falls in Q4 2015/16.

The above data shows an increase in the number of falls from height during the quarter, up from 23 in Q4 2015/16 to 67 in Q1 2016/17.

There have been 4 serious incidents relating to falls with harm and root cause analysis investigations are underway for each of these falls to identify learning and actions to prevent recurrence. Further details on falls is given in the Safe section of this report.

2.2 Incidents by Department:

The table below identifies the highest reporting ward/department (Top 10), with labour delivery recovery post-natal unit now being the highest department reporting incidents in Q1 2015/16. This is suggestive of an improved reporting culture in this area.

Q4 15-16 **Top 10 by dept/ward**	
Operating Theatre	163
Labour Delivery Recovery Post-natal Unit	146
Accident and Emergency	129
Intensive Care Unit/High Dependency Unit	91
Outpatient Department	81
HWD5	68
HWD19 Trauma	60
HWD8	60
HRI MAU	59
Health Centre/Clinic	56
Totals:	913

Q 1 16-17 Top 10 by dept/ward	
Labour Delivery Recovery Post-natal Unit	215
Accident and Emergency	137
Calderdale birth Centre WD1A	96
Operating Theatre	96
HWD19 Trauma	86
Outpatient Department	77
HRI MAU	76
HWD5	73
HWD8	64
Intensive Care Unit/High Dependency Unit	62
Total	982

Incidents by Severity:

The numbers of incidents by severity are:

by severity	Q4 2015/16	Q1 2016/17
GREEN	**2065** (78.1%)	**1966** (75.8%)
YELLOW	**530** (20.1%)	**551** (21%)
ORANGE	**39** (1.5%)	**60** (2.3%)
RED	**8** (0.3%)	**16** (0.6%)
Totals:	2643	2593

There is a 2.3% decrease in the number of incidents reported. However, the incidents with harm have increased for all *harm* incidents. It is worth noting that incidents are now coded and categorised by the reporters and incident managers/handlers.

In Quarter 1, 13 incidents were identified as being “serious” and required reporting to the CCG/NHS England via STEIS. The types of incidents were:

Serious Incidents reported to CCG/NHS England via STEIS.	2016/17 Q1
HCAI/Infection control incident meeting SI criteria	1
Screening issues meeting SI criteria	1
Sub-optimal care of the deteriorating patient meeting SI criteria	1
Surgical invasive procedure incident meeting SI criteria	1
Treatment delay meeting SI criteria	1
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria: (mother and baby)	1
Slips/tips/falls meeting SI criteria	4
Medication incident meeting SI criteria	1
Diagnostic Incident meeting SI criteria (including failure to act on test results)	1
Grade 3 Pressure Ulcer	1
Totals:	14

All incidents were reported on STEIS within the 48hr timescale.

Learning from Incidents
Information on learning from incidents is shared within divisional Patient Safety Groups and for serious incidents via the Quality Committee.

Learning from Incidents

Information on learning from incidents is shared within divisional Patient Safety Groups and for serious incidents via the Quality Committee. Learning identified from incidents during the quarter is given below.

Learning the Lessons - Medicine	
Issue:	Learning:
Pressure Ulcer On washing patient discovered category 3/4 in sacral cleft. looks deep approximately 1cm possibly secondary to moisture. Surrounding tissue looks macerated. Barrier spray applied. Observed pressure ulcer prevention care plan and no evidence of the sore on admission. Sister informed. Pressure mattress ordered but patient may not be stable enough to transferred onto it.	Found to be moisture linear skin damage secondary to faecal and urinary incontinence. Waterlow calculated wrong (too low) on 3 occasions. Skin inspections carried out x 2 daily no detection of pressure damage to natal cleft until March 27. but moisture damage found. Intentional rounding should have been 2 hourly and not 4 hourly as completed. Moving and handling careplan should have been in situ. Urine incontinence careplan should have been in use also. Closer inspection of all patient pressure areas should be
Observation Called to bed 8 a side by nurse call bell from bed 7 to tell us that the patient was out of bed and disorientated when we then realised she had dislodged her chest drain. on further questioning the lady in bed 7 Thought she had seen patient take a pair of scissors to her actual chest drain, on inspection this looked the case. The drain was found on floor in two parts with a piece of suture connected to one part of it with the possibility of the tip being embedded into the tissue. This was not visible on inspection. EWS 2 O2 in place.	Patients with chest drains need very close observations during the day and night. This patient was in a three bedded room off the main ward area. In the future we should be considering these patient being in a high visibility bed for safety. To discuss in the ward meeting.
Blood Products Member of clinical team brought 3 bottles of 20%HAS that had been sitting on the ward (in sunlight) for 3 weeks. The Blood Transfusion Department had followed the traceability protocol and a letter regarding the fate of these units had been used to the ward. The ward had returned this legal document and had stated that the returned units were transfused to the named patient.	To ensure that all qualified nursing staff sign for all blood products when they have administered them and ensure that unused blood products are returned immediately to the transfusion department. Stress to nursing staff the cost of wasted units.
Equipment training HCA informed me that on transferring patient with samhall turner, she was unable to take her own weight on her legs and hca lowered her to the floor and came for assistance.	Member of staff tried to transfer patient using equipment. This type of equipment needs X 2 members of staff. Training need identified. Staff member in question has been spoken to. The moving and handling co-ordinator on the ward is ensuring that all relevant competencies are up to

	date.
Discharge Medication Discharged home with buprenorphine patches. one 20mcg box with one patch in and one 5mcg box with one patch in. Neither box had a patients name on but specified the ward. Date on 20mcg box was 5.5.16 and date on 5mcg box was 12.5.16 Patient normally takes fentanyl patches 25mcg every 72 hours.	Adherence to the CHFT Medicine Code and RGN accountability for their actions. Discharge medications to be prepared in advance to promote a smooth discharge for the patient. Clear communication between departments post angio procedure to ensure ward is fully aware of discharge plans.
Lack of handover The patient was brought up to the ward post having a peg put in place without a handover from Medical Assessment Unit (MAU). The patient had been on MAU that day but was transferred to ward 6 without a handover. Only a name was given. Endoscopy also phoned us asking to collect the patient who had been sedated however we did not as we knew nothing about the patient. She was eventually brought to the ward unexpectedy where the nurses from endoscopy gave a handover from their point of view.	It is imperative that we communicate effectively when transferring patients to other specialist areas. To ensure a safe patient experience.

Learning the Lessons - Surgical Division

Issue:	Learning:
Underlying condition - An orthopaedic inpatient had an undiagnosed heart block - The fall the patient suffered could have been as a result of this	- The need for a holistic approach to all patients who have underlying and known conditions - Information must be followed up at the time of test result so as not to 'get lost in the system' - The need to complete documentation fully in particular in this case the falls bundle
Pressure Ulcer - Patient had a hospital acquired grade 3 pressure ulcer - Poor documentation led to not being able to evidence where this pressure damage occurred	- Documentation has to be completed at time of admission and transfer - Collaborative working between Divisions where there is discrepancy as to where incident occurred - All staff should be able to assess pressure damage categories and arrange for suitable equipment where necessary. Need for more staff training - Share learning regarding incident with all ward staff (Surgical and Medical Divisions)
- Failure to escalate a deteriorating patient with NEWS between 12 and 14. Patient died - Delay in certifying the death	• instances where escalation should have occurred but did not – Nerve Centre now in place to highlight elevated NEWS and to reduce risk of occurrence.

	• Death certificate training is now included in the Junior Doctor's training pack • Need for holistic approach to all patients
Insulin / handover - Insufficient insulin checks - Empty fluid bag - Poor handover of diabetic patient	- All staff on ward received up to date training on managing patients who are insulin dependent - Staff training regarding handover of all patients and in particular those who are insulin dependent - Continuous monitoring of record keeping standards - All staff have received training and have signed off competencies in new blood sugar monitoring
Learning the Lessons - FSS	
Issue:	Learning:
Labour / Delivery - Emergency caesarian section for failure to progress at 5cm. Epidural top up ineffective, Remifent given. - Unable to deliver baby - delivered as breech in poor condition, no respiratory effort, full resuscitation given and transferred to Special Care Baby Unit.	- Escalation to Consultant where necessary for all surgical procedures in a timely manner. - Importance of keeping the anesthetist informed of progress and complications - Learning from experience newsletter to remind staff about timely summoning of consultant paediatrician in a timely manner. - Findings to be presented at Perinatal Mortality Meeting
Labour Delivery - Delay in admission for undiagnosed breech presentation. - Baby born in poor condition.	- It is crucially important to listen to what the woman is telling us - Health care staff should keep the woman the focus of care - If a woman is unhappy with the clinical advice she is given this should be escalated and dealt with immediately. -
Stillbirth Unexpected stillbirth at Emergency Caesarean Section in maternity theatre	- CTG interpretation was incorrect in the last hour - The category of Caesarean section declared and documented was incorrect reflecting the lack of urgency - Misinterpretation of the fetal growth based on the last scan as well as incorrect SFH - Measurement after the scan which would contribute to the compromise in reserves - This was an IVF pregnancy which has an increasing risk of small babies and a two to four fold risk of stillbirth
Intra Uterine Death (IUD)	- This woman had a large uterine fibroid but

- high risk pregnancy, uterine fibroids. - Attended for augmentation in view of spontaneous rupture of membranes (SROM). Prostin administered at 01 50, CTG following classified as reassuring, therefore discontinued at 02:59. - Reports to have been contracting frequently. Care taken over on day shift, history noted, planned for CTG monitoring, unable to locate fetal heart rate, escalated this to shift coordinator and registrar. Portable scanner used by registrar, still unable to locate fetal heart. Transferred to main scan room to be scanned by sonographer. IUD confirmed on scan.	growth scans were discontinued at 36 weeks. - Fundal height palpation (which plotted on the 90th centile) was inappropriate in this case. i. Fetal growth scan should have been continued until delivery. ii. Offer immediate augmentation for term SROM as per NICE and our guidelines.

Improvements:

An update against improvement areas for 2016/17 is given below:

- Changes have been made to the incident reporting and investigation process. Incidents are now categorised (coded) by the reporter and quality checked by the investigating managers. This process gives the incident administrators the opportunity to check and assure the quality of the information provided as well as to follow up on actions. The change was introduced mid May 2016. It is proving a challenge to ensure that coding, and therefore incident analysis , information is accurate and important that incident reporters and investigating managers check coding accuracy. Individual feedback is being given to reporters and Datix drop in sessions are in place to support staff. The incident team and system super users have held sessions and been out to wards to train staff in the coding process.

- Ensuring that duty of candour is undertaken in a timely way for incidents with harm and evidencing this within the incident reporting system is also proving a challenge. This is being monitored closely and a toolit is to be developed for staff, as well as a more prominent area within the recording system to record duty of candour discussion dates.

Complaints

Complaints are a vital source of information for the Trust, helping to identify where the quality and safety of services and care require improvement for service users.

This section provides a quarterly summary of Patient Advice and Complaints contacts using information collected from the data held on the Trust's Patient Advice and Complaints database. This section includes information on:

- Performance re: complaints management in 2016/17
- Information on complaints by Division
- Learning from complaints
- Improving complaints management in 2016/17
- Areas for improvement

Key points detailed in the section below are:

- A small decrease of 6% in the number of complaints received in this quarter, compared to the same quarter in 2015/16; however, there has been an increase 15% from the last

quarter of 2015/16.

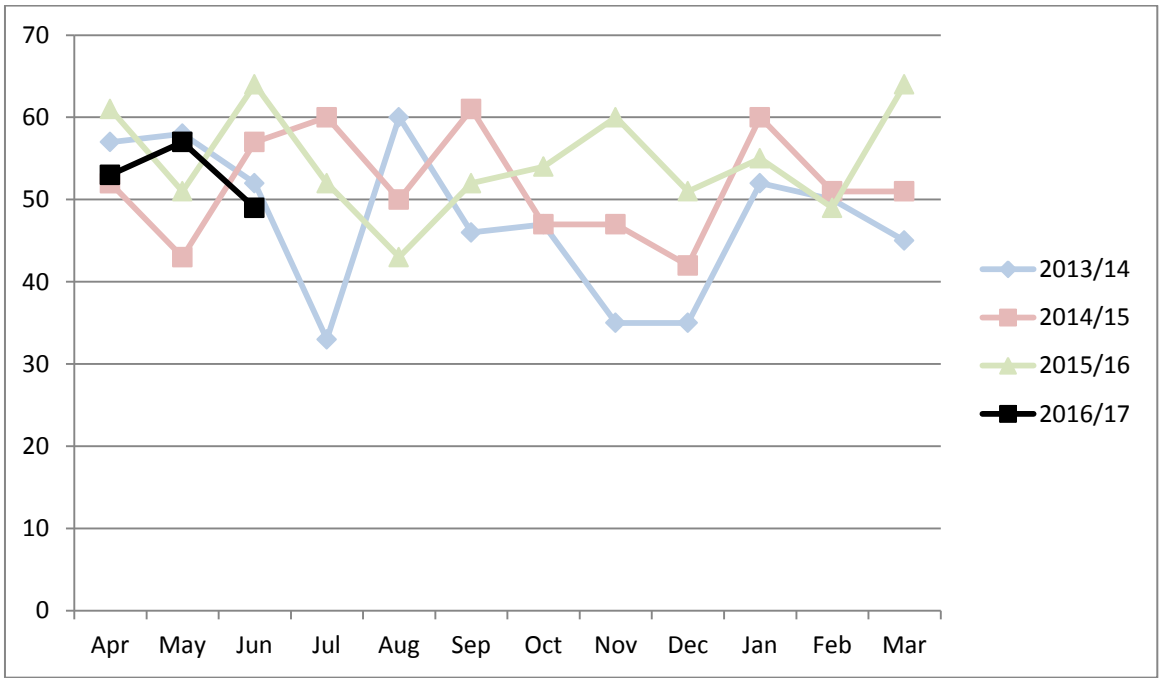
- The majority of complaints (70%) were graded as yellow or green, ie no lasting harm / minimal impact on care
- Clinical treatment and communications are the main subjects of complaints; this was the same as the financial year.
- Appointments and access to appointments are the main areas of concern
- Medicine is the Division with the highest number of complaints; however, it is also the largest Division and the number of complaints reflects its size.

Key Performance Indicators

Complaints 2016/17	**2016/17 Q1**
Number of new complaints received	159
% increase / decrease on 2015/16	↓ 6% (169)
Number of complaints closed	177
% complaints upheld	45%
% complaints partially upheld	34%
% complaints not upheld	18%
Number of complaints re-opened following final response	19
Number of complaints received from Ombudsman for investigation	10
Number of complaints upheld by Ombudsman (includes partially upheld)	2
Number of complaints not upheld by Ombudsman in quarter	0

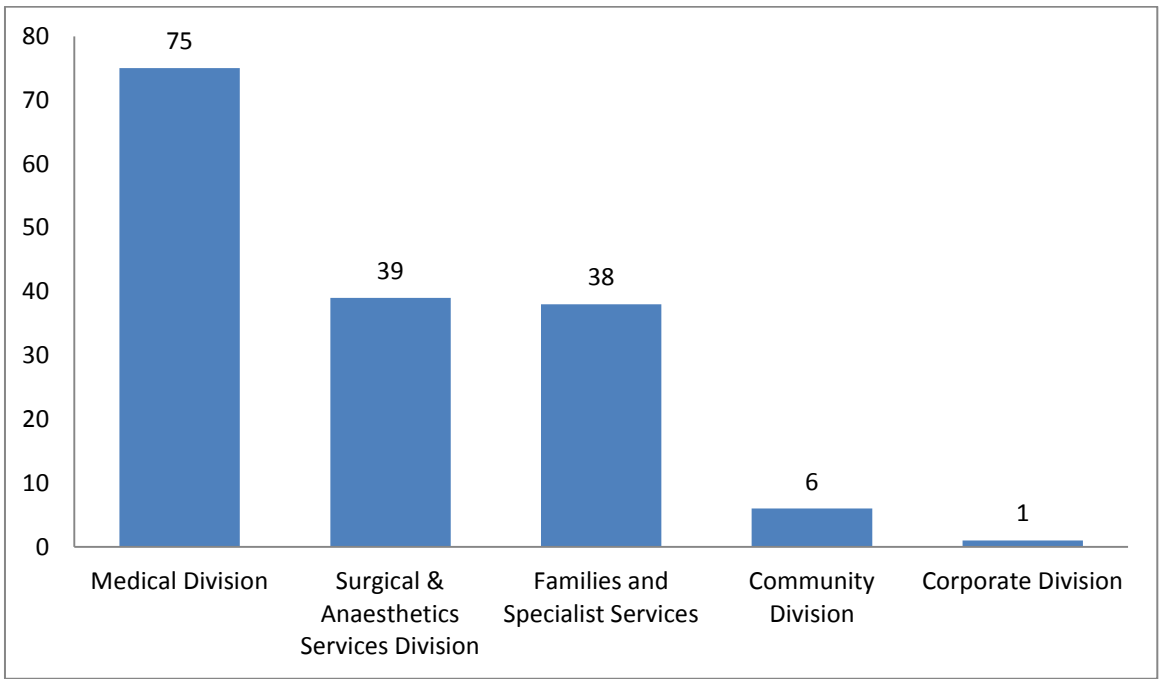
Complaints Performance 2016/17

Comparison of complaints from 2013/14 to present:
Complaints data reflecting the trends in the number of complaints for the past three years – including numbers for this quarter



Complaints Received:
At the end of quarter 1 of 2016/17 the Trust received a total number 159. This is an decrease of 10% from the same quarter last year and a decrease of 5% from the same quarter in 2013/14. National complaints data for quarter 1 of 2016/17 has not yet been released from the HSCIC.

Quarterly Complaint Numbers by Directorate:



Of the 159 Complaints received in 2015/16:

- 47% of complaints received related to the Division of Medicine, which is the largest

division with Accident and Emergency Services. The Emergency Network was the Directorate within Medicine with the highest number of complaints, a total of 39. Acute Medical received a total of 19 complaints and Integrated Medical received a total of 17.

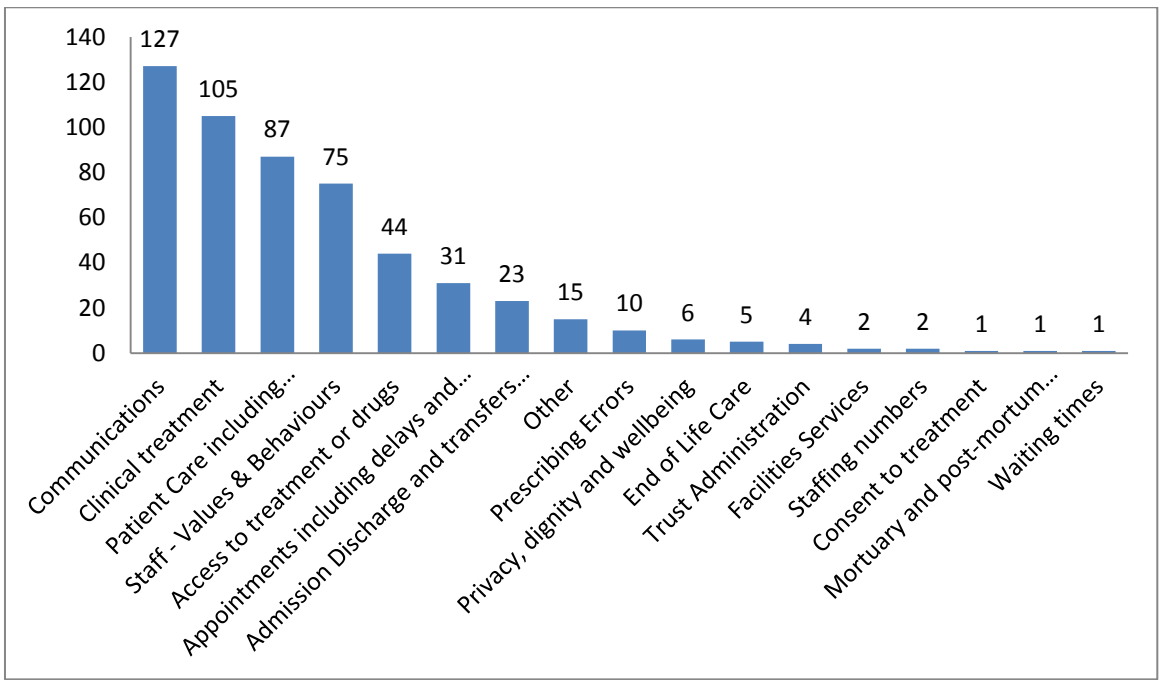
- 25% complaints received related to the Division of Surgery and Anaesthetic Services (SAS). General and Specialist Surgery was Directorate within SAS with the highest number of complaints, a total of 22. Head & Neck received a total of 12 complaints, Orthopaedic a total of 12, and Critical Care received a total of 2.

- 24% complaints received related to the Division of Family and Support Services (FSS). Woman's Services was the Directorate within FSS with the highest number of complaints, a total of 20. Radiology received a total of 7 complaints, Outpatient and Records a total of 5, Children's Services a total of 4, and Pathology and Pharmacy both received a total of 1.

- 3% complaints received related to the Division of Community. Intermediate and Community was the Directorate within Community with the highest number of complaints, a total of 5. Families Directorate received 1 complaint.

Analysis of Complaints by Theme

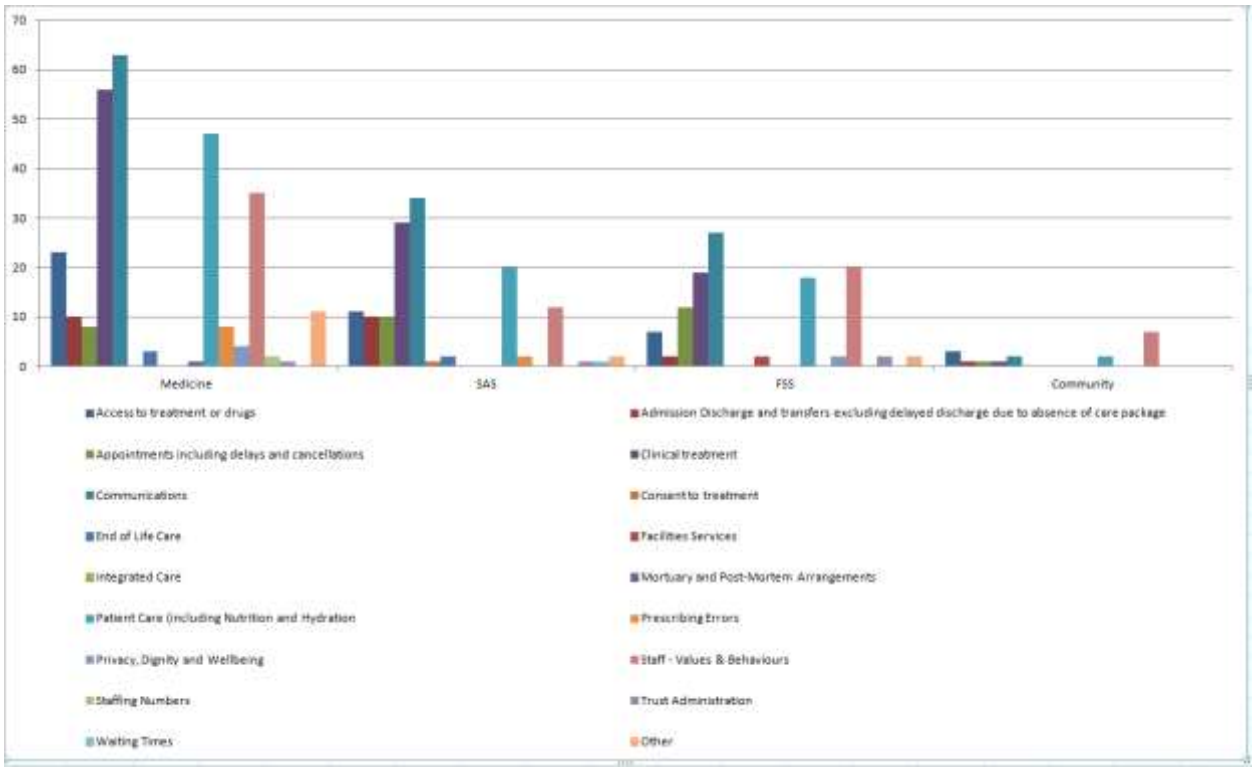
Complaints are analysed below by Primary Subjects, within each complaint subject there will be a number of different sub categories with more detail relating to the complaint. There are often a number of issues logged for a single complaint, which is way the number of Primary Subjects differs from the total number of complaints received.



The top three subjects of Complaints for the Trust are as follows:

Subject	Percentage
Communication	24%
Clinical Treatment	19%
Patient Care (including Nutrition and Hydration)	16%

Quarter 1 Complaints received by Division and Primary Subject



- The top subject of complaint for Medicine was Communication, representing 23% of all complaint subjects received for Medicine within Quarter 1. Clinical Treatment represented 21% and Patient Care (including Nutrition and Hydration) 17%.

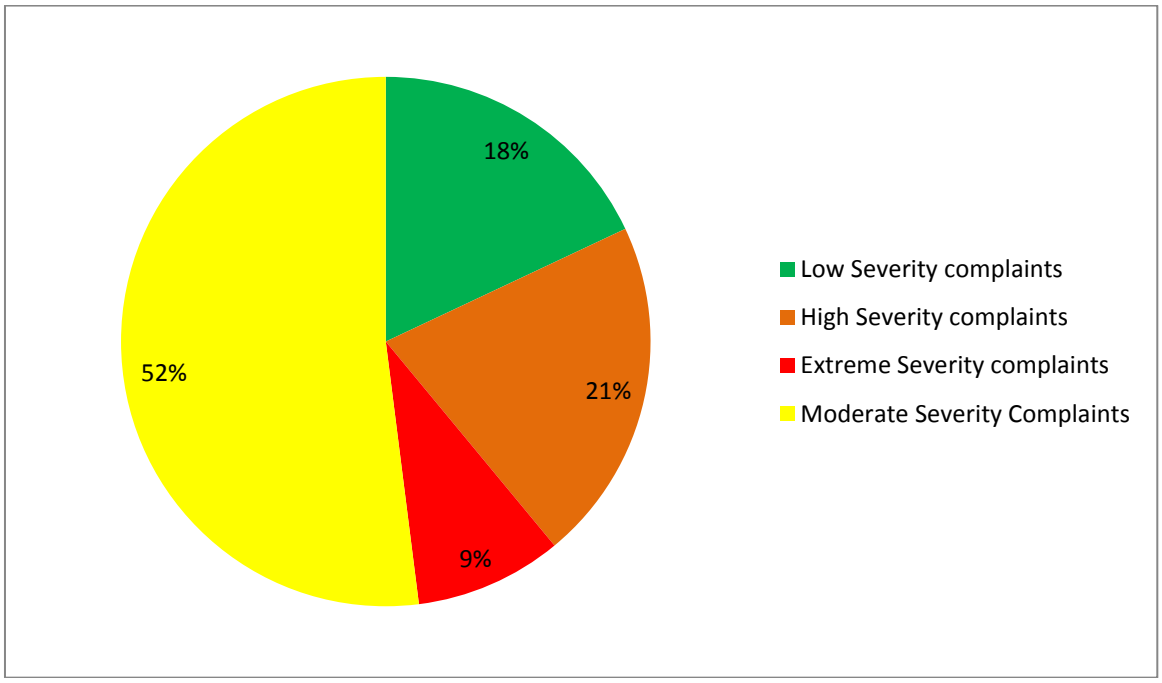
- The top subject of complaint for SAS was Communication, representing 25% of all complaint subjects received for SAS within Quarter 1. Clinical Treatment represented 21% and Patient Care (including Nutrition and Hydration) 15%.

- The top subject of complaint for FSS was Communication, representing 24% of all complaint subjects received for FFS within Quarter 1. Staff – Values & Behaviours represented 18% and Clinical Treatment 17%.

- The top subject of complaint for Community was Staff - Values & Behaviours representing 41% of all complaint subjects received for Community with Quarter 1. Access to Treatment or Drugs represented 18% and Communication 12%.

Severity of Complaints Received

The majority of complaints received in are graded as yellow severity; no lasting harm (52%) in Quarter 1. 9% complaint received were graded Red.



Key: Green – no / minimal impact on care, Yellow – no lasting harm,
Amber – quality care issues/ harm, Red – long term harm, death, substandard care

Red Complaints Data

A red complaint is a case where the patient, or their family, feels the action or inaction of the Trust have caused the death or significant and non-reversible harm to the patient. A complaint may also be graded Red, although the Trust has not caused the death or significant and non-reversible harm to the patient, if the complaint has had a significant impact on patient experience or Trust reputation.

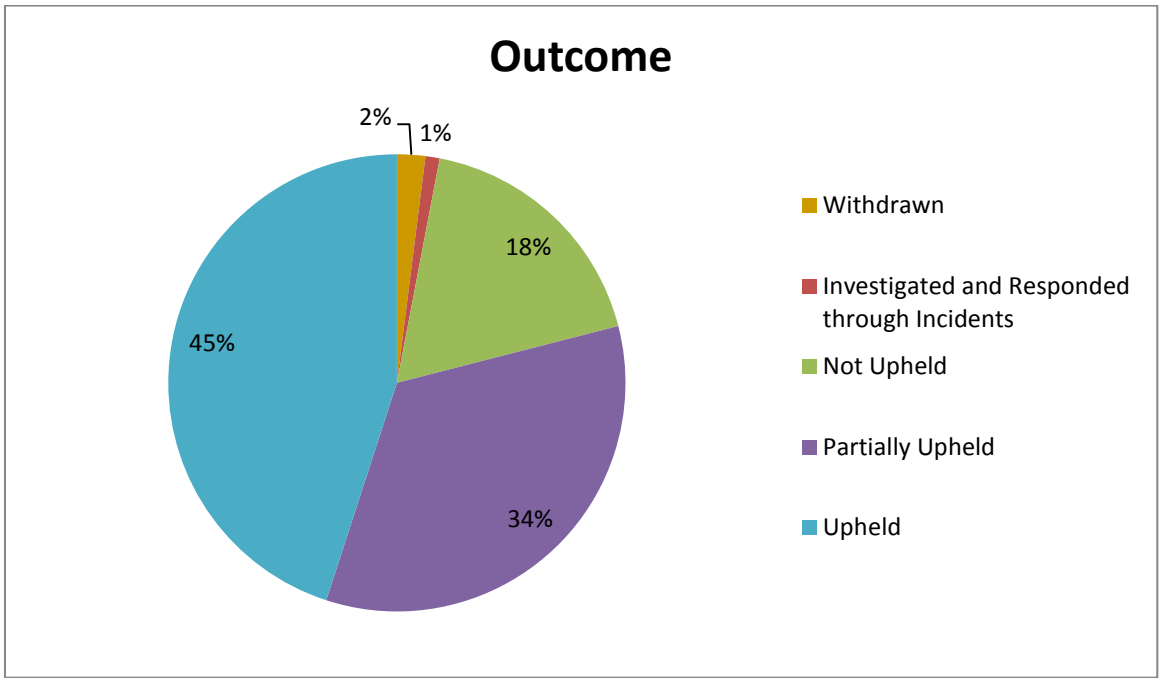
For Quarter 1 of 2016/2017 the Trust received a total of 14 Red complaints, this is a 50% increase from the same quarter last year. Of these 14 complaints 3 are linked to an incident and 1 is linked to a claim.

Acknowledgement Time

1 out the 159 complaints received within Quarter 1 of 2016/17 was not acknowledge within three working days, this represents less than 1% of all complaints received. The complaint was not acknowledge within time as complaints staff needed to find the details for the Next of Kin, to complete the complete the consent form that would that accompanies the acknowledgment.

Complaints Closed

The Trust closed a total of 177 within Quarter 1 of 2016/17. This is a decrease of 12% from the same quarter last year. Of these 177 complaints closed 45% were upheld, 34% were partially upheld (The HSCIC counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 80%), 18% were not upheld, 2% were withdrawn, and 1% of complaints were closed, investigated and responded to through incidents.



Re-Opened Complaints

The Trust re-opened a total of 19 complaints in Quarter 1 of 2016/17. This is 24% decrease from the same quarter last year. The Trust will re-open a complaint for 1 of the following three reasons.

i. Response failed to address all issues and concerns
ii. New issue and concern
iii. Parliamentary and Health Service Ombudsman Investigation

In 2015/16 the Trust undertook a piece of work to improve the overall quality of its responses to complaints so that people received a full and detailed response to the issues they had raised. We introduced a robust quality checking process; the decrease in re-opened complaints would suggest an increase in the quality of complaints responses.
The Trust has developed a Patient Satisfaction questionnaire which will be sent out to complaints responded to in 2016/17. Responses from these will be used in conjunction with the continued monitoring of the re-opened complains to assess the quality of the responses provided by the Trust.

Overdue Complaints

Closing overdue complaints remains a primary focus for the Trust in 2016/17. The total number of overdue complaints at the end of Quarter 1 2016/17 was 44. The number of overdue complaints for the same quarter last year has not been recorded; however, at the end of Quarter 1 2016/17 there has been an increase of 52% from the number overdue from the end of the last financial year.

The breakdown of overdue complaints at year end is as follows:

0 – 1 month overdue: 21 complaints
1 – 2 months overdue: 15 complaints
2-3 months overdue: 7 complaints

3-4 months overdue: 1 complaint

Weekly monitoring reports continue to be provided to divisions to ensure that all cases overdue are clearly identified and timescales for completion of complaints that are due are clear.

Parliamentary and Health Service Ombudsman Complaints (PHSO)

The Trust received a total of 9 complaints in Quarter 1 of 2016/17 for investigation from the PHSO.

By the end of Quarter 1 of 2016/17 the Trust had 17 active cases which the Ombudsman is investigating.

The breakdown of these are as follows:

Division	Directorate	Received	Description
Community	Intermediate and Community	01/04/2016	Failure to provide a Lymphoedema Clinic
SAS	Head and Neck	14/04/2016	Complaint regarding lack of treatment/diagnosis dating back to December 2007
Medicine	Integrated Medical	20/04/2016	Delay in diagnosing brain tumour and communication regarding Lymohoma.
Medicine	Emergency Network	20/04/2016	Care and treatment of patient leading up to their death
Medicine	Acute Medical	16/05/2016	Complainant claimed incorrect medication prescribed which caused Atrial Fibrillation. Inappropriate discharge.
Medicine	Acute Medical	16/05/2016	Dates back to 2013; ambulance failed to arrive to transport patient to x-ray appointment. Patient admitted and died a few days later.
Medicine	Acute Medical	19/05/2016	Daughter concerned her late mother was put on care of dying pathway. Daughter does not feel it was the correct decision and is concerned this was not communicated with her in detail.
Medicine	Acute Medical	24/05/2016	Soup given when nil by mouth so procedure couldn't go ahead. Daughter complains that this affected her mother's medical care
Medicine	Emergency network	14/06/2016	Sub standard care in A&E. Errors in documentation and treatment provided and in discharge information

The red line indicates a complaint graded and managed as a red complaint, i.e. where Trust actions / inactions caused death or significant and non-reversible harm.

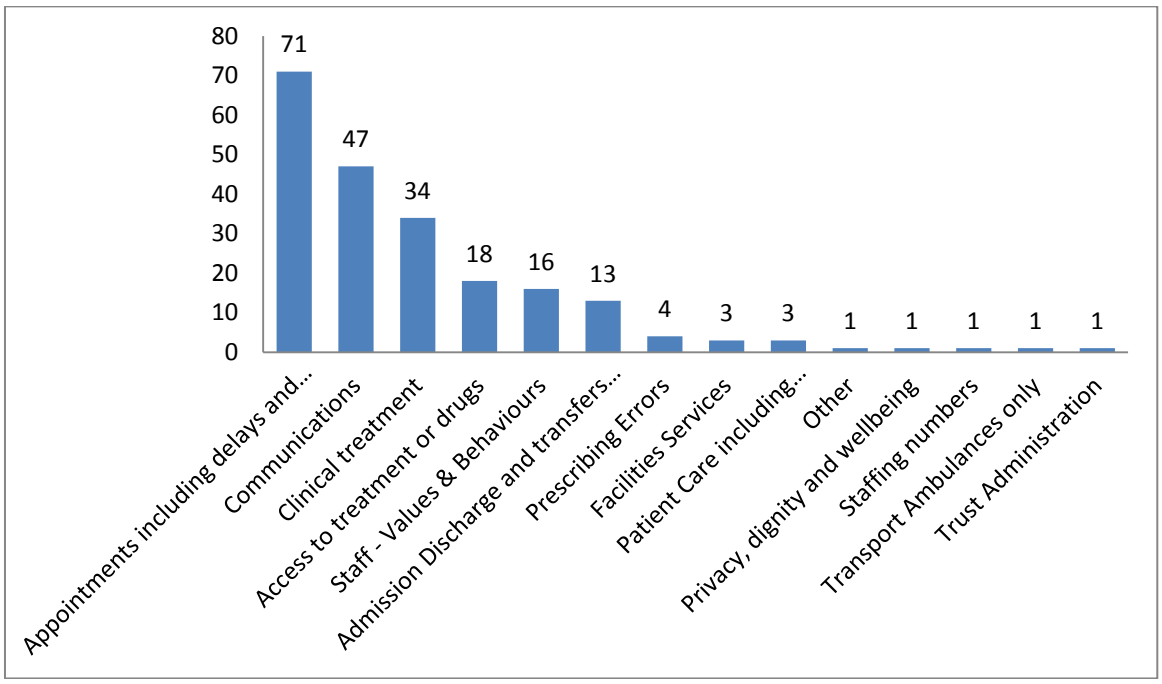
3 PHSO complaints were closed in Quarter 1 of 2016/17; of these 2 were part upheld and 1 was withdrawn. Learning from PHSO cases is given at the end of this section.

Patient Feedback from Other Sources: Concerns, Patient Opinion and Compliments

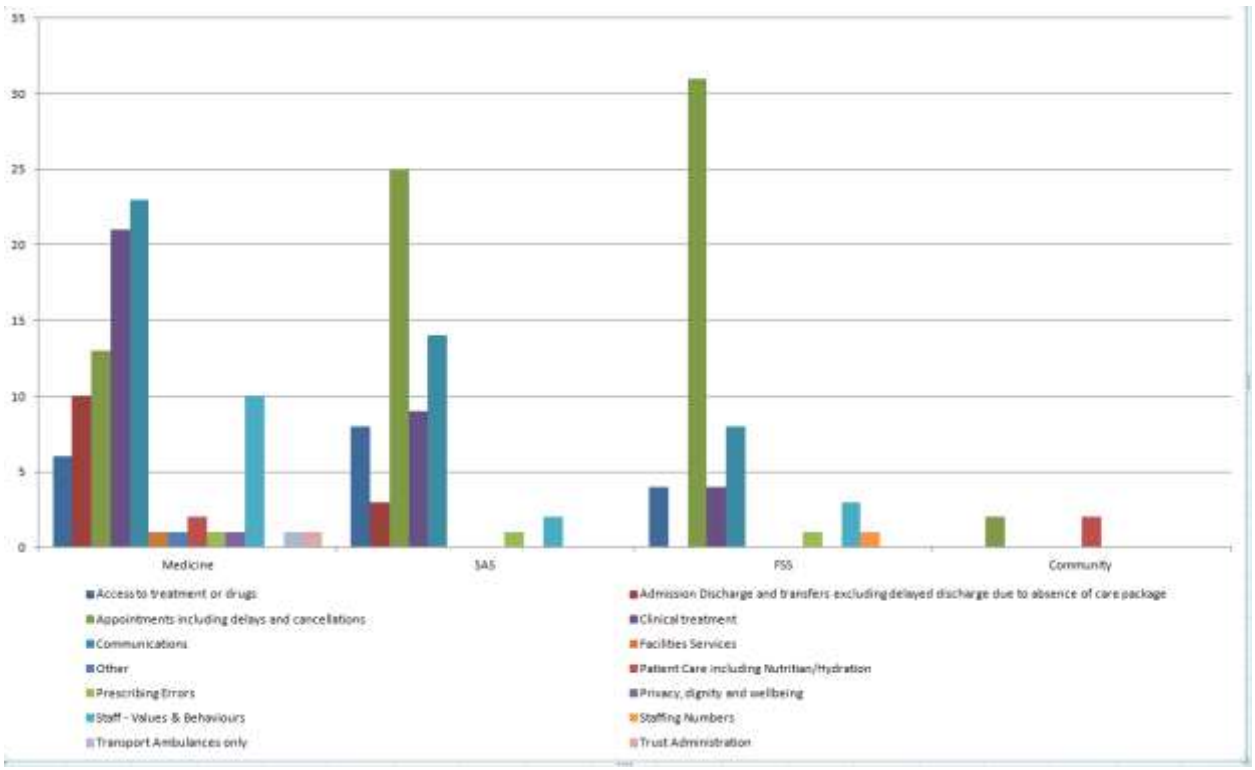
Concerns

The Trust received a total number of 210 concerns in Quarter 1 of 2016/17. Concerns are issues raised by patients or relatives via the Patient Advice Team. There has been a 29% increase in the number of concerns received in Quarter 1 of 2016/17 compared to the same quarter last year.

Analysis of Concerns by Theme



Appointments and Appointments including Delays and Cancellations has dominated the concerns received in Quarter 1 of 2016/17 representing 33% of all subjects. Communication represented 21% and clinical treatment represented 16%.



- The top subject of concern for Medicine was Communication, representing 25% of all

concern subjects received for Medicine within Quarter 1; this was also the top complaint subject received for Medicine within Quarter 1. Clinical Treatment represented 22%, again similar to the second largest complaint subject for Medicine with Quarter 1, and Appointments including Delays and Cancellations 17%.

- The top subject of concern for SAS was Appointments including Delays and Cancellations, representing 40% of all concerns subjects received for SAS within Quarter 1, unlike complaints subjects where Communication was the largest complaint subject received for SAS within Quarter 1. Communication represented 23% and Clinical Treatment) 15%.

- The top subject of concern for FSS Appointments including Delays and Cancellations, representing 61% of all concerns subjects received for FSS within Quarter 1, unlike complaints subjects where Communication was the largest complaint subject received for FSS within Quarter 1. Communication represented 13% and Access to Treatment or Drugs 8%.

- The top subject of concern for Community was Appointments including Delays and Cancellations, representing 66% of all concerns subjects received for FSS within Quarter 1, unlike complaints subjects where Staff - Values & Behaviours was the largest complaint subject received for Community within Quarter 1. Patient Care (including Nutrition and Hydration) 33%.

Whilst Appointments including Delays and Cancellations was top subject of concern in Quarter 1 and the top subject for SAS, FSS and Community, it was not in the top three subjects of complaint, nor was it with the top three for any Division. This would suggest that the majority of these issues are resolved through Patient Advice.

Patient Opinion Feedback 2015/16

Patient Opinion is an independent website about patient's experiences of health services, good and bad. The Patient Advice Team review comments receive and advise people leaving negative feedback to contact the service if they wish to take their concerns further.

Compliments 2015/16

12 compliments were recorded on the Datix risk management system by staff. The numbers below under estimate the number of compliments received by staff, as many compliments are made direct to teams and wards and are not captured in a central system.

The Trust is currently developing a user manual, which will guide ward staff through upload a compliment onto Datix step by step. Once this has been developed and roll out we hope to have a truer reflection of compliments received by the Trust, and use these to prompt learning from good practices.

Division	Number of Compliments recorded on Datix Q3 2015/16 by directorate
Medicine	4
Surgical and Anaesthetics	1
Family and Specialist Services	7

Learning from Complaints

The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's experience.

As an organisation we aim to ensure that we learn from complaints so that we can:

- Share good practice
- Increase patient safety
- Improve the patient experience
- Reduce the number of complaints

Our complaints process includes identifying learning from each complaint and sharing this and each service and division is required to be clear:

- How the services records learning from complaints
- How this learning is disseminated within the service / directorate / division
- How it can point to changes arising from learning from complaints

Information on learning from complaints for each division is given below.

Learning:

Medicine	
- Giving the patient incorrect technical information.	- Small errors in wording can lead to confusion and stress for the patient. - Response letters to be over read by specialist in that area to ensure technical information is correct and to review how it will sound to the patient.
- Inadequate level of support and follow-up instructions given in Emergency department	- Staff are ill prepared/trained to do adequate discharges in an area where they usually do not discharge patients. - Training regarding the discharge process for all staff in the area.
- Family felt that the wrong information/ diagnosis was given about their loved one. Doctor stated stroke, nurse stated TIA.	- Patients and their families can be confused by different definitions given for one condition. - Explained both definitions, which without correct assessment, present in exactly the same way in the majority of cases and assured that both definitions were correct.
- Investigations were not performed and a diagnosis was missed as a result.	- Patient stated that they had already had an investigation however this was not followed up. - To repeat investigations if results cannot be verified.
- Lack of perceived input from the clinical team with regards to changes in patient's skin condition	- Improved communication between clinical staff and families following examinations and reviews to ensure the family and patient are aware that that their concerns have been acknowledged and addressed. Comprehensive clinical documentation in patient's clinical records regarding changes in patient's skin condition's needed.
- Delay in prescribing medications	- This would have ensured that the patient received the appropriate treatment for recent eye surgery. - Medical staff need to be more vigilant when taking drug history and nursing staff need to be more proactive in ensuring medications are transcribed once alerted that they have been omitted.
- Patient did not have a bath or shower while on ward	- In this instance the patient had the capacity to be able to make this decision however documenting clearly will evidence the offers made to patients and also include alterative

	options for hygiene needs to be met. - To ensure that staff are aware to inform family if needed they can support with this.
- No follow up appointment made with the appropriate consultant	- This would have ensured that the patient received the follow up care that was required. All staff are having clear training on leaving the correct information to the ward clerks to ensure they can send copies of discharge letters on that are needed
- Patient was found off the ward causing distress for patient and family	- Staff to be more vigilant with checking on patients if needed. - If the patient is confused may need to consider DOLs. Will help support staff to ensure patient who are confused and lack capacity may require 1:1 care or increased visual checks
- Confidentiality policy not adhered to as patient diagnosis was discussed at a handover within the hearing of patients and visitors to the department	- To ensure that all handovers are completed using nervecentre technology and that diagnoses are not verbally referred to at patient's bedside.
FSS	
Emergency LSCS for failure to progress at 5cm. Epidural top up ineffective, Remifent given. - Unable to deliver baby - delivered as breech in poor condition, no respiratory effort, full resuscitation given and transferred to SCBU.	- Escalation to Consultant where necessary for all surgical procedures in a timely manner. - Importance of keeping the anesthetist informed of progress and complications - Learning from experience newsletter to remind staff about timely summoning of consultant paediatrician in a timely manner. - Findings to be presented at Perinatal Mortality Meeting
- Delay in admission for undiagnosed breech presentation. - Baby born in poor condition.	- It is crucially important to listen to what the woman is telling us - Health care staff should keep the woman the focus of care - If a woman is unhappy with the clinical advice she is given this should be escalated and dealt with immediately
Following up an anomaly with final rinse water results from the Nasendoscope washer disinfector; it was discovered that there was a series of process failures associated with the decontamination of the scopes	Prior to implementation of new equipment that require decontamination: a. An operational policy should have been in place b. Clear, user friendly Standard Operating Procedures for the various elements of the task should be in place c. Staff should be trained to follow these SOP's and have documentary evidence of training and competence in them d. Documentation to support traceability at each critical point of the process should be in place with a planned audit schedule prior to implementation of the new equipment.
- high risk pregnancy, uterine fibroids.	- This woman had a large uterine fibroid but

- Attended for augmentation in view of spontaneous rupture of membranes Prostin administered at 01 50, CTG following classified as reassuring, therefore discontinued at 02:59. - Reports to have been contracting frequently. Care taken over on day shift, history noted, planned for CTG monitoring, unable to locate fetal heart rate, escalated this to shift coordinator and registrar. Portable scanner used by registrar, still unable to locate fetal heart. Transferred to main scan room to be scanned by sonographer. IUD confirmed on scan.	growth scans were discontinued at 36 weeks. - Fundal height palpation (which plotted on the 90th centile) was inappropriate in this case. i. Fetal growth scan should have been continued until delivery. ii. Offer immediate augmentation for term SROM as per NICE and our guidelines.
Unexpected stillbirth at Emergency Caesarean Section in maternity theatre	- CTG interpretation was incorrect in the last hour - The category of Caesarean section declared and documented was incorrect reflecting - the lack of urgency - Misinterpretation of the fetal growth based on the last scan as well as incorrect SFH - Measurement after the scan which would contribute to the compromise in reserves - This was an IVF pregnancy which has an increasing risk of Small babies and a two to four fold risk of stillbirth

Key National Publications

Parliamentary and Health Service Ombudsman - A Report of Investigations into Unsafe Discharge from Hospital, May 2016

The report focuses on nine experiences drawn from recent complaints the Parliamentary and Health Service Ombudsman investigated, which best illustrate the problems they are seeing.

People told the Parliamentary and Health Service Ombudsman how their loved one's traumatic experience of leaving hospital, including repeated emergency readmissions, added to their pain and grief. One woman captured the sentiment of many, saying she would be 'haunted for the rest of her life' by her mother's avoidable suffering before her death.

The Parliamentary and Health Service Ombudsman identified four areas of concerns which were:

1. Patients being discharged before they are clinically ready to leave hospital
2. Patients not being assessed or consulted properly before their discharge
3. Relatives and carers not being told that their loved one has been discharged
4. Patients being discharged with no home-care plan in place or being kept in hospital due to poor co-ordination across services

The Trust is doing a piece of work to look into these issues, which will be present at the Patient experience group.

Claims

CLINICAL CLAIMS

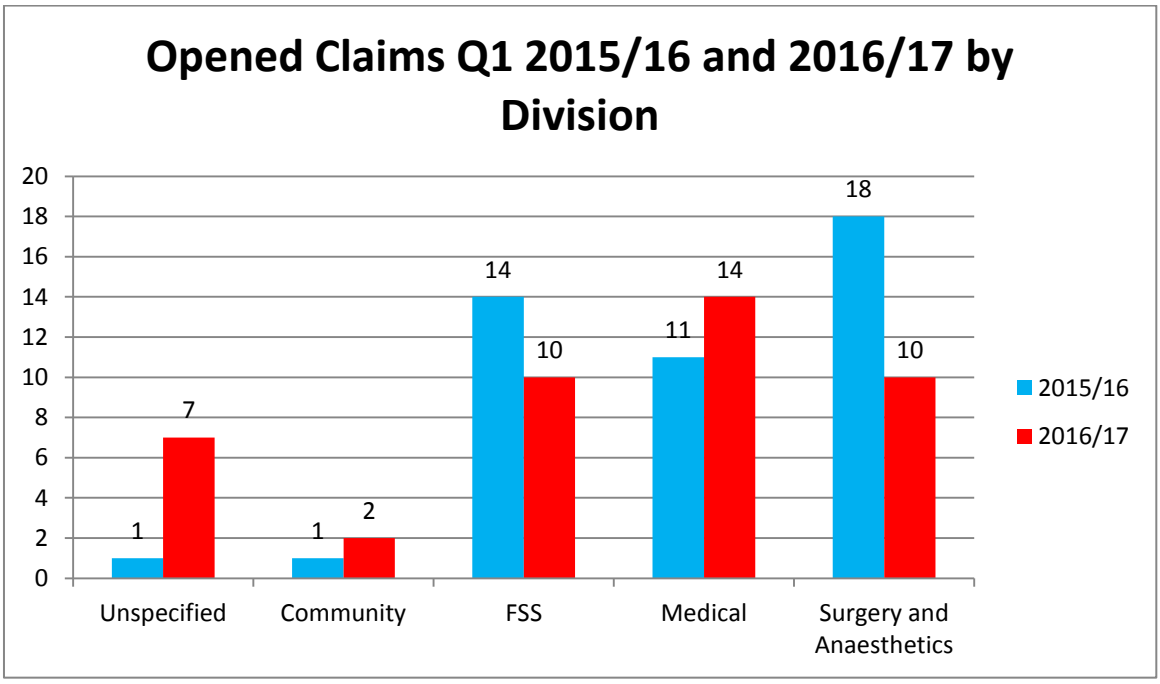
During the last 5 financial years up to 30 June 2016, CHFT has opened 874 new clinical negligence claims. Nationally NHS Trusts have seen a sharp increase in the number of clinical negligence claims brought.

Opened Claims

In Q1 2016/17 43 new clinical claims were opened. In the same quarter of 2015/16 45 new claims were opened. This represents a small decrease of 4.4%.

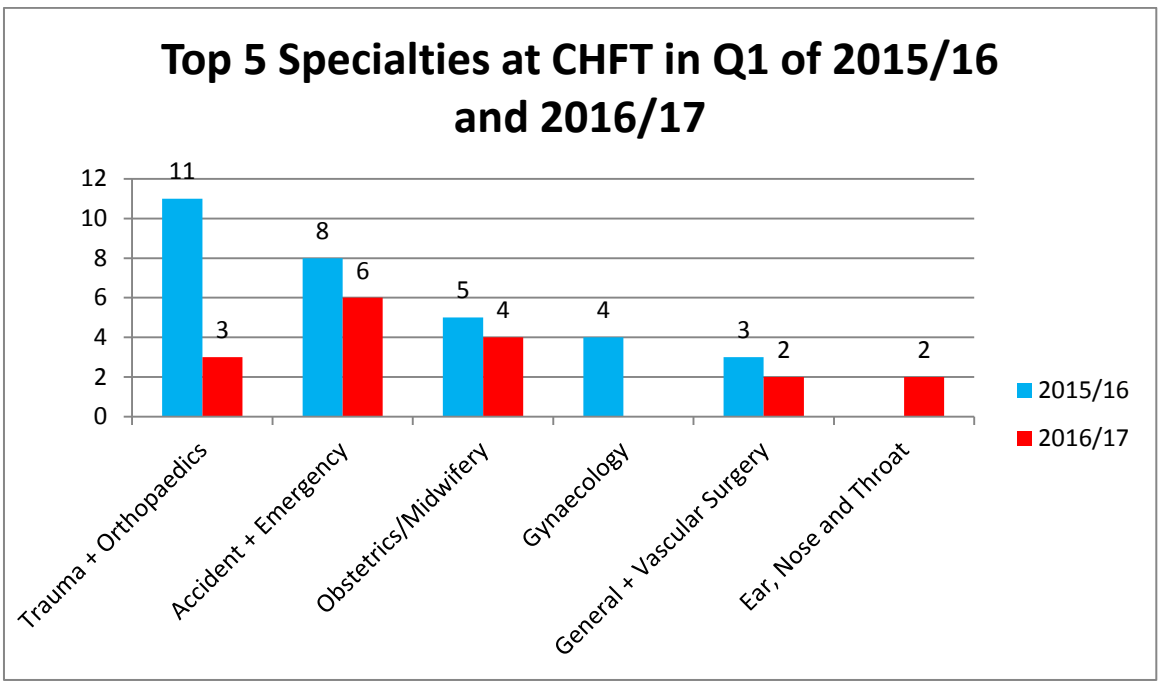
Opened Claims by Division

The graph below shows the number of opened claims over the comparable quarters by Division during Q1 of 15/16 and 16/17. Notable trends show a decrease in FSS from 14 to 10 claims (28.5%) and a large decrease in Surgery and Anaesthetics from 18 to 10 claims (44.4%).
Of note is the large number of claims in Q1 of 2016/17 which are unallocated to a division. It is not uncommon for claimant solicitors not to specify the nature of the claim despite the Legal Services Team asking them to specify the nature of the intended claim in line with the Clinical Negligence Protocol.



Claims Opened by Specialty

The Top 5 specialties at CHFT for Q1 of 2016/17 and 2015/16 are detailed below.



Trauma and Orthopaedics have seen a marked decrease from 11 to 3 claims (266%) in the last year. A+E, Obstetrics and Midwifery and General and Vascular Surgery have seen small decreases in the number of claims whilst still remaining in the top 5 specialty claim types for both quarters.

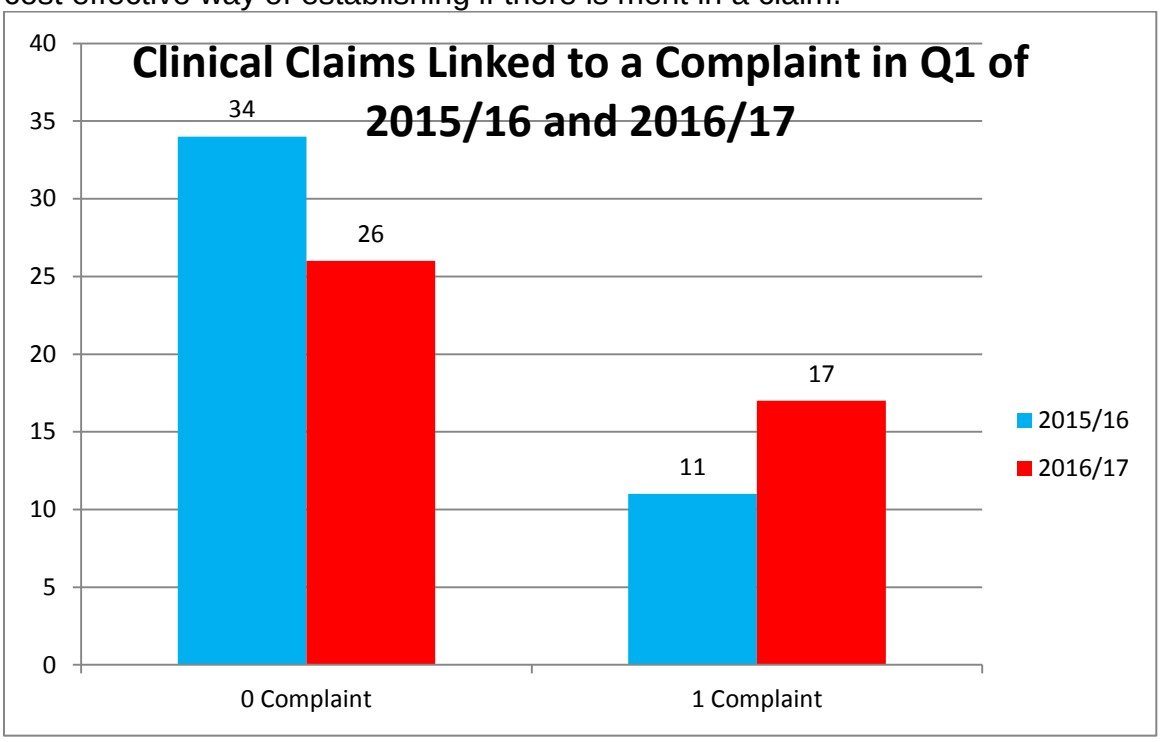
Ear, Nose and Throat have newly entered in to the top 5 of claim specialty in 2016/17 with 2 claims. Looking at these claims in more detail they relate to:

a) One claim relates to an alleged delay in diagnosis of throat cancer. The case is at the disclosure of medical records stage and comments will be obtained by our staff;

b) One claim relates to the alleged negligent fitting of a hearing aid. The medical records have been disclosed on this matter.

Claims Linked to Complaints

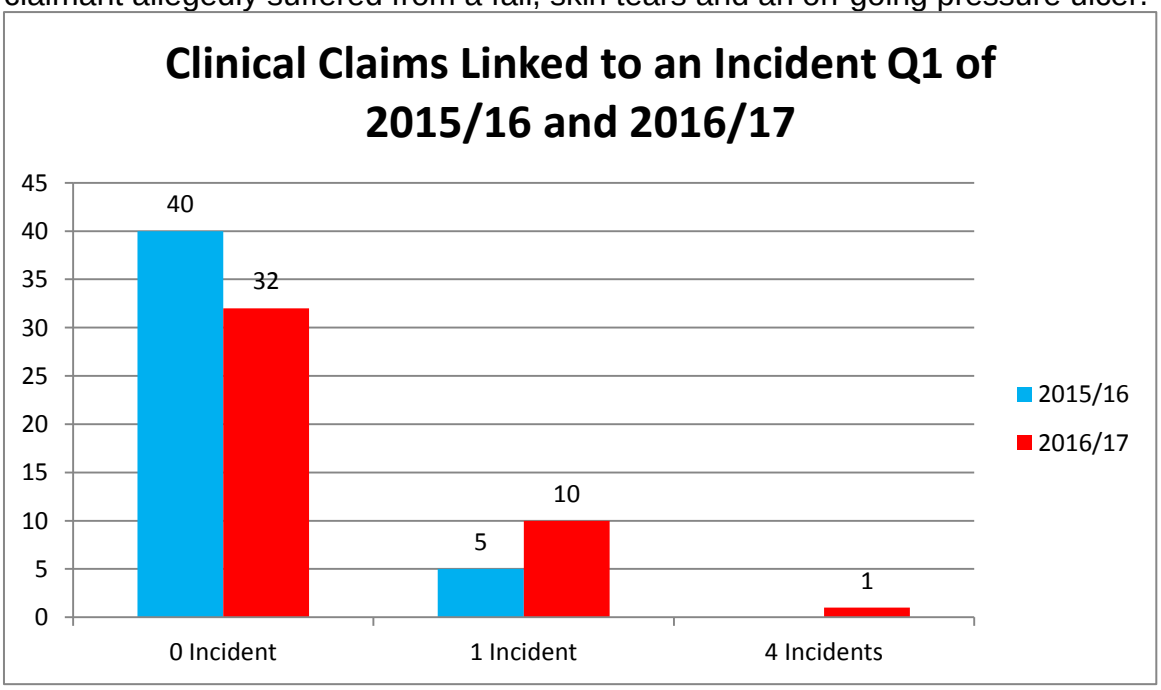
The bar graph below shows that in2016/17 17/43 (39.5%) claims were linked to a complaint. In the same quarter of 2015/16 11/45 (24.4%) claims were linked to a complaint. This shows a marked increase over the last two quarters. One reason for this is that pursuing a complaint is a cost effective way of establishing if there is merit in a claim.



Claims Linked to Incidents

The bar graph below shows the number of claims linked to an incident. In Q1 of 2016/17 11/43 (25.5%) of claims were linked to at least 1 incident. In Q1 of 2015/16 5/45 (11.1%) of claims were linked to an incident.

The claim linked to 4 incidents relates to treatment from 2 June to October 2015 during which the claimant allegedly suffered from a fall, skin tears and an on-going pressure ulcer.



Closed Claims

In Q1 of 2016/17, 14 claims were closed. Of the 14 claims that were closed 7 claims (50%) closed without any payments being made. Of the 7 claims that closed with payments, the highest payment was from Medicine Division for £148,380 (comprising of £40,000 damages, £95,000 claimant costs and £13,380 of defence costs) for a failure to diagnose a left hand scaphoid fracture.

In Q1 of 2015/16, 20 claims were closed. 10/20 (50%) closed without any payments being made. The remaining 10 closed with a payment being incurred.

Learning from Claims

Claims that closed between 1 January 2016 and 1 June 2016 resulting in a payment of damages to patients and staff have been circulated to the divisions for them to action and evidence what has and will be done to prevent or minimise a recurrence. A summary is provided below.

CWS	Management of breech delivery
CWS	Alleged failure of adequate obstetric care resulting in a still birth
DATS	Failure to diagnose Quadriceps muscle damage
DATS	Failure to diagnose fracture of Ankle
Medical	Failure to diagnose severed tendon in hand
Surgical & Anaesthetics	Failure to implement gall bladder pathway resulting in death
Medical	Slip on floor in hydrotherapy pool area
Medical	Patient assault injury to hand

EMPLOYEE AND PUBLIC LIABILITY CLAMS

During the last 5 financial years up to 30 June 2016, CHFT has opened 110 new employee and public liability claims.

Opened Claims

In Q1 of 2016/17 7 new claims were instigated against CHFT. In Q1 of 2015/16 6 claims were brought.

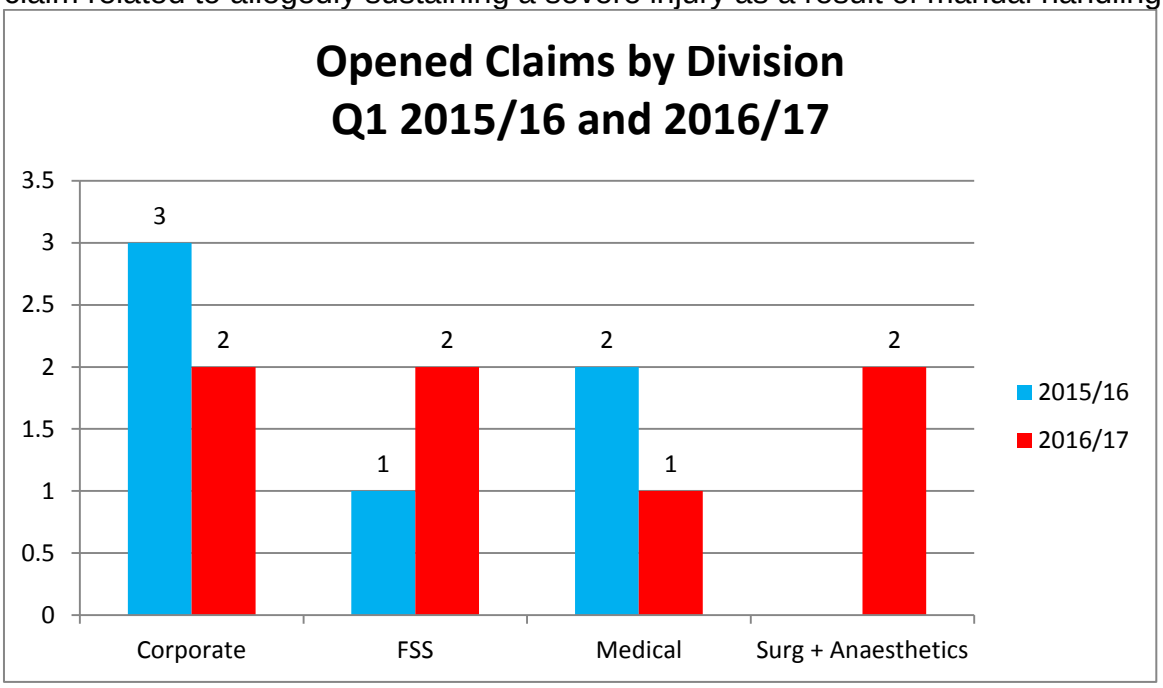
An extract of the claims descriptions brought in Q1 of 2016/17 is provided below.

Ref	Description (Policies)
PL CLAIM	Incident occurred on 1st floor of Acre Mill of Female Public Toilet in disabled toilet cubicle Patient used it between 16.10-16.15 hrs Apparently no witnesses she was using toilet and wanted to exit and pulled the door open and door fell off its hinges and hit her left Arm ? also shoulder as she tried to push it off herself and pushed the door back and lent it against wall so that she could exit Toilet. She then went to Nurse in ENT who she first met to tell her also what had happened.
PL1	Claimant's fingers trapped by an electrical recliner chair in the WEEE compound CRH
2989	Claimant walked into theatre 2 and she went to get a phone base and the boom that the gases come down through had been left down and not pushed back up to the ceiling and the Claimant walked into the boom and banged her head and was knocked to the floor as a result of this incident.
2946	The Claimant is a driver. He was making a delivery on behalf of his Employer, Polar Speed Distribution Ltd, when he slipped on pieces of broken black plastic that were littered on the floor of the parking area to the loading bay. He fell heavily to the ground.

2967	Slipped on wet floor in scrub room. Tried to prevent myself from falling but went down on my left knee and on my right hand.
2948	Claimant's statement verbatim on EL1 Form: "Due to the way the ward was on the day i had no choice but to move a demanding patient onto a slipper pan by myself...as i turned the patient i felt my left elbow give way.... thinking that it was a pulled muscle i continued to work after reporting the incident to the qualified member of staff that was on duty with me....i know i shouldn't off moved him but the patient declared that he would defecate the bed if i didn't.....and that would of taken three members off staff to deal with said patient... And at the time off the incident they were not available...."
2999	Whilst getting trolley cleaned down in wash up area near waste food bin slipped on the floor and fell down on left hand side of body left buttock, Shoulder, arm and elbow. Slipped on custard that had been spilt on the floor. Area had been signed with a slippery floor sign.

Claims by Division

The graph below shows the number of opened claims over the comparable quarters by Division during Q1 of 16/17 and 2015/16. The claims relating to Corporate Division come from the Estates and Facilities specialty. In 2016/17 3/7 (42.8%) of these claims related to a slip and 1/7 (14.2%) claim related to allegedly sustaining a severe injury as a result of manual handling.



Claims Linked to Incidents

In Q1 of 2016/17, 5/7 (71.4%) claims were linked to an incident. In Q1 of 2015/16, 4/6 claims were linked to an incident. If a claim is not linked to an incident the Trust has the possibility of a reasonable defence.

Closed Claims

In Q1 of 2016/17 4 claims were closed. ¼ claims closed with a payment of damages to the claimant (a staff member). The claim relates to a failure to provide extra staff for a known aggressive patient who subsequently assaulted the staff member. The damages payment was £7,500, defence costs £9,300 and defence costs were £480. The remaining 3 closed without any payment of damages or costs.

In Q1 of 2015/16, 3 claims were closed. 1/3 claims closed with a payment of damages to a staff member which was lodged against Surgery and Anaesthetics. This was for a needlestick injury. The damages were £1,500, claimant's costs were £1,080 and defence costs were nil. 1 claim closed without any payments and 1 claim closed with defence costs only.

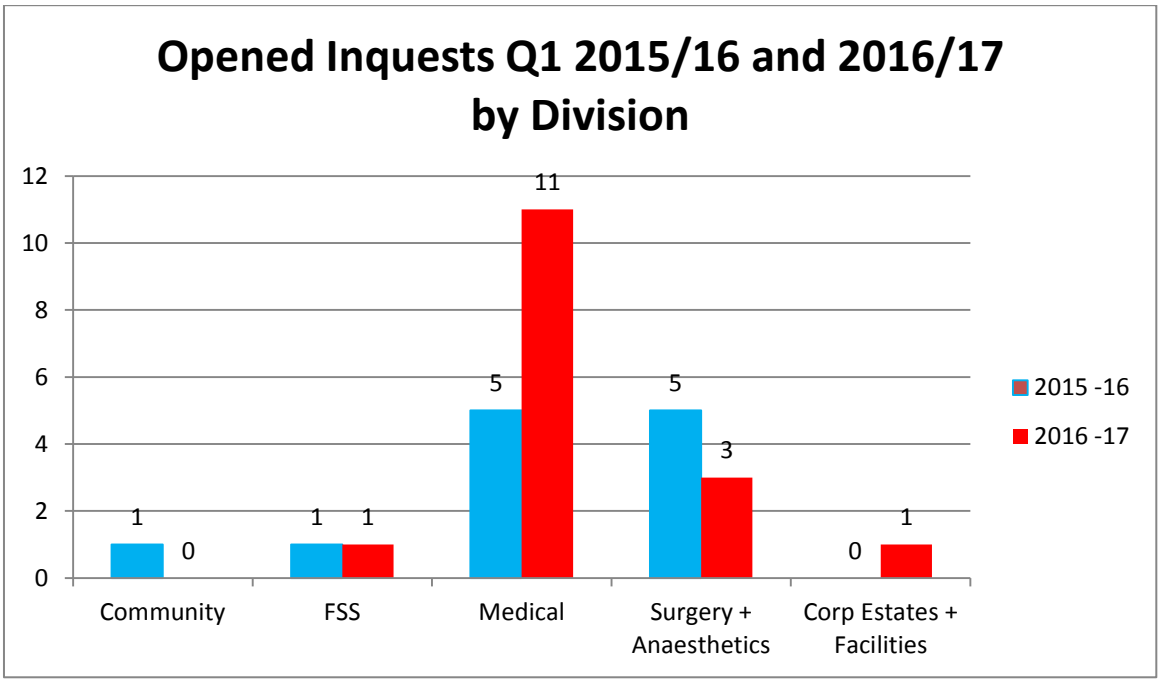
INQUESTS
As at 30 June 2016 the Trust opened 54 inquest cases. An inquest by HM Coroner is held where here is a concern that the patient suffered a violent or unnatural death, or if the cause of death cannot be ascertained, and by a post mortem.

Opened Inquests

In Q1 of 2015/16 12 new inquests were opened. In Q1 of 2016/17 16 new inquests were opened. This represents an increase of 33.3% in the corresponding quarters.

Opened Inquests by Division

The graph below shows the number of inquests opened by each division in Q1 over the last two financial years. Notable trends are that Medicine has seen a 120% increase in the number of inquests from 5 to 11 inquests over the corresponding quarters.



Looking at the 11 opened inquests for Q1 of 2016/17:
4/11 (36.3%) relates to A&E but of note is that 2 of these 3 relates to fatalities pre-dating admission to CHFT.
3/11 (27.2%) inquests relate to Acute Medicine.
1/11 (9%) relate to Cardiology; 1/11 relate to elderly care; 1/11 relate to Rheumatology; 1/11 relate to Short Stay.
Of particular note is that 5/11 (45.4%) of the above inquests are related to a fall sustained whilst being treated at CHFT hospitals.

Closed Inquests and Learning

In Q1 of 2015/16 7 inquests were closed. In the same quarter of 2016/17 5 inquests were closed. They are detailed below.

Where there is a robust investigation with evidenced actions on how the incident (giving rise to the death) can be prevented HM Coroner is less minded to issue a Regulation 28 report.

ID	Description	Determination (at Inquest) and Learning
2740	Died on Ward 5d CRH following admission. Patient admitted due to self-neglect and burns. DoL in place and Safeguarding Alert raised at time of death.	INQUEST OUTCOME: NATURAL CAUSES Actions from investigation on-going. HM Coroner applauded CHFT for thorough incident investigation.
2772	Died following reaction to cement inserted to repair hip fracture. Reported to HMC as died within 24 hours of procedure. Statements obtained from 2 x staff plus investigation report sent to HM Coroner.	Narrative verdict reached. Paper Inquest held on 26/2/16. No witnesses called as there were no issues to resolve.
2690	Male was admitted to Calderdale Royal Hospital on the 3rd June following a collapse at home. He remained overnight. Examination showed air under the diaphragm in keeping with spontaneous bowel perforation. High mortality rate discussed and agreed with the patient prior to consent. He was transferred to Huddersfield Royal Infirmary on 06/06/15 and taken to theatre on 07.06.15. At operation, two perforations in the small bowel were identified and a 20cm segment of bowel was removed. There was no evidence of necrosis. The operation was successful and he was taken to the ICU for the following two days. On the 12th June he developed diarrhoea possibly thought to be due to antibiotics but then rapidly deteriorated. It is unclear whether there was an anastomotic leak or bowel ischaemia. He died on 13.06.15.	Misadventure. No further learning for CHFT. CHFT staff commended by HM Coroner and the family.
2667	Safeguarding concern raised by Nursing Home re decision to discharge in early hours of morning readmitted	INQUEST OUTCOME: The verdict was a narrative verdict which essentially sets out the

	same day 3.5.15 with chest symptoms, subsequently died 11.5.15. A Safeguarding and incident investigation took place. Issues regarding loss of IV access and aggressive behaviour were investigated.	circumstances. The Trust is required to write to the Coroner to set out the lessons learned regarding their involvement with the patient arrangements to make to avoid future miscommunications with the home and other similar care homes Response provided to HM Coroner on 16 June 2016 setting out the integration process Pose a Risk Documentation that is to be incorporated before December 2016.
2784	Preliminary cause of death is sepsis. Safeguarding Referral to Police led to Forensic PM. Inquest is not listed and case is closed. Awaiting formal notification from HM Coroner as at 16/3/16 and 29/03/16.	No inquest hearing.

One inquest that was concluded in the Quarter 4 of 2015/16 but from which the actions were ongoing in to Q1 of 2016/17 and concluded was the inquest of a patient who had had a GI bleed and died after transfer from CRH to HRI, following which CHFT received a Prevention of Future Death (PFD) letter from HM Coroner.

A PFD letter is issued by HM Coroner who is now under a duty (no longer discretion) to issue the same where they consider that a future death can be prevented.

The detail is provided below:

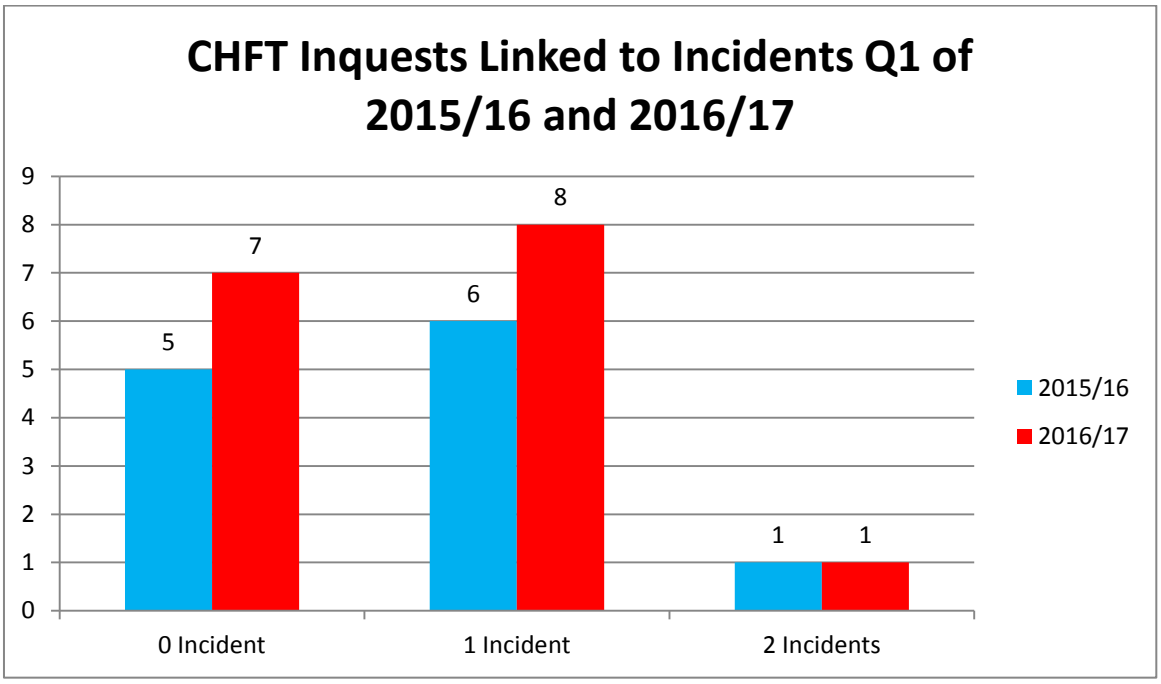
ID	**Description**	**Determination (at Inquest) and Learning**
2542	Patient under GI bleed protocol bled prior to transfer to CRH and was unstable - patient deteriorated and died on arrival. The Trust was criticised for its management of the suspected GI bleed that she presented with and the transfer arrangements. Had the patient been transferred before the afternoon of 16 December 2014, she would in all probability have survived the GI bleed she suffered from.	PFD response received with 7 specific points for CHFT to address. Detailed action plan (with evidence) including the roll out of the new GI Bleed Protocol Trust wide and documentation process for all staff submitted to HM Coroner.

Inquests Linked to Incidents and Complaints

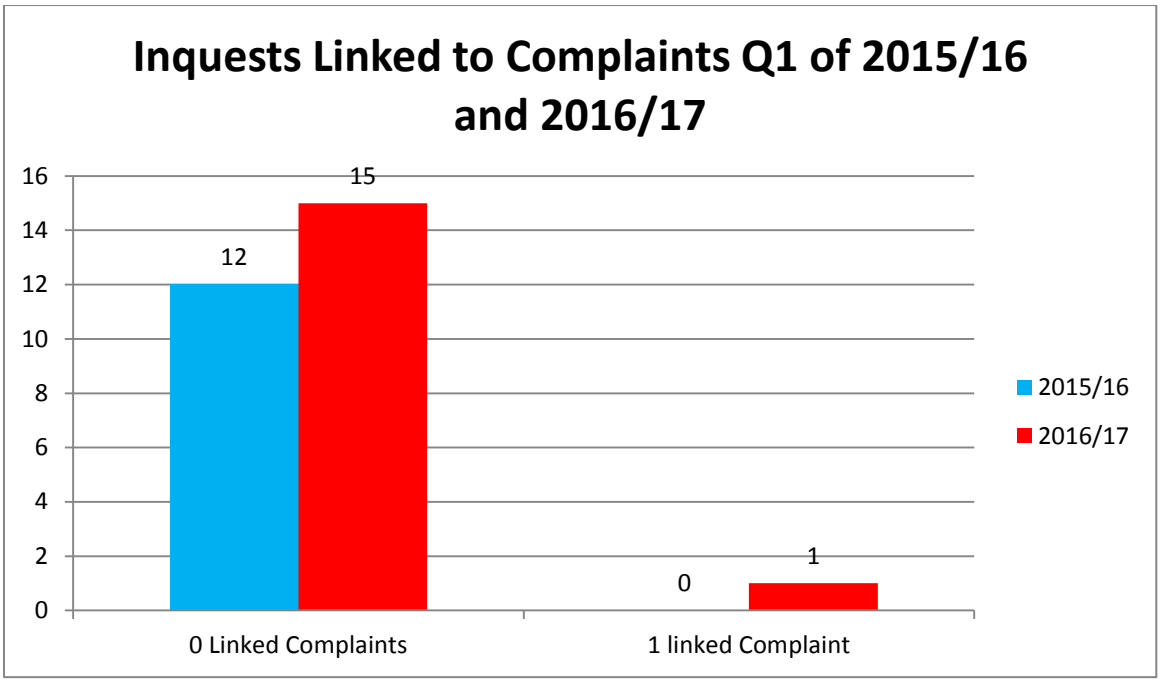
The Legal, Complaints and Investigations teams are triangulating data from their respective areas to highlight and action where inquests are related to incidents and complaints so that better family, Trust and coronial engagement can take place.

Often families will use the inquest process as a vehicle to air their concerns where a complaint could have resolved the issues that they have. Relationships are being forged to assist HM Coroner where our Trust can dispense with issues that relate to a complaint.

The graph below shows that in Q1 of 2015/16 7/12 (58.3%) inquests were linked to at least 1 incident. In the same quarter of 2016/17 9/16 (56.25) of inquests were linked to an incident.



In Q1 of 2015/16 no inquests were linked to a complaint.
In Q1 of 2016/17 1/16 (6.25%) inquests were linked to a complaint.



4.2 Appointment Slot Issues (ASI)

Background

E-Referral

In order to understand the difference between national e-referral data and the CHFT reported position, a review of the April 2016 ASI position has been undertaken (the available data is 2 months in arrears).

In the month of April,1159 patients were unable to book an appointment at the first attempt and were “deferred to provider” for booking. The data confirms that 531 (46%) of these patients were allocated appointments on the same or next working day. Excluding these patients who were given an appointment within 24 hours reduces the Trust’s ASI position for April to just 8%. This is a month on month improvement (February 39% and March 40%)

April 2016 data

1159	Total ASI's
531	Total booked next working day
46%	**% resolved next working day**

The elements supporting next day resolution are predominantly additional capacity becoming available through the nightly harvesting of slots (booked via the national telephone line or e-booking system), or lifting of the waiting time bar by the Appointment Centre where the numbers of ASIs are small and will not impact on the referral to treatment pathway.

Trust Current Position

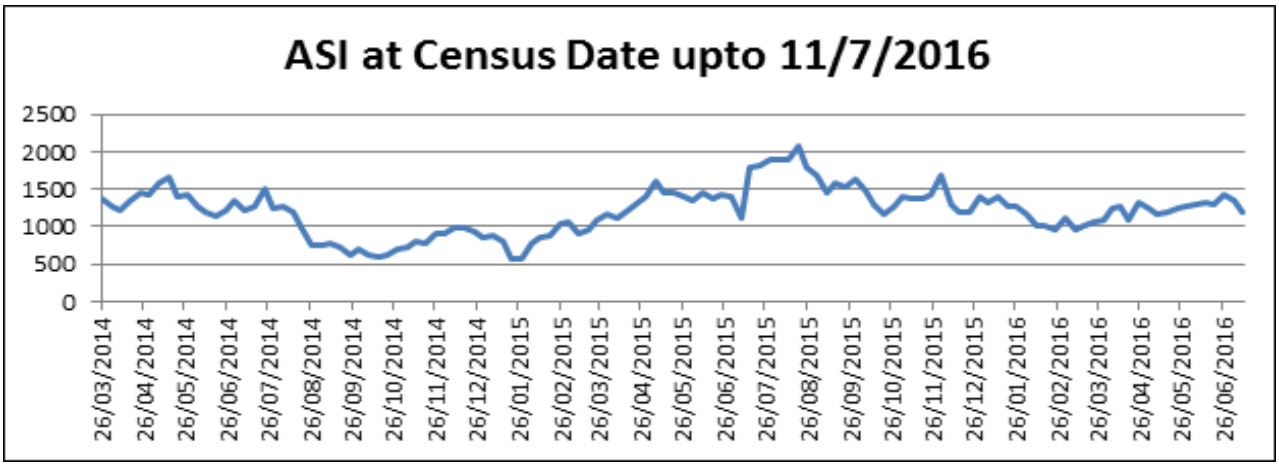
As at the 15 July there were 1050 referrals awaiting appointment of which 343 are e-referrals. This is a reduction of 774 referrals from the 22nd July 2015 position of 1824.

By way of illustration the average number of daily bookings via the e-referral service is 200. Assuming a current Trust ASI rate of 16%, this 200 can be summarised as follows:

- 168 patients get an appointment at the first time of asking (84%).
- Of the 32 patients who do not get an appointment at first time of asking 15 of these are successful within 24 hours
- The remaining 17 patients see a delay in getting an appointment with the Trust >1 day and would be placed onto the Trust’s ASI list and managed in line with the process set out.

- It should be noted that of the 8% of patients who do not get an appointment within 24 hours, more than half of these referrals will be ERS and therefore the referral cannot be seen until an appointment is given.

- The longest wait for an e-referral appointment being from March 2016 (4 months), in the specialties of Colorectal Surgery, Respiratory. The average wait for those unable to get an appointment and still on the waiting list is 30 days. A minimal number of ERS ASIs relate to the system being unavailable (16 in April), but the majority relate to a lack of immediate capacity.



The inability to place a patient into a clinic appointment at the first attempt results in a disruption to the patient's pathway and can also result in a significant amount of rework within the system in attempting to create additional clinical capacity within a necessary short period of time.

No patients should wait beyond the maximum waiting time to be seen by specialty. However the current ASI position regularly results in patients waiting beyond the recommended 6 (urgent) and 11 (routine) days for an appointment to be offered.

All paper referrals are triaged by Consultants as part of the registering process, however, triage of referrals received via ERS cannot be undertaken until an appointment has been allocated. This means that any reclassification of priority cannot be determined until an appointment is allocated

Capacity Requirements (as at 15th July 2016)

The table below shows the number of patients waiting for appointment by time band :

	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**

ASI Reporting and Validation

The Waiting List is managed centrally by the Appointment Centre; Appointment Slot Issues are added daily from the E-Referral Service (ERS) report of patients unable to book an appointment, and the list of paper referrals unable to book.

The daily report is filtered by specialty by the Appointment Centre, in non-problem specialties, and for small numbers of ASIs, the waiting time bar is lifted (on the day of receiving the ASI) in order to allocate an appointment. The remaining ASIs are forwarded to the specialty leads in the clinical divisions for action. On receipt of additional capacity (which can take days/weeks), contact is made with each patient in chronological order, and appointments booked.

Currently the ASI list is contained in a spreadsheet, which is both labour intensive and not designed for the current volumes of ASIs. A database is under production, to enable real time management and reporting.

Action Plan

The clinical divisions (at divisional Access meeting) regularly review current clinic capacity v demand in order to evaluate where there are / will be any capacity pressures. A gap analysis is undertaken at specialty level and shared with the operational managers for action.

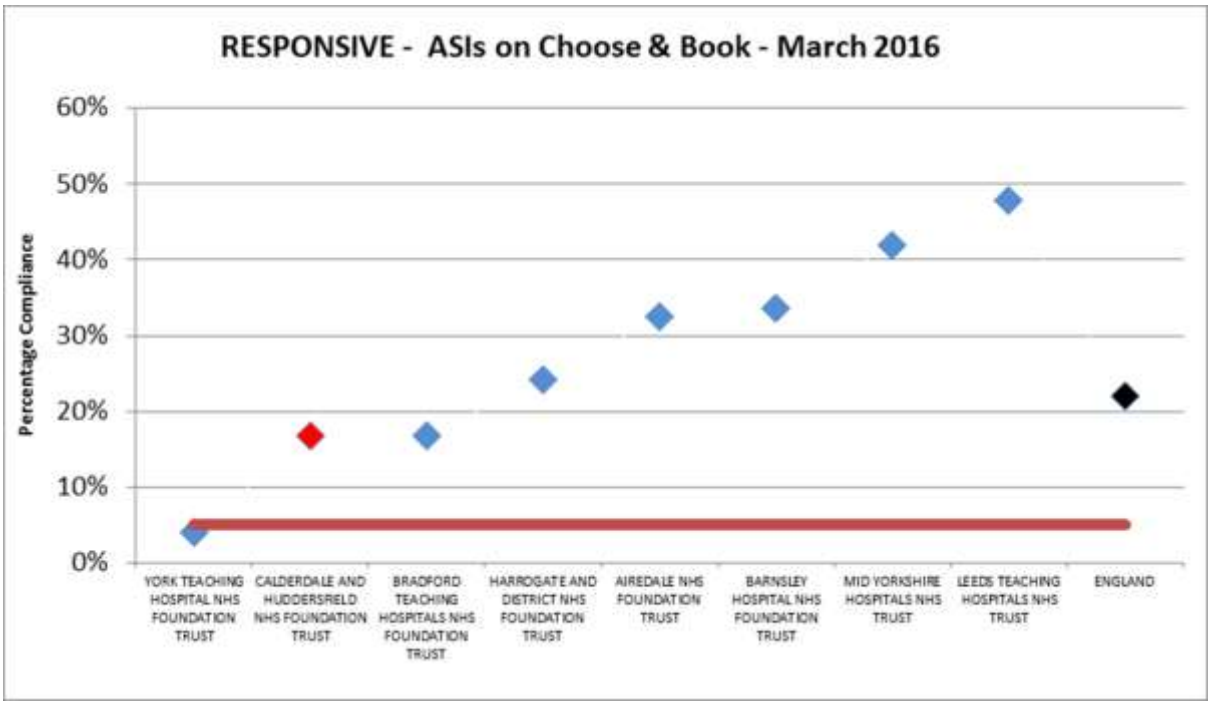
Capacity and demand modelling is an integral part of the Access meeting and the Information Team regularly discuss with service leads in order to ascertain any pressures. Additionally they report on referral demand monthly by specialty, as any growth over contract will also cause a pressure on the ASI.

Current ASI Action Plan (appendix 1) which has been developed to reduce the current ASIs and maximise slot availability, and provides a timeline to improve the ASI position in those specialities which are currently most challenged.

Monitoring of the Action Plan takes place via the weekly Performance Meetings and progress reported to the monthly Divisional Business Meetings.

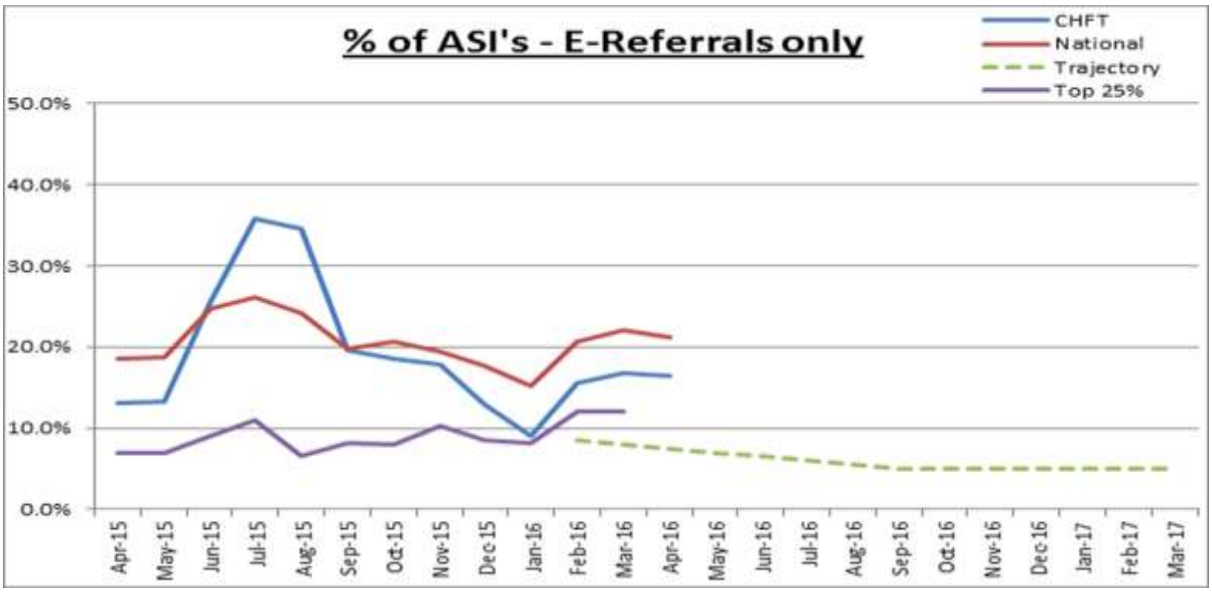
Benchmarking

The graph below shows the E-referral ASI position in comparison to other local Trusts. Contact has been made with York Trust to understand the excellent ASI position (4%), which we now appreciate is achieved through extending the polling range for appointments beyond the 18 weeks ceiling. Incidentally, York's 18 weeks non admitted RTT performance is 95% and admitted 70%, in comparison to 86% and 98% at CHFT.



Trajectory

The graph below shows the proposed trajectory to recover the ASI position based on the actions described above. It is anticipated that the ASI position of <5% will be achieved by September and will be monitored thereafter via the Performance and Outpatient Productivity Divisional Challenge meetings.



Recommendations

The following actions are proposed in order to reduce ASIs to the 5% threshold and ensure patients are seen in a timely manner, and any delays to treatment are within a clinically acceptable timeframe:

- Clinical Divisions to concentrate efforts on reducing ASIs in the on top 4 specialties of Colorectal, Respiratory Medicine, Ophthalmology and Cardiology as the combined specialties represent 80% of the total waiting list.
- Clinical Divisions to review capacity and demand plans to minimise future ASIs.
- Clinical Divisions to support delivery of a Trust maximum standard of 11 working days from appointment identification to allocation to minimise impact on patient experience.

4.3 Patient Flow

A number of patient flow indicators are reported through the Trust's IPR and Divisional Performance Review.

A full report into Patient Flow, inclusive of A&E quality performance, is in development and will be available from Q2.

Domain Five – Well Led: The Leadership, management and governance of the organisation assure the delivery of high quality person centred care, supports learning and innovation and promotes an open and fair culture.

Well Led Compliance summary:

Indicator	Compliance
5.1 Safe Staffing	Reporting Only
5.2 Mandatory Training	Partial Compliance
5.3 Appraisal	Partial Compliance
5.4 Patient and Public Involvement	Reporting Only
5.5 Operational Management and Succession Planning	Reporting Only
5.5 Sickness and Absence	Reporting Only
5.6 Staff Experience and Engagement	Reporting Only
5.7 WRES	Reporting Only
5.8 Duty of Candour (DOC)	Reporting Only

Highlights:

- Safe Staffing – Roster efficiency tool introduced to support safe staffing levels and roster efficiency approval for overseas recrutiment campaign for nursing staff

- Sickness and absence – improved position (though can't tell what it has improved from)

- 7 Day service – progress in General Surgery towards a more Consultant delivered 7 day service.

5.1 Safe staffing

Aim and Objectives of Work

The Nursing Workforce Strategy Group implements and lead the Nursing and Midwifery Workforce Strategy, providing monitoring and assurance of the Nursing and Midwifery Workforce across the Trust.

Objectives include:

- To set direction of the Nursing and Midwifery Workforce including defining, monitoring and continually updating the Trusts policies and procedures to ensure that the workforce is safe, effective and able to deliver high quality compassionate care consistently;
- To monitor and manage the Hard Truths requirements ensuring data is accurate, utilised to provide assurance and incorporated into workforce planning;
- To define standards for the workforce;
- To oversee nursing establishments which are linked to acuity and dependency studies, evidence based tools and professional judgement.

1.0 Safe Staffing Levels

Average fill rates are monitored and reported to the Board each month. The report has been developed within the last quarter to include Care Hours Per Patient Day (CHPPD) data. Areas of concern are noted within the monthly report alongside mitigating action taken and any resulting impact from reduced staffing levels.

Areas with average fill rates of less than 75% for Registered Nurses (RN) have remained a challenge throughout the last quarter.

Table 1: Average Fill Rates Registered Nurses and Care Staff

Average Fill Rates				
	Registered Nurses		Care Staff	
	Day	Night	Day	Night
June 2016 HRI	87.1%	94.0%	104.9%	128.6%
June 2016 CRH	83.7%	92.0%	96.3%	110.1%
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%

Fill rates in excess of 100% have been reported for care staff within the last quarter. This has been attributed to supporting reduced fill rate for RN and providing 1-1 care requirements.

Average fill rates of less than 75% within the last quarter have been attributed to: increased bed capacity; sickness levels; vacancies and increased long days (resulting in the right number of nurses on shift, but reduced total nursing hours against planned per day.)

Average fill rates are reviewed by the senior nursing team at any point utilising the daily staffing tool, but as a minimum weekly reports are circulated to the senior nursing team.

During the last quarter the nursing workforce team have developed a roster efficiency tool which has been launched within divisions to aid weekly confirm and challenge sessions focussing on ensuring safe staffing levels and roster efficiency.

2.0 Staffing Data

The nursing workforce team have worked with health informatics and have begun to develop a dynamic dashboard to enable real time and accurate data to be available to assist in supporting safe staffing levels.

Quality dashboards developed by the nursing workforce team in 2015 are utilised and a task and finish group reviewing the content in light of recommended indicators to include following the recently published National Quality Board Guidance (2016).

CHPPD have been reported for the last two months externally and the nursing workforce team are reviewing planned against actual CHPPD each month for clinical areas.

As the efficiency portal is developed the nursing workforce team will review CHPPD against peers utilising the portal.

3.0 Recruitment and Retention

Best practice guidance published by Health Education England (2016) to inform retention of the nursing workforce has been reviewed by the nursing workforce strategy group and current practice mapped against this. A “Band 5” competency document based on the NMC’s standards for competency for registered nurses was launched to the nursing workforce in October 2015. Clinical teams are now utilising the document & records of compliance are held on ESR.

Following review of national frameworks & guidance in relation to preceptorship, CHFT have developed a new robust preceptorship document & support package for new registrants within the organisation

Recommendations for action have been taken forward to the nursing workforce strategy group and form part of the retention strategy currently being reviewed by the senior nursing team.

Recruitment both local and international has continued.

Robust keep in touch events for soon to be qualified nurses and midwives has been completed to maintain engagement with nurses / midwives recruited well in advance of their planned arrival at CHFT in September 2016.

International recruitment has continued via skype interviews resulting in 31 nurses arriving in 2016 to join CHFT. The available pool of nurses from the EEA has been impacted upon by the introduction of the IELTs requirement by the Nursing and Midwifery Council (NMC).

The nursing workforce team have worked with colleagues at CHFT and the NMC to assist nurses through the NMC registration process and will continue to support nurses through their IELTs requirements as this becomes necessary from Eighteenth July 2016.

Recent approval has been received by the team to undertake an overseas recruitment campaign for 75 nurses which is being developed at pace.

Further work with the communications team has been started to improve the recruitment and branding of the nursing workforce at CHFT

4.0 Additional roles within the Nursing Workforce

A task group has been reviewing additional roles and the potential benefits of introducing these at CHFT. Advance Clinical Practitioner roles; Associate Nurse roles and Assistant practitioner roles have been considered.

Scoping of areas which would benefit from additional roles within the workforce has been completed and the nursing workforce team are currently working with partners to develop next steps.

5.0 Conclusion

The Nursing Workforce Strategy Group continue to implement and lead the nursing workforce to ensure safe staffing levels are reviewed, monitored and reported.

5.2 Mandatory Training

Aims and objectives of the work

The aim of mandatory training is to help enable employees achieve safety and efficiency in a timely manner. The mandatory training programme enables the Trust to demonstrate that employees regularly have mandatory training designed to ensure they can undertake their job roles safely and maintain a safe and healthy work environment. The approach describes what training employees are required to complete, how often they are required to complete the training and how to access the training.

Current performance

Mandatory training compliance as at 30 June 2016 is detailed below:-

Compliance As Of: 30/06/2016	Information Governance	Equality and Diversity	Infection control	Moving and Handling	Health, Safety and Welfare	Safeguarding	PREVENT	Fire Safety	Dementia Awareness	Conflict Resolution
Medical	13.88%	81.56%	14.17%	84.60%	81.56%	74.62%	52.06%	10.05%	79.98%	75.63%
Corporate	13.04%	90.68%	13.04%	88.20%	88.82%	81.06%	80.12%	14.60%	84.16%	84.78%
Families & Specialist Services	11.74%	93.42%	11.26%	93.69%	92.88%	87.11%	72.86%	13.57%	91.11%	89.28%
Surgery & Anaesthetics	10.60%	88.01%	10.60%	88.88%	87.49%	82.88%	60.12%	17.29%	86.10%	82.54%
Health Informatics	6.57%	99.49%	9.09%	98.99%	99.49%	92.93%	87.37%	11.62%	96.97%	96.46%
Community	13.94%	93.35%	14.42%	92.38%	93.03%	87.36%	84.12%	13.94%	91.73%	88.49%
Estates & Facilities	12.10%	77.15%	13.44%	75.81%	76.61%	71.51%	46.77%	7.80%	75.81%	75.54%
Trust	**12.18%**	**88.24%**	**12.38%**	**88.88%**	**87.81%**	**81.90%**	**65.48%**	**11.10%**	**86.07%**	**83.40%**

Improvement plans for 2016/2017

Issues:-

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.

Response:-

Business case for replacement learning management system considered and approved by the July Commercial Investment and Strategy Committee meeting.

Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 31 July 2016.

Prevent paper to be submitted to Executive Board in July 2016 by Head of Safeguarding.

A paper describing the options to manage mandatory training compliance, as a consequence of EPR implementation in 2016, to be considered by Executive Board on 21 July 2016.

5.3 Appraisal

Aims and objectives of the work

A formal annual appraisal process provides employees with information around how they may be perceived within their team and organisation and offers constructive feedback about their performance at work. A good appraisal also helps colleagues understand the strengths they should capitalise on and the weaknesses where improvement may be required. This helps to ensure that each individual in the team understands how their input contributes to the whole and how achieving their goals will ensure the organisations vision of compassionate care is delivered.

The aims of the work are:-

- To ensure all colleagues have access to a simple and effective appraisal structure
- To maximise progress using that simplified structure towards the 100% annual target (90% by 31 December)
- To facilitate effective and timely reporting for the organisation to ensure compliance
- To provide access to a high quality appraisal interaction

Current performance

April	May	June	Target	Trajectory
4.28%	6.77%	6.77%	100.00%	24% (100% at 31 March 17)

Improvement plans for 2016/2017

Issues:-

There is an absence of a sanction for non-compliance.

The appraisal scheduler tool which captures planned activity has not in previous years been fully or consistently utilised.

Limited opportunity for appraiser training.

The quality of appraisal is reported through the staff survey as requiring improvement.

Response:-

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 – 31 July 2016.

Audit the use of the appraisal scheduler in Division/ corporate directorates to ensure a robust plan exists for all service areas - 15 August 2016.

A proposal for a pilot three-step appraisal training programme is being costed as part of a business case for resource for the Education and Learning Group.

An approach has been made to NHS Employers to commission an audit study of the quality aspect of appraisal.

5.4 Patient and Public Involvement

To be received in Q2 – reported to Quality Committee every 6 months.

5.5 Operational Management & Succession planning

Aims and Objectives

- New Operational management structure with increased opportunities for management progression within CHFT
- Introduction of clear Clinical Leadership structure
- Development and Implementation of a Talent Management Strategy

- Development and implementation of management & leadership development programme

Action plans are in place as part of the CQC response group. Currently on track to meet interim objective which include:

- Operational structures for Clinical Divisions agreed including opportunity for development at General Manager, Matron and ADD level
- Operational Management numbers increased and new Divisional support posts introduced to give opportunities for junior staff to become involved in management roles and ADDs to develop formal deputy functions to the COO
- Within nursing some developmental Matron roles in place and renewed; additionally band 6 posts increased and formal band 6 development posts in place and supported through all
- New Director of Nursing designing a ward manager development programme including awareness of management issues
- Clinical Management Proposals developed and agreed at Commercial Investment Committee; recruitment process and development plan yet to be confirmed
- Standards for managers being developed using a WTGR process
- Local management training programme in conjunction with University of Huddersfield

5.6 Sickness and Absence

Aims and Objectives

The Trust aims to ensure that employees are able to make the most effective contribution, individually and collectively, to improving the services that that Trust provides. Managing sickness absence and improving sickness rates is an indicator of creating both a healthier and more efficient workplace.

Current Performance

1) The table below shows the Trust's performance against the 4% threshold for Q1.

Quarter	CHFT (%)	2016/17 Q1	RAG
2016/17 Q1	4.41%	4.00%	

2) The table below shows the long term and short term sickness absence split for Q1.

Month	Avail FTE	ST FTE	LT FTE	ST FTE %	LT FTE %	Total Sickness %
2016 / 04	152,071.10	2,379.93	4,288.97	1.57%	2.82%	4.39%
2016 / 05	157,459.34	2,146.58	4,469.70	1.36%	2.84%	4.20%
2016 / 06	152,818.10	2,201.78	4,895.78	1.44%	3.20%	4.64%
	462,348.54	**6,728.29**	**13,654.44**	**1.46%**	**2.95%**	**4.41%**

3) The table below shows the sickness absence rate for Q1 2016/2017 in comparison to Q4 2015/2016 broken down by Division:-

Division	2015/16 Q4	2016/17 Q1	Change	Movement	Trust Threshold	RAG 2015/16 Q4	RAG 2016/17 Q1
Surgery	5.58%	5.05%	-0.53%	↓	4.00%	□	□
Medical	5.21%	5.51%	0.30%	↑	4.00%	□	□
Community	4.55%	4.41%	-0.14%	↓	4.00%	□	□
FSS	4.15%	3.62%	-0.53%	↓	4.00%	□	□
Estates	5.05%	4.44%	-0.61%	↓	4.00%	□	□
Corporate	2.80%	2.72%	-0.08%	↓	4.00%	□	□
THIS	2.13%	1.17%	-0.96%	↓	4.00%	□	□

Work undertaken in 2016/2017

100% of long term sickness absence have a 'wrap round' 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 2nd week each month.
Return to work forms analysed to ensure short term absence is managed in accordance with policy triggers.

Return to work interview dates to be automatically transferred from e-roster to ESR - 31 August 2016.

On a monthly basis contact non-compliance areas to obtain an understanding of the reasons why return to work interviews are not undertaken or recorded - 31 July 2016.

Drop in open surgery sessions for line managers organised - up to 31 August 2016.

5 worst performing areas identified in each Division and meetings to be held with Directorate Managers to discuss action required - 31 August 2016.

5.7 Staff Experience and Engagement

Staff Friends and Family Test

The Staff Friends and Family test aims to provide a simple, headline metric which can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients and the working conditions of its staff. The survey questions are:

A – Would you recommend your Trust as a place to receive treatment?
B – Would you recommend your Trust as a place to work?

The survey runs on a quarterly basis with the exception of Q3 (October to December) when the National Staff Survey takes place.

The 2016/17 Q1 survey was an on-line survey only and focused on Families and Specialist Services and THIS. The results are as follows:

Staff would recommend the Trust as a place to receive treatment:
FSS – 81%, THIS – 70%
Staff would recommend the Trust as a place to work:
FSS – 58%, THIS – 70%

Analysis of the qualitative feedback received through the surveys and actions plans are produced within the respective divisions in order to identify themes and the necessary responses to improve colleague experience in the Trust. These actions are monitored by the Colleague Engagement, Health and Wellbeing Group and learning shared between divisions.

NHS Staff Survey

The Trust participated in the 13th national annual NHS Staff Survey in 2015. A total of 850 colleagues were randomly selected in our sample by Picker Institute Europe, our survey administrator. The formal benchmarking results were released by NHS England on 23 February 2016. The Trust incorporated local questions in the survey in the same way as it did in 2014 focusing on patient experience, raising concerns, Trust values and its financial position.

The following initiatives have been introduced in 2015/16:

- Colleague engagement and communication plan supported by divisional specific plans
- "Star Award" – we made our first nomination in January – a Wall of Fame has been introduced on each of the hospital sites
- Appraisal planning tool
- New approach to mandatory training – online access (compliance to be monitored by the Colleague Engagement, Health and Wellbeing Group)
- Back to the floor/leadership walk round activity
- Monthly 'Big Brief' events led by Executive Directors
- 'Ask Owen' facility on the intranet
- Work Together Get Results (WTGR) workshops with senior teams to support the sustainability of the consistent approach to change management that has colleague engagement at its core
- Enhanced resources for line managers to assist in the management of colleague health and well being

- Board of Directors Workforce Committee with a sub group structure that includes colleague feedback, which will support the design of a more effective feedback capture model and robust response to feedback to ensure continuous improvement
- Attendance Management Team with dedicated resource into divisions
- Focus group activity as part of the CQC Inspection preparations and Investors in People assessment*
- Redesign of the Trust's website
- Focus groups for staff to improve engagement on the staff survey results
- Focus groups for BME staff to improve opportunities for career progression, training and development led by the Chief Executive

* The Trust had a successful outcome to a recent Investors in People (IIP) assessment against the national IIP Standard. The Trust achieved a Bronze Award – one step up from the core standard recognition in previous years.

Further Developments for 2016/17

- A colleague health and wellbeing strategy, developed through involvement of key stakeholders
- A recruitment and retention strategy, developed through involvement of key stakeholders
- Extend the Trust's values-based recruitment approach to all staff groups (already operational for therapies and diagnostic staff)
- BME Staff Network commencing in September 2016
- Colleague Engagement Network commencing in September 2016
- Develop a social media engagement plan
- Create a network of "raising concerns" champions to signpost colleagues to appropriate resources and processes
- Design a communication strategy to support the "raising concerns" process

The Trust will be participating in the 14th national annual survey from September 2016 using the basic sample, which has been increased in 2016 to 1,250.

5.8 Duty of Candour

The Trust Being Open/Duty of Candour Policy and Incident Reporting Policy sets out that the Trust has a duty to limit the potential impact of clinical and non-clinical risks and put in place robust and transparent systems to make sure that all incidents which might cause actual or potential harm to patients, visitors and staff are identified, investigated and rectified.

In particular, it involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment or when in-patients or outpatients of the Trust. Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out the legal obligation under-pinning the Duty of Candour.

During Quarter 1 there were 4 duty of candour breaches across red and orange incidents.

Improvement Plans:

Revised performance management framework will increase accountability within divisions for monitoring and delivery of duty of candour.

Meeting with CCG in quarter 2 to re-affirm Trust position regarding duty of candour at both the start and end of an incident and the investigation.

The Trust will continue to implementation of duty of candour internal audit report recommendations.

5.9 7 Day Services

Background

7DS (7-day services) is a nationally driven Quality Improvement initiative and is a key area of focus on the trust's QI plan. It stems from an initial perspective that patients admitted over the weekend were at a greater risk of dying than patients admitted during the week. This has been subject to some controversy and the evidence to support is somewhat contradictory. Never the less the emphasis is now more about reducing variation in care over the seven days for better patient experience, reduced LOS (length of stay) and readmissions, and possibly improved patient outcomes such as mortality. The vehicle driving this improvement are the 7DS ten clinical standards described by Sir Bruce Keogh. Whilst these standards refer to unplanned admissions to hospital there is an emphasis on a multi-agency response to 7DS especially with respect to standard 9. For further information regarding the ten clinical standards: http://www.nhsiq.nhs.uk/media/2638611/clinical_standards.pdf

NHSE have stipulated that standards 2 (time to first consultant review), 5 (diagnostics), 6 (consultant led interventions) and 8 (on-going review) are priority standards for implementation. CHFT, as part of West Yorkshire, is an early implementer of these priority standards aiming to achieve compliance by March 2017.

Current Performance

To date the focus has been on understanding the trust's current position (Reality) against the clinical standards. In September 2015 the trust submitted data towards the first national 7DS survey. The results from the 2015 survey demonstrated significant gaps against all four priority standards with the exception of General Surgery. Following this there was an initial high level review of the potential cost of implementing the four priority standards across all specialties. This cost highlighted the extreme challenge in achieving compliance with the priority standards and therefore further work was undertaken looking specifically at Medicine.

Early in 2016 CHFT collaborated with colleagues from NHSI to develop a high level action plan submitted to NHSE. The action plan detailed the challenges faced by CHFT with particular reference to the 5-year plan for the future of hospital services.

In April 2016 the trust submitted data once again towards the second 7DS national survey. The methodology differed to the first survey and involved a review of 40 unplanned admissions for 7 consecutive days. The results published in June 2016 showed that just under 50% of all unplanned admissions are to acute medicine with 15% to general surgery and paediatrics equally. The survey data showed variable performance against each standard but overall still below expected to be deemed to be compliant. A full analysis of the 2016 survey is attached.

The current position is that the 2015 and 2016 surveys have been shared with Clinical Directors with a request for each directorate to develop their own action plan for improvement. Directorate action plans will be collated to form a trust-wide action plan with the aim of further

reviewing the high level cost for implementing 7DS balanced with qualitative and financial benefits to the organisation.

Finally, there has been a significant improvement in General Surgery towards a more consultant delivered 7-day service. Early indicators are that these changes have seen significant improvements in surgical outcomes and possibly mortality too but not LOS. Further work is needed to evaluate the impact on patient experience and outcomes whilst optimising the consultant delivered service. It should however be noted that these changes in general surgery did incur an additional financial burden on the trust and for a period a reduction in planned activity.

Improvement plans for 2016/17
Much of the plan for improvement for 2016/17 is detailed above. As stated Directorate action plans are being formed to support a trust-wide action plan for 7DS. It is anticipated that this trust-wide plan leads to a further more detailed analysis of the cost of implementing 7DS versus the qualitative and financial benefits from improved LOS.

Finally we are actively engaged in dialogue with CCGs and partners in both health and social care on a system response to 7DS. A multi-agency event was held on 13 July 2016 with good representation from commissioners, other acute and community providers, and social care from both Kirklees and Calderdale. A proposal lead by CHFT and Calderdale CCG is being developed and will be proposed to the System Resilience Group later this year.

5.10 Workforce Race Equality Standards (WRES)

Background

The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Simon Stevens, Chief Executive of NHS England, said: "The Five Year Forward View sets out a direction of travel for the NHS – much of which depends on the health service embracing innovation, engaging and respecting staff, and drawing on the immense talent in our workforce.

"We know that care is far more likely to meet the needs of all the patients we're here to serve when NHS leadership is drawn from diverse communities across the country, and when all our frontline staff are themselves free from discrimination. These new mandatory standards will help NHS organisations to achieve these important goals.

A number of key pieces of work have been commenced and a full report will be available from Q2.

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 29th September 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: CQC Inspection update - This is an update to the Trust Board about proposals to manage the CQC inspection report recommendations. This paper also provides an overview of the stages within the CQC process and describes the current position for CHFT and details the actions taking place.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee 23rd August 2016	
Governance Requirements: To approve the response process described within the paper.	
Sustainability Implications: None	

Executive Summary

Summary:

This is an update to the Trust Board of Directors about proposals to manage the CQC inspection report recommendations. This paper also provides an overview of the stages within the CQC process and describes the current position for CHFT and details the actions taking place.

Main Body

Purpose:

The Trust Board of Directors is asked to approve the proposed method of managing the findings from the CQC reports.

Background/Overview:

Please see detail within attached paper.

The Issue:

Please see detail within attached paper.

Next Steps:

Detailed under recommendations within Next Steps listed within attached paper.

Recommendations:

To approve the actions recommended in the paper

Appendix

Attachment:

CQC update and next steps paper - Sept 16.pdf

CQC update – August 2016

1. Introduction

This is an update to the Trust Board about proposals to manage the CQC inspection report recommendations. This paper also provides an overview of the stages within the CQC process and describes the current position for CHFT and details the actions taking place.

The CQC inspection process has several phases;

- initial data gathering and confirming of the data
- planning for the inspection
- the actual inspection and immediate follow up including further data submission
- receipt of the draft document for factual accuracy checking and possible challenge to the ratings
- Quality Summit and production of the action plan
- further follow up inspections on areas that require improvement

2. CHFT current position

2.1 Report

The final report was published on the CQC website on Monday 15th August 2016. There was a press rerelease from both the Trust and the CQC.
A number of staff briefing sessions were delivered by the Chief Executive and the Director of Nursing during this day.
The final overall rating for the Trust was requires improvement, with over 70% of service areas rated as good.

Final ratings for Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

2.2 Factual accuracy checks

The draft document for factual accuracy checking was received on the 25th July 2016 and the Trust was given until 09.00 on the 9th August 2016 to submit any factual accuracy challenges and any challenges to the ratings for the core services. The reports were sent to a number of colleagues within the organisation for them to review with their teams and return to the Quality Team for checking and collation.

We returned 27 documents to the CQC which included 524 challenges and 8 ratings challenges. Additionally we submitted a letter which challenged 7 of the requirement notices served by the CQC.

Core services	Site	Documents returned to CQC	Ratings challenged	Ratings amended	Number of factual accuracy challenges made	Number accepted
ED	CRH	1			23	23
	HRI	1			22	19
Medical care	CRH	1			17	13
	HRI	1			11	8
Surgery	CRH	1			2	1
	HRI	1			2	1
Critical care	CRH	1	Safe, Well Led	Safe	50	41
	HRI	1	Safe, Well Led	Safe	58	46
Maternity & gynaecology	CRH	1	Well Led		30	24
	HRI	1	Well Led	Well led	24	21
Children & Young people	CRH	1	Well led		36	26

	HRI	1	Well led		32	22
End of life care	CRH	1			26	26
	HRI	1			27	27
Outpatients	CRH	1			14	11
	HRI	1			16	11
Community adults		1			14	13
Community children		1			9	9
Community end of life care		1			0	
Trustwide		1			49	40
Corporate HRI		1			13	10
Corporate CRH		1			21	18
Safeguarding		5			28	19
Total		**27**	**8**		**524**	**429 (82%)**

The factual accuracy checks dealt with a number of issues which included;

- minor recommendations include grammatical changes
- requests to change the tone of statements, usually to provide more balance to the statement
- changes to the data either to correct data that we had submitted as part of the investigation process or to query data that we did not believe related to us and hadn't been submitted by us
- requests to remove statements and we provided evidence to support the request
- request to reconsider and reword statements in light of further information supplied by us

The Trust received feedback on the factual accuracy challenges on the 15th August, with 82% of these being fully or partially accepted.
The most frequent reasons for rejecting our challenges were:

- Data that had been previously supplied by the Trust, e.g. staffing levels, training rates,
- Observed at the time of inspection, e.g. availability of rota for GI bleeds, availability of action plans
- Descriptions given by staff, e.g. feedback from incidents, understanding of Duty of Candour
- CQC guidance e.g. Endoscopy sits in CQCs 'Medical Care' core service framework, whereas this is part of the surgical services at CHFT

2.3 Rating Challenges

As part of this process we had to consider whether we believed the ratings were an accurate reflection of the evidence supplied within the report. After considering the report and the feedback from colleagues we have submitted 8 rating challenges, these are described above. We also engaged with Capsticks solicitors to help with the evidence to support the challenge.

The challenges were considered at the final CQC panel meeting which took place on 11th August, 3 of these were successfully amended from requires improvement to good:

- Critical care HRI – safe
- Critical care CRH – safe
- Maternity & gynaecology HRI – well led.

These resulted in a change to the overall rating for maternity & gynaecology at HRI moving from requires improvement to good.
The overall trust score for Responsive was also moved from requires improvement to good.

3. Next Steps

3.1 Trust action plan

The report is now being used to inform a Trust action plan. This is based on the 19 must do and 12 should do actions detailed in the final report (appendix 1), which also feature in the requirement notices issued to indicate where the Trust is failing to meet the fundamental standards (appendix 2).

The Trust plan contains **all** must and should do actions, some of which impact on all Divisions and others which are specific to a core service and impact on an individual division.

3.2 Divisional improvement and sustainability plans

These plans will be made up of issues raised in the core service reports that do not feature in the must and should do actions, along with any actions migrated from existing plans which are required to ensure services sustain the good practice observed at the time of the CQC inspection.

3.3 Management of the plans

Each action will indicate:

- The associated CQC domain and whether the action is relevant for all services or a specific core service.
- The issue / issues raised by the CQC that led to the action
- The expected outcomes (measurable)
- The Director responsible for the action
- The manager responsible for delivery of the action
- The group / committee / board with responsibility for the governance oversight of the action

A BRAG rating will be applied to each of the actions within the plan, using the framework bellow:

Delivered and sustained
Action complete
On track to deliver
No progress / Not progressing to plan

In order for an action to become green, robust evidence is required as assurance that:

- The action has been completed
- The action will achieve the intended impact
- Any identified risks are captured on the risk register
- There is a plan in place to monitor the effectiveness of the actions, including the impact for patients / staff

In order for an action to become blue, a period of monitoring / measuring must be completed which demonstrates:

- A sustained delivery of the expected outcome

3.4 Governance arrangements

CQC Response Group: oversee the delivery of the plan, monitor progress, sign off actions, agree submission of sustained position to the Trust Quality Committee (must and should do actions)

Trust Quality Committee: provide assurance to the Board that the plan is achieving the expected impact and give final sign off for sustained actions.

WEB: receive a monthly report ahead of the Quality Committee, in order to be informed of any emerging concerns and agree any actions required by WEB.

Divisional PSQBs: oversee the delivery of the core service plans; escalate to Divisional performance meetings by exception any impacts on performance requiring Executive support, provide progress updates to the CQC Response Group.

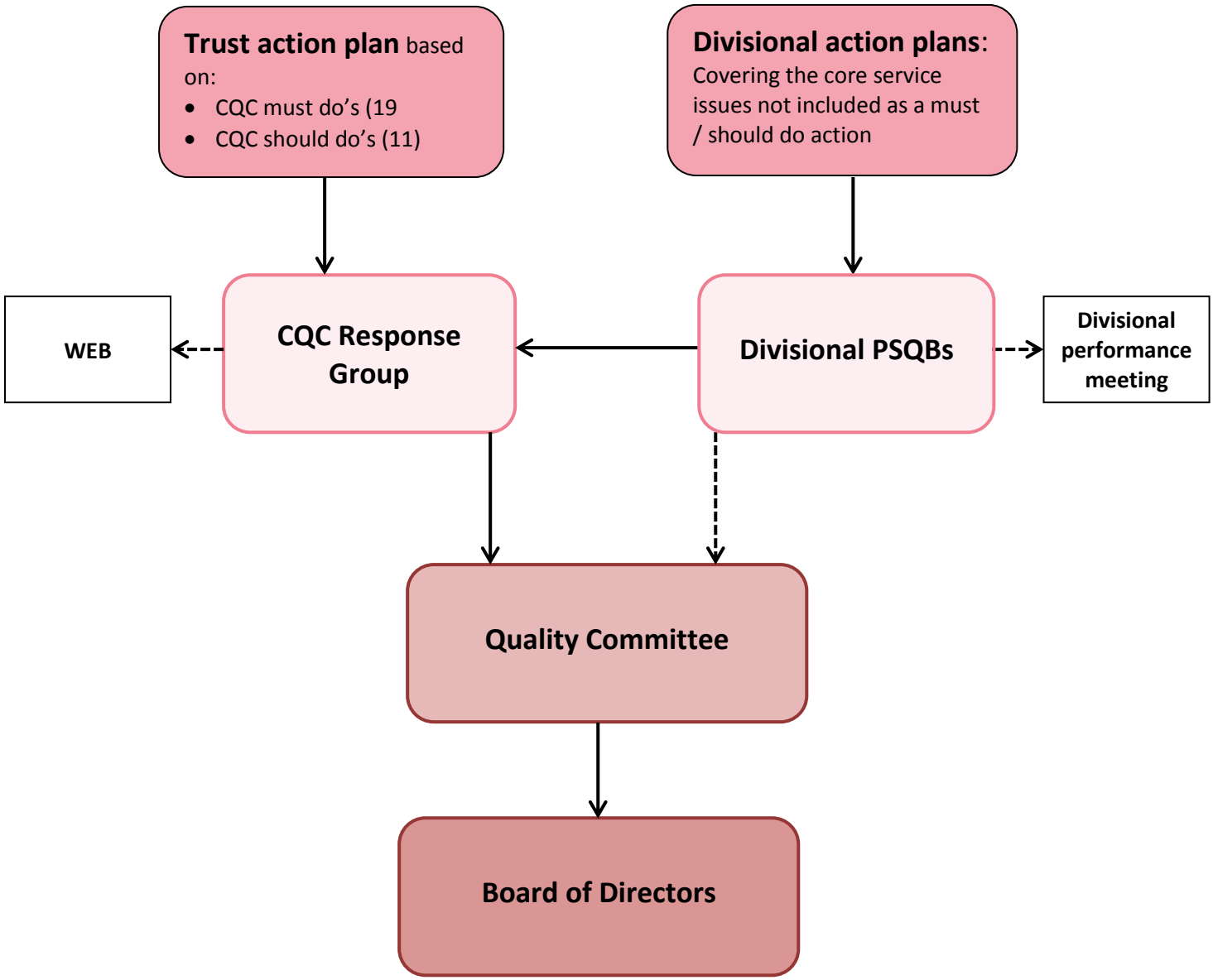
3.5 Reporting

- The CQC Response Group will receive a monthly update of all the must and should do actions. In addition there will be a reporting schedule for receipt of Divisional updates.
- The CQC Response Group will provide a monthly update report to the Quality Committee focused on the must / should do plan. This will include any proformas requesting green → blue sign offs.
- Divisional updates to the Quality Committee will be included in the Quarterly Divisional PSQB reports.
- The Quality Committee will provide a monthly assurance report to the Board of Directors.

4.0 Recommendations

- The Trust Board is asked to approve the proposed method of managing the findings from the CQC reports.

Governance arrangements



Appendix 1

Must do actions:

• The trust must continue to ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
• The trust must continue to embed and strengthen governance processes within the clinical divisions and at ward level.
• The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.
• The trust must continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.
• The service must ensure staff have an understanding of Gillick competence.
• The trust must continue to identify and learn from avoidable deaths and disseminate information throughout the divisions and the trust.
• The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role. The service must also ensure all relevant staff are aware of Female genital mutilation (FGM) and the reporting processes for this.
• The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.
• The trust must ensure that interpreting services are used appropriately and written information is available in other languages across all its community services.
• The trust must ensure that appropriate risk assessments are carried out in relation to mobility and pressure risk and ensure that suitable equipment is available and utilised to mitigate these risks.
• Within maternity services the service must focus on patient experience and ensure women feel supported and involved in their care.
• The trust must review the provision of a second emergency obstetric theatre to ensure patients receive appropriate care.
• The trust must continue work to reduce the numbers of third and fourth degree tears following an assisted birth and the incidence of PPH greater than 1500mls following delivery.
• The trust must review the admission of critical care patients to theatre recovery when critical care beds are not available to ensure staff suitably skilled, qualified and experienced to care for these patients.
• The trust must continue to review arrangements for capacity and demand in critical care.
• The trust must ensure that patients on clinical decision unit meet the specifications for patients to be nursed on the unit and standard operating procedures are followed.
• The trust must ensure there are improvements to the timeliness of complaint responses.
• The trust must ensure there is formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant
• The trust must review the model of care for the services provided on the paediatric assessment unit at Huddersfield Royal Infirmary.

Should do actions:

• The trust should ensure that the equipment inventory is updated in community adult services and that all equipment in use is properly maintained and checked.
• The trust should review the availability or referral processes for formal patient psychological and emotional support following a critical illness.
• The trust should review the handover arrangements from the hospital at night team to the critical care team to ensure continuity of patient care across the hospital.
• The trust should ensure that relevant staff have received training in root cause analysis to enable them to provide comprehensive investigations into incidents.
• The trust should provide consultation opportunities and team collaboration in the development and completion of its business strategy and vision for end of life care.
• The trust should ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.
• The trust should ensure signage throughout the HRI main building and Acre Mills reflect the current configuration of clinics and services.
• The trust should ensure there is access to seven-day week working for radiology services.
• The trust should continue to escalate, take an action plan forward and meet with stakeholders about therapy service provision.
• The trust should audit the effectiveness of the pathway between midwifery and the health visiting service.
• The trust should ensure that staff are informed about new tendering arrangements as they develop.
•The trust should ensure that there are systems to measure effectiveness and responsiveness of the services within community adult services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) Care and treatment must be provided in a safe way for service users How the regulation was not being met: Medicines were not always managed appropriately. Within the medical, surgical and maternity divisions there was inconsistent monitoring of medicines requiring refrigeration. For example out of range fridge temperatures were not always acted upon. On one of the medical wards visited we identified that a controlled drug date expired but this had continued to be administered on a further five occasions over three days before a replacement supply was obtained Within maternity services controlled drug checks were not always checked in line with trust policy and recorded. In critical care services there were delays in discharges and admissions which led to patients being cared for in the theatre recovery area. There was no formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance

Regulation 17 (1) Systems and processes must be established and operated effectively to:

(2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.

How the regulation was not being met:

There was a governance framework in place however there was a need to embed and strengthen governance processes within the clinical divisions and at ward level.

During the inspection there were a number of concerns raised within maternity services there was limited assurance that the systems in place for sharing information, monitoring and identifying risks were effective in addressing these concerns.

At the inspection there were issues with flow and these had not been identified and therefore adequately addressed and patients were being admitted to the CDU for inappropriately long times.

There was a lack of comprehensive data for community adult services which impacted on the ability of the service to measure its effectiveness and responsiveness.

Data provided by the trust was not always accurate with different information provided for the same time period. Mandatory training and appraisals data was unreliable with trust and divisional data differing from ward level records.

There was a backlog across the trust in responding to complaints and this failed to meet the trust timescales.

Within children's services there were some patient safety issues identified on the inspection. The trust's own systems had not highlighted these risks. For example resuscitation trolleys behind locked doors, button batteries in unlocked cupboards in an area accessible to children.

Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty. How the regulation was not being met: Nurse staffing levels in some clinical areas were regularly below the planned number. This included accident and emergency for nursing and medical staffing, medical care, children's services and adult community services. Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform. How the regulation was not being met: Staff appraisals were below trust target in some areas. There were variable rates of appraisals across the divisions within the trust. In some services there was inconsistency in the way staff received clinical supervision and this required standardising and strengthening. At least 50% of nursing staff should have post registration training in critical care nursing; this had been completed by 39% of nursing staff. Mandatory training compliance did not meet the trust's target in several areas including accident and emergency, medical care, critical care, maternity services, children's services and community adult services. Level 2 and Level 3 children's safeguarding training compliance in children's and maternity services was below the trust target of 100%. Within maternity services there was variable knowledge and understanding of female genital mutilation. Level 2 safeguarding adults training was also below the trust target in maternity services, surgical services and medical services.

There was variable understanding of the mental capacity act and deprivation of liberty safeguards.

There were occasions where critical care patients were cared for in recovery. Theatre nursing staff were not trained in critical care competencies and access to ITU staff for support and advice was limited.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th September 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - SEPTEMBER 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. Review of Board of Directors Meeting Dates
2. Board Workplan
3. Use of Trust Seal
4. Board of Directors Attendance Register
5. Declaration of Interests Register - BOD
6. NHS Improvement - Feedback from Q1 Submission

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. Review of Board of Directors meeting dates
In line with the revised performance management arrangements, the Board agreed to move its meeting to the first Thursday in the month (action 109/16).
The Board is asked to AGREE the revised meeting dates attached at Appendix 1.

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 y

3. Use of Trust Seal
Five documents have been sealed since the last report to the Board in June 2016 and a copy of the register of sealing is attached for information at Appendix 3. These were in relation to:-
- Integrated Sexual Health Services Contract (Calderdale)
- Works to install a key fob system
- Variation to the contract for Calderdale Royal Hospital
- Speech and Language Therapy Contract extension (Calderdale)
- Variation to Pennine Property Partnership Contract
The Board is asked to RATIFY the sealings.

4. 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 March to August 2016 is attached at appendix 4.
The Board is asked to NOTE the attendance register.

5. Board of Directors Declaration of Interest Register
The Board of Directors Declaration of Interest Register is at appendix 5
Board members are asked to CONFIRM that their entry on the Register is correct before publication on the Trust website.

6. Q1 Response from NHS Improvement
The Trust received feedback from NHS Improvement in relation to the Q1 2016/17 submission and a copy is attached at appendix 6.
The Board is asked to RECEIVE the Q1feedback.

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:
1. Agree the Review of Board of Directors Meeting Dates
2. Agree the items on the Board Workplan and consider any outstanding
3. Ratify the Sealings
4. Note the attendance register
5. Confirm the entries on the Declaration of Interest Register
6. Receive the NHS Improvement - Feedback from Q1 Submission

Appendix

Attachment:

COMBINED GOVERNANCE REPORT ATTACHMENTS.pdf

This page has been left blank

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

REVISED BOARD OF DIRECTORS MEETINGS – NOVEMBER 2016 TO DECEMBER 2017

Unless otherwise stated all meetings will commence from 9.00 am – 12.30 pm in the venues indicated below unless otherwise stated:

DATE OF BOD MEETING		VENUE
Thursday	3 November 2016	HRI - Boardroom
Thursday	1 December 2016	HRI - Boardroom
Thursday	5 January 2017	CRH – Large TR
Thursday	2 February 2017	HRI – DR 1
Thursday	2 March 2017	HRI – DR 1
Thursday	6 April 2017	HRI - Boardroom
Thursday	4 May 2017	CRH – Large TR
Thursday or Friday	25 May 2017 ? PM OR 26 May 2017 ? AM (Signing off ARA)	(25.5.16) - CRH – Large Training Room, Learning Centre **AND** (26.5.16) – CRH Large TR
Thursday	1 June 2017	CRH – Large TR
Thursday	6 July 2017	Todmorden Health Centre
Thursday	3 August 2017	CRH – Large TR
Thursday	7 September 2017	HRI - Boardroom
Thursday	5 October 2017	CRH – Large TR
Thursday	2 November 2017	HRI - Boardroom
Thursday	7 December 2017	CRH – Large TR

CRH - Lge TR, LC = Calderdale Royal Hospital Large Training Room, Learning Centre, HX3 0PW
HRI – Boardroom = Huddersfield Royal Infirmary, Boardroom, HD3 3EA
HRI – DR1 = Huddersfield Royal Infirmary, Discussion Room 1, Learning Centre HD3 3EA

KB/BOD-REVISED BOD MEETING DATES NOV 2016 – 2017
Sept 2016

DRAFT BOARD WORK PLAN 2016-2017 - WORKING DOCUMENT - NOT SUBMITTED – UPDATED 1.9.16

Date of meeting	28 April 2016	26 May	30 June	28 July	25 Aug (NO MEETING)	29 Sept	27 Oct MEETING CANCELLED	3 Nov	1 Dec	5 Jan 2017	2 Feb 2017	2 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		24.10.16	5.12.16	19.12.16	23.1.17	20.2.17
Date final reports required	20.4.16	18.5.16	22.6.16	20.7.16	17.8.16	16.9.15		26.10.16	7.12.16	21.12.16	25.1.17	22.2.17
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/SOD review (+ March 2017)								✓				
- Non-Executive appointments (+ Nov - SINED & Deputy)								✓				
- Board workplan			✓			✓			✓			✓
- Board skills / competency									✓			
- Code of Governance	✓											
- Board meeting dates						✓						

- Committee review and annual report												✓
Date of meeting	**28 April 2016**	**26 May**	**30 June**	**28 July**	**25 Aug (NO MEETING)**	**29 Sept**	**27 Oct MEETING CANCELLED**	**3 Nov**	**1 Dec**	**5 Jan 2017**	**2 Feb 2017**	**2 March 2017**
- Annual review of NED roles								✓				
- Use of Trust Seal			✓			✓			✓			✓
- Quarterly Feedback from NHSI			✓			✓			✓			✓
- Declaration of Interests (annually)												✓
- Declaration of Interests Policy (Jan 2018)												
- Attendance Register (Apr+Oct 2017)						✓						
- BOD TOR + Sub Committees												✓
- Constitutional changes (+as required)								✓				
- Compliance with Licence Conditions (April 2018)												
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	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
ANNUAL ITEMS												
Annual Plan												✓
Annual Plan feedback from Monitor						✓						
Date of meeting	**28 April 2016**	**26 May**	**30 June**	**28 July**	**25 Aug (Prov)**	**29 Sept**	**27 Oct MEETING CANCELLED**	**3 Nov**	**1 Dec**	**5 Jan 2017**	**2 Feb 2017**	**2 March 2017**
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)				
Capital Programme												✓
Equality & Inclusion update				✓ (update)						✓(AR)		
DIPC annual report				✓								
Fire Safety annual report		✓										
Medical revalidation & appraisal				✓								
Whistleblowing Annual Report										✓		
Review of Board Sub Committee TOR								✓				
ONE-OFF ITEMS												
Membership Council Elections	✓											
Single Oversight Framework (VP/GB)						✓						

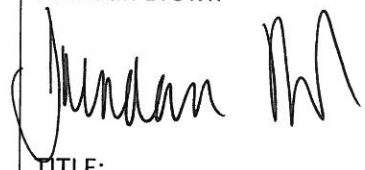
DRAFT BOARD WORK PLAN 2016-2017 - WORKING DOCUMENT - NOT SUBMITTED – UPDATED 1.9.16

Date of meeting	28 April 2016	26 May	30 June	28 July	25 Aug (Prov)	29 Sept	27 Oct MEETING CANCELLED	3 Nov	1 Dec	5 Jan 2017	2 Feb 2017	2 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	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Hospital Programme Board minutes						✓		✓	✓	✓	✓	✓
EPR update (monthly)	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
5 Year Strategic Plan								✓	✓	✓	✓	✓
Property Partnership/St Luke's Hospital/PR (as required)						✓						
Equality and Diversity (discussion)		✓										
Sustainability and Transformation Plan						✓						

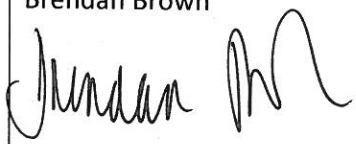
REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
244	12.7.16	12.7.16	Public Health Services Contract – Integrated Sexual Health Services	NAME: Keith Griffiths,  TITLE: Exec Director of Finance
				NAME: Victoria 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
245	10.8.16	10.8.16	Confirmed Works Variation relating to Elmdale Ward Key Fob System	NAME: Brendan Brown  TITLE: Exec Director of Nursing
				NAME: Victoria 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
246	10.8.16	10.8.16	Confirmed Variation Instruction 63 – PFI Hospital Project	NAME: Brendan Brown  TITLE: Exec Director of Nursing
				NAME: Victoria 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
247	16.8.16	16.8.16	Speech and Language Therapy – Contract Extension – Calderdale Council/CHFT – Variation Agreement	NAME: Brendan Brown TITLE: Exec Director of Nursing
				NAME: Victoria 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
248	5.9.16	5.9.16	Agreement to Vary the Contract – Pennine Property Partnership – SLHsp and Surplus Land, Acre Mill	NAME: Brendan Brown  TITLE: Exec Director of Nursing
				NAME: Victoria Pickles  TITLE: Company Secretary

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) NO MEETING	15.9.16 JOINT BOD/ MC AGM	29.9.16	27.10.16 MEETING RE-ARRANGED TO 3.11.16	3.11.16	1.12.16	5.1.17	2.2.17	2.3.16	TOTAL
A Haigh (Chair)	√	√	√	√	-	√		-						
D Anderson	√	x	√	√	-	√		-						
Helen Barker	√	√	√	√	-	x		-						
D Birkenhead	√	√	x	√	-	√		-						
B Brown (from 13.6.16)	-	-	√	√	-	x		-						
K Griffiths	√	√	√	√	-	√		-						
K Heaton	√	√	√	√	-	x		-						
L Hill	√	√	x	√	-	x		-						
R Hopkin	√	√	√	√	-	x		-						
P Oldfield	√	√	x	√	-	x		-						
L Patterson (Sabbatical leave 1.1.16 to Sept 2016)	-	-	-	-	-	√		-						
P Roberts	√	√	√	√	-	x		-						
I Warren (from 1.8.16)	-	-	-	-	-	√		-						
O Williams	√	√	√	√	-	√		-						
J Wilson	√	√	√	√	-	√		-						
Vicky Pickles	√	√	√	√	-	√		-						
J Green (Interim Dir W & OD from April 2015 – 30.6.16)	√	√	x	-	-	-	-	-	-	-	-	-	-	
A Basford	√	√	√	√	-	√								
Mandy Griffin	√ (private)	√	√	√	-	√		-						
Lindsay Rudge (Acting DoN)	√	√	-	-	-	√		-						

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)	-
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 – fee paid to CHFT
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 Hopkin	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
19.9.16	Brendan Brown	Executive Director of Nursing	-	-	-	-	-
21.9.16	Ian Warren	Executive Director of Workforce and OD	-	-	-	-	-

All the above Board Directors have confirmed that they continue to comply with the Fit and Proper Person Requirement

STATUS: COMPLETE

P:Declaration of Interest-bod - kb

31 August 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

Q1 2016/17 monitoring of NHS foundation trusts

Our analysis of your Q1 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 in September.

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.

We have already raised our concerns arising from our review of the trust's Q1 submissions in our letter dated 16 August 2016, following our Progress Review Meeting on 19 July 2016.

A report on the aggregate performance of all NHS providers (Foundation and NHS trusts) from Q1 2016/17 is available on our website (in the Resources section), which I hope you will find of interest.

For your information, we have issued a press release setting out a summary of the report's key findings.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0484 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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th September 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: SINGLE OVERSIGHT FRAMEWORK - With effect from 1 October 2016, NHS Improvement will be using the Single Oversight Framework to monitor and oversee all providers (both Foundation Trusts and NHS Trusts). The framework is also intended to identify where providers may benefit from or require improvement support across a range of areas.	
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 Finance and Performance Committee	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

With effect from 1 October 2016, NHS Improvement will be using the Single Oversight Framework to monitor and oversee all providers (both Foundation Trusts and NHS Trusts). The framework is also intended to identify where providers may benefit from or require improvement support across a range of areas.

The Single Oversight Framework replaces Monitor's Risk Assessment Framework.

Main Body

Purpose:

To describe the Single Oversight Framework and the main changes for the Trust from the Risk Assessment Framework.

Background/Overview:

All NHS foundation trusts require a licence from Monitor (now NHS Improvement) stipulating the specific conditions they must meet to operate, including financial sustainability and governance requirements. The Risk Assessment Framework was the document used by Monitor to assess each NHS foundation trust's compliance with two specific aspects of its provider licence: the continuity of services and governance licence conditions.

The Issue:

The paper describes the five themes within the new oversight framework and, where the information is available, the way in which the Trust will be assessed against these themes.
The paper also describes the segmentation process whereby NHS Improvement will identify the level of support and oversight for each Trust.

Next Steps:

The Integrated Board Report will incorporate reporting on the new SOF from October and further updates as to its implementation by NHS Improvement will be brought to the Board as they are released. The list of trust segmentation is likely to be published in November.

Recommendations:

The Board is asked to NOTE the new Single Oversight Framework.

Appendix

Attachment:

Board report on SOF.pdf

1. PURPOSE OF THE REPORT

1.1 To describe the Single Oversight Framework and the main changes for the Trust from the Risk Assessment Framework. This report is being considered in more detail at the Finance and Performance Committee on 26 September to assess the impact on the Trust, our licence position and the likely segmentation.

2. BACKGROUND

2.1 All NHS foundation trusts require a licence from Monitor (now NHS Improvement) stipulating the specific conditions they must meet to operate, including financial sustainability and governance requirements. The Risk Assessment Framework was the document used by Monitor to assess each NHS foundation trust's compliance with two specific aspects of its provider licence: the continuity of services and governance licence conditions.

2.2 The Risk Assessment Framework looked at:

- significant risk to the financial sustainability of a provider of key NHS services that endangers the continuity of those services and/or
- poor governance at an NHS foundation trust, including poor financial governance and inefficiency.

2.3 As part of this NHS foundation trusts were assigned a financial sustainability risk rating (CoSRR) calculated using a capital service metric, liquidity metric, income and expenditure (I&E) margin metric and variance from plan metric. The Trust has a CoSRR of 2.

2.4 The governance rating was determined using information from a range of sources including national outcome and access measures, outcomes of Care Quality Commission (CQC) inspections and aspects related to financial governance and delivering value for money. The Trust has a red governance rating due to our breach of licence.

3. CURRENT POSITION

3.1 From 1 October, NHS Improvement (NHSI) is introducing the Single Oversight Framework (SOF) which brings together elements of the Monitor Risk Assessment Framework and the NHS Trust Development Authority Accountability Framework. It applies equally to all trusts.

3.2 The SOF aims to provide an integrated approach for NHSI to oversee both foundation trusts and NHS trusts, and identify the support they need to deliver high quality, sustainable healthcare services. It aims to help providers attain and maintain CQC ratings of 'good' or 'outstanding'.

3.3 In carrying out its role NHSI will oversee and assess providers' performance against five themes:

	Theme	Overview of oversight measures
1	Quality of Care	NHSI will use CQC's most recent assessments of whether a provider's care is safe, effective, caring and responsive in combination with in-year information where available Delivery of the four priority standards for 7-day hospital services
2	Finance and use of resources	Focus on a provider's financial efficiency and progress in meeting its control total Use of resources approach is being co-developed with CQC
3	Operational performance	NHS constitutional standards (18 week wait; cancer referrals) Other national standards (62 day cancer; A&E 4 hours; 6 week diagnostics)
4	Strategic change	How well providers are delivering the strategic changes set out in the Five Year Forward View with a particular focus on STPs, new care models and devolution (where relevant)
5	Leadership and improvement capability	Building on their well-led framework CQC and NHSI will develop a shared system view of what good governance and leadership looks like, including ability to learn and improve

3.4 Depending on the extent of support needs identified through its oversight process and performance against the above measures, NHSI will segment providers into one of four categories. Segmentation will be based on:

- All available information on providers – both obtained directly and from third parties
- Identifying providers with a potential support need in one or more of the above themes
- Using NHSI's judgement, based on relationship knowledge and/or findings of formal or informal investigations, or analysis, consideration of the scale of the issues faced by a provider and whether it is in breach or suspected breach of licence conditions (or equivalent for NHS trusts).

Segment	Description	Support	Frequency
1 - Maximum autonomy	No potential support needs identified across five themes – lowest level of oversight and expectation that providers in segment 1 will support providers in other segments.	Universal support	Providers in segment 1 will only be reviewed on a quarterly basis (unless there is evidence that a provider is in breach of its licence

2 - targeted support	Potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed	Universal support Targeted support as agreed by provider: • To address issues • Help provider move to segment 1	Ongoing – Where in-year, annual or ad-hoc monitoring flags a potential support need, NHSI will review the provider's situation and consider whether it needs to change its allocated segment.
3 – mandated support	The provider is in actual/suspected breach of the licence (or equivalent for NHS trusts) and/or requires formal action	Universal support Targeted support Mandated support as determined by NHSI: • To address specific issues and help provider move to segment 2 or 1 • Compliance required	Ongoing – as above
4 – special measures	The provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that may mean that they are in special measures	Universal support Targeted support Mandated support as determined by NHSI: • To help minimise the time the provider is in segment 4 • Compliance required	Ongoing – as above

3.5 Of the five themes, there is currently only clarity on how providers will be assessed in two areas: finance and use of resources; and operational performance.

3.5.1 **Finance and use of resources metrics**

NHS Improvement will oversee and support providers in improving financial sustainability, efficiency and compliance with sector controls such as agency staffing and capital expenditure. They are also, with CQC, co-developing a shared approach to assessing and rating how well trusts use their resources. They may consult on the use of resources metrics separately.

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

These metrics are similar to the ones currently used to calculate the Trust's CoSRR, with the addition of the agency spend metric. Providers will score 1 (best) to 4 against each metric and then the score will be averaged across all the metrics to derive a use of resources score. For the Trust this means we would currently score 3.4. Where providers have a score of 4 or 3 in the financial and use of resources theme, this will identify a potential support need under this theme.

NHS Improvement is currently considering two other metrics – change in cost per weighted activity unit and capital controls. These will be introduced in 'shadow' form in 2016/17, to assess how best to use them thereafter.

3.5.2 Operational performance metrics

The operational performance metrics are those that are used for our Sustainability and Transformation Funding. NHS Improvement will consider whether there is a potential support need if a provider fails to meet any trajectory for at least two consecutive months.

Standard	Frequency	Standard
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	Monthly	95%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate − patients on an incomplete pathway	Monthly	92%
All cancers – maximum 62-day wait for first treatment from: - urgent GP referral for suspected cancer - NHS cancer screening service referral	Monthly	 85% 90%
Maximum 6-week wait for diagnostic procedures	Monthly	99%

3.6 **Other themes**

A table of the Quality of Care metrics are being considered at the Finance and Performance Committee on 26 September 2016. There are five that do not currently feature on our Integrated Board Report: Executive team turnover; Proportion of temporary staff; Aggressive cost reduction plans; emergency C-section rate; and HSMR – weekend. It is not yet clear what the thresholds will be for these or how they will be assessed.

There is also no clarity yet on how the Strategic Change and Leadership elements will be assessed. It is NHS Improvement's intention to work with the CQC to come to a single view on the well-led framework.

4. NEXT STEPS

4.1 The Integrated Board Report will incorporate reporting on the new SOF from October and further updates as to its implementation by NHS Improvement will be brought to the Board as they are released. The list of trust segmentation is likely to be published in November.

5. FURTHER INFORMATION

More information at NHS Improvement:
https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework.pdf

Or NHS Providers:
https://www.nhsproviders.org/media/2220/nhs-providers-on-the-day-briefing-nhsi-single-oversight-framework-september-2016.pdf

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Karen Marsden, Safeguarding Administrator
Date: Thursday, 29th September 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Safeguarding Update - Adults and Children - The Board is asked to receive and approve the Safeguarding Update Report.	
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 purpose of this report is to provide a brief update to the Board of Directors about safeguarding activity within the Trust,and to provide accurate and current information about the effectiveness of internal systems and processes to demonstrate the status of the Trust's compliance with statutory safeguarding requirements and regulatory compliance.

Main Body

Purpose:

Update to the Board of Directors about children's and adult safeguarding activity within the Trust.

Background/Overview:

Six monthly update to the Board of Directors.

The Issue:

Please see detail within report.

Next Steps:

Please see detail within the report.

Recommendations:

The Board is asked to receive and approve the bi-annual Safeguarding Update report.

Appendix

Attachment:

CHFT SAFEGUARDING UPDATE SEPT 2016.pdf

1. Foreword

This is Calderdale and Huddersfield Foundation Trusts (CHFT) Adult and Children's Safeguarding Update Report. This reporting period covers April 2016 to September 2016. The report will describe and inform CHFT Board of Directors and Non-Executive Directors of the commitment and pledge to ensure Safeguarding Adults and Children remains a key Trust priority. The report has been written by the Head of Safeguarding in conjunction with the Named Nurse for Safeguarding Children, Adults and the Named Midwife.

2. Introduction

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

The Trust adheres to key safeguarding legislation. Safeguarding Children is a statutory requirement under the Children Act 1989/2004, which imposes a legal duty on all professionals to safeguard and protect children. 'Working Together 2015' further emphasises the collective interagency arrangements of how agencies including NHS organisations must work together, and how this is implemented locally. The Intercolliage document further places responsibilities on organisations to ensure roles, responsibilities and competencies for key professionals who safeguard children are adhered to. This report describes how the Trust meets these requirements.

The introduction of the Care Act 2014 in April 2015 places Adult Safeguarding on a statutory footing and imposes a legal duty on NHS organisations. Work is ongoing to safeguard the most vulnerable of our communities.

CHFT is a partner organisation and works towards both the North and West Yorkshire Safeguarding Adults Policies and procedures and the Children's West Yorkshire Safeguarding Policy and Procedures. Both CHFT policies reflect these District wide policy and procedures to ensure all West Yorkshire partners are working together and are aligned in their working practices.

Work continues across the Trust, both at an operational and strategic level to ensure that safeguarding Adults and Children is 'everybody's business' as opposed to it being seen as a separate entity that is the responsibility of a few specialist practitioners. It is essential that a safeguarding culture continues to be embedded across all departments and staff who work for CHFT, and that this key message is adopted across divisions.

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

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

3. 6 monthly update

3.1 March 2016 Trust CQC Inspection

The Trust Inspection carried out in March 2016 identified key areas of must dos for the Safeguarding agenda.

- The Trust must continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.
- The service must ensure staff have an understanding of Gillick competence.
- The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role.
- The service must also ensure all relevant staff are aware of Female genital mutilation (FGM) and the reporting processes for this.

In achieving compliance with the requirements from the report action plans are in place to address these areas highlighted. These are currently rated amber and are on track to progress as planned.

3.2 **A further Review of health services for children Looked After and Safeguarding in Calderdale**

The review was carried out in April 2016 and conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical commissioning groups. This inspection explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. All health partners were inspected. A finalised report has not yet been received.

3.3 Section 11 audits

Section 11 audits are statutory under the Children's Act. The Trust has submitted audits completed by the Safeguarding Team, Health Visiting, the Integrated Sexual Health Service and Breast Feeding. Additional audits were requested this year and submitted to the Calderdale safeguarding Children's Board. There is a section 11 challenge event arranged for later this year by Calderdale Safeguarding Children's Board.

3.4 Training

Safeguarding training is mandatory for all staff depending on their role and responsibility within the Trust and contact with adults and children. A significant piece of work has taken place this year that has reviewed the different levels of training in line with the Intercollegiate Document (2014) for safeguarding children and the draft intercollegiate document for safeguarding adults (2015).

Current Trust compliance with training is;

- Level 1 training figures are increasing and are 80%
- Level 2 adults and children continues to increase and now at 66% and 67% respectively
- Level 3 adults – is increasing and is 21%. This is part of a new targeted level not previously captured before and continues to increase
- Level 3 Children is increasing and is now 52%. The number of training sessions has been increased to two per month with individual departmental sessions delivered.
- PREVENT is a one off training session that can be delivered in any organisation as long as it was the WRAP training advised by NHS England. New staff do not need to complete this if they can produce evidence of previous attendance. Prevent figures are increasing and now at 68%.

Further Improvements for Q3 and Q4

1. As part of ongoing assurance for Mandatory safeguarding training for medical staff and paediatricians the Named Doctor is leading work to support and ensure medical staff are meeting their statutory requirements for safeguarding children and this is recorded correctly on the electronic staff register, and at appraisal. This work will increase the Trust compliance figures in level 3 and ensure that this is captured correctly.
2. While Trust staff receive MCA DoLS training as part of Adult safeguarding training, this is planned to become an essential skill for staff and delivered at different levels
3. Work has begun to ensure relevant staff are trained in FGM. This will comprise of an eLearning package and also become an essential skill for targeted areas.
4. A Prevent paper has been presented at the safeguarding committee to consider utilising eLearning as part of the Prevent Competencies Framework 2015. This means not all our staff will be required to attend face to face Health Wrap training which will allow greater flexibility of training delivery for staff and increase compliance.
5. To ensure compliance with the Intercollegiate Document staff are also required to complete the necessary number of hours of mandatory safeguarding children training. This can include attending group, peer and individual supervision with trained members of staff able to facilitate safeguarding supervision. There are planned facilitators sessions booked within paediatrics, accident and emergency department and maternity services in November 2016.
6. A task and finish group has begun work in ensuring all staff are aware of Fraser competencies and ensuring these are embedded at operational level.

3.5 Safeguarding Supervision Children:

Staff continue to require safeguarding supervision in line with the recommendations from the Intercollegiate Document 2014 and Working Together to safeguard Children 2015. All Health Visitors are meeting their requirements for Safeguarding Supervision and there has been (Level 3 – 50, Level 4 – 71 and Level 5 – 145) 266 cases discussed. The Safeguarding Children team have provided advise and support to community professionals for 53 cases and 19 cases for the Family Nurse Partnership.

Further work is ongoing to improve the uptake of safeguarding supervision within in-patient paediatrics, SCBU, the emergency department and in-patient maternity; this remains low due to the capacity in releasing staff to the planned sessions. Paediatric out-patients members of staff are up to date with their supervision and 8 members of staff from ward 3 have attended supervision up to August 2016. A de-brief for ED staff was held recently and 6

staff from Paediatrics and 4 from the ED attended. This will count towards safeguarding supervision, due to the safeguarding concerns. Between April 2016 – July 2016 supervision was completed with the Child Development Unit and for 3 children's therapists. No supervision took place for the children's diabetes team; the children's community nursing team and the epilepsy specialist nurse due to long term sickness. Sessions are planned to address this from August 2016 onwards. In response to the CQC inspection safeguarding supervision is now planned to take place with staff working in Yorkshire fertility and the first session for this is planned for September 2016. The need to provide safeguarding supervision for staff working in Gynaecology and Adult out-patients has also been recognised and the safeguarding team are in the process of arranging this with the departmental Matrons. Regular monthly safeguarding supervision is carried out within the Integrated Sexual health service facilitated by the Named Nurses.

All children admitted to an inpatient paediatric bed with mental health issues are followed up by the paediatric liaison sister. The Named Nurse now attends the joint CAMHS/ Paediatric meetings.

Training and supervision compliance remains a concern and is monitored closely by the safeguarding committee.

3.6 Adult Safeguarding Supervision

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

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

From April to June 2016 there have been 150 urgent authorisations in total made to both Kirklees and Calderdale Metropolitan Councils regarding patients who are deprived of their liberty whilst being cared for as inpatients. CHFT can grant itself an urgent authorisation for up to a period of 14 days whilst the Local Authority determines whether or not to authorise the deprivation of liberty.

From these urgent authorisations made 28 urgent authorisations progressed and the standard authorisation was authorised under the DoLS. Whilst this may appear to be small numbers, 71 of the authorisations were cancelled by the Trust; as per policy or it was more appropriate for the Mental Health Act to be used as the legal authorisation, or they regained capacity and therefore it was not lawful to continue with the deprivation of liberty. A small number of the urgent authorisations have lapsed (49). This occurs when the Local Authority do not complete all their assessments within 14 days of the urgent authorisation being applied. In these cases the Safeguarding Team continues to monitor the patient to ensure that the deprivation is still valid, the patient still lacks capacity, all restrictions in place remain least restrictive whilst ensuring the patient remains safe on the wards, and that there are no objections to the DoL.

4.0 Management Arrangements/ Governance

4.1 Children Looked After Service

The recent CQC inspection of the service in April 2016 identified a number of actions for the team and the service to address. As part of the action plan Commissioners are reviewing the service in Calderdale to identify gaps in service provision. It will report on the delivery of the current service specification and further key performance indicators required.

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

4.3 Safeguarding Committee Meetings. One of the main functions of the committee is to review practice and ensure robust arrangements are in place, to share good practice and learn lessons, as well as monitor compliance issues around training. There has been further work in relation to capturing divisional safeguarding activity. The safeguarding committee's reporting schedule also ensures it receives regular updates from key named professionals for example child sexual exploitation.

4.4 Attendance at External Meetings

The Head of Safeguarding represents CHFT at the Local Safeguarding Adults and Children's Board for Calderdale and Kirklees Councils. The Named and Designated

Professionals for CHFT attend and pro-actively contribute to the work of the sub-groups of the Boards. Our Safeguarding staff meets with the Designated Professionals for Safeguarding Adults and Children (CCG) regularly, and the Designated Professionals also attend our Safeguarding Committee meeting. Further links have been made with the Domestic Abuse.

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

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

- DHRs – 4 ongoing and 1 pending
- SCRs- 3 ongoing and 6 pending
- SAR – 1 ongoing and 1 pending
- Learning lessons reviews 2 ongoing

6 Further plans for 2016-2017

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

b) The Domestic Abuse Policy requires updating this year and is in progress

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

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

e) Safeguarding training compliance will be monitored closely at each safeguarding committee meeting and actions taken where training figures do not continue to increase and meet the targets set.

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

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

h) Joint work with SWYPFT to ensure compliance with the Mental Health Act is close to completion. This has involved securing honorary contracts to enable Mental Health Liaison Psychiatrists to act as Responsible Clinicians for CHFT detained patients, writing a Mental Health Act policy to include roles and responsibilities, processes and

training strategies and finalising a service level agreement for the Mental Health Liaison Team service and servicing of Mental Health Act papers by SWYPFT.

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

Conclusion

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

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 29th September 2016	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: INTEGRATED BOARD REPORT - The Board is asked to receive and approve the Integrated Board Report for August 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 (22.9.16)	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

Performance in August remained positive overall with the Safe domain moving to a green position and no domains red. Within the regulator KPIs, 2 indicators remain red; C Difficile and the Emergency Care Standard. Other KPIs to note are Friends and Family, SHMI, Complaints Closed and Patients Admitted to a Stroke Ward within 4 hours.

The Carter dashboard is a balanced picture, with 8 indicators deteriorating and 8 improving of those deteriorating complaints is a second month downward trend with vacancies improving for the 3rd month.

The Divisional Performance Review Process continues to embed, with greater focus on actions to secure recovery and support with more complex issues.

The new Single Oversight Framework has recently been published and is included in this month's Board papers

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 August 2016

Appendix

Attachment:

IPR Board Report (5 pages).pdf

Board Report

August 2016

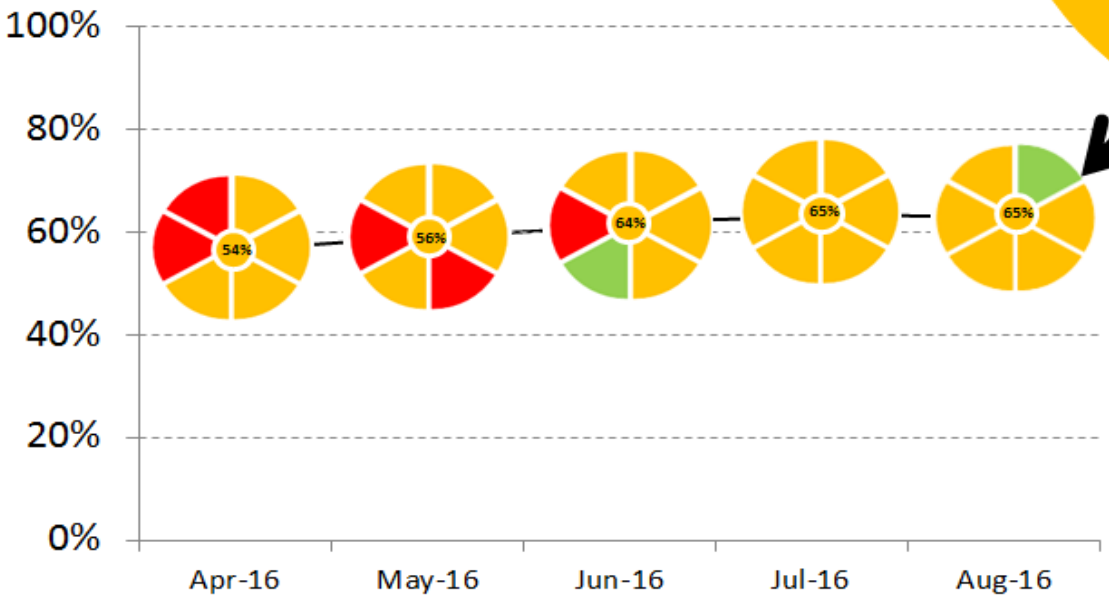
Performance Summary

Most recent month's performance

RAG Movement

August's Performance Score has remained at 65% for the Trust. Within the **Safe** domain improved performance in the Major PPH - Greater than 1000mls standard has edged the domain to a GREEN rating. 3 of the 6 domains improved in month with **Responsive** just short of a Green rating at 74%. Mixed Sex breaches meant a drop for **Caring** score and YTD long term sickness increased to reduce the **Workforce** domain score. An avoidable C-diff case kept the **Effective** domain score at 57%.
Improvements in last minute cancellations, stroke performance and readmissions balanced out the above mentioned underperformance for the Trust as a whole.

Total performance score by month



CHFT

August Score by Domain		
Safe	77%	↑
Caring	54%	↓
Effective	57%	↔
Responsive	74%	↑
Workforce	60%	↓
Efficiency & Finance	65%	↑
Performance Score	65%	↔

Regulatory Targets

CDiff Cases 4 (0)	Cancer 62 day Referral to Treatment
Avoidable Cdiff 1 (0)	Cancer 62 day Screening to Treatment
ECS 4 hours 94.59% (95%)	Cancer 31 day targets x3
RTT Incomplete Pathways	Cancer 2 Week Referral to Date first seen
Data Completeness Community Care x3	Cancer 2 week Breast Symptoms

Other Key Targets

VTE Assessments	FFT targets x7
Never events	FFT A&E 86.9% (90%)
MRSA	FFT OP 90.6% (95%) Community 87% (96%)
SHMI 113.8 (100)	Stroke % admitted 4 hours 74.29% (90%)
HSMR 109 (100)	Diagnostics 6 weeks
Emergency Readmissions GHCCG 7.6% (7.05%)	Net surplus/(deficit) £120k
% Complaints closed 60% (100%)	Sickness 4.43% (4%)

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	98.2%	97.9%	↑	96%
	Inpatient Complaints per 1000 bed days	2.5	2.4	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	5.4	5.1	↓	5.17
	Delayed Transfers of Care	2.49%	3.40%	↑	5%
	Green Cross Patients (Snapshot at month end)	104	91	↓	40
	Hospital Standardised Mortality Rate (12 months Rolling Data)	108.67	109.31	↑	100
	Theatre Utilisation (TT) - Trust	84.70%	84.07%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.54%	0.70%	↑	0.6%
	Emergency Care Standard 4 hours	94.59%	94.36%	↑	95%
	% Incomplete Pathways <18 Weeks	95.46%	96.32%	↓	92%
	62 Day GP Referral to Treatment	88.5%	91.6%	↓	85%
SAFE	% Harm Free Care	95.14%	95.42%	↓	95.0%
	Number of Outliers (Bed Days)	997	688	↓	495
	Number of Serious Incidents	3	3	↔	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: % Stroke patients spending 90% of their stay on a stroke unit. At 91.4% this is the best performance since January.

Improved: Short Term Sickness Absence rate(%). At 1.29% back at May's level, previous lowest level was back in August 2015.

Improved: Theatre Utilisation (TT) - Main Theatre - HRI. At 95.6% highest utilisation since February.

MOST DETERIORATED

Deteriorated: Number of Mixed Sex Accommodation Breaches which relate to Critical Care and discharge delays where a combination of flow and poor escalation. First breaches since January.

Deteriorated: 38 Day Referral to Tertiary. At 38.5% lowest position since August 2015.

Deteriorated: RTT Total incomplete waiting list and RTT Waiting 18 weeks and over have both peaked at over 20,000 and over 900 respectively.

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.

ACTIONS

Action: ICU staff now proactively escalating via bed meetings when a patient has been declared fit to stand down and when the breach time is. This will prevent a recurrence.

Action: Action plans requested from all specialties to secure required improvement by October; deep dive for Urology reflecting high level of delays in this specialty.

Action: Divisions are triangulating with Capacity and Demand Review and will present at September Performance Review meetings.

Arrow direction count ↔ 2 ↑ 8 ↓ 8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	Available from Q2			
Sickness Absence Rate	4.4%	4.8%	↑	4.0%
Turnover rate (%) (Rolling 12m)	13.7%	14.0%	↑	12.3%
Vacancy	459.0	487.8	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4	79.00%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4	60.00%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	£1.94	£0.90	
Expenditure vs Plan var (£m)	-£2.28	-£1.02	
Liquidity (Days)			
I&E: Surplus/(Deficit) var (£m)	£0.12	£0.13	
CIP var (£m)	£1.41	£1.32	
FSRR	2	2	
Temporary Staffing as a % of Trust Pay Bill			

Executive Summary

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

Area	Domain
Safe	• **All Falls/Number of Incidents with Harm -** Aim to see a reduction on the wards where the safety huddles are implemented. The plan is to achieve daily involvement from an MDT perspective in relation to safety huddles. Appropriate use of falls equipment, quality measures are met, risk assessment, management of patient placement on the wards. 6 month roll out project. • **Total C-Section Rate -** Whilst there has been a marginal increase in C-section rate, the weekly governance meeting enables robust analysis of indications for caesarean section and decision making. • **Maternity - % PPH ≥ 1500ml/Major PPH - Greater than 1000mls -** PPH deep dive to be discussed at FSS PRM meeting in September. • **Number of Category 4 Pressure Ulcers Acquired at CHFT -** There have been 3 Category 4s in the period to the end of July.
Caring	• **Complaints closed within timeframe -** Slight deterioration in month to 60% however the total number of complaints that were closed in August 2016 was 59, which is a 32% increase from July. • **Friends and Family Test Outpatients Survey** - % would recommend is stabilising at 90- 91% against a target of 95%. Improvement plans are in place around car parking and clinic waiting times. Further work to continue as part of directorate action plan to achieve Q3 improvement trajectory (December 16). • **Friends & Family Test (Maternity Survey)** - Response Rate - In month performance of 91.6% is lower than previous months. However this performance is partly driven by a higher than typical proportion of patients selecting 'don't know'. 2 patients selected that they were unhappy with their care in August. The cases have been followed up with the individuals. • **Friends and Family Test Community Survey** - FFT continues to report 3% of people would not recommend services. This month that there are a number of respondents that are unhappy to be contacted every month when they remain on the caseload. An options paper for FFT recording will be presented at October Board and will be shared at PRM with a recommendation. • **Number of Mixed Sex Accommodation Breaches - I**nvestigated by the matron for ICU and clinical commander. ICU staff now proactively escalating via the bed meetings when a patient has been declared fit to stand down in line with the breach time to prevent recurrence. Patient flow team to ensure speciality beds allocated to ICU to facilitate transfers as per EMSA policy.
Effective	• **Total Number of Clostridium Difficile Cases -** Further 4 in August 1 of which deemed avoidable. YTD 14 against an annual plan of 21. • **Perinatal Deaths (0-7 days)** - Unfortunately there were 2 very premature deliveries in August. • **Hospital Standardised Mortality Rate** (1 yr Rolling Data July 15 - June 16) - As anticipated performance has improved further to **108.7** and the Trust is no longer classed as a significant outlier. • **Mortality Reviews** - The completion rate for Level 1 reviews has reduced to 21.9% in August. This reduction was anticipated as internal processes are adapted to capture more robust data from Q3 onwards. • **Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG -** Improvement in month and reflecting recent service changes the Community division will report to September PRM on conversations with partners. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours -** Improvement in month to 71.7% for discharges in August. Monitoring admissions in August demonstrated a performance of 93%.

Background Context

New compliance regime

NHSI plans to introduce its Single Oversight Framework (SOF) from 1 October 2016, at which point the Monitor Risk Assessment Framework and the TDA Accountability Framework will no longer formally apply and NHSI will be collecting information from the provider sector using the SOF. The sector's segmentation is then likely to be publicly available from November 2016. Depending on the extent of support needs identified through its oversight process and performance, NHSI will segment providers into four. Maximum autonomy, Targeted support, Mandated support or Special measures.

The SOF aims to provide an integrated approach for NHSI to oversee both NHS foundation trusts and trusts, and identify the support they need to deliver high quality, sustainable healthcare services. It aims to help providers attain and maintain CQC ratings of 'good' or 'outstanding'.

A&E has seen activity continue to over-perform but to a lower level than that seen in month 4. Activity is 1% above the month 5 plan and cumulatively 3.2% (1,994 attendances) above plan.
Non-elective activity overall is 2.2% below the month 5 plan but excess bed days are above the norm. Cumulatively activity is 1% below planned levels due to long stay patients. The impact is that the Trust has continued to rely on additional capacity in August with 14 beds open above plan and associated staffing challenges

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. (currently at 18%). Surgical Division has expereinced gaps in the divisional management team as well as Consultant vacancies in some key specialties

Elective demand in several specialties has increased significantly particularly from Calderdale CCG impacting on total waiting list and the ASI position. CCGs are currently working on demand management strategies which will need to be conisdered alongside new capacity plans internally.

Planned day case and elective activity has improved in month 5 with activity 5.2% above plan. This is driven by continued over-performance within day case activity with elective activity remaining consistently below plan. Day case continues to over-perform mainly within Ophthalmology and Gastroenterology with a large increase within General Surgery in month, recovering some of the under-performance seen in prior months. Urology has also seen an increase due to a vacant post following retirement now being

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours -** August's position was still below the 95% target at 94.59%. A recovery plan is in place. • **A&E Trolley Waits** - The Trust reported one 12 hour trolley wait for August which has been raised as a Serious Incident and a full investigation is taking place. • **Stroke -** All 4 stroke indicators improved in month with only those admitted to a stroke ward within 4 hours and scanned within 1 hour not being achieved. The division of Medicine will submit a business case to continue the pilot with Radiology as a permanent service. • **RTT pathways over 26weeks** - a further small increase in month with plans to eradicate specialties with small numbers by the end of October with the exception of Patient Choice. • **38 Day Referral to Tertiary** is now at its lowest position since August 2015. Action plans are in place to improve performance in October 2016.
Workforce	• **Sickness Absence rate** has improved in month and is now achieving its short term sickness target. • **Return to work Interviews have** improved again in month to 58% but are still some way short of 100% target. • **Mandatory Training and appraisal -** Executive Board decision on 21st July 2016 to focus on compliance in 2016/2017 due to EPR implementation on 4 elements of mandatory training - Information Governance, Fire Safety, Infection Control and Manual Handling. Currently just Manual Handling is off plan.
Efficiency/ Finance	• **Finance:** Year to date: The financial position stands at a deficit of £10.07m, a favourable variance of £0.12m from the planned £10.20m. In month, clinical activity has seen another strong month as was the case through quarter one, rebounding from the flatter July performance. This drives an overall income position at Month 5 which is £1.94m above planned levels in the year to date, an increase of £1.04m from Month 4. The in-month over-performance in clinical income is seen across planned inpatient and non elective admissions as well as outpatients, critical care and A&E attendances. However, as has been the case in recent months, to deliver activity and access standards the Trust continues to rely heavily upon agency staffing. Total agency spend in month was £2.17m, a slight fall for the third month in succession but remaining above the NHSI trajectory and a significant draw on pressured cash resources. • **Theatre Utilisation** has stabilised around 84% with room for further improvement although the main theatre at HRI hit over 95% for the first time since February.
CQUIN	• **Sepsis - % of patients Screened (admission Units)** - All CQUIN schemes achieved the required targets in Q1 with the exception of Sepsis where 3 out of the 4 targets were met. The Sepsis CQUIN is meeting all Q2 targets. Targets are set each quarter in agreement with the commissioners and aligned with internal improvement trajectories. The Q4 targets are however nationally set and may prove challenging. Further risks on forecast achievement of the Sepsis Screening, Staff Well Being Flu Vaccination and Antimicrobial Resistance CQUINs are also being flagged with actions being put in place to address these.
Activity	• Activity has seen significant growth in month 5 across all points of delivery, with the exception of A&E where although still above plan, the level of growth has slowed when compared to month 4.

Background Context

Additional capacity was required throughout August as a combination of medical and surgical pressures with peaks seen on Mondays and Tuesdays. This is impacting on staffing which is compounding vacancy related pressures although new graduates will start to take up post during September and October

Divisional teams are working closely with ward sisters weekly to ensure controls on non-contracted spend are in place and roster management is efficient and a 'buddy system' is in place. This is working well preventing on-day staff moves. Further work is required to embed this and support reduced OoHs decisions.

Medical rotas are now being reviewed weekly. Reduced vacancies on the HRI on-call registrar rota are supporting the reduced agency spend and reliance.

The Trust participated in a call with NHSI on agency spend and are currrently developing an improvement plan for submission early October 16.

A Radiology summit was held during August with good attendance from all divisions. Radiology continues to see growth in 16/17 of around 25% across all modalities. There is a scheme of work devised to respond to this.

Within the Community services division there are challenges in increased demand. MSK service and GP direct referrals to orthotics continue to be the services that requires focus from a capacity and demand perspective.

Outpatient activity overall has seen a significant increase in month 5 and is above plan by 4.7% . This is a shift from month 4 when activity was below plan. The over-performance is across both first and follow-up attendances including procedures. The specialties with the more significant over-performances within first attendances are ENT, Paediatrics, Rheumatology, Dermatology and Gynaecology. Under-performances continue within General Surgery and General Medicine. Cumulatively Outpatient activity is now 2.7% above plan however with demand continuing at high levels this is not resulting in a reduced waiting list size.

This page has been left blank

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th September 2016	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: FINANCIAL NARRATIVE - MONTH 4/5 - 2016 - The Board is asked to approve the Month 4/5 Financial Narrative	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee:- 23.8.16 and 27.9.16	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 4/5 Financial Narrative

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 4/5 Financial Narrative

Appendix

Attachment:

COMBINED FINANCIAL COMMENTARY - MONTH 4 AND 5 2016.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 4 JULY 2016/17 NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

The notes below provide a management commentary on the financial position of Calderdale & Huddersfield NHS Foundation Trust at the end of July 2016.

- The report is structured into three sections to describe:
- Key messages;
- Detailed commentary for the period with variance analysis against the annual plan as submitted to NHSI;
- Financial Sustainability Risk Rating (FSRR) and forecast.

1. Key Messages

The year to date financial position stands at a deficit of £6.62m, a favourable variance of £0.95m from the planned £7.57m, of which £0.82m is purely a timing difference on the accrual of Strategic Transformation Funding versus the planned quarterly profile. The underlying position is a £0.13m favourable variance from year to date plan.

In month, clinical activity has seen a switch in the trend from the last few months with a stronger performance in day case and electives contrasting with a reduction in emergency long stay and outpatients. In the round, clinical contract income is in line with the in-month plan expectations and therefore the overtrade generated in the first quarter has been retained. The combination of reduced non-elective pressure and pro-active measures being put in place has reduced the spend on nursing agency to its lowest level in the year to date. However, as has been the case in recent months, to deliver activity and access standards the Trust continues to rely heavily upon agency staffing. Total agency spend in month was £2.2m, a slight fall for the second month in succession but remaining above the NHSI trajectory and a significant draw on limited cash resources.

Month 4, July Position (Year to Date)

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	122.72	124.44	1.72
Expenditure	(121.78)	(122.66)	(0.88)
EBITDA	**0.94**	**1.78**	**0.84**
Non operating items	(8.50)	(8.26)	0.25
Deficit excluding restructuring costs	**(7.57)**	**(6.48)**	**1.09**
Restructuring costs	0.00	(0.14)	(0.14)
Deficit including restructuring costs	**(7.57)**	**(6.62)**	**0.95**

- EBITDA of £1.78m, a favourable variance of £0.84m from the plan.
- Of this operating performance £0.82m is driven by a timing difference on the accrual of Strategic Transformation Funding versus the planned quarterly profile.
- A bottom line deficit of £6.62m, a £0.95m favourable variance from plan.
- Delivery of CIP of £3.82m against the planned level of £2.50m.
- Contingency reserves of £1.08m have been released against pressures.
- Capital expenditure of £5.00m, this is below the planned level of £6.17m.
- A cash balance of £1.92m in line with the planned level of £1.95m, supported by borrowing.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

In the year to date, the activity over performance has driven overall income recovery in excess of plan by £1.72m. This sits alongside strong CIP delivery, achieving £1.32m in advance of the planned timescale. The combined benefit has not flowed through in full to the bottom line but has rather absorbed the activity related expenditure pressures and one off issues such as the Junior Doctors' strike action. Of the £2m contingency reserves, £0.99m has been released in the year to date which when considered along with the timing difference on CIP delivery places a significantly greater level of financial risk in the remainder of the year.

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

Operating income	£1.72m favourable variance
Operating expenditure	(£0.88m) adverse variance
EBITDA	**£0.84m favourable variance**
Non-Operating items	£0.25m favourable variance
Restructuring costs	(£0.14m) adverse variance
Total	**£0.95m favourable variance**

Operating Income

There is a £1.72m favourable variance from the year to date plan within operating income. Of this operating performance £0.82m is driven by a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile.

NHS Clinical Income

Within the £1.72m favourable income variance, NHS Clinical income (excluding the timing difference on STF) shows a favourable variance of £1.68m. As described above, overall activity has sustained planned levels in month but with some change from previous year to date trends by point of delivery. Cumulatively the overtrade position still stands.

- Planned day case and elective performance is 1.2% (47 spells) above the month 4 plan which is an improvement from month 3 when activity was below plan. The month 4 position is driven by a continued over-performance within day case activity of 3.3% (100 spells), with elective activity levels continuing to be slightly below plan but at a reduced level. The improvement from month 3 is due to an improved performance within both day case and elective.

- Day case in-month over-performance continues to be mainly within Gastroenterology (20.7%, 55 spells) and Ophthalmology (10.5%, 32 spells) but increases have also been seen within Trauma & Orthopaedics (T&O) and ENT. Cumulatively activity is 2.1% (255 spells) above plan across all specialties.

- The impact of the Junior Doctors' 48hr Strike and slower than planned retraction of medical patients from T&O beds seen in April has not been recovered and has been exacerbated by a number of medical staff vacancies and so cumulatively elective continues to be materially below planned levels. General Surgery, ENT and T&O all saw improved performance in month however closing some of the previous gap to 389 spells below plan.

- Non-elective activity overall is 1.2% (51 spells) below the month 4 plan. This is a decrease in activity when compared to month 3 when activity was 2.6% (109 spells) above plan. Cumulatively activity is just 0.6% below planned levels.

- A&E has seen activity has continued to over-perform and is 6.6% (825 attendances) above the month 4 plan. This is an increase in the level of over-performance seen in month 3 and also represents a 7.4% increase in activity levels seen in July 2015 which has brought some pressure to performance in month. In the year to date activity is 3.8% (1,874 attendances) above plan.

- Outpatient activity overall is below the month 4 plan level by 2.8% (776 attendances) which is a change in trend from the high level of over-performance seen in previous months. Cumulatively activity remains 2.2% (2,548 attendances) above plan.

The clinical contract PbR income position is driven by these areas of over-performance and Adult Critical Care (as previously reported), Rehabilitation and Diagnostic testing & imaging. This position reflects an over-performance against the Trust's year to date plan and a greater over-performance against contracts with the Trust's Commissioners. The 2016-17 contracts with the Trust's commissioners reflected 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 Trust remains in close contact with commissioners to highlight this position both from a point of view of securing cash relating to the overtrades in a timely manner and also to guard against unexpected challenges given the affordability pressures to the health economy as a whole. On this basis, no provision against contractual challenges is reflected within the position.

Other income

Overall other income is £0.78m below the planned level cumulatively. This continues to be due to a combination of: lower than planned income within the Trust's Pharmacy Manufacturing Unit; and Donated Asset Income. The Trust also planned for Bowel Scope income as part of non-NHS Council funding which changed contractually to be funded through NHS England, showing below plan within non-NHS Clinical income off-set by over-performance within NHS Clinical income.

Operating expenditure

There was a cumulative £0.88m adverse variance from plan within operating expenditure across the following areas:

Pay costs	(£0.22m) adverse variance
Drugs costs	£0.40m favourable variance
Clinical supply and other costs	(£1.06m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £0.22m higher than the planned level in the year to date; although the absolute spend level is supressed in July. In month a £0.55m benefit to pay is seen through a combination of: agreement of a credit for relating to prior years for Consultant sessions charged from Bradford Teaching Hospitals NHS FT; and reduced pay costs as a result of the transfer of the West Yorkshire Audit Consortium to a new host organisation. The latter is offset by a corresponding reduction in income. It should be noted that £2.0m of contingency reserves are planned against pay in equal instalments across the first six months of the financial year. Three months of this contingency, £1.38m, has been released against the pay position, meaning that the underlying divisional year to date pay overspend was £1.74m.

As has been the case through this year it is the high vacancy levels in clinical staff groups that is causing reliance on agency staffing with the associated premium rates that drives the overspend. The largest area of overspend by staff group is nursing, the combined overspend against qualified nursing and support to nursing (Healthcare Assistants) is £1.15m in the year to date. This level of

overspend has however abated in month, with the overall spend in July being at budgeted level for nursing for the first time this year. The escalation protocols for booking of nursing agency shifts have been reviewed and further strengthened by the new Director of Nursing and use of the highest cost agency (Thornbury) ceased in all but exceptional circumstances from late June, the drive to recruit permanent staff continues.

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 cost of agency is offset by these unfilled staffing gaps, however the absolute cost of medical agency is however high at £5.27m in the year to date, 58% of the overall agency spend. There is a balance to be struck in engaging medical staffing between the high cost of employment against the potential performance standards and income lost through staffing gaps. The assessment of the risk of switching off this agency cover has been made on a case by case basis by Divisions and as with nursing the drive to recruit staff is ongoing including pursuing overseas recruitment.

With regards to agency and bank staffing the administration arrangements for booking flexible staff are being centralised with investment having been agreed to bolster this function to ensure control and use of best practice; and new IT systems have been implemented to streamline processes; new recruitment and retention strategies are also being put in place. The impact of these strategies needs to be substantial in support of the Trust's ability to manage what is one of the most significant risks to delivery of the financial plan.

Drug costs

Year to date expenditure on drugs was £0.40m below the planned level, with considerable movement from a £0.09m underspend at month 3 driven by lower than planned 'pass through' drugs costs. The income and corresponding spend on ‘pass through’ high cost drugs is £0.59m below plan. Underlying drug budgets are therefore overspent by £0.19m.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £1.06m above the plan, a continuation of the position seen last month. 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 now subject to a deep dive analysis by the responsible division to ensure that the best balance is being maintained between access times and value for money in delivery of the service.

As was the case last month, an element of the overspend in this area is driven by purely technical reasons. The annual plan includes £2.0m of contingency reserves which was planned as pay spend of £1.34m in the year to date. There has been a release of £0.99m contingency reserves to the bottom line in the year to date position; a provision has been made against the balance of the available contingency, £0.35m, for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan. In addition the bad debt provision has increased versus plan based upon those debts overdue beyond 90 days; this is primarily driven by NHS debtors as the Trust bears the brunt of other organisations constrained cash positions.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.25m below the planned level. As was the case last month, this is driven mainly by lower than planned depreciation charges. The adoption of a different valuation method for the PFI site has reduced the asset value upon which depreciation is chargeable. This sits alongside a review of equipment lives and an extension of the assessed life of recent large IT investments in particular which spreads the depreciation changeable over a longer period at a lower rate. The lower depreciation charges impact the year to date and forecast position and contribute towards CIP delivery.

This benefit is supplemented by the £0.06m gain on disposal 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 of £0.14m have been incurred in the year to date to fund redundancy costs which will deliver savings in the future periods.

Cost Improvement Programme (CIP) delivery

In the year to date, £3.82m of CIP has been delivered against a plan of £2.50m, an over performance of £1.32m. This is an increase from the over performance of £0.69m seen at month 3. The over delivery comes in a number of areas, most materially being as follows:

£0.6m Estate related commercial opportunities including securing rates and utilities rebates, a gain on disposal of Trust property and reduced depreciation charges as a result of adopting a new asset valuation method;
£0.2m reduction in consultant costs recharged from other NHS organisations;
£0.1m increase in delivery against the Nursing portfolio through the use of the apprentice scheme;
£0.2m over performance on the Surgical Pathways portfolio with increased productivity in specific specialties

Whilst the level of over performance is positive news it should be noted that the year end forecast is for delivery in line with plan and this is therefore a timing difference rather than an over achievement against the £14m savings target that is embedded within the financial plans. The year end forecast is for achievement of £14.14m savings, slightly over the £14m planning requirement but not to the extent of the year to date.

The £1.32m over performance against CIP plans in the year to date has not translated to an equivalent benefit to the Trust's bottom line financial performance but has rather offset other pressures. The concern that this raises is that whilst CIP across the full year is forecast to deliver to plan, the year to date over performance is matched off by a corresponding underperformance in the latter part of the year. This will lead to a financial pressure against plan which will have to be mitigated and will need to form part of the divisional recovery plans.

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

Statement of Financial Position and Cash Flow

At the end of July 2016 the Trust had a cash balance of £1.92m against a planned position of £1.95m, a slight adverse variance of £0.03m. Pressures on working capital have brought forward the need for borrowing and if the position does not improve will bring pressure to the overall availability of cash by quarter 4 assuming no increase to borrowing. In addition, any crystallisation of the pressures to achievement of the I&E position in the latter part of the year, such as the EPR implementation (as discussed with NHSI since the planning stage), will translate to cash pressures.

The key cash flow variances against plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	0.95
	Non cash flows in operating deficit	(0.19)
	Other working capital movements	(7.49)
	Sub Total	**(6.73)**
Investing activities	Capital expenditure	1.19
	Movement in capital creditors	(2.20)
	Sub Total	**(1.01)**
Financing activities	Drawdown of external DoH cash support	7.97
	Other financing activities	(0.26)
	Sub Total	**7.71**
	Grand Total	**(0.03)**

Operating activities

Operating activities show an adverse £6.73m variance against the plan. The favourable cash impact of the I&E position of £0.76m (£0.95m favourable I&E variance offset by £0.19m non-cash flows in operating deficit) is in addition to a £7.49m adverse working capital variance from plan, including £0.82m relating to the month 4 STF which will be paid in arrears. The working capital variance reflects the catch up of payments to suppliers.

Total aged debt based on invoices raised is £2.1m, whilst outstanding creditors approved for payment to suppliers stood at £0.95m at month end. The performance against the Better Payment Practice Code has improved in month following a dip last month driven by the payment of a volume of old invoices. In month 59% of invoices have been paid within 30 days against the 95% target.

Investing activities (Capital)

Capital expenditure in the year to date is £5.00m which is £1.17m below the planned level of £6.17m.

Against the Estates element of the total, year to date expenditure is £1.22m against a planned £1.96m. The main area of spend in month was on the continuation of the Theatre refurbishment programme with a year to date spend of £0.91m, this is coupled with spend on backlog maintenance including the continuation of fire compartmentation, fire detection and roofing work.

IM&T investments total £2.79m against a plan of £2.70m. The main areas of spend in month were the continuation of the Electronic Patient Record (EPR), and EDMS projects and replacement of PCs and laptops. The primary reasons for the £0.12m overspend versus plan is due to EPR related spend; £0.30m due to pressures on overtime, £0.18m on EDMS to bring scanning work forwards in readiness for the EPR go live date. These costs are offset in part by £0.21m on PC/Laptops and £0.10m underspend on wired network which hasn't commenced in line with planned timescales.

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

In overall terms the capital expenditure is currently expected to be £27.61m, £0.61m below the planned full year value of £28.22m. There will be switch in categories of spend between IT and Estates. EPR is now forecast to increase against the original plan by £2m with this being offset by the ward refurbishment not proceeding in full. This forecast is as per the submission made to NHSI in June and whilst this has not been explicitly approved by the regulator, no concerns have been raised and a level of verbal assurance has been received with regard to the availability of cash support. On this basis, after an internal review of our cash, operational, and legislative compliance requirements, the Trust has decided to proceed with our plans. This follows the completion of a full risk assessment.

The favourable cash impact of the £1.19m under spend, (£1.17m capital underspend plus £0.02m non-cash donated asset), is offset by a £2.20m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way.

Financing activities

Financing activities show a £7.71m favourable variance from the original plan, of which £7.97m is due to additional cash support through borrowing. This position includes borrowing brought forward in earlier months to settle supplier invoices and an additional £2.83m draw down in July due to STF cash funding not being released by NHSI within the timescale that the Trust had anticipated at the planning stage. At the time of writing this cash funding has now been received in mid-August. Whilst this will ease short term pressure on borrowing levels, the Trust remains keen to pursue with NHSI the process to convert our funding structure from a Working Capital Facility (at 3.5% interest) to a Revenue Support loan (at 1.5% interest), in order to reduce interest charges.

3. Financial Sustainability Risk Rating (FSRR) and forecast

FSRR

Against the FSRR the Trust stands at level 2 in both the year to date and forecast position, in line with plan.

Forecast – Income and Expenditure

The year end forecast position continues to be delivery of the planned £16.1m deficit and control total. 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 and contingent upon delivery of the planned deficit. It has been acknowledged in discussion with NHSI, both at the time of setting the plan and subsequently, that the £16.1m control total excluded any I&E or cash pressures for EPR 'go live' and similarly the implementation of the Junior Doctor's contract.

There are inevitably other areas of underlying pressure and risk emerging in year, including areas that have impacted in the year to date which are beyond the organisation's direct control, such as the Junior Doctor's strike action and the higher than planned rate of interest being borne on current borrowing. This pressure is heightened in the remainder of the financial year as the Trust plans to deal with the combination of EPR implementation; delivery of complex CIP schemes with greater returns; response to the outcome of the CQC inspection and commencement of the Junior Doctor's contract; and managing winter pressures alongside quelling agency staff usage.

Operational plans are in place and being constantly refined against the above. At the same time, the Trust's Divisions are required to financial deliver recovery plans to mitigate against issues in their respective areas of service. In addition there will need to be Trust wide action to address these risks and balance the need for innovative solutions with the maintenance of rigorous budgetary control.

It is with these actions in mind that the Trust continues to plan and drive to deliver a deficit in line with the control total at £16.1m.

Forecast – Capital and cash

Capital expenditure is currently expected to be £27.61m, £0.61m below the planned full year value of £28.22m. The switch in categories of spend between IT and Estates as described last month still stands. EPR is forecast to increase against the original plan by £2m with this being offset by the ward refurbishment not proceeding in full. After an internal review of our cash, operational, and legislative compliance requirements, the remainder of the plan is continuing to be implemented. This follows the completion of a full risk and quality impact assessment. Total borrowing forecast to be drawn down in year remains at £37.63m as planned, with the cash benefit on reduced forecast capital investment being offset by the non-cash I&E benefit of lower than planned depreciation.

Owen Williams
Chief Executive

Keith Griffiths
Executive Director of Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 5 AUGUST 2016/17 NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

The notes below provide a management commentary on the financial position of Calderdale & Huddersfield NHS Foundation Trust at the end of August 2016.

The report is structured into three sections to describe:

- Key messages;
- Detailed commentary for the period with variance analysis against the annual plan as submitted to NHSI;
- Financial Sustainability Risk Rating (FSRR) and forecast.

1. Key Messages

The year to date financial position stands at a deficit of £8.19m, a favourable variance of £2.0m from the planned £10.20m, of which £1.88m is purely a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The underlying position is a £0.12m favourable variance from year to date plan.

In month, clinical activity has seen another strong month as was the case through quarter one, rebounding from the flatter July performance. This drives an overall income position at Month 5 which is £3.82m above planned levels in the year to date, an increase of £2.10m from Month 4 (£1.06m due to STF timing, £1.04m underlying performance improvement in August). The in-month over-performance in clinical income is seen across planned inpatient and non elective admissions as well as outpatients, critical care and A&E attendances. However, as has been the case in recent months, to deliver activity and access standards the Trust continues to rely heavily upon agency staffing. Total agency spend in month was £2.17m, a slight fall for the third month in succession but remaining above the NHSI trajectory and a significant draw on pressured cash resources.

Month 5, August Position (Year to Date)

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	152.21	156.03	3.82
Expenditure	(151.77)	(153.91)	(2.14)
EBITDA	**0.44**	**2.12**	**1.68**
Non operating items	(10.63)	(10.17)	0.46
Deficit excluding restructuring costs	**(10.20)**	**(8.05)**	**2.14**
Restructuring costs	0.00	(0.14)	(0.14)
Deficit including restructuring costs	**(10.20)**	**(8.19)**	**2.00**

- EBITDA of £2.12m, a favourable variance of £1.68m from the plan.
- Of this operating performance £1.88m is driven by a timing difference on the accrual of Strategic Transformation Funding versus the planned quarterly profile.
- A bottom line deficit of £8.19m, a £2.00m favourable variance from plan.
- Delivery of CIP of £4.98m against the planned level of £3.58m.
- Contingency reserves of £0.99m have been released against pressures.
- Capital expenditure of £6.50m, this is below the planned level of £7.98m.
- A cash balance of £4.56m, this is above the planned level of £1.95m, supported by borrowing.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

In the year to date, the activity over performance has driven overall income recovery in excess of plan by £1.72m. This sits alongside strong CIP delivery, achieving £1.41m in advance of the planned timescale. The combined benefit has not flowed through in full to the bottom line but has rather absorbed the activity related expenditure pressures and one off issues such as the Junior Doctors' strike action. However, of the £2m contingency reserves, £1.68m was planned for in the year to date, £0.69m has not been released but rather has been held back to mitigate against pressures in the latter part of the year. This lesser reliance on contingency reserves in the year to date is supported by the income over performance and CIP delivery.

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

Operating income	£3.82m favourable variance
Operating expenditure	(£2.14m) adverse variance
EBITDA	**£1.68m favourable variance**
Non-Operating items	£0.46m favourable variance
Restructuring costs	(£0.14m) adverse variance
Total	**£2.00m favourable variance**

Operating Income

There is a £3.82m favourable variance from the year to date plan within operating income. Of this operating performance £1.88m is driven by a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The £1.88m STF represents full achievement of financial and operational criteria in the year to date. There has been a slight under-performance against the A&E trajectory in months 4 and 5 but this is overridden by the cumulative year to date performance which is above the agreed year to date trajectory. This will remain a challenging target for the Trust due to activity levels described below.

NHS Clinical Income

Within the £3.82m favourable income variance, NHS Clinical income (excluding the timing difference on STF) shows a favourable variance of £2.74m. As described above, overall activity has had a strong performance in month which augments the position seen in the first quarter. The breakdown by point of delivery is as follows:

- Planned day case and elective activity has improved in month 5 with activity 5.23% (203 spells) above plan. This is driven by continued over-performance within day case activity mainly within Ophthalmology and Gastroenterology with a large increase within General Surgery in month, recovering some of the under-performance seen in prior months. Urology has also seen an increase due to a vacant post following retirement now being covered by an agency locum.

- Non-elective activity overall is 2.2% (89 spells) below the month 5 plan. This is a decrease in activity when compared to month 4. Cumulatively activity is 1% (198 spells) below planned levels.

- A&E has seen activity continue to over-perform, activity is 1% (120 attendances) above the month 5 plan and cumulatively 3.2% (1,994 attendances) above plan.

- Outpatient activity overall has seen a significant increase in month 5 and is above plan by 4.7% (1,352 attendances). This is a shift from month 4 when activity was below plan. The over-performance is across both first and follow-up attendances including procedures.. Cumulatively outpatient activity is now 2.7% (3,800 attendances) above plan.

- Adult Critical Care is 50% (147 bed days) above the month 5 plan which is a large shift from the month 4 position. This is mainly due to the discharge of 2 long-stay patients in month. This adds to the previously reported discharge of a 5-organ supported very long stay patient in quarter 1.

The clinical contract PbR income position is driven by these areas of activity over performance as well as Rehabilitation and Diagnostic testing & imaging. The non elective activity under-performance is compensated in income terms by case mix changes.

This position continues to reflect an over-performance against the Trust's year to date plan and a greater over-performance against contracts with the Trust's Commissioners. The 2016-17 contracts with the Trust's commissioners incorporated 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 Trust remains in close contact with commissioners to highlight this position both from a point of view of securing cash relating to the overtrades in a timely manner and also to guard against unexpected challenges. Whilst the Trust is mindful of the affordability pressures to the health economy as a whole, no provision against contractual challenges is reflected within the position.

Other income

Overall other income is £0.03m below plan for month 5 and £0.80m in the year to date. This is driven by a number of factors. The transfer of the West Yorkshire Audit Consortium to another host organisation has reduced income by £0.37m. Lower than planned income within the Trust's Pharmacy Manufacturing Unit and Donated Asset Income is partially offset by an improvement in Injury Cost Recovery Unit income. The Trust also planned for Bowel Scope income as part of non-NHS Council funding which changed contractually to be funded through NHS England, showing below plan within non-NHS Clinical income, off-set by over-performance within NHS Clinical income at a cumulative value of £0.26m.

Operating expenditure

There was a cumulative £2.14m adverse variance from plan within operating expenditure across the following areas:

Pay costs	(£0.80m) adverse variance
Drugs costs	£0.30m favourable variance
Clinical supply and other costs	(£1.64m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £0.80m higher than the planned level in the year to date. £20.32m was spent on pay in-month which is an increase against last month. This has been seen through an increase in substantive staffing costs which is not compensated by an equivalent reduction in agency costs. It should be noted that £2.0m of contingency reserves are planned against pay in equal instalments across the first six months of the financial year. Five months of this contingency, £1.72m, has been released against the pay position, meaning that the underlying divisional year to date pay overspend was £2.52m.

As has been the case through this year it is the high vacancy levels in clinical staff groups that is causing reliance on agency staffing with the associated premium rates that drives the overspend. The largest area of overspend by staff group is nursing, the combined overspend against qualified nursing and support to nursing (Healthcare Assistants) is £1.48m in the year to date whilst Medical staffing is overspent by £0.14m in the year to date. Both staff groups have seen an increase in absolute spend in August versus July which is congruent with the activity trend.

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 cost of agency is largely offset by these unfilled staffing gaps, however the absolute cost of medical agency is however high at £6.59m in the year to date, 58% of the overall agency spend. There is a balance to be struck in engaging medical staffing between the high cost of employment against the potential performance standards and income lost through staffing gaps. The assessment of the risk of switching off this agency cover has been made on a case by case basis by Divisions and as with nursing the drive to recruit staff is ongoing including pursuing international overseas recruitment. Work is also underway to seek to drive down the contractual rates paid to Medical agencies and develop a tiered approach to bookings.

These initiatives are being co-ordinated through the flexible workforce team with investment having been agreed to bolster this function to ensure control and use of best practice; new IT systems have been implemented to streamline processes; new recruitment and retention strategies are also being put in place. The impact of these strategies is intrinsic to the Trust's ability to deliver the required divisional recovery plans.

Drug costs

Year to date expenditure on drugs was £0.30m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £0.52m below plan. Underlying drug budgets are therefore overspent by £0.22m.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £1.64m above the plan. This overspend reflects activity related factors such as outpatient test volumes and a considerable increase in MRI usage driving hire costs and outsourced reporting charges, with growth in internal diagnostics demand outstripping the overall activity increase. This has been subject to a deep dive analysis 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.

As was the case last month, an element of the overspend in this area is driven by purely technical reasons. The annual plan includes £2.0m of contingency reserves which was planned as pay spend of £1.66m in the year to date. There has been a release of £0.99m contingency reserves to the bottom line in the year to date position, a provision has been made against the balance of the available contingency, £0.67m, for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.46m below the planned level. This is driven by a combination of lower than planned depreciation charges and Public Dividend Capital payable. The adoption of a different valuation method for the PFI site and a review of equipment asset lives have reduced the asset value upon which both depreciation and PDC are chargeable. This benefit is supplemented by the £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.

These benefits are offset in part by higher than planned interest payable due to both the timing of drawing down borrowing and higher than planned interest rates. The greater impact of this interest pressure is included in the full year forecast where a continuing to bear the current interest rate of 3.5% for a Working Capital Loan as opposed to the planned switch to a Revenue Support Loan at 1.5% will cost £0.5m more than plan.

Restructuring costs of £0.14m have been incurred in the year to date to fund redundancy costs which will deliver savings in the future periods.

Cost Improvement Programme (CIP) delivery

In the year to date, £4.98m of CIP has been delivered against a plan of £3.58m, an over performance of £1.41m. The over delivery comes in a number of areas, most materially being as follows:

£0.6m Estate related commercial opportunities including securing rates and utilities rebates, a gain on disposal of Trust property and reduced depreciation charges as a result of adopting a new asset valuation method;
£0.2m reduction in consultant costs recharged from other NHS organisations;
£0.1m increase in delivery against the Nursing portfolio through the use of the apprentice scheme;
£0.2m over performance on the Surgical Pathways portfolio with increased productivity in specific specialties

Whilst the level of over performance is positive news it should be noted that the year end forecast is for delivery in line with plan and this is therefore a timing difference rather than an over achievement against the £14m savings target that is embedded within the financial plans. The year end forecast is for achievement of £14.05m savings, slightly over the £14m planning requirement but not to the extent of the year to date.

As was the case last month, the £1.41m over performance against CIP plans in the year to date has not translated to an equivalent benefit to the Trust's bottom line financial performance but has rather offset other pressures. The concern that this raises is that whilst CIP across the full year is forecast to deliver to plan, the year to date over performance is matched off by a corresponding underperformance in the latter part of the year. This will lead to a financial pressure against plan which will have to be mitigated and will need to form part of the divisional recovery plans.

Work is now also required to ensure that the step up in monthly delivery in the latter part of the year can be secured, this is where the highest risk schemes are due to commence delivery, for example the complex portfolio focussing on operational productivity through improved patient flow. Additional savings opportunities also need to be progressed in support of the divisional recovery plans that are required to deliver the overall financial control total of £16.1m deficit. An Executive Director time-out was held in early September to generate ideas, these will need to be swiftly converted from design to delivery stage alongside the balance of the recovery plans.

Statement of Financial Position and Cash Flow

At the end of August 2016 the Trust had a cash balance of £4.56m against a planned position of £1.95m, a favourable variance of £2.61m. This is due to the request for cash support of £2.5m being submitted on the advice of NHS Improvement, as there had been no confirmation that the quarter 1 Strategic Transformation Funding (STF) of £2.8m would be issued to the Trust in August. However the STF was received in August at short notice in addition to the cash support also being received.

The key cash flow variances against plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	2.00
	Non cash flows in operating deficit	(0.38)
	Other working capital movements	(6.50)
	Sub Total	**(4.88)**
Investing activities	Capital expenditure	1.50
	Movement in capital creditors	(1.63)
	Sub Total	**(0.13)**
Financing activities	Drawdown of external DoH cash support	7.97
	Other financing activities	(0.35)
	Sub Total	**7.62**
	Grand Total	**2.61**

Operating activities

Operating activities show an adverse £4.88m variance against the plan. The adverse cash impact of the I&E position of £1.62m (£2.00m favourable I&E variance offset by £0.38m non-cash flows in operating deficit) is in addition to a £6.50m adverse working capital variance from plan, including £1.88m relating to the months 4 and 5 STF which will be paid in arrears. The balance of the working capital variance reflects the catch up of payments to suppliers.

Total aged debt based on invoices raised is £3.79m, whilst outstanding creditors approved for payment to suppliers stood at £0.85m at month end. The performance against the Better Payment Practice Code has continued to improve in month. In month 79% of invoices have been paid within 30 days against the 95% target.

Investing activities (Capital)

Capital expenditure in the year to date is £6.50m which is £1.48m below the planned level of £7.98m.

Against the Estates element of the total, year to date expenditure is £1.67m against a planned £2.93m. The main area of spend in month was on the continuation of the Theatre refurbishment programme with a year to date spend of £1.1m, this is coupled with spend on backlog maintenance including the continuation of fire compartmentation, fire detection and roofing work.

IM&T investments total £3.61m against a plan of £3.28m. The main areas of spend in month were the continuation of the Electronic Patient Record (EPR), and EDMS projects and replacement of PCs and laptops. The primary reasons for the £0.35m overspend versus plan is due to EPR related spend; £0.22m due to pressures on overtime, £0.15m on EDMS to bring scanning work forwards in readiness for the EPR go live date. These cost are offset in part by an underspend on wired network which hasn't commenced in line with planned timescales.

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

The favourable cash impact of the £1.50m (£1.48m capital expenditure variance plus £0.02m funded by donated assets) under spend is offset by a £1.63m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way.

Financing activities

Financing activities show a £7.62m favourable variance from the original plan, of which £7.97m is due to additional cash support through borrowing. This position includes borrowing brought forward in earlier months to settle supplier invoices and an additional £2.83m draw down in July due to STF cash funding not being released by NHSI within the timescale that the Trust had anticipated at the

planning stage. Earlier advice from NHSI that this cash, relating to quarter 1 performance, was unlikely to be forthcoming before October, was overturned in mid-August when the STF cash was paid into the Trust's account by DH at short notice.

The Trust is keen to pursue with NHSI any opportunity to convert our loan from a Working Capital Facility (at 3.5% interest) to a Revenue Support loan (at 1.5% interest) in order to reduce interest charges.

3. Financial Sustainability Risk Rating (FSRR) and forecast

FSRR

Against the FSRR the Trust stands at level 2 in both the year to date and forecast position, in line with plan.

Forecast – Income and Expenditure

The year end forecast position continues to be delivery of the planned £16.1m deficit and control total. 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 and contingent upon delivery of the planned deficit. It has been acknowledged in discussion with NHSI, both at the time of setting the plan and subsequently, that the £16.1m control total excluded any I&E or cash pressures for EPR 'go live' and similarly the implementation of the Junior Doctor's contract.

There are inevitably other areas of underlying pressure and risk emerging in year, including areas that have impacted in the year to date which are beyond the organisation's direct control, such as the Junior Doctor's strike action and the higher than planned rate of interest being borne on current borrowing. This pressure is heightened in the remainder of the financial year as the Trust plans to deal with the combination of EPR implementation; delivery of complex CIP schemes with greater returns; response to the outcome of the CQC inspection and commencement of the Junior Doctor's contract; and managing winter pressures alongside quelling agency staff usage.

Operational plans are in place and being constantly refined against the above. At the same time, the Trust's Divisions are required to financial deliver recovery plans to mitigate against issues in their respective areas of service. In addition there will need to be Trust wide action to address these risks and balance the need for innovative solutions with the maintenance of rigorous budgetary control.

It is with these actions in mind that the Trust continues to plan and drive to deliver a deficit in line with the control total at £16.1m.

Forecast – Capital and cash

Capital expenditure is currently expected to be £27.61m, £0.61m below the planned full year value of £28.22m. The switch in categories of spend between IT and Estates as described last month still stands. EPR is forecast to increase against the original plan by £2m with this being offset by the ward refurbishment not proceeding in full. After an internal review of our cash, operational, and legislative compliance requirements, the remainder of the plan is continuing to be implemented. This follows the completion of a full risk and quality impact assessment. Total borrowing forecast to be drawn down in year remains in line with plan, with the cash benefit on reduced forecast capital investment being offset by the non-cash I&E benefit of lower than planned depreciation.

Owen Williams
Chief Executive

Keith Griffiths
Executive Director of Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th September 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from each of the sub-committees.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from each of the sub-committees:
- Quality Committee - minutes of 26.7.16, 23.8.16 and verbal update from meeting 27.9.16
- Finance and Performance Committee - minutes of 26.7.16, 23.8.16 and verbal update from meeting 27.9.16
- Audit and Risk Committee - minutes of 21.7.16
- Membership Council Draft Minutes of 6.7.16
- Nomination and Remuneration Committee (Membership Council) minutes of 21.7.16

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the updates and minutes from each of the sub-committees:
- Quality Committee - minutes of 26.7.16, 23.8.16 and verbal update from meeting 27.9.16
- Finance and Performance Committee - minutes of 26.7.16, 23.8.16 and verbal update from meeting 27.9.16
- Audit and Risk Committee - minutes of 21.7.16
- Membership Council Draft Minutes of 6.7.16
- Nomination and Remuneration Committee (Membership Council) minutes of 21.7.16

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES ATTACHMENTS.pdf

APPENDIX A

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Quality Committee held on
Tuesday 26 July 2016 in the Board Room, Sub Basement, Huddersfield Royal Infirmary

PRESENT

David Anderson	Non-Executive Director / Committee Chair
David Birkenhead	Medical Director
Diane Catlow	Associate Nurse Director, Community Division
Juliette Cosgrove	Assistant Director of Quality
Tracy Fennell	Associate Director of Nursing, Medical Division
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Andrea McCourt	Head of Governance and Risk
Lynn Moore	Membership Council Representative
Kristina Rutherford	Assistant Divisional Director, Surgical Division
Jan Wilson	Non-Executive Director

IN ATTENDANCE / OBSERVERS

Michelle Augustine	Clinical Governance Secretary

ITEM NO	
131/16	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
132/16	**APOLOGIES** Rob Aitchison – Assistant Divisional Director, FSS Division Kirsty Archer – Deputy Director of Finance Helen Barker – Chief Operating Officer Karen Barnett – Assistant Divisional Director, Community Division Stuart Baron – Deputy Director of Finance Elaine Brotherton – Patient Safety & Quality Lead - FSS Division Brendan Brown – Executive Director of Nursing Martin DeBono – Divisional Director, FSS Division Jason Eddleston – Deputy Director of Workforce and Organisational Development Tracy Fennell – Associate Nurse Director, Medical Division Keith Griffiths – Executive Director of Finance Carole Hallam – Senior Nurse Clinical Governance Anne-Marie Henshaw – Associate Nurse Director/Head of Midwifery, FSS Division Jackie Murphy – Deputy Director of Nursing, Modernisation Joanne Middleton – Associate Nurse Director, Surgery and Anaesthetic Services Julie O'Riordan – Divisional Director, Surgery and Anaesthetic Services Vicky Pickles – Company Secretary Lindsay Rudge – Associate Director of Nursing Sal Uka – Divisional Director, 7 Day Service/Hospital at Night Bev Walker – Assistant Divisional Director, Medical Division
133/16	**DECLARATIONS OF INTEREST** There were no declarations of interest to note.
134/16	**MINUTES OF THE LAST MEETING** The minutes of the last meeting held on Tuesday, 28th June 2016 were approved as a correct record.

135/16	**ACTION LOG AND MATTERS ARISING** **Mock paediatric cardiac arrest** A paper was provided by Estates and Facilities, giving assurance on the issue of the bleep system and DECT phones at Calderdale Royal Hospital (CRH): Pagers An upgrade has been carried out to the multi-tone pager system at CRH resulting in additional and new transmitters being located across CRH Site and new pager handsets. Pagers are used at CRH due to a number of blackspots (affecting mobile signal) located around the CRH Site with the main areas being OPD and A&E. A text and verbal message is provided via the paging units via switchboard. An incident occurred in June 2016 whereby the on-call registrar did not receive an emergency call via the paging system. On investigation it was found that the riser housing the transmitter had been used to store equipment which had resulted in the transmitter being dislodged. Colleagues are reminded that the risers are not for storage of ward equipment and should only be used to house estates infrastructure. The following checks are now in place:- • Weekly checks to ensure the transmission of voice messages via pagers are audible and transmitted correctly • All areas housing transmitters are now locked off and currently checked on a daily basis to ensure the transmitter remains in position. DECT Phones Digital Enhanced Cordless Telecommunications (DECT) phones are devices that can be used to communicate through phone lines without a cord connecting the handset and base. With digital technology, the sound is clearer, the distance between the phone and the base station can be greater, and a wider range of frequencies are available. This type of phone is also commonly used at CRH. Discussion ensued and the Committee agreed that the actions were sufficient. **OUTCOME**: The Committee received and noted the content of the report and are satisfied with actions taken. **Risk Register** Following the last meeting, feedback was given that the risk on defibrillators is now on the risk register and the scoring of the risk is being reviewed. It was also reported that further discussion took place at the Risk and Compliance Group and actions have been taken. The Committee agreed that the feedback does not provide assurance that if a child has a cardiac arrest, that they will have access to the correct equipment and staff, as presently, adult cardiac arrest devices have paediatric pads, but staff need the knowledge base, the challenge being confidence levels of adult nurses for managing a paediatric cardiac arrest. **OUTCOME**: The Committee agreed that more detail on the assurance of the risk is needed. **ACTION: That the Families and Specialist Services (FSS) division and the Resuscitation team are invited to the meeting in September to give more detail on the assurance of the risk.** **Incident case summaries to PSQBs** This action has now been completed - all incident case summaries have now been circulated to the Patient Safety and Quality Board meetings. **HSE annual report** Following the last meeting, the Health and Safety update was received by the Committee and any actions from the report are reviewed at the Health and Safety Committee.

136/16	**NICE GUIDANCE REPORT** Juliette Cosgrove presented a paper (Appendix C) giving an update on NICE guidance and the position on work being undertaken to ensure Clinical Guidelines, Interventional Procedures and Technology Appraisals are working towards full compliance, regularly reviewed, and that non-compliant guidelines are validated. Any guidelines with a risk are placed on the local risk register and mitigated. The majority of reasons for non-compliance are due to commissioning issues, and a list of guidelines which these apply to were noted. The overall position of non-compliance is monitored through the Clinical Effectiveness and Audit Group (CEAG) and the Clinical Outcome Group (COG). It was agreed that assurance and understanding of the commissioning issues and specific risks for non-compliance will be brought back to this Committee in six months' time. **OUTCOME:** The Committee accepted report and agreed that furthers reports will be presented on a six-monthly basis, with assurance and understanding of non-compliance with commissioning issues being presented at the meeting in January 2017.
137/16	**VANGUARD PROGRAMME** **ACTION: That this report is deferred to the meeting in September 2016.**
138/16	**CQC REPORT** Juliette Cosgrove presented a paper (Appendix E) giving an update on actions being progressed by the CQC Response Group in advance of receiving the final report, and the approach taken to address any issues. The draft CQC report was received on 25 July, and a meeting with the core service leads was held to go through factual accuracy checking. Areas of concern were as expected, however, the next steps for the report cannot be shared at this moment in time whilst factual accuracy checks are underway. Communication will be circulated throughout the Trust by the end of the week, and the target publication of the report is Monday, 15th August 2016. **OUTCOME:** The Committee noted progress to date and is aware that the draft report is anticipated within the next few weeks and supports the approach being taken to deliver and monitor the action plan.
RESPONSIVE	
139/16	**QUALITY AND PERFORMANCE REPORT** The Quality and Performance report for June 2016 was presented (Appendix F), and the following highlights were noted: Safe – Harm free care – same concerns as last month and work is ongoing. – Post-Partum Haemorrhage (PPH) - still some work to do, as well as work on 3rd and 4th degree tears, access to theatres and capacity issues. – Action plan from Royal Colleges – weekly performance meetings are taking place, and the complete maternity action plan is reviewed at the CQC Response Group. Effective – Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR) – Predicting further falls with HSMR which will hopefully take Trust to the expected range. Mortality review group is continuing to meet. – Fractured Neck of Femur - target is still difficult. Looking at quality of RCAs from the perspective of a patient who has not undergone surgery within 36 hours against one that has, and looking at learning. Caring – Complaints – reduction in those within timescale, and seeing improvement in quality of complaints, interaction of complainants, and the learning. Continuing work with

	divisions. – Friends and Family Test (FFT) outpatients and community – There is generally a lot of improvement with FFT. <u>Responsive</u> – Daily discharges before 12:00 noon – the anticipated month on month improvement of 10% per month has not been seen and currently undergoing small tests of change to improve compliance. – Green cross patients – this remains high and discharge coordinators are using a case management model to improve patient experience, discharge planning, continuity and integration with social care. – Stroke – Improvements noted in all indicators and ongoing work to achieve full compliance continues. <u>Workforce</u> – Sickness - Absence rate continues to fall to 4.1% against 4% target. Long-term sickness is 2.9% against 2.7% and short-term sickness is 1.24% against 1.3% target. – Appraisals and Mandatory Training - compliance remains a challenge. Appraisal training proposal paper received at the Education Learning Group in June 2016. <u>CQUIN</u> Achieving targets with CQUINS. **<u>OUTCOME</u>:** The Committee noted the content of the report, and ask that any risks are highlighted in the Clinical Outcomes Group report.
140/16	**<u>QUALITY QUARTERLY REPORT, Q1 2-16/17</u>** Andrea McCourt presented the comprehensive report (Appendix G) on quality performance for quarter 2016 /17 which includes contractual, quality account, national and local quality priority requirements and priorities. The report is structured into the five Care Quality Standards domains. It was stated that there is not as much performance data as would normally have as this is the Q1 report for 2016/17. It was noted that four areas that will be included in the Q2 report are dementia, Public Patient Involvement (PPI), patient flow and the workforce race equality standard (WRES);these will be reported on a six-monthly basis. **<u>OUTCOME</u>:** The Committee noted the content of the report.
SAFETY	
141/16	**<u>BOARD ASSURANCE FRAMEWORK</u>** The Board Assurance Framework (Appendix H) will be submitted to the Board this month. **<u>OUTCOME</u>:** The Committee received and noted the content of the report.
142/16	**<u>SERIOUS INCIDENT REPORT AND LEARNING</u>** Andrea McCourt presented the report (Appendix I) relating to serious incidents in June 2016: – Four serious incidents – two relating to falls and two relating to care / treatment omissions – No serious incident reports submitted to commissioners during June 2016, therefore no case summaries with learning to share – Learning from incidents is submitted to divisions, Quality Committee, then Patient Safety and Quality Board (PSQB) meetings. – Patients and families receive a report within 10 days, which covers Duty of Candour. **<u>OUTCOME</u>:** The Committee received and noted the content of the report

143/16	**SAFEGUARDING ADULTS AND CHILDREN'S REPORT** Juliette Cosgrove presented the safeguarding adults and children's report (Appendix J) which gave updates on training, the Goddard Inquiry, Calderdale Children Looked After Service, Children's Safeguarding Supervision, MCA and DoLS and progress regarding the Domestic Abuse Hub in Calderdale. Discussion took place on concerns raised at a focus group with community staff, including health visitors, regarding management of information shared with the current provider of the 5-19 school nurse contract, highlighting issues around the sharing of information not being as seamless since the transfer of the contract from CHFT in April 2015, and that where they identified needs they did not always appear to meet the referral criteria into the school nurse service, based on the 5-19 service specification. The health visitors complete a face-to-face handover of caseloads with school nurse team members at school entry, and are able to refer into the service electronically any identified needs, or contact the team through a single point of access. They would also make referral to care services of any safeguarding needs identified on routine contact and inform the school nursing service that this had been done, however, they voiced the perception that some of the information shared is not acted upon or follow up is not forthcoming . This issue has been raised with the current local authority commissioner, raised at the recent Trust CQC visit and the safeguarding children CQC visit. CHFT safeguarding team are aware of the situation and have offered joint supervision with health visitor and school nurses, and there has been liaison with local authority care services. Since the change in contract and since the CQC visit, there has been liaison with the provider to improve record sharing and communication. **OUTCOME:** The Committee received and noted the content of the report.
COMPLIANCE	
144/16	**CORPORATE RISK REGISTER** Andrea McCourt presented the risk register report (Appendix K) for July – there were nine top risks and no new risks for addition in July. It was noted that the Risk and Compliance Group discussed the paediatric resuscitation risk discussed at the Quality Committee on 28 June 2016. It was agreed that Helen Barker would undertake further discussion on this risk with the Family and Specialist Services division. It was also noted that the risk needed discussions within the Resuscitation Committee. Following these discussions the risk will be re-presented to the next meeting of the Risk and Compliance Group, which is 13 September 2016. **OUTCOME:** The Committee received and noted the content of the report.
EFFECTIVENESS	
145/16	**CLINICAL OUTCOMES GROUP REPORT** David Birkenhead gave a summary of the Clinical Outcomes Group report (Appendix L) highlighting: – Independent Service Reviews: Respiratory, Stroke and Elderly undertaken and maternity review is currently being held – Stroke – Sentinel Stroke National Audit Programme (SSNAP) data which has been released for 2014-2015 and awaiting 2015-2016 data at the end of the year. – Crude mortality remains around the mean. **OUTCOME:** The Committee received and noted the content of the report.

146/16	**MORTALITY SURVEILLANCE GROUP** David Birkenhead presented the Mortality Surveillance Group report (Appendix M). **OUTCOME:** The Committee accepted the minutes and the work ongoing.
CARING	
147/16	**PATIENT EXPERIENCE AND CARING GROUP REPORT** Juliette Cosgrove presented the report from the Patient Experience and Caring Group (Appendix N) which included minutes from the meeting on 28th June. The following matters were identified as items to be escalated to the Quality Committee: – Robust QIA process described and agreed that the Group need only be involved if a wider view on the impact on patient experience is required. – Complaints performance remains a concern - process are being introduced to help monitor the current position with all open complaints and a focus is being placed on the quality of the responses. – Results of the National Inpatient Survey were published in June 2016, the Trust scored 'about the same' for all but 2 questions where the Trust scored better than the majority of other Trusts: ▪ Were hand-wash gels available for patients and visitors to use? Scoring 9.8 ▪ Were you given enough privacy when being examined or treated on the ward? Scoring 9.7 – The community patient experience is progressing against plan with a draft survey established for out-patient physiotherapy It was stated that the Group was very well attended and good discussions were had at the meeting. **OUTCOME:** The Committee received and noted the content of the report.
WELL LED ORGANISATION	
148/16	**WORKFORCE (WELL-LED) COMMITTEE REPORT** There was no report as the next meeting will be held on 15 August 2016.
HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE	
149/16	**HEALTH AND SAFETY COMMITTEE UPDATE** Lesley Hill presented the Health and Safety Committee update (Appendix O) including the minutes from the meeting on 15th June 2016. **OUTCOME:** The Committee received and noted the content of the report
RESEARCH AND DEVELOPMENT	
150/16	**RESEARCH** David Birkenhead presented the six month summary report (Appendix P) highlighting the number of studies that were recruiting to time and target by division and other like-for-like Trusts. The Committee was asked to encourage Divisions to support the Clinical Research Lead initiative in helping to identify suitable candidates which was outlined in the paper. **OUTCOME:** The Committee received and noted the content of the report

151/16	**RESEARCH** David Birkenhead presented a paper (Appendix Q) on the selected activities completed over the last six months with the joint clinical academic post to raise the profile of the Trust in nurse research at a national and international level. **OUTCOME:** The Committee received and noted the content of the report
ITEMS TO RECEIVE AND NOTE	
152/16	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** – Assurance on bleep system and equipment issues will be addressed by next meeting. – Good progress on NICE guidance report and CCG issues to be bought back in six months' time – CQC Report – work ongoing – Performance indicators – risks on falls and work on sepsis – Serious incident report - sharing learning – Quality report – good processes in organisation – Changes in reporting safeguarding with change in organisation – Issue of new Community with MCA/DoLS – Compliant in patient experience to identify good metrics for patient experience and monitor complaints response time and quality of the responses. Quality of response has improved. – Mandatory training requirements – Improving picture of recruiting to research – Fire training uptake.
153/16	**WORK PLAN** The workplan for 2016-2017 was noted.
154/16	**ANY OTHER BUSINESS** It was noted that the Patient Safety and Quality Board (PSQB) reports are due for the next meeting.
DATE AND TIME OF NEXT MEETING	
Tuesday 23 August 2016 2:00 - 5:00 pm Boardroom Sub-Basement, Huddersfield Royal Infirmary	

Minutes of the Quality Committee held on Tuesday, 23rd August 2016 in the Board Room, Sub Basement, Huddersfield Royal Infirmary

PRESENT

David Anderson	Non-Executive Director / Committee Chair
Karen Barnett	Assistant Divisional Director, Community Division
Gemma Berriman	Deputy Associate Director of Nursing (Medicine)
David Birkenhead	Medical Director
Brendan Brown	Executive Director of Nursing
Juliette Cosgrove	Assistant Director of Quality
Mike Culshaw	Clinical Director of Pharmacy
Mark Davies	Clinical Director for Emergency Medicine
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Andrea McCourt	Head of Governance and Risk
Lynn Moore	Membership Council Representative
Jackie Murphy	Deputy Director of Nursing, Modernisation
Julie O'Riordan	Divisional Director, Surgery and Anaesthetic Services
Lindsay Rudge	Associate Director of Nursing
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Michelle Augustine	Clinical Governance Secretary

ITEM NO	
155/16	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
156/16	**APOLOGIES** Rob Aitchison – Director of Operations, FSS Division Asif Ameen – Director of Operations, Medical Division Kirsty Archer – Deputy Director of Finance Helen Barker – Chief Operating Officer Stuart Baron – Deputy Director of Finance Elaine Brotherton – Patient Safety & Quality Lead - FSS Division Diane Catlow – Associate Nurse Director, Community Division Martin DeBono – Divisional Director, FSS Division Jason Eddleston – Deputy Director of Workforce and Organisational Development Tracy Fennell – Associate Nurse Director, Medical Division Carole Hallam – Senior Nurse Clinical Governance Anne-Marie Henshaw – Associate Nurse Director/Head of Midwifery, FSS Division Joanne Middleton – Associate Nurse Director, Surgery and Anaesthetic Services Kristina Rutherford – Director of Operations, Surgical Division Nicola Sheehan – Head of Therapies, Community Division Vicky Pickles – Company Secretary Sal Uka – Divisional Director, 7 Day Service/Hospital at Night Ian Warren – Executive Director of Workforce and Organisational Development
157/16	**DECLARATIONS OF INTEREST** See item 162/16 – Anticoagulation Service
158/16	**MINUTES OF THE LAST MEETING** The minutes of the last meeting held on Tuesday, 26th July 2016 were approved as a correct record.

159/16	**ACTION LOG AND MATTERS ARISING** All actions and matters arising on the action log are due next month.
160/16	**MEDICAL DIVISION – PSQB REPORT** Gemma Berriman (Deputy Associate Director of Nursing) presented the detailed division's Patient Safety and Quality Board (PSQB) Report for Quarter 1 1st April to 30th June 2016) (Appendix C) and summarised the key exceptions including: • Patient Flow – The Associate Director of Nursing is leading on this by supporting ward sisters to improve compliance and expect a month on month improvement of 10% for both short stay wards over the next 4 weeks. • A&E – there has been a notable increase in attendances compared to the previous year • Stroke – Ongoing management and close monitoring through weekly improvement groups. Radiology confirmed capacity to deliver Computerised Tomography (CT) within one hour. 77.27% of stroke patients were scanned within one hour of hospital arrival against a 90% target. • Complaints – there has been a notable increase from 33% to 77% of complaints being responded to on time. • Friends and Family Test – the Emergency department's performance has improved over the last two months of Quarter 1, however, this month there has been a slight dip with the 'would recommend' compliance rate of 12% against a target of 14%. Work is being targeted with ward sisters through weekly meetings in order to improve. • Falls – Falls quality improvement lead now in post, and a full re-assessment of falls equipment is underway across the Trust. The Director of Nursing has approved a plan to move away from the 10% trajectory and focus on quality of patient care. • Sickness – absence rate is currently 5.61% against a 4% target. All sisters/matrons and General Managers are working with attendance management team to have clear visibility of actions taken to reduce sickness levels and support given to the individual staff who are off sick. • Vacancies – these continue to rise predominantly in nursing and medical staffing. New exit tool introduced at ward level in order for ward managers and matrons to understand reasons for staff leaving and explore opportunities to retain staff. Discussion ensued regarding the radiology teams arrangements to provide CT scans within the hour. **ACTION:** Mike Culshaw to get feedback from Radiology on the status of scans for stroke and thrombolysis patients. The Committee stated that feedback on the two Independent Service Reviews from the division (Respiratory and Elderly) were not included in the report, as well as feedback and performance on CQUINS. It was agreed that standardisation of the divisional reports is needed to ensure that all divisions are reporting on the same issues. **ACTION**: That Independent Service Reviews are separate agenda items for the Medical and FSS divisions for future meetings – Medicine to report at the September meeting and FSS to report at the October meeting. **OUTCOME:** The Committee received and noted the content of the report.
161/16	**SURGERY AND ANAESTHETICS DIVISION – PSQB REPORT** Dr Julie O'Riordan (Divisional Director) presented the detailed division's Patient Safety and Quality Board (PSQB) Report for Quarter 1 - April to June 2016 (Appendix D) and summarised the key exception of Fractured Neck of Femur Best Practice Tariff (BPT). Compliance was reported at 66% for Quarter 1. This was mainly due to the reduced compliance with the time to theatre within 36 hours which was 72% for Quarter 1.

	Since the last report: • Red and orange incidents - 1 red and 9 orange incidents closed; • Complaints - 36 complaints were closed (2 red, 7 orange, 18 yellow and 9 green), and response rates are steadily climbing. The division has assurance that all complaints are regularly updated. • Risk register – continuing to maintain accurate register that is used across the division. There are 72 open risks (26 graded 12, 27 graded 8-10, 19 graded 6 and below). • Duty of Candour – 10 orange and 1 red incident were reported in Q1, and the division was 100% compliant. Will continue to ensure that where requested, investigation outcomes are fed back. The CCG have agreed that following a mortality review, the division only contact relatives if harm was caused (following the investigation not before). **OUTCOME:** The Committee received and noted the content of the report.
162/16	**FAMILY AND SPECIALIST SERVICES DIVISION – PSQB REPORT** Mike Culshaw (Clinical Director for Pharmacy) presented the detailed division's Patient Safety and Quality Board (PSQB) Report for Quarter 1 - April to June 2016 (Appendix E) and summarised the key exceptions: • Risk to patients with AKI requiring nephrostomy and compliance with NICE guidance - Option appraisal for nephrostomy service – Urology to inform final decision to fully understand impact. • Risks to Isotope Imaging Service from failing Gamma camera - risk assessment being updated following meeting with the Trust's Radiation Protection Advisor. Currently risk rating of 12 – plan to replace, but as yet unidentified estates costs. • Anticoagulation Service – *The Chair made a declaration of interest as his practice is a community provider of this service.* There was a sharp increase in the numbers of International Normalised Ratio (INRs) greater than 8.0. The division regularly audit high INR results, and in the previous quarter, most high results were attributed to associated illness with antibiotic and steroid prescribing. All patients who had an INR greater than 8 were treated as per protocol and received vitamin K on the same day as the high result. Due to the higher than expected numbers, from next month all hubs will report all INRs greater than 8 and these will all be investigated. Since the last report: • Radiology - Red Risk – delay in acting upon radiological results - a process been agreed for radiology reporting. This was attached to the report at Appendix 1. • Pathology suffered a severe hardware failure resulting in loss of the laboratory IT system for 5 days. This has been investigated as a Serious Incident. The conclusion of this investigation is that whilst the laboratory maintained an adequate manual system of reporting during the downtime, the APEX back-up system in its current format is not fit for purpose. An action plan is in place which will be monitored through PSQB. • Pharmacy - risks following medium term vacancies in senior posts in the Pharmacy stores and procurement have been mitigated through an interim senior team taking control of this area. KPIs have been developed to monitor improvements and there has been a reduction in the number of 'to-follows' of stock medicines to wards; a reduction in ad-hoc requests from wards and a reduction in the number of 'outstanding invoices'. The new procurement manager started mid-June and the new Chief Technician for Stores and Procurement at the end of July.

	• Maternity - CQC inspection highlighted areas of concern for maternity services across all 5 domains. An action plan to address areas for improvement is in place and currently delivering in line with target timeframes. A maternity dashboard has been further developed with enhanced reporting and audit function. • Children's Services - action plan formulated from resuscitation simulation training to ensure future emergency equipment is fit for purpose. Updated action plan to be reviewed at Paediatric forum meeting. NICE Guideline 43 - Transition to Adult Services - a bi-monthly task and finish group has been initiated to discuss areas of non-compliance, terms of reference and to agree the transition policy. First meeting was held on 13th July 2016. Discussion ensued on the CQUINs for anti-microbial resistance and the self-administration of medicines. The requirements for both indicators were achieved in Q1. **OUTCOME:** The Committee received and noted the content of the report.
163/16	**COMMUNITY SERVICES DIVISION – PSQB REPORT** Karen Barnett (Assistant Divisional Director) presented the division's Patient Safety and Quality Board (PSQB) Report for April to June 2016 (Appendix F) and gave the key exceptions for the Committee to consider including serious incident investigations, complaints and the CQC action plan. Since the last report, the division continues to drive forward its governance framework. At the beginning of the quarter, the division were in a strong position to develop the frameworks in place, but due to the individual providing governance support leaving in April 2016, there are areas that have not progressed as the division would have wished. These include audit, clinical guidelines development and review and NICE guidance. The level of staffing and sickness are being closely monitored and reasons for leaving are being reviewed. The Executive Director of Nursing is aware of the challenges that the division face regarding governance support, and has committed to reviewing governance resource across the organisation to ensure equity of resource is available in the near future. The Committee was asked to note the issue of governance support within the division which is impacting on progress against the governance framework and to acknowledge the progress on pressure ulcers and complaints resolution in recent months. **OUTCOME:** The Committee received and noted the content of the report, as well as the issue of governance support within the division.
164/16	**ESTATES AND FACILITIES DIVISION – PSQB REPORT** Lesley Hill (Executive Director) presented the division's Patient Safety and Quality Board (PSQB) Report for April to June 2016 (Appendix G) and gave the key exceptions: • Control of Substances Hazardous to Health (COSHH) training and risk assessments complete; engagement programme to embed within the Trust. • Fire safety training being rolled out. Staff reminded that 2016/17 is face-to-face training. • The division welcomed the Medical Engineering Department to join their division in April 2016. • Achievement of Food & Nutrition CQUIN 2015/16:- – *Reduction of 2.5% patient food waste* – *Increase in patient satisfaction relating to food* – *Vending specification to be developed* • Catering files on each ward detailing menus and additional options for patients with menu fatigue • Estates and Interserve received the award for Integration and Collaborative Working at the Constructing Excellence Yorkshire and Humber awards.

	Since the last report: • CQC - the division received positive verbal feedback from the CQC during their inspection on being patient focussed, however, there is still work to be done to ensure signage throughout HRI and Acre Mills relfect the current configuration and services, and further improvements to progress planned preventative maintenance for medical engineering. • Staff related incidents - areas being focussed on are slips, trips and falls. • Car-parking audit – this is now completed and an action plan is in place to improve the permit process. • 'Bring me food' introduced at CRH which involves visitors / staff having food delivered to wards. This is currently in the early trial stages and further feedback will be available for the next report. • New national CQUIN relating to Health and Wellbeing of staff, visitors and patients, which includes the banning of price promotions on sugary drinks, foods high in fat, sugar and salt; banning of advertisement on NHS premises of the above, and ensuring healthy options are available at any point for those staff working night shifts (tender for vending currently being completed). • Emergency Preparedness, Resilience and Response (EPRR) – gap analysis completed and security awareness identifying risks in both areas which are captured on the risk register as significant risks. Work-plans in place and support to be provided to manage risks appropriately. **OUTCOME:** The Committee received and noted the content of the report.
165/16	**CQC REPORT** Brendan Brown (Executive Director of Nursing) presented a paper (Appendix H) on the CQC proposals which will be submitted to the Trust Board for sign-off, to manage the CQC inspection report recommendations. It has been six months since the CQC inspection and the paper provides an overview of the stages within the CQC process and describes the current position for CHFT and details the actions taking place. The final report was published on the CQC website on Monday 15th August 2016. A number of staff briefing sessions were delivered by the Chief Executive and the Director of Nursing during this day. The final overall rating for the Trust was 'Requires improvement', with over 70% of service areas rated as good. The final report is now being used to inform a Trust action plan, which is based on the 19 'Must do' and 11 'Should do' actions detailed in the report. The action plan will be monitored in various forums and this Committee will provide assurance to the Board that the plan is achieving the expected impact and give final sign-off for sustained actions. The Quality Committee also has a significant responsibility to ensure that evidence is presented of sustained improvement, and to ensure that the improvement is embedded. The CQC will make a return visit and will not only review the services that received a 'requires improvement' rating, but those that received a 'good' rating also. The next CQC report will include a detailed action plan and what needs to be done before submitted to the Board. It was discussed how the new process for managing the CQC action plan will be communicated to the Board members in the absence of a Board meeting in August. **ACTIONS**: All non-executive directors to be sent a link to the CQC website, as well as copies of the CQC summary reports. Brendan to liaise with the Chairman on how to manage this through the Board. **OUTCOME:** The Committee noted the proposals for managing the findings from the CQC report and will await validation from the Board.

166/16	**INTEGRATED PERFORMANCE REPORT** The Integrated Performance Report for July 2016 was presented (Appendix I), and it was stated that the majority of the report has been covered in the divisional PSQB reports, however, the following was noted: • Hospital Standardised Mortality Rate (HSMR) - as anticipated, performance has improved to 109.3 and is expected to reduce over the coming months. The Trust is no longer classed as a significant outlier. • Summary Hospital-level Mortality Indicator (SHMI) remains an outlier. The next SHMI is expected to remain at a similar level, as it reflects a delayed period of time when the HSMR was also stabilised. • Crude mortality rates - For July 2016 the in-hospital death rate continues to drop and is now at 1.17%. • July's summary shows a further overall performance score of 65%, which is an improvement for the Trust. The Workforce domain has moved to amber for the first time in this financial year due to improvements in mandatory training and the Safe domain has also seen an improvement, most notably within Harm Free Care. Unfortunately, the Responsive domain slipped back to amber from green as a result of the Trust missing the Emergency Care Standard 4-hour target and the Effective performance reduced due to the four C.Difficile cases in July.
167/16	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** – Medical Division – recruitment; respiratory and elderly ISRs; CT scans – Surgery – Fractured neck of femur best practice tariffs; – FSS Division – Anticoagulation service – Estates – capital prioritisation; emergency planning; LSMS – Community – recruitment; – CQC - process
168/16	**WORK PLAN** The work plan for 2016-2017 was noted.
169/16	**ANY OTHER BUSINESS** There was no other business.
DATE AND TIME OF NEXT MEETING	
Tuesday 27 September 2016 2:00 - 5:00 pm Boardroom Sub-Basement, Huddersfield Royal Infirmary	

Minutes of the Finance & Performance Committee held on Tuesday 26 July 2016 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Anna Basford	Director of Transformation & Partnerships
Brendan Brown	Director of Nursing (In part)
David Birkenhead	Medical Director
Keith Griffiths	Director of Finance
Lesley Hill	Director of Planning, Performance and Esates & Facilities
Richard Hopkin	Non-Execuitve Director
Phil Oldfield	Non-Executive Director - Chair
Owen Williams	Chief Executive
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Stuart Baron	Assistant Director of Finance
Gary Boothby	Deputy Director of Finance
Mandy Griffin	Interim Director of Health Informatics
Brian Moore	Membership Councillor
Victoria Pickles	Company Secretary (In part)
Betty Sewell	PA (Minutes)

ITEM

107/16 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed Brendan Brown, Director of Nursing to the meeting.

108/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Helen Barker – Chief Operating Officer

109/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

110/16 MINUTES OF THE MEETINGS HELD 28 JUNE 2016

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

011/16 MATTERS ARISING AND ACTION LOG

069/16 & 085/16: Agency Spend Reduction – The Director of Nursing presented the paper, it was noted that agency spend is gathering national attention and a considerable amount of work has taken place within the Trust with regard to temporary staffing. The key issue is around the use temporary staffing as opposed to safe staffing. Standard Operating Procedures have been introduced across all staff groups which documents the controls authorisation for both temporary and agency staffing. A positive impact has already been seen within some staff groups but there is more work to do. There is still a challenge within nursing and medical staffing and improved communications, overseas recruitment and introduction of different roles are all being investigated, The long term plan would be to introduce a Workforce Strategy. Further discussions took place with regard the Brookson bank

and agency worker engagement model and the re-negotiation of agency payment terms, it was confirmed that the use of on-framework agency engagement was taking place, however, this then meant that standard rates and payments terms are implemented and the challenge for the Trust still relates to medical agencies.

It was highlighted that the sustainability of the nursing improvement needs to be monitored along with the associated safety matrix. In terms of medical, the Trust has a detailed line by line understanding of all vacancies. Discussions with NHS Improvement were referenced and it was noted that they seemed comfortable with our approach to agency staffing levels as long as there is no overall effect to the control total. It was recommended that non-EPR admin expenditure is scrutinised to ensure all expenditure is valid.

It was acknowledged that new models of working need to be investigated and the development of a West Yorkshire agency bank may be a way forward.

Brendan Brown left the meeting.

033/16: EPR Update – This item to be covered under the Agenda.

264&267/15: Review of Admission Criteria – In the absence of the Chief Operating Officer, a paragraph was included in the Month 3 Integrated Performance Report (Appendix H) of the papers – **action closed**.

FINANCE AND PERFORMANCE

112/16 MONTH 3 FINANCE REPORT

The Committee received the Month 3 Finance Report, the following highlights were noted:

- Year to date financial position stands at a deficit of £5.02m, in month the Trust has seen £150k favourable variance.
- Income is continuing ahead of plan and pay/non-pay pressures also continue.
- CIP position is over-performing but this due to profiling.

Within the income position, clinical income is over performing which gives us risks which link into the cash discussions. Challenge from the CCGs to do something differently was also called out as a risk for the Trust.

Workforce – there are 521 vacancies which equates to 9% of the workforce in the system and work will continue with regard to controls for agency staff. However, in order to suppress the unaffordable use of agency staff, recruitment to these posts is a priority. It was noted that June was the first month the hours worked was less than plan.

STF – Clarification and guidance of the payment of funding conditions have been received in month. It has been confirmed that 70% of the fund is based on achieving the Control Total and 30% is based on hitting the performance improvement trajectory. Our original plans assumed receipt of the first payment of the fund in July, however, it is now likely that we will receive the first payment in either October or November which in turn gives the Trust an added cash challenge.

CIP - £14m schemes are at Gateway 2 approved and the risk level has improved, work continues to ensure schemes will deliver.

Capital – A review of the overall plan of £28.2m has taken place and following discussions at the Capital Management Group and the Commercial Investment & Strategy Committee, schemes totalling £19m have been given approval and schemes totalling £9m have been held back.

Cash – Cash is one of the most serious challenges for the organisation with daily discussions taking place to improve our cash position. It was noted that an additional £5m has been drawn down ahead of plan, which is linked to the delayed receipt of the STF, overspend on agency and timing of receipts from Commissioners for overtrades. This has resulted in delayed payments to suppliers which could have an adverse effect on our reputation and supplier confidence. It was noted that the Cash Committee have re-prioritised supplier payments and supplier calls with regard to outstanding invoices are now being escalated to the Deputy Director of Finance and Director of Finance to help support the Accounts Payable team. It was also noted that this situation is not unique to our Trust, it is a national challenge.

The Committee discussed the scope to re-negotiate payment terms and it was noted that in terms of some of our largest suppliers there is a level of discount associated with payment terms, however, the procurement teams have been briefed that when negotiating future tenders, payment terms need to be improved.

With regard to the Finance Report, further discussions took place with regard to our elective activity, which is below plan and the reasons for this. The Director of Transformation & Partnerships reported that overall, for the first quarter, there is an aggregate under-performance on elective and daycase activity

It was noted that this includes an over-performance on daycase activity and an under-performance on inpatient activity. It was agreed that the original planned levels of elective inpatient and daycase activity remains the target. As part of the monthly Divisional Performance Meetings, the Surgical Division have been challenged to implement recovery plans to improve elective activity performance and achieve the plan (i.e. not to assume a variation in the plan in respect of the proportion/volume of daycase and inpatient procedures).

Discussions took place with regard to the activity over-trade against the CCG contracts and Commissioners ability to fund this level of activity.

It was also noted that the Trust's forecast year end position does not include a provision for the cost of implementing the new Junior Doctors contract. Work is currently being undertaken to assess the impact this will have.

As part of Month 3 discussions the confidence in the year end forecast came under review, the Director of Finance described the rigour which is undertaken at month end with the forecast process, the Committee received assurance that the Divisions are challenged, however, it was agreed that the forecast and assumptions should be clarified and further reassurance will come back to the Committee for the next meeting.

ACTION: It was agreed that more time will be dedicated to the forecasts re risks and assumptions at the next meeting – **KG/GB**

Financial Risks – The Committee will recommend to the Board that the Risk scores should remain at the reported level.

113/16 CASH FLOW PROJECTIONS

The Deputy Director of Finance presented the Cash Report which informed the Committee of the detail behind the funding which is in place for the Trust. It was confirmed that a number of actions and positive engagement with services has taken place to try to reduce the cash pressure, this work is on-going. Further potential cash pressures and risks were highlighted within the report and based on these factors it is not unreasonable to estimate a potential cash shortfall for the rest of the year. The challenge for the Trust is to ensure staff payments are prioritised which will inevitably lead to delayed payments to suppliers.

The report went on to describe a number of opportunities which could be pursued and considered to alleviate some of the risks and pressures and these were discussed. It was acknowledged that there had been great progress with operational teams including the Overseas Visitors Team and Estates team in improving processes to ensure payments are being made in advance for services and treatment but these relate to relatively small amounts of cash.

The Chief Executive queried the rationale for NHS Improvement and NHS England to offer the Working Capital facility rate at 3.5% interest as opposed to the Revenue Support Loan at 1.5% and suggested it would be useful to continually check the consistency of approach across other providers.

Discussions turned to the purchasing of consumables through the NHS Supply Chain and the opportunities available to negotiate their pricing, the Deputy Director of Finance confirmed that the Trust had written to Supply Chain to ask for improved terms he also suggested that NHS Improvement are pushing the Supply Chain route to enable better purchasing power. It was also noted that a Head of Procurement had recently been appointed which will give the Trust the skills and capacity to drive conversations further and to engage in wider collaboration.

The Director of Finance commented that it was important to note that we are reminding NHS Improvement at every opportunity that the EPR expenditure of £5m is inevitable and will not be cash back.

STRATEGIC ITEMS

114/16 TURNAROUND PROGRAMME UPDATE

The Chief Executive reported that discussions have taken place with regard to the development of a broader plan for CIP to 2021 and this will be brought back to the Committee. Also, a piece of work which will examine the Workforce numbers will be undertaken looking at the comparative growth of the workforce and safety and quality.

ACTION: A CIP plan to 2021 to come back to the Committee – **OW/AB**

115/16 EPR FINANCE UPDATE & HIGHLIGHT REPORT

The Interim Director of Health Informatics reported the current position of the EPR project with regard to the CHFT risks stating that the Divisional Operational group are now meeting weekly. Significant progress is being made and the individual divisional plans are close to sign off, the Operational Plan will be re-presented back to WEB next week. Additional costs are still a challenge but work is on-going to minimise this pressure. With regard to benefits realisation, work with divisions continues to provide further assurance for achieving £350k CIP in 2016/17. In addition, it was noted that the Business as Usual (BAU) model was signed off yesterday.

From a technical readiness point of view, it was noted that CHFT are in Trial 02 and the results should be available at the end of next week. The system testing has gone well for both trusts with fewer errors than expected.

The dual go-live will still present a challenge not just financially but with regard to the availability of workforce to support the go-live. It was also reported that EPR Friends training has been completed which unfortunately did not attract as many people as expected with 300 'friends' being trained.

Finance Update

The Assistant Director of Finance (SB) reported on the financial impact of the EPR programme reiterating the risks associated with the project for the Trust in relation to cash, capital and revenue. The following highlights were also called out:-

- YTD the project is overspent by £258k against the original capital plan.
- Risks – any further changes to the go-live date will affect the contingency.
- Operational costs of £45m are not reflected in the forecast at the moment.

The Chief Executive stated that the dual go-live is still potentially high risk and went on to report the complexities behind the EPR dual launch. A conversation will be taking place later today with the Chief Executives of both Trusts where a position statement will be made.

The exit criteria was discussed and Cerner are 2-3 weeks away from making a decision with regard to dual go-live which will be critical.

It was noted that there would be a verbal update to the Private Session of the Board.

The Committee received and noted the contents of the report.

116/16 REFERENCE COSTS SIGN-OFF

The Assistant Director of Finance, Stuart Baron, presented the annual Reference Cost submission for 2015/16, as part of the governance arrangements the paper is required to be presented to a Board Sub-Committee. The paper sets out details of the submission and provides an overview of the Trust's approach to completing this mandatory return. The Committee noted and approved the report.

ACTION: To provide the Committee with the key findings from the submission and comparison data once available - **SB**

GOVERNANCE

117/16 INTEGRATED PERFORMANCE REPORT

In the absence of the Chief Operating Officer, the Director of Transformation & Partnerships reported on the indicators which are a particular focus for the Finance & Performance Committee as follows:

- All Regulatory targets which are green in June
- A&E performance has improved
- Sickness absence has reduced
- Outliers have reduced
- Length of Stay is a reducing trend
- Bed numbers have seen a reduction by 13 from May to June, which is 3 beds under plan
- Non-elective admissions have also seen a reduction.

However,

- Harm-free care has deteriorated
- Vacancy numbers have increased

It was noted that a correlation with regard to agency spend/staffing and the increase in harm-free care is being looked at.

118/16 MONTH 3 COMMENTARY TO NHS IMPROVEMENT

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

119/16 WORK PLAN

The Work Plan was noted by the Committee.

120/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES

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

- Recognition of the forecast risk going forward
- Issues around Capital/Cash and the management of those risks
- Cash position – continue to support the work done by the Cash Committee and to look at Supply Chain elements.
- STF clarification to go to Board
- CIP 2021 risks
- Workforce impact
- EPR – Verbal update to be given at the Private Session of the Board
- IPR – Positive trends but to acknowledge the increase in Harm Free care

121/16 ANY OTHER BUSINESS

No items were raised and the meeting was closed.

DATE AND TIME OF NEXT MEETING

Tuesday 23 August 2016, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

Minutes of the Finance & Performance Committee held on Tuesday 23 August 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
Keith Griffiths	Director of Finance
Andrew Haigh	Chair - CHFT
Lesley Hill	Director of Planning, Performance and Esates & Facilities (part)
Richard Hopkin	Non-Execuitve Director
Phil Oldfield	Non-Executive Director - Chair
Owen Williams	Chief Executive

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Stuart Baron	Assistant Director of Finance
Mandy Griffin	Interim Director of Health Informatics
Kathy Bray	Board Secretary (Minutes)

ITEM

122/16 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed everyone to the meeting.

123/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Brendan Brown, Executive Director of Nursing
Brian Moore, Membership Councillor
Victoria Pickles, Company Secretary
Betty Sewell, PA
Ian Warren, Executive Director of Workforce & OD
Jan Wilson, Non-Executive Director

124/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

125/16 MINUTES OF THE MEETINGS HELD 26 JULY 2016

The minutes of the last meeting were approved as an accurate record subject to the Executive Director of Finance re-wording the 'Capital' item on Page 3 with reference to the scheme costs.

ACTION: KG – Rewording required for the Capital Item

126/16 MATTERS ARISING AND ACTION LOG

113/16 – Procurement Report

Kirsty Archer, Assistant Director of Finance presented the Procurement report. The Committee were reminded about the discussions which had prompted the preparation of the report. These had centred on NHS Supply Chain Costs and cash

implications. It was noted that all organisations had been reviewed as outlined in the paper which also contained a summary of the benefits of using the NHS Supply Chain. It was reported that last year a traffic light system on stock levels had been undertaken which provided logistics support. It was noted that the Trust was not tied into the Supply Chain completely and it used a number of competitors with costs being tested on a regular basis.

It was suggested that the frequency of contract/tender reviews should be increased to enable further challenge of suppliers to ensure the Trust obtains best costs. It was noted that this process had already been undertaken with regard to Agency costs and Council rates and it was agreed that a mechanism would be developed to question suppliers on a yearly basis about the possibility of renegotiating cost effective contracts.

ACTION: Mechanism/strategy to be developed to renegotiate contracts - KG

Discussion took place regarding the Calderdale PFI and it was requested that the capital element of the costs be stripped from the report.

ACTION: Capital element costs of PFI taken from report - KA

It was suggested that the Trust should look at the cost implications of mobile MRI/CT scanning equipment and drugs to review the opportunities available particularly related to CIP and marketing the Pharmacy Manufacturing Unit (PMU). The Chief Operating Officer advised that the Trust had already purchased an MRI which was currently being installed and would see the cessation of the mobile MRI.

113/16 – Working Capital Facility & Revenue Support Loan Understanding

The Executive Director of Finance reported on the interest rates related to the working capital facility against the Revenue Support loan and it was noted that this would be discussed by the Regional Directors of Finance at a meeting to be held later that week. Further information would be brought to the next F&P Committee meeting.

ACTION: Update on Directors of Finance meeting discussions around Working Capital Facility and Revenue Support Loan 26.9.16 - KG

FINANCE AND PERFORMANCE

127/16 MONTH 4 FINANCE REPORT

The Committee received the Month 4 Finance Report, the following highlights were summarised by Kirsty Archer, Assistant Director of Finance as:

- Year to date financial position stands at a deficit of £7.44m versus a planned deficit of £7.57m.
- Capital expenditure year to date is £5.00m against a planned £6.17m.
- Cash balance is virtually on plan with £1.92m against a planned £1.95m
- The Trust has drawn down loans earlier than planned. The total loan balance is £51.79m against a planned £44.00 m.
- CIP schemes delivered £3.82m in the year to date against a planned target of £2.50m.

- The Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

The Executive Director of Finance advised that Month 4 had delivered on plan but it was important for the Committee to discuss and understand the forecast position from now to year end. It was acknowledged that there were a number of pressures in the system which may produce risks for the future which currently included:

Elective growth/demand management – input from Commissioners
Operational pressures - Workforce/Agency spend
CIP plan risks
Overspend in Divisions – although expected to deliver on plan at year-end
CQC report – implications from CQC action plan
Performance of Safer Patient Programme

It was noted that mitigations were in place to deal with these risks and the Committee received assurance that a robust decision process was in place through the Divisions, although it was agreed that at the next meeting a detailed report would be brought outlining the mitigations and include the financial implications of the CQC Action plan.

The Chief Executive highlighted the need to focus on staff engagement and work around the staff action plan to ensure there were no gaps between leadership and frontline staff. The challenges to recruitment of the medical workforce were noted and work continued through the Workforce Strategy to address this. The strategy would be brought to the Board of Directors within the next few months.

In summary it was agreed that the Committee understood the forecast issues and risk and that these may alter with the system changes in the future. It was therefore agreed that the Committee should regularly review the position for early recognition of potential problems.

ACTION: Detailed re-analysis of the forecast to be brought to the next F&P Committee including financial implications of CQC Action Plan. It was agreed that PO and RH would work with the finance team to gain clarity and confidence on behalf of the Non-Executive Directors on the re-analysed forecast – KG/PO/RH

STRATEGIC ITEMS

128/16 TURNAROUND PROGRAMME UPDATE

The Chief Executive reported that the CIP to 2021 would be brought to the October 2016 Committee. As discussed earlier in the meeting work was underway to complete the Workforce Strategy which would be completed within the next few months.

ACTION: CIP plan to 2021 to come back to the Committee October 2016 – OW/AB

129/16 EPR FINANCE UPDATE & HIGHLIGHT REPORT

The Director of Health Informatics reported the current position of the EPR project and the contents of the paper setting out an overview of the programme, along with the financial position to date was noted.

The Director of Health Informatics reported that following a report received from GE Finnamore a dual go-live date would not be progressed for the 19 November 2016 and the two Trusts would be discussing this further at their next Board meetings. Discussions were taking place involving the two Trusts and Cerner to review the windows of opportunity for 'go-live', but on the grounds on patient safety it had been agreed that the go-live date of 19 November 2016 was not feasible. It was noted that the Turnaround Executive would be monitoring the capital position.

The Committee discussed the financial implications regarding the delayed 'go-live'. It was noted that a communications plan would be developed to ensure that all staff, Board and Membership Councillors were aware of the decision. In summary the key issues under consideration currently were:-

- development of a communications plan
- investigation of contractual issues in delay of go-live
- work to continue on building data to ensure a robust position on both sites
- provision of training support to ensure sustainable teams on both sites and enhanced operational plans.

The Committee received and noted the contents of the report and it was agreed that an updated position would be brought to the Committee following discussion and finalisation by the two Board of Directors meetings.

130/16 CONSULTATION – FEEDBACK REPORT

The Chief Executive advised that the report had not yet been received but that a process for deliberation of the findings was being discussed and that legal advice was being sought. It was noted that public feedback was still expected on the 20 October 2016. Discussions were on going with the NHS Improvement team regarding the process for financial support from the Treasury.

GOVERNANCE

131/16 INTEGRATED PERFORMANCE REPORT

Chief Operating Officer reported on the indicators which are a particular focus for the Finance & Performance Committee as follows; it was noted that some issues had already been discussed earlier in the meeting. The Carter dashboard showed 8 improved, 8 deteriorated and 2 unchanged metrics, issues brought to the attention of the Committee included:-

- Improved overall performance rate of 65%
- Improvement in vacancies and complaints closed within timescales
- Deterioration in C.Diff position and emergency care standard in June. An action and this posed a financial risk.
- Improved Harm Free Care
- Improved reduction in outlier bed days
- Deterioration in percentage of non-elective #NOF patients with admission to

procedure within 36 hours. Action plan being developed

- Deterioration in maternity PPH. Action plan developed by Division.
- Deterioration in Length of Stay

132/16 MONTH 4 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee received and noted the paper which provided the Management Commentary on the financial position of the Trust at the end of July 2016 for submission to NHS Improvement. KA, Assistant Director of Finance explained to the Committee that the anomalies in the report would be rectified each quarter end on receipt of the STF income.

133/16 WORK PLAN

The Work Plan was noted by the Committee. It was agreed that The IPR update will cover headlines monthly with a quarterly deep dive. The first deep dive will be at the September meeting

ACTION: Agenda to be scheduled to facilitate a deep dive on the IPR in September

134/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES

The Chair of the Committee advised that there were no items to escalate to the Board of Directors (BOD) and the next BOD meeting was scheduled for 29 September 2016.

135/16 ANY OTHER BUSINESS

a. Review of F&P Meeting Dates

It was noted that following the revision of the BOD meeting dates to allow the Divisions to review the Integrated Performance Report in detail, it would be necessary for the Committee Secretary to alter the Finance and Performance Committee Meeting dates to occur in the same week as BOD meetings.

ACTION: To review F&P Committee Meeting dates for 2017 - BS

b. Cash

The Executive Director of Finance agreed to review the cash forecast at the next meeting and this item would be prioritised on the agenda.

There were no other items raised and the meeting was closed.

DATE AND TIME OF NEXT MEETING

Monday 26 September 2016, 1.00pm – 4.00pm, Meeting Room 4, Acre Mill Outpatients building. (PLEASE NOTE CHANGE OF DAY AND TIME).

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Audit and Risk Committee Meeting held on Thursday 21 July 2016 in Acre Mill, 3rd Floor commencing at 10:45pm

MEMBERS

Prof Peter Roberts	Chair, Non-Executive
Richard Hopkin	Non-Executive Director

IN ATTENDANCE

David Anderson	Non-Executive Director (Quality Committee Chair)
Gary Boothby	Deputy Director of Finance
Michael George	Internal Audit Manager
Andrew Haigh	CHFT Chairman
Adele Jowett,	Local Counter Fraud Specialist
Helen Kemp-Taylor	Head of Internal Audit
Andrea McCourt	Head of Governance and Risk
Peter Middleton	Membership Councillor
Clare Partridge	External Auditor
Victoria Pickles	Company Secretary (minutes)

Item

40/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Brendan Brown, Non-Executive Director
Keith Griffiths, Executive Director of Finance
Phil Oldfield, Non-Executive Director

41/16 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

42/16 MINUTES OF THE MEETING HELD ON 26 MAY 2016

The External Auditors requested that two amendments be made to the minutes of the meeting held on the 26 May 2016:

034/16 g wording be amended to
The External Auditor had issued an unqualified audit opinion on the accounts and a qualified limited assurance opinion on the Quality accounts……..

……..With regard to the Use of Resources, it was concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness, except for the fact that enforcement undertakings and the additional licence condition remain in place at the date of the report.

OUTCOME: Subject to these amendments the Committee **APPROVED** the minutes as a correct record.

43/16 ACTION LOG AND MATTERS ARISING

a. 72/15 - Update on the Risk Management Strategy and Policy

The Company Secretary presented a short paper describing the progress made in strengthening the risk management processes within the Trust and described the next steps to develop the Risk Management Policy and Strategy. She highlighted that a recent internal audit of risk management had received an opinion of significant assurance. It was also noted that the board's risk appetite had been discussed at a workshop on 13 July 2016. Further work would be done to develop this into a risk appetite statement for approval by the Board.

OUTCOME: The Committee noted the work undertaken to date and agreed to receive a

draft of the policy and strategy and an update at the next meeting in October.

44/16 COMPANY SECRETARY'S BUSINESS

The Company Secretary presented a number of reports relating to governance within the Trust.

44/16 (1) REPORT ON CURRENT REGULATORY COMPLIANCE ISSUES

The Audit and Risk Committee were asked to receive the updated Regulatory Compliance Register and note that no breaches have arisen in meeting the deadlines. It was clarified that the Trust is informed by NHS Improvement if any deadlines are missed or any information submitted is incomplete so that this can be rectified immediately.

OUTCOME: The Audit and Risk Committee **RECEIVED** the regulatory compliance register and **NOTED** that all appropriate submissions had been made within the deadlines.

44/16 (2) AUDIT AND RISK COMMITTEE CHAIR AND JOB DESCRIPTION

The Committee reviewed the job description for the Audit and Risk Committee Chair in line with agreed review timescales.

OUTCOME: The Committee **RECEIVED** and **NOTED** the job description

44/16 (3) STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

The Company Secretary confirmed that the Standing Orders (SOs) and Standing Financial Instructions (SFIs) had been reviewed and changes had been made to both documents to reflect the change in the regulator from Monitor to NHS Improvement. It was noted that reference to Monitor had been retained where it related to guidance that had been issued while Monitor was the regulator. Within the SOs, the other proposed changes reflected the change in the numbers on the Board of Directors and otherwise were typographical.

The Committee asked that reference be made to the Fit and Proper Person requirements in relation to the composition of the board of directors in SO 1.2.

ACTION: VP

The Deputy Director of Finance explained that for the SFIs a recommendation was being made to revise the authorised limits and particularly the petty cash limit. He clarified that there was no issue in the Trust, but that the proposed changes were linked with the Trust's cash position and the need to maintain good internal control. He added that the changes reflected a review of the SFIs in comparison to other Trusts. Once the limits were approved, the Scheme of Delegation would be updated to reflect these changes.

The Committee asked that the document be updated to ensure that the Audit and Risk Committee is referred to appropriately.

ACTION: GB

OUTCOME: Subject to the requested amendments, the Committee **APPROVED** the revisions to the Standing Orders and Standing Financial Instructions.

45/16 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

45/16 (1) Review Waiving of Standing Orders

The Deputy Director of Finance presented a report detailing the waving of Standing Orders for the first financial quarter of 2016/2017. During this quarter, 14 contracts were placed as a result of standing orders being waived, at a total cost of £457,039.16. No amendments to earlier single sources were made this quarter.

Discussion took place relating to the waiver of the item at £185,273.80. It was explained

that this was the renewal of the licence for one of the Trust's IT systems. It had been agreed to maintain this licence until after implementation of EPR. The Committee asked that in future, for items of significant value a line of explanation is included in the report.

The Deputy Director of Finance informed the Committee that a Head of Procurement had been appointed to drive forward efficiencies in contracts and the potential savings in procurement, in partnership with other organisations. It was noted that savings of £500K had been made so far.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the report.

45/16 (2) Review of Losses and Special Payments

In accordance with the Standing Financial Instructions, the Deputy Director of Finance presented the losses and special payments for the quarter ending 30 June 2016.

The Committee discussed the item relating to a claim. The Deputy Director of Finance confirmed that there was no suggestion that this was likely to recur.

OUTCOME: The Committee **RECEIVED** the report.

46/16 INTERNAL AUDIT

46/16 (1) Review of Internal Audit Follow-up Report

The Internal Audit Manager presented the report and noted the progress made around the majority of recommendations.

He highlighted two areas of ongoing concern. The first related to the re-audit of payroll, which had identified a number of areas not yet addressed. He explained that there was recognition of the issues within the team and systems solutions were being sought. However, the required checks were not being completed and this suggested that further work was required on the culture and practice within the team. The Deputy Director of Finance confirmed that there was a weekly meeting between the Deputy Director of Finance, the Deputy Director of Workforce and OD and the Payroll Manager to progress the actions. It was highlighted that the team benchmarked low in relation to resourcing and that this would also be addressed. Internal audit will re-check at each stage of the actions to see whether it has had the desired outcome and if not what else needs to be put in place.

The Committee asked that the Payroll Manager be invited to attend the meeting in October.

ACTION: KB

The second area of concern was midwifery as no update had been received. The Company Secretary agreed to follow this up.

ACTION: VP

OUTCOME: The Committee **RECEIVED** the report.

46/16 (2) Review of Internal Audit Progress Report

The Internal Audit Manager reported that since the last report to the Committee in April 2016 the following reports had been issued to and discussed with management:

Report No	Report	Opinion
CH26/2016	Divisional Risk Management	Significant
CH27/2016	Debtors	Significant
CH28/2016	Ordering, Receipts and Payments	Limited
CH29/2016	Financial Ledger	Full
CH30/2016	Car Parking	Limited
CH31/2016	Pharmacy & Medicines Management	Limited

CH32/2016	Safer Staffing	Significant
CH33/2016	Policy Implementation	Significant
CH34/2016	E Rostering	Significant
CH35/2016	Clinical Coding	Full
CH36/2016	Payment by Results	Full
CH37/2016	Capital Planning and Projects	Significant
CH38/2016	Divisional Cash Management (including Treasury/ Working Cap Management)	Significant
CH39/2016	Budgetary Review – to follow	Significant
CH40/2016	PFI Monitoring	Significant
CH41/2016	Infection Control – Cleaning Standards	Significant
CH42/2016	CQUIN Compliance	Significant
CH43/2016	Provider Licence Conditions	Full
CH44/2016	Clinical Audit	Significant
CH45/2016	IT Business Continuity	Significant
CH46/2016	EPR- to follow	Significant

It was confirmed that all of the reports had been in draft stage at the time of the production of the Head of Internal Audit Opinion and had therefore been reflected in the document.

The Committee Chair commented that it was pleasing to see so many reports with significant or full assurance.

The Committee discussed the three limited assurance reports in more detail:

CH28/2016 Ordering, receipts and payments
The Internal Audit Manager highlighted the concerns that the Trust's on-line ordering system, iProc, is only used for a third of expenditure and that any non-purchase order expenditure is manually input by Finance and is not subject to a secondary check or further authorisation. He pointed out that the work had not identified any abuse of these control weaknesses and that lack of secondary approval has arisen because the Genisys invoice system and the ordering systems do not interface appropriately. There was also recognition that agency requests would go through a separate authorisation process and would account for a proportion of the non-purchase order spend.

CH30/2016 Car parking
It was noted that around 300 staff had not been paying for car parking due to an administrative error. These staff would be written to and payment sought from 1 July 2016. Concerns had also been identified in relation to the safeguards around accounting for the money taken from the car park machines.

CH31/2016 Pharmacy and medicines management
The audit had identified some non-adherence to the code relating to the transport of medicines. The Committee recognised that there had been a number of audits relating to pharmacy and medicines management that had resulted in limited assurance. The Internal Audit Manager explained that work was being done jointly with the pharmacy staff to address weaknesses. The Committee asked that a quick follow-up on the recommendations be undertaken.

The Chair commented that audits also highlighted weaknesses in controls that could be areas of focus for local counter fraud work.

OUTCOME: The Committee **RECEIVED** the report and **NOTED** the good work and improvements demonstrated by some of the audits, as well as the need to strengthen some processes and practice.

46/16 (3) Internal Audit Annual Report

The Head of Internal Audit presented the Internal Audit Annual Report which pulls together and consolidates all the audits completed throughout the year. She explained that in future the report would also cover the qualitative aspects of the work and would include performance against an agreed set of key performance indicators.

The Chair of the Committee asked that the report be amended to reflect the full title of the Committee and a clearer connection to the risk agenda. The Head of Internal Audit confirmed that the audit plan is mapped against the risks identified in the corporate risk register and the Board Assurance Framework.

ACTION: HKT

The Head of Internal Audit explained that following the decision in March to merge the West Yorkshire Audit Consortium (hosted by CHFT) and the North Yorkshire Audit Consortium (hosted by York District NHS FT) a membership event would be held on 6 September 2016 to elect a new Board and ratify governance documents. This presented an opportunity for both the service, and audit and risk committees to look at what internal audit do now and what may need to change. It was agreed to share further detail with the Committee on the future provision of internal audit, what it will include and the costs involved. It was noted that members of the Committee are not available on 6 September to attend the membership event.

ACTION: HKT / GB

A question was asked about IT fraud. The Head of Internal Audit confirmed that the Trust had a cyber security lead and that an audit would be undertaken in the 2016/17 plan on cyber security. An information risk day was also being held on 22 September 2016. Further details would be circulated.

ACTION: HKT / KB

OUTCOME: The Committee **RECEIVED** and **APPROVED** the Annual Report.

47/16 LOCAL COUNTER FRAUD

47/16 (1) Local Counter Fraud Specialist Progress Report

The Local Counter Fraud Specialist (LCFS) presented the progress report which is based on the 2016/2017 Key Framework of Duties approved by the Audit and Risk Committee in April 2016. It sets out the work which has been delivered against the work plan in the year to date. It was noted that a large number of presentations on fraud had been carried out across crucial areas. Meetings had also been held with key members of staff and fraud alerts issued where necessary. No criminal sanctions had been made during the year. The LCFS explained that the main reason that investigations don't progress relates to the recording of information by managers.

OUTCOME: The Committee **RECEIVED** the report.

47/16 (2) Local Counter Fraud Specialist Annual Report

The LCFS presented the Annual Report and highlighted the work undertaken to prevent and investigate fraud across the Trust in 2015/16.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the annual report.

47/16 (3) Investigations report

The LCFS presented a report on the current investigations.

- One case had been closed by NHS Protect due to lack of evidence. Work had been done with the team to look at the weaknesses within the function to ensure that this couldn't happen again.
- There are two live cases. One relating to a member of staff working without appropriate qualification. The second relating to car parking fraud.

- There are two current enquiries relating to someone working while on sick leave and duplicate claim forms being submitted by a supplier.

The LCFS confirmed that once investigations are complete, there would be publicity about the successful cases to support the prevention agenda.

48/16 EXTERNAL AUDIT

Technical Update

The External Auditor explained that the Technical Update was for information and highlighted three areas of particular interest:

- The 'Think Future Study' on how university shapes career perceptions on the impact on Generation Z.
- KPMG's Brexit Hub
- New York Study on new models of care.

A question was asked about the local Sustainability and Transformation Plan in comparison to other areas. It was recognised that the West Yorkshire Plan had been developed from the bottom up rather than top down and that there was a need to progress the work around data to support the plans quickly. The Membership Councillor highlighted that sharing and understanding data had been an important first step in the New York study.

OUTCOME: The Committee **NOTED** the report and **ASKED** that it be shared more widely with Board members. The Chair requested a copy of the New York Study.

ACTION: KB

49/16 CLAIMS UPDATE – CLINICAL NEGLIGENCE

The Head of Governance and Risk presented a paper on claims. She explained that claims information was now being reported regularly to the Finance and Performance Committee and quarterly to the Executive Board. A report on themes and any learning from claims was also shared with the Quality Committee as part of the quarterly Quality Report. It was noted that there was an increasing trend of claims being made and this represented a significant proportion of the Trust's budget.

Discussion took place on how individual clinicians learn from claims. The Head of Governance and Risk explained that the claims scorecard was shared and reviewed by clinical directors. It was agreed to check whether these were also discussed at individual appraisals alongside complaints information.

ACTION: AMc

The Committee asked to see the claims section from the last two Quality Reports.

ACTION: AMc

OUTCOME: The Committee **RECEIVED** the report.

50/16 QUALITY COMMITTEE ANNUAL REPORT TO THE AUDIT AND RISK COMMITTEE

The Company Secretary explained that all board sub-committees were now undertaking a review of their effectiveness, in line with the process previously tested by the Audit and Risk Committee. The process includes a self-assessment of the Committee, a review of its terms of reference and a short annual report setting out the main areas of scrutiny and assurance, achievements over the year and any areas for further development. The Annual Reports would then be brought to the Audit and Risk Committee in its role as scrutineer of the Trust's governance arrangements.

Following the testing by the Audit and Risk Committee, the Quality Committee was the first to have completed this review and the Head of Governance and Risk presented the annual report which had been approved by the Quality Committee at its meeting in June.

Discussion took place around the visibility of serious incidents in the Committee. The Head of Governance and Risk explained that there is a monthly report to the Quality Committee on serious incidents, including never events, as they occur which is then followed up post-investigation by a one-page summary of any learning.

OUTCOME: The Committee **RECEIVED** the Quality Committee Annual Report.

51/16 INFORMATION TO RECEIVE

The Committee **RECEIVED** the following minutes:

a. Quality Committee Minutes – 24.5.16
b. Risk & Compliance Group Minutes – 9.5.16
c. THIS Executive Meeting Summary Notes – 13.5.16

52/16 REPORT ON WHISTLEBLOWING AND OTHER EXPRESSIONS OF CONCERN

The Company Secretary explained that there was no update to report.

53/16 ANY OTHER BUSINESS

There was no other business to note.

54/16 MATTERS TO ESCALATE TO BOARD

The Committee noted the following items to be brought to the attention of the Board at its meeting on 28 July 2016:

- Compliance with regulatory reporting
- Approval of the amendments to the Standing Orders and the revised authorised limits in the Standing Financial Instructions
- Approval of the job description for the Chair of the Audit and Risk Committee
- The outstanding internal audit recommendations relating to payroll and maternity
- Three limited assurance internal audit reports
- The newly merged internal audit service
- Approval of the Annual Reports for Internal Audit, Counter fraud and Quality Committee
- The current live counter fraud investigations

55/16 DATE AND TIME OF NEXT MEETING

Tuesday 18 October 2016 at 10.45 am – 3rd Floor Acre Mills Outpatient Building.

56/16 REVIEW OF MEETING

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

/VP/ARC-21.7.16

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL MEMBERS MEETING HELD ON WENESDAY 6 JULY 2016 IN THE BOARDROOM, SUB-BASEMENT, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Chair
Rosemary Hedges	Public elected – Constituency 1
Di Wharmby	Public elected – Constituency 1
Wayne Clarke	Public elected – Constituency 2
Peter Middleton	Public elected – Constituency 3
Dianne Hughes	Public elected – Constituency 3
Grenville Horsfall	Public elected – Constituency 5
Kate Wileman	Public elected – Constituency 7
Lynn Moore	Public elected – Constituency 7
Brian Moore	Public elected – Constituency 8
Eileen Hamer	Staff elected – Constituency 11
Chris Bentley	Staff-elected – Constituency 13 (Reserve Register)
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
Cath O'Halloran	Nominated Stakeholder - University of Huddersfield

IN ATTENDANCE:

Dr David Anderson	Non-Executive Director/SINED
Helen Barker	Chief Operating Officer
Kathy Bray	Board Secretary
Brendan Brown	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Ruth Mason	Associate Director of Engagement & Inclusion
Victoria Pickles	Company Secretary
Owen Williams	Chief Executive

40/16 APOLOGIES:

Apologies for absence were received from:

George Richardson	Public elected – Constituency 5
Annette Bell	Public elected – Constituency 6
Brian Richardson	Public elected – Constituency 6
Jennifer Beaumont	Public elected – Constituency 8
Mary Kiely	Staff-elected – Constituency 9
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
Dawn Stephenson	Nominated Stakeholder – SWYPFT
Naheed Mather	Nominated Stakeholder – Kirklees Metropolitan Council
Sharon Lowrie	Nominated Stakeholder – Locala

Anna Basford	Director of Transformation and Partnerships
David Birkenhead	Executive Medical Director
Mandy Griffin	Director of The Health Informatics Service
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Prof. Peter Roberts	Non-Executive Director

The Chair welcomed everyone to the meeting. The Chair introduced and welcomed Brendan Brown, newly appointed Executive Director of Nursing.

41/16 DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

42/16 MINUTES OF THE LAST MEETING – 7 APRIL 2016

The minutes of the last meeting held on 7 April 2016 were approved as an accurate record.

43/16 MATTERS ARISING

38/15a – Car Parking - The Chairman reminded the Membership Council of the discussions held at the last meeting and the subsequent amendments made to the proposal which had been circulated to the Membership Council and approved at the Board of Director's Meeting in May with specific comments from two Membership Councillors flagged. The feedback had been given to the Estates team to ensure that in future any proposed changes are discussed first at the Divisional Reference Group.

STATUS: Closed

All other matters arising were included within the agenda.

44/16 CHAIR'S REPORT

a. Consultation Process

It was noted that the Consultation period had now closed and this had been discussed in detail within the private Membership Council Meeting. Over 7,000 responses had been received by the Clinical Commissioning Group (CCG). It was confirmed that the comments from the Membership Council had been sent to the CCG for inclusion in the formal responses.

It was agreed that the Board of Directors would share the comments made to the CCG with the Membership Councillors.

ACTION: Chair/Board Secretary

The timeline for feedback following the close of the consultation was noted. The two clinical commissioning groups would meet in parallel on 20 October 2016 when the next steps would then be determined.

OUTCOME: The Membership council noted the progress with the Consultation

b. Board Appointment Updates

The Chairman reminded the Membership Council of the appointment of Brendan Brown, Executive Director of Nursing who had taken up post on the 13 June 2016.

c. Update from Chairs' Information Exchange

The Chair advised that the Chair's Information Exchange had been held on 1 July 2016. A number of actions had been agreed including investigation of utilisation of the Huddersfield Birthing Centre.

Thanks were given by the Membership Council to the Divisional staff for their input and enthusiasm at the DRG Meetings.

It was agreed that the minutes from this meeting would be circulated in due course.

ACTION: Membership Office

d. CQC Inspection Feedback

The Chief Executive reported that the feedback from the CQC inspection which had taken place over the period 8-11 March 2016 was expected at the end of July 2016.

The Executive Director of Nursing advised that following the verbal feedback received at the visit an action plan had been put in place and this would be reviewed on receipt of the full report.

Peter Middleton raised the recent media article regarding maternity compensation payments and asked whether there was any link with the CQC feedback. The Chief Executive assured the Membership Council there were no areas of risk identified from the CQC with regard to maternity claims. The Executive Director of Nursing advised that further work was underway to ensure any concerned existing or prospective service users could access an appropriate level of support within the Trust.

e. **HSJ Patient Safety Award**

It was noted that the Trust had received a Patient Safety Award from the Health Service Journal the previous day for the work undertaken in Dementia Care. It was noted that this work had been highlighted by the CQC as exemplar. Thanks were given to the team for their work.

f. **Organ Donation Committee**

The Chairman requested expressions of interest from any Membership Councillors interested in sitting on the Organ Donation Committee. It was noted that this Committee meets four times per annum. The focus of the Committee is in raising awareness about the importance of organ donation and overseeing the work that the team do in hospital. Any membership councillors interested should contact the Chairman.

Dianne Hughes expressed an interest in this role at the meeting if no other Membership Councillors express an interest.

CONSTITUTION

45/16 MEMBERSHIP COUNCIL REGISTER

The updated register of members was received for information. It was noted that the vacant positions had been included in the forthcoming elections.

46/16 REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The updated Register of Interests/Declarations was received. Any amendments were requested to be notified to the Board Secretary as soon as possible. It was requested that the members with outstanding declarations listed at the end of the Register ensure that a response is forwarded to the Board Secretary as soon as possible.

47/16 CONSTITUTIONAL AMENDMENTS

Following comments received from Membership Councillors prior to the meeting it had been agreed that this item would be deferred and the document would be re-worked and circulated for comment. It was requested that any additional comments be forwarded to the Company or Board Secretaries as soon as possible.

ACTION: COMPANY/BOARD SECRETARY

OUTCOME: To be circulated to Membership Councillors for comment once amendments had been made.

48/16 TRUST PERFORMANCE

In order to allow the Chief Operating Officer to attend another meeting later that evening, the Chairman confirmed that this item would be moved up the agenda.

a. Integrated Performance Report

The Chief Operating Officer gave an overview of the key themes from the May IPR report. The areas of specific note were:

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 Naso-gastric (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 - % Post partum hemorrhage (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 a 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 has 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 Fractured Neck of Femur (#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 26 weeks 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 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

- Finance - referred to later in the meeting
- 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.

COUIN

- 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.

The Membership Council asked a number of questions around:-

- Community Services collaborative approach,
- Improvements in DNA rates due to texting system being in place,
- Domiciliary visits – impact on the Trust of patients not being at home when staff attended to give care,
- Green Cross Patients – new work being undertaken to reduce the number of green cross patients through the safer patient programme, developed with partner organisations.
- It was requested whether the Membership Council could see some granular breakdown of the A/E attendances/admissions and the Chief Operating Officer confirmed that internal metrics were available and she would arrange for this to be brought to the next meeting.

ACTION: Chief Operating Officer

Helen Barker, Chief Operating Officer and Owen Williams, Chief Executive left the meeting.

b. MONTH 2 – MAY 2016 FINANCE REPORT

The Executive Director of Finance presented the finance month 2 report as at the 31 May 2016.
The key issues included:-

Summary Year to Date:

The year to date financial position stands at a deficit of £5.87m, an adverse variance £0.06m from the planned £5.81m. In month, the Trust has seen a stronger performance against planned activity, catching up some of the shortfall seen in Month 1. However, to

deliver activity and maintain staffing ratios across the bed base the Trust continues to rely heavily upon agency staffing at premium rates to cover both medical and nursing vacancies driving a pay overspend in both of these areas. Total agency spend in month was just under £2.5m, an increase on an already high run rate and a significant draw on limited cash resources impacting the Trust's ability to pay for other goods and services in a timely way.

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

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

Forecast:
Whilst there have been one-off benefits in the year to date, the run rate on underlying expenditure is bringing ongoing pressure with a particular risk around ongoing high levels of agency expenditure. CIP has delivered as planned at Month 2 but it should be noted that the planned profile of CIP is heavily weighted into the latter part of the year and just under half of the £14m required is flagged as 'high risk'. In addition the £2m contingency reserves are planned across the first six months of the year and will therefore bring limited respite against these risks.

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

OUTCOME: The Performance and Finance Reports were received and noted.

Discussion took place regarding the difficulties in being able to recruit to substantive posts and it was noted that further discussion would take place outside the meeting with the Medical Director and University of Huddersfield representatives.

ACTION: DB/CO'H

UPDATE FROM BOARD SUB COMMITTEES

49/16 Audit and Risk Committee

Peter Middleton reported that this was a focused Committee. The last meeting had been held on the 26 May 2016 to sign off the Annual Report and Accounts. He was pleased to advise that Clinical Audit was becoming visible to this Committee and at his request a paper had been submitted to the Membership Council, to be discussed later in the meeting.

50/16 Electronic Patient Record (EPR)

Rev Wayne Clarke confirmed that Kate Wileman and Brian Moore had both agreed to help as representatives of the Membership Council at future EPR meetings when Rev Clarke was not available. It was noted that the Membership Council had received an update on the implementation of the system which was due to go live in November in the private part of the meeting.

51/16 Finance and Performance Committee

Brian Moore confirmed that all issues had been raised by the Executive Director of Finance earlier in the meeting.

52/16 Quality Committee

Lynn Moore advised that all performance issues discussed at the Quality Committee had been included in the Integrated Performance Report presented by Helen Barker earlier in the meeting.

Other areas of focus by the Committee included:-

- Paediatric Cardiac Arrest Simulation
- Outpatient Appointment – Choose and Book system assurance received that the problems with the booking system did not jeopardise patient safety.

53/16 Charitable Funds Committee

Kate Wileman advised that fundraising activity had now commenced with:-

- Lottery system funds through Huddersfield Giants
- University of Huddersfield placements

54/16 Workforce Well-Led Committee

Rosemary Hedges advised that the main issues raised at the last meeting held on 14 June 2016 had been included within the Board of Directors papers at its meeting on the 30 June 2016. These included:-

- Sickness – work on-going to reduce sickness was noted.
- Mandatory Training – targets noted
- Breaches – in agency staff discussed and action plan noted.
- Medical and Nursing Workforce Strategy Group – arrangements made for this to feed into this Committee.
- Chair of WWLC – to be taken over by Karen Heaton, Non Executive Director
- Schedule of Meetings – Committee to meet monthly with effect from August 2016.

55/16 MC/BOD AGM Task and Finish Group

Ruth Mason reported that arrangements were in hand for the interactive healthfair part of the AGM on Thursday 15 September 2016 to focus on 'IT's vital to your health'.

The formal AGM would commence at 6.00 pm

Both the Healthfair and AGM would be held in the Learning Centre, Calderdale Royal Hospital.

OUTCOME: The Membership Council noted the arrangements were in hand for the AGM/Health Fair

56/16 MC Walkabout FSS HRI – Birth Centre, Radiology and Pharmacy

Kate Wileman updated the Membership Council on the excellent visit recently held and thanked staff for making the arrangements and for the support members of the Membership Council had received.

57/16 STRATEGIC PLAN AND QUALITY PRIORITIES 2016/17

The Company Secretary presented the Strategic Plan and Quality Priorities for 2016/17 which had been developed at the BOD/MC Workshop held on the 10 May 2016.

It was agreed that an update on each of the priority areas would be presented to the Membership Council as part of a rolling programme and would be built into the work plan for the meeting.

ACTION: Company Secretary

OUTCOME: The Membership Council approved the Strategic Plan and Quality priorities 2016/17

58/16 CLINICAL AUDIT AND INTERNAL AUDIT REPORTS

Peter Middleton had asked the Audit and Risk Committee for this information to be circulated to the Membership Councillors to raise the awareness of the Membership Council of the work of clinical audit and its links with both the internal and external auditors. It was noted that Martin DeBono would be attending the Membership Council Development event on 12 July to discuss clinical audit in more detail.

OUTCOME: The Membership Council received the information regarding the Internal Audit plans and its links with Clinical Audit.

59/16 ELECTION PROCESS FOR THE APPOINTMENT OF DEPUTY CHAIR/LEAD GOVERNOR-COUNCILLOR PROCESS

The process and timeline for the appointment of Deputy Chair/Lead Governor Councillor had been circulated for approval. All present noted the contents of the paper and supported the process which would commence on the 11 July and conclude with the formal announcement at the AGM pm the 15 September 2016.

Rev Wayne Clarke gave a brief overview of the role and confirmed that he would not be standing for re-election.

OUTCOME: The Membership Council approved the process for the election process for the appointment of Deputy Chair/Lead Governor-Councillor process.

60/16 CHAIR AND NON-EXECUTIVE DIRECTOR APPRAISAL

Andrew Haigh and Brendan Brown left the meeting

a. Chair Appraisal

Dr David Anderson presented the paper previously circulated to Membership Councillors which identified the appraisal process and confirmed the overall positive responses received from the Membership Council, Non-Executive Directors and Executive Directors.

Rev Wayne Clarke advised that 15 out of 21 questionnaires had been returned from the Membership Council and thanked everyone for the input. Unfortunately Membership Councillors' had not found the questionnaire easy to complete and it was suggested that for future years the Membership Council should have an informal meeting to share feedback with the Lead Governor-Councillor via the existing form which would then be shared with the SINED. All present agreed this arrangement, although it was noted that if there was no consensus of opinion it may be necessary to revert back to questionnaires being returned from individual Membership Councillors.

b. Non-Executive Appraisal

David Anderson left the meeting for this item.

The Chair returned to the meeting and presented the contents of the paper previously circulated and confirmed that he was in full supportive of the work and activities of the Non-Executive Directors during the year. It was noted that the Nominations and Remuneration Committee were due to meet on the 21 July 2016 to discuss the two Non-Executive tenures which were due to expire later in the year.

OUTCOME: The Membership Councillors received the Chair and Non-Executive Appraisal and confirmed their support.

61/16 FUTURE MC MEETINGS

The proposed meeting dates for 2016/17 were approved:-

DATE	TIME	VENUE
Thursday 15 September 2016 **Joint BOD/MC AGM**	6.00 pm	CRH - Lecture Theatre, Learning Centre, Calderdale Royal Hospital
Wednesday 9 November 2016	4.00 pm	HRI - Boardroom, Sub-basement, Huddersfield Royal Infirmary
2017		
Tuesday 17 January 2017	4.00 pm	HRI - Boardroom, Sub-basement, Huddersfield Royal Infirmary
Wednesday 5 April 2017	4.00 pm	CRH – Large Training Room, Learning Centre Calderdale Royal Hospital
Thursday 6 July 2017	4.00 pm	HRI – Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary
Thursday 14 September 2017	TBC	TBC
Thursday 9 November 2017	4.00 pm	CRH – Large Training Room, Learning Centre Calderdale Royal Hospital

OUTCOME: The Membership Council meeting dates for 2016/17 were received and approved.

62/16 INFORMATION TO RECEIVE

The following information was received and noted:

a. Updated Membership Council Calendar – updated calendar received and contents noted.

63/15 ANY OTHER BUSINESS

a. S&A Walk About

Ruth Mason reported that arrangements were being made for a tour of HRI Day Surgery, Theatres and Ward 19 on either 3 or 10 August 2016 and requested preferred dates from interested Membership Councillors be notified to Vanessa Henderson in the Membership Office.

b. Community Nursing Homes – red bags

Lynn Moore brought to the attention of the Membership Council a recent article which promoted the use of red bags, packed by Community Nursing Homes in readiness for any patient requiring hospitalisation. It was agreed that this would be passed to Community Services to note.

c. Follow-up Letters to GPs and PLACE Inspection

Brian Moore highlighted the time delay in follow-up GP letters and thanked the PLACE Inspection team for their hard work.

d. Membership Council Elections

The Chair highlighted to the Membership Council that this meeting could be the last for some Membership Councillors whose tenure would cease at the Annual General Meeting. Although thanks would be given at the AGM, the Chairman wished to formally note thanks to all non-elected members for their help in supporting the Membership Council.

64/15 DATE AND TIME OF NEXT MEETING

Thursday 16 September 2016 – Joint MC/BOD Annual General Meeting **commencing at 6.00 pm in the Lecture Theatre, Learning Centre, Calderdale Royal Hospital.**

Wednesday 9 November 2016 – Public Membership Council Meeting **commencing at 4.00 pm in the Boardroom, Sub-basement, Huddersfield Royal Infirmary**

The Chair thanked everyone for their contribution and closed the meeting at 6.15 pm.

APPENDIX A

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE MEETING OF THE NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)

HELD ON THURSDAY 21 JULY 2016 AT 9.00 AM IN THE CHAIR'S OFFICE, TRUST OFFICES, HUDDERSFIELD ROYAL INFIRMARY

PRESENT: **Mr Andrew Haigh (Chairman)**
Mr Peter Middleton, Publicly Elected Member
Mr Brian Moore, Publicly Elected Member
Mrs Dawn Stephenson, Nominated Stakeholder
Mrs Di Wharmby, Publicly Elected Member

IN ATTENDANCE:
Miss Kathy Bray, Board Secretary

1. APOLOGIES

Apologies were received from:-
Rev. Wayne Clarke, Publicly Elected Member
Mrs Eileen Hamer, Staff Elected Member
Mr Brian Richardson, Publicly Elected Member
Mr Owen Williams, Chief Executive

2. MINUTES OF THE LAST MEETING

The minutes of the last Nomination and Remuneration Committee (Membership Council) meeting held on the 7 December 2015 were accepted as a correct record.

3. MATTERS ARISING

There no matters arising which had not been actioned.

4. TERMS OF REFERENCE

The Terms of Reference had been circulated to identify that the changes requested at the last meeting had been made. There were no further amendments to be made.

RESOLVED: **The Committee approved that there were no further changes required to the Terms of Reference**

5. DECLARATIONS OF INTEREST/ELIGIBILITY TO SERVE

There were no declarations of interest to note.

6.1 DISCUSSION PAPER

As outlined in the paper circulated, the Chairman reported that the tenure of two Non-Executive Directors was due to expire in September 2016 (Dr Linda Patterson and Mr Phil Oldfield). It was noted that under the Constitution both could be offered a further 3 year tenure. The Chairman reminded the Committee that the Membership Council had received feedback on the Non-Executive Directors appraisal at the Membership Council meeting held on 6 July 2016.

The Committee discussed the qualities which were brought to the Board by Dr Linda Patterson and Phil Oldfield but concern was expressed regarding their future availability.

The Chairman reported that Dr Patterson had indicated that she would be returning to the role following her return from Australia on the 1 September 2016. The Committee acknowledged the many skills and competencies which she brought to the Board, as outlined in the discussion paper. The Committee agreed that subject to the Chairman receiving assurance about her availability, a further tenure should be offered.

The Chairman reported that he had discussed with Phil Oldfield the possibility of extending his tenure and although he had recently taken on a new commercial post and his availability had been limited, he would like the opportunity to continue with the Trust. The Committee acknowledged the skills and competencies which he brought to the Board and again, subject to the Chairman confirming with him his availability, approved a further tenure being offered.

Discussion took place regarding the skills brought by the remaining Non-Executives and whether there would be any merit in reviewing their portfolios to ease difficulties in availability. The Chairman reported that this exercise would be undertaken if necessary.

OUTCOME: Following discussion by the Chair with Dr Patterson and Phil Oldfield regarding availability, the Committee approved the extension of tenures.

ACTION: Payroll to be notified.

The Chairman took the opportunity of raising the question of remuneration of the Finance and Performance Chair (currently Phil Oldfield). It was noted that the additional remuneration had been approved when this Committee was formed and was meeting twice a month. Since this had now reduced to monthly meetings and in line with other Trust remunerations to Non-Executive Directors it was agreed that the Chairman should have a discussion with Phil Oldfield regarding this remuneration ceasing.

ACTION: Chairman

6.2 NON EXECUTIVE TENURES

The Chairman referred to the paper contained within the papers which highlighted the Non-Executive tenures. It was noted that four Non Executives tenures were due to expire in 2017, including the position of Chair:-

Andrew Haigh – tenure expires 6.7.17
Dr David Anderson - " 22.9.17
Prof Peter Roberts - " 22.9.17
Jan Wilson - " 30.11.17

Discussion took place regarding the options available and the need to stagger replacements to these posts to ensure greater consistency on the Board in the future.

It was agreed that a further meeting would be arranged in September/October 2016 when the Chief Executive would be available to attend to discuss the tenures, particularly the position of Trust Chairman. This would allow sufficient time for the posts to be advertised as necessary. The Chairman nominated Peter Middleton to Chair this meeting during his absence. It was agreed that an options paper, including an outline of each Non-Executive Directors skills and expertise would be available for this meeting.

ACTION: Meeting to be arranged September/October 2016 – Board Secretary

7. ANY OTHER BUSINESS

There was no other business to note.

8. DATE AND TIME OF NEXT MEETING

To be confirmed - September/October 2016

This page has been left blank