Meeting of the Board of Directors

To be held in public

Thursday 26 February 2015 from 1:30pm

Venue: Boardroom, Sub Basement, Huddersfield Royal Infirmary HD3 3EA.

AGENDA

1.	Welcome and introductions:- Mr Martin Urmston, Publicly Elected Membership Councillor/Deputy Chair Mr Peter Middleton, Publicly Elected Membership Councillor	Chairman	
2.	Apologies for Absence:	Chairman	
3.	Patient Story – presented by Interim Director of Operations re: Green Cross Patients	Executive Director of Nursing Interim Director of Operations	**PRESENTATION**
4.	Declaration of interests	All	**VERBAL**
5.	Minutes of the previous meeting ▪ Held on 29 January 2015	Chairman	**APP A**
6.	**Action Log and Matters arising:** a. Voluntary Redundancy Scheme Update	Chairman Executive Director of Workforce & OD	**APP B** **VERBAL**
7.	**Chairman's Report:-** a. Informal MC/NED Workshop held 12.2.15	Chairman	**VERBAL**
8.	**Chief Executive's Report:-** a. Institute for Fiscal Studies – Green Review	Chief Executive	**VERBAL**
Keeping the base safe			
9.	**Integrated Board Report** - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Monitor Indicators - Community	 Interim Director of Operations Executive Director of Nursing Executive Director of Nursing Executive Medical Director Executive Director of Workforce and OD Executive Director of Nursing Interim Director of Operations Executive Director of Planning,	**APP C**

	- Finance Financial Position Update – Month 10	Performance, Estates & Facilities Director of Finance Executive Director of Finance	**APP C1**
10.	Risk Register	Executive Director of Nursing	**APP D**
11.	Draft Board Assurance Framework	Company Secretary	**APP E**
12.	Director of Infection Prevention and Control Report	Executive Medical Director	**APP F**
13.	Safeguarding Annual Report – 2013-2014	Executive Director of Nursing	**APP G**
Improvement and innovation through strategic alliance			
NO ITEMS			
Transforming Care			
NO ITEMS			
14.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 27.1.15 and verbal update from meeting held 24.2.15) ▪ Strategic Health & Safety Committee Minutes – 27.1.15 ▪ Draft Audit & Risk Committee Minutes - 20.1.15 ▪ Draft Membership Council Meeting Minutes – 20.1.15 ▪ Risk Management Policy – Version 1		**APP H** **APP I** **APP J** **APP K** **APP L**
Date and time of next meeting Thursday 26 March 2015 at 1.30pm Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW.			

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 29.1.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 29 January 2015.	
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 29 January 2015.

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 29 January 2015.

Appendix

Attachment:

APP A - public bod minutes - 29 1 15.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 29 January 2014 in the Large Training Room, Learning Centre, Calderdale Royal Hospital and video-linked to Discussion Room 2, Learning Centre, Huddersfield Royal Infirmary

PRESENT

Andrew Haigh	Chairman (HRI)
Dr David Anderson	Non-Executive Director (HRI)
Dr David Birkenhead	Executive Medical Director (CRH)
Julie Dawes	Executive Director of Nursing and Operations (CRH)
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities (HRI)
Julie Hull	Executive Director of Workforce and Organisational Development (HRI)
Jeremy Pease	Non-Executive Director (HRI)
Owen Williams	Chief Executive (CRH)
Jan Wilson	Non-Executive Director (HRI)
Keith Griffiths	Executive Director of Finance (CRH)
Dr Linda Patterson	Non-Executive Director (CRH)

IN ATTENDANCE

Mags Barnaby	Interim Director of Operations (part of meeting)
Kathy Bray	Board Secretary
Mary Kiely	Membership Councillor & Consultant in Palliative Medicine (part of meeting)
Dr Pierre-Antoine Laloë	Member of the public (observer)
Ruth Mason	Associate Director of Engagement and Inclusion (part of meeting)
Victoria Pickles	Company Secretary CRH)

Item

1/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:-

Philip Oldfield	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Anna Basford	Director of Commissioning and Partnerships

The Chairman welcomed everyone to the meeting. It was noted that video-conferencing facilities had been arranged on both sites due to the adverse weather conditions.

2/15 PATIENT/STAFF STORY

Dr Mary Kiely, Consultant in Palliative Medicine and Membership Councillor attended the meeting to share with the Board the progress on the development of the Integrated Care of the Dying document. The Board noted that the Liverpool Care Pathway which had previously been used for the care of dying had been reviewed in July 2013 and withdrawn with no national replacement. A local review was undertaken in May 2013 through use of audit tools and identified five priorities for the care of the dying patient emerging:

- The possibility that a person may die within the next few hours/days is recognised and clearly communicated.

- Sensitive communication takes place between staff and the dying patient and those important to them.
- The dying patient and those identified as important to them are involved in decisions about treatment and care.
- The needs of families and others important to the dying patient are explored, respected and met as far as possible.
- An individual care plan, including food and drink, symptom control and psychological and spiritual support is agreed, coordinated and delivered with compassion.

Other measures introduced locally included the use of information leaflets for patients and relatives. In addition 'comfort bags' had been obtained through use of charitable funds providing useful items for relatives staying overnight at short notice.

It was noted that an audit would be undertaken later in the year to monitor the progress of this changed pathway and this would include a questionnaire to relatives and those identified as important to the bereaved.

The Board were requested to nominate a Board member with the specific responsibility for the care of the dying. Julie Dawes, Director of Nursing and Operations was nominated and accepted this role.

The Board received the report presented by Dr Kiely. Discussion took place regarding training needs for staff and the difficulties of enforcing statutory mandatory training within the Trust were noted The links between care of the acutely ill patient and care of the dying were acknowledged and it was noted that the Trust's mortality rate was subject to regular scrutiny by the Quality Committee. Further work would be undertaken to ensure that all staff, including community staff are aware of the Integrated Care of the Dying document and the five priorities in identifying and addressing the dying patient's needs.

The Board thanked Dr Kiely for her presentation.

3/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

4/15 MINUTES OF THE MEETING HELD ON THURSDAY 18 DECEMBER 2014

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

5/15 MATTERS ARISING FROM THE MINUTES

a. 182/14a Feedback from Monitor's Investigation – The Chairman reported that discussions had taken place with Monitor and copy of the final wording for the Enforcement Letter had been circulated to Board members.

b. 183/14a Voluntary Redundancy Scheme Update – The Executive Director of Workforce and Organisational Development advised that 477 applications for voluntary redundancy had been received and to date 34 had been formally approved. A number of applications had been declined. The remainder were being held until all requests had been received so that the full impact and value for money could be considered. It was noted that the scheme was due to close on the 31 January 2015. It was agreed that an updated position report would be brought to the February meeting.

ACTION: BOD Agenda Item – February 2015 (JRH)

c. 201/14 Health & Safety Policy - The Executive Director of Planning, Performance, Estates and Facilities advised that further work had been undertaken on the Policy since the review by the Board in December and it had now been loaded to the policies system following ratification by the Strategic Health & Safety Committee.

d. 184/14 Fire Risk Assessment – The Executive Director of Planning, Performance, Estates and Facilities advised that a fire risk assessment had been undertaken and the resulting actions were available. It was been agreed that this function would be taken back from the Divisions into the Estates Department who will own the risks and work with the Divisions on implementing the actions.

e. 184/14 Community Services – The Executive Director of Planning, Performance, Estates and Facilities advised that further work was being undertaken on the community indicators within the integrated board report. It was noted that community equipment needs were being addressed via the Perfect Week feedback. An updated position would be available within the monthly Integrated Board Report.

6/15 ACTION LOG

There were no actions outstanding on the Action Log.

7/15 CHAIRMAN'S REPORT

a. Membership Council Meeting – 20.1.15 – The Chairman gave a brief overview of the Membership Council Meeting held on 20 January 2015. Within the pre-meeting the Membership Council had discussed Monitor's investigations.

John Rayner, Director of the Health Informatics Service and Dr Alistair Morris, Clinical Director for Modernisation had attended the meeting to give an update on the procurement of the Electronic Patient Record. The Membership Council had asked some key questions around training and the benefits associated with this programme.

8/15 CHIEF EXECUTIVE'S REPORT

a. A/E THROUGHPUT – The Chief Executive reported that the quarter 3 position had been challenging for patient flow. The current position at quarter 4 was 91.36% which was an improvement on the previous 2-3 weeks which had resulted in a year to date position of 94.5 against the target of 95%. It was acknowledged that staff were working hard to improve the position but this remained a challenge. Discussion took place regarding the reasons for the delay in discharging 'green patients'. This was reported to be due to social care, Trust re-admissions and both Trust and Social Care challenges. It was acknowledged that there was a whole-system problem and the Urgent Care Board was considering the hospital and local authority patient pathways.

9/15 INTEGRATED BOARD REPORT

The Executive Director of Nursing introduced the performance report as at 31 December 2014 and explained that each area would be presented in detail by the appropriate director.

Responsive - the Interim Director of Operations highlighted to the Board the key issues from the executive summary commentary:-

- There has been a further increase in urgent and emergency activity in line with the rest of the country. All Trust beds are open. This additional activity has put pressure on both A&E departments which led to a reduction in performance against the 4 hour target. In December we delivered 89.4 and did not meet the quarter 3 target of achieving 95%.

- The additional beds have put further pressure on nurse staffing levels. Bank and agency staff have been used to bring these staffing levels up. There has however, been some occasions where levels have been below the agreed level within the 'Hard Truths Requirements'.
- Performance against the access to diagnostics within 6 weeks target has improved and should be delivered by the year end.
- There has been a dip in performance against some of the quality indicators. It is likely that this is as a result of the number of beds being open and the impact on staffing levels. The Trust's summary hospital-level mortality indicator (SHMI) remains at 111, with the un-rebased hospital standardised mortality ratio (HSMR) at 102.41. The average diagnosis per coded episode is 4.05 against a target of 4.90. This may be affecting our SHMI and HSMR.

Discussion took place regarding the 'green cross' patients within the system, those that are medically fit for discharge but which require other support to enable them to go home. It was noted that the local authorities were finding it challenging to access more packages of care and in Kirklees out of area packages were being sourced. It was agreed that this would be discussed outside the meeting involving the Interim Director of Operations, Executive Director of Nursing & Operations and the Chief Executive.

ACTION: Discussion outside the meeting (MB/JD/OW)

It was noted that the feedback from the Perfect Week had identified some areas where the Trust and healthcare partners could work together to improve the patient pathway and reduce lengths of stay. Work had already commenced internally with the Executive Board having received an action plan. It was agreed that the Chair would meet with the Chairs of partner organisations to discuss the issues identified and how these might be resolved.

ACTION: Chair to meet with neighbouring Chairs

Caring – the Executive Director of Nursing reported:-

- **Complaints** – 11% of the 65 complaints closed in December were within the agreed timescale. Significant focus had been placed on addressing the backlog of open complaints with 65% now closed.
- A significant reduction has been made in the number of complaints open, although the trajectory has not been met.
- A new trajectory would be drawn up for the remainder of the financial year and improved monitoring introduced with a fortnightly breakdown to Divisions. A Plan for Every Complaint had been introduced in the Patient Advice and Complaints Team.

- **Family and Friends – the Executive Director of Nursing reported:-**
- Since the green counters had been stopped in A/E, there had been a drop in the level of Friends and Family Test feedback received. Concern was expressed that this was now a CQUIN measure. Alternative ways of getting feedback from patients was being looked at and it was hoped that the position would be improved by the next meeting.

- **Safety – the Executive Director of Nursing reported:-**
- **Falls** – A 10% reduction target had been set and would not be met. Work continued and it was noted that the number resulting in harm had reduced.

- **Serious Untoward Incidents** – Concerns had been expressed by the CCG regarding the delay in root cause analysis investigations and work was in hand to address this.

- **Duty of Candor** – The Trust was working through what was required and how to capture evidence of compliance with the statutory duty to inform patients/relatives/carers in writing within 10 days of the incident.

Effectiveness – The Executive Medical Director reported**:-**

- **Mortality** – It was noted that this would be discussed in detail within the 'Care of the Acutely Ill Patient Report' later in the meeting.
- **Fractured Neck of Femur** – Due to the increased level of activity the target had not been achieved. It was expected that this position would improve through January. Jan Wilson reported that this had been discussed in detail at the Quality Committee.

Well Led – the Executive Director of Workforce and Organisational Development reported **t**hat work was being undertaken to develop the indicators in this section of the report.

- **Sickness rates** – A programme of work on 'high absence incidence' service areas has commenced. An internal taskforce is working to support divisional colleagues in managing attendance. The taskforce is taking a hands-on role in developing an overall approach to effective management in these service areas and in individual cases. This approach is supported by intensive briefing of colleagues with regard to how attendance impacts on our ability to deliver safe services and high quality patient care.
- **Staff Survey** – Results will be brought to the next meeting together with a recommendation on how the Trust focuses on the Family and Friends Test in the future.

ACTION: BOD AGENDA ITEM – FEBRUARY 2015 (JRH)

- **Staff Appraisals** – The monthly compliance target for appraisals is 8%. All areas forecast compliance of 100% at 31 March 2015. There is strong evidence that appraisal activity is concentrated in last 3 months of the financial year. Resources provided by the Workforce Development team are still being added to the intranet available toolkit. For example, appraisal planning and appraisal preparation videos are new additions.

- **Hard Truths** - The Executive Director of Nursing and Operations reported:- Maintaining staffing levels with an increasing and fluctuating demand has remained difficult. Increased staffing reviews throughout each day have been implemented to identify priorities and maintain a safe base. The development of a staffing forecast utilising the e-rostering system has also been developed to assist identification of any areas with staffing flexibility. Increased agency usage is being monitored closely and an additional recruitment drive in December of non-qualified nurses was undertaken which has assisted in achieving safe staffing levels and reducing agency spend from the first week in January. Two successful recruitment trips to Spain have been completed resulting in the offer of positions to 21 qualified nurses who are due to arrive in January 2015. The web-based safe staffing tool was successfully trialled and will be utilised to report nursing and midwifery staffing in inpatient areas from the beginning of the year. In addition to providing accurate data the staffing tool will also collate professional judgement to inform future staffing plans.

Finance – the Executive Director of Finance reported:-

Summary Year to Date

- Additional activity in month has resulted in bed capacity pressures
- Capital expenditure of £15.71m against revised plan of £16.05m, and underspend of £0.34m (£5.51m below original plan)
- The cash balance was £15.46m versus a planned £20.82m, £5.36m lower than planned.
- The Continuity of Service Risk Rating (CoSRR) stands at 3, although underlying performance is at level 2.

Summary Forecast

- The year-end deficit is forecast to be £2.42m against a planned surplus of £3.00m.
- When restructuring costs are included the forecast year-end deficit is £5.54m, resulting in a Continuity of Service Risk Rating (CoSRR) of 2
- CIP schemes are forecast to deliver £8.92m against the planned £19.53m. This is a shortfall of £10.61m and will have an impact on 2015/16.
- £1.5m has been committed to extra substantial nurse staffing - additional winter expenditure has also been included within the forecast position
- £1.5m additional income to support quality investments has been agreed by commissioners
- The revised Capital forecast is a £21.79m spend , a reduction of £2.53m from the revised plan (£7.41m lower than the original plan)
- The forecast year-end cash balance is £10.65m against the planned £22.71m

The Board noted the contents of the report regarding:

- CQINS
- Monitor Indicators
- Community – in particular it was noted that this section of the report required further development and a review against available benchmarking information.

RESOLVED: The Board approved the Integrated Board Report

10/15 RISK REGISTER REPORT

Following the feedback received at the last meeting, the Executive Director of Nursing and Operations reported the top risks within the organisation:

- Progression of service reconfiguration impact on quality and safety
- The risk to the Trust's financial position
- Monitor Investigation
- Risk of poor patient outcomes due to dependence on middle grades and locums
- Risk of poor patient outcomes and experience caused by blocks in patient flow
- HSMR and SHMI
- Overarching risk for infection control

The risk with an increased score was failure to meet cost improvement programme targets and this score had increased from 20 to 25.

The Board noted the new risks and the risks to be discussed by the Risk and Compliance Group.

It was noted that external work was being undertaken to review the risk register and board assurance framework and that a draft would be brought to the February meeting.

RESOLVED: The Board received the report, noted the high level risks and agreed to receive a full report at its next meeting.

ACTION: BOD AGENDA ITEM – FEBRUARY 2015 (JD/VP)

11/15 DIRECTOR OF INFECTION, PREVENTION AND CONTROL (DIPC) REPORT

The Executive Medical Director presented the DIPC report and highlighted areas of concern:

- No C.Difficile cases had been reported in December. The Trust remains at 19 cases against a ceiling of 18. Three cases had occurred in January and were awaiting root cause analysis.
- 1 MRSA bacteraemia (post admission) had been assigned to the Trust.
- Aseptic Non-Touch Technique (ANTT) compliance is well below the 95% target and plans have been put in place to improve competency assessments.
- Flu Vaccinations – It was reported that 64% of front line staff had received the flu vaccine.

RESOLVED: The Board received the report.

12/15 CARE OF THE ACUTELY ILL PATIENT

The Executive Medical Director presented the updated report which it was noted had been debated in a number of forums. The progress on the 8 themes included within the report were received and noted:-

1. **Reducing Mortality** (Overall outcome measures) - SHMI remained at 111. It was expected that this would reduce to 110 in the next quarter. Concern was expressed that crude mortality had risen slightly from the previous year's position. This had been reported at Quality Committee and analysis was being undertaken. A review of all deaths was being undertaken and would be reported to the Quality Committee by March. The new 'Nerve Centre' system was being rolled out across the Trust. The capacity of junior medical staff particularly overnight and at weekends was being looked at alongside implementing metrics to test the use of care bundles. The Board acknowledged that the Trust needed to focus on this as highlighted in the presentation received from Dr Kiely earlier that afternoon.
2. **Ensuring the recognition and prompt treatment of our deteriorating patients.** Three key actions in this work stream, firstly the move to 'Nerve Centre' (the electronic observations and escalation system). The second action is focused on ensuring our escalation teams are correctly organised to respond to deteriorating patents and the third action is around appropriate and timely end of life care decisions.
3. **Delivering high standard of care through reliable delivery of care bundles.** Care bundles are a group of actions that if properly validated and implemented are proven to lead to improved clinical outcomes for the condition or symptom to which they apply. As such if chosen correctly they will support the Trusts high level aims to reduce harm and mortality.
4. **Frailty.** Care of frail patients is a theme that has emerged from some of the mortality alert reviews and via on going trust improvement work e.g. Dementia. These patients tend to have a complex pathway of care, coming into contact with multiple teams and support services.
5. **Effective -** Focus on the Courage to Put Patient First programme.
6. **Focus on SHMI Conditions of Interest.** In order to drive down the trusts SHMI a sensible approach is to maintain a focus on those conditions that either alert or

have a higher mortality rate than expected. here has been no new data released since the last report.

7. **Well Led Organisation.** The actions contained are all designed to ensure that key barriers to support the programme aims are overcome. There is ongoing work improving the metrics for this theme.
8. **Coding** – Training and recruitment of Coding staff was being addressed.

RESOLVED: The Board received the report and agreed that a further report would be presented in March 2015.

13/15 REVALIDATION REPORT

The Executive Medical Director presented the updated revalidation report and the Board noted the progress made:-

- As at 31 December 2014, 312 doctors were linked to Calderdale and Huddersfield NHS Foundation Trust and therefore required revalidation by the Trust.
- In the current appraisal year (1 April 2014 – 31 March 2015) 55% of those doctors had been appraised by 31 December 2014 and their appraisal submitted to the Revalidation Office. Based on the request that doctors complete their appraisal during their month of birth the completion rate is currently 76%.
- The Trust was on target to meet General Medical Council target of 90% by the year-end.

The Executive Medical Director explained that there would be a focus on the quality of appraisal during 2015. A further report would be brought to the Board at the year end.

ACTION: Full year report to be brought to the Board in April - DB

The Executive Director of Nursing commented that this would become part of the Well-Led dashboard going forward. She added that revalidation for nurses would be coming into force by the end of the financial year as one of the lessons from the Francis Report. Work was still being done to determine how this would be implemented. Feedback from the pilot areas had not yet been received. This would be a more complicated process due to the numbers of staff involved. It was agreed that further detail on this would be brought to the Board in April.

ACTION: Revalidation for nurses report to be brought to the Board in April – JD

14/15 QUALITY REPORT

The Executive Director of Nursing and Operations presented the Quality Report focusing on Q4. It was noted that this report had been arranged around the 5 Care Quality Commission domains, highlighting the key areas and compliance with the standards. Where gaps have been identified it showed the work on-going to address these. Progress against these actions would be reported in the subsequent report to be presented to the Board of Directors in April 2015.

It was noted that this report had been circulated to the Quality Committee and any feedback was should be sent to the Executive Director of Nursing and Operations.

ACTION: BOD AGENDA ITEM – APRIL 2015 (JD)

15/15 PUBLIC SECTOR EQUALITY DUTY ANNUAL REPORT

Ruth Mason, Associate Director of Equality and Inclusion attended the meeting to present the Equality & Diversity Report and Public Sector Equality Duty (PSED) Compliance Evidence. It was noted that this had been brought to the Board to as

part of the Trust's statutory duty to publish progress against, and achievement of, agreed equality and diversity objectives by the end of January 2015.

The report presented details of the ways in which the Trust meets the general duties of the Act to:
• Eliminate unfair discrimination, harassment and victimisation
• Advance equality of opportunity between different groups
• Foster good relationships between different group.

RESOLVED: The Board noted the achievement of statutory timescales in relation to production of the PSED report and agreed its publication before the end of January 2015.
The Board noted the additional organisational requirement to introduce EDS2 by end March 2015 and the Workforce Race Equality Standard (WRES) by March 2016.

16/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES
The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 16.12.14 and a verbal update from the meeting on 27.1.14 which included:
  - R&D Strategy received – importance of R&D within the Trust acknowledged.
  - CQC – report being developed with a shared understanding for all levels of the organisation.
  - Well-led issues – statutory training discussed.
  - Complaints – increase in compliance required.
  - Trained Nurses in Paediatric A/E – known weakness – requires mitigation before CQC visit.

- **Strategic Health & Safety Committee Minutes** – 23.12.14 minutes received and contents noted.

- **Audit & Risk Committee – 20.1.15** – It was agreed that the minutes of this meeting would be brought back to the next meeting.

ACTION: BOD AGENDA ITEM – FEBRUARY 2015

17/15 DATE AND TIME OF NEXT MEETING
Thursday 26 February 2015 at 1.30 pm in the Boardroom, Huddersfield Royal Infirmary.

The Chairman thanked everyone for their attendance and contributions and closed the meeting at approximately 4.00 pm.

…… ……
Mr Andrew Haigh, Chairman Date

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - FEBRUARY 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 February 2015	
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 February 2015.

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 February 2015

Appendix

Attachment:

APP B - ACTION LOG - BOD - PUBLIC - As at 1 February 2015.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 February 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
30.10.14 140/14	**PATIENT/STAFF STORY** 30.10.14 - 'Carol's Story' extract video. 27.11.14 – 'Mr P' – Drug Error 18.12.14 – Dr Sarah Hoye 29.1.15 – Dr Mary Kiely – Care of the Dying	Executive Director of Nursing	Regular item on BOD Agenda going forward.	Monthly Reports		
18.12.14	**VOLUNTARY REDUNDANCY SCHEME – WORKFORCE PLAN** 27.11.14 – Draft proposal discussed in Private Board Meeting. Discussions to take place with Staff Representatives.	Executive Director of Workforce & OD	18.12.14 – Verbal update received 29.1.15 – Verbal update received	26.2.15		
25.7.13 113/13	**HSMR/MORTALITY/CARE OF THE ACUTELY ILL PATIENT** Presentation received from BC & HT. Action Plan discussed. Update on actions to be brought to BOD Meetings on a bi-monthly basis.	Executive Medical Director	Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 26.9.13 – Update on worsened position received. Key themes and actions identified. Agreed that an updated plan would be brought back to the October 2013 BoD Meeting. 24.10.13 – Update and Action Plan received and note. Board endorsed plan and supported its implementation. Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 19.12.13 – Update on progress received. Agreed that updated Action Plan would be brought to the Board in February 2014. 27.2.14 – Further work being undertaken by Divisions – roll out of mortality review process from March 2014 24.4.14 – Update received. 26.6.14 – Update received 25.9.14 – Update received	March 2015		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 February 2015 / 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
			27.11.14 – Update received 29.1.15 – Update received			
24.11.11 134/11b.	**APPOINTMENT OF VICE CHAIR & SINED** Role of Vice Chair and SINED split into two. Alison Fisher – Vice Chair and Jane Hanson – SINED. Effective from 1.12.11. To be reviewed October 2012.	Chairman/ Director of Workforce & OD	18.10.12 – Agreed that current arrangements continue for a further 12 months 26.9.13 – Appointments made:- Jan Wilson and Vice Chair, David Anderson, SINED. To be reviewed 25.9.14 25.9.14 – Appointments extended for 12 months for Vice Chair, SINED and Audit & Risk Committee Chair – to be reviewed in September 2015	24.9.15		
95/14 b.	**INTELLIGENT MONITORING REPORT** The Quality Committee had asked the CQC to explain how the indicators would be applied. Agreed that this would be brought back to the BOD at a future meeting.	Executive Director of Nursing & Operations		TBC		
29.1.15 14/15	**QUALITY REPORT** Report received. Feedback welcomed to the Executive Director of Nursing and Operations.	Executive Director of Nursing & Operations	Progress against actions to be reported to the Board in April 2015.	23.4.15		
29.1.15 13/15	**REVALIDATION REPORT** Update on progress within Trust on medical revalidations and appraisals was received. Revalidation for nurses to be introduced by end of financial year. Information on implementation awaited.	Executive Medical Director Executive Director of Nursing and Operations	1. Full year report to be brought to Board in April. 2. Revalidation for nurses report to be brought to the Board in April.	23.4.15 23.4.15		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: INTEGRATED BOARD REPORT - PERFORMANCE AND QUALITY REPORT - The Board is asked to note and approve the contents of the Integrated Board Report.	
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, Quality Committee	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to note and approve the contents of the Integrated Board Report attached.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to note and approve the contents of the Integrated Board Report.

Appendix

Attachment:

Integrated Board Performance Report Jan15.pdf

Board Of Directors Integrated Performance Report

Report For: January 2015

THIS

Calderdale and Huddersfield NHS
NHS Foundation Trust

Contents

Executive Summary Commentary

During January we have over-performed on non-elective care. This has led to bed pressures resulting in both delays discharging patients, and also increasing the number of outliers. We had a significant number of surgical outliers at the start of the month, and this switched to medical outliers by the end of the month. This has continued into February. The increase in emergency patients, and the slow down on the movement of patients out of the hospital has also affected our A&E 4 hour wait target. In January we achieved 91.89%, and the position to 15th February was 92.42% for quarter 4.

The snow during January affected our DNA rates, which rose in month. This is against the recent trend where we have seen DNA rates slowly falling.

There are still capacity issues in MRI and endoscopy creating problems for our diagnostic undertaken within 6 weeks target. These will be resolved by year end.

	Report For: January 2015	Indicator Source	Report For: January 2015						Year To Date						Year End Forecast	Data Quality
			Target	Trust	Surgical	Medical	CWF	DATS	Target	Trust	Surgical	Medical	CWF	DATS		
Activity	% Elective Variance	Local	0.00%	-10.10%	-13.90%	1.30%	-15.10%	50.00%	0.00%	-8.40%	-8.80%	6.00%	-19.90%	7.00%		
	% Day Case Variance	Local	0.00%	-6.70%	-2.60%	-8.30%	-30.30%	-59.10%	0.00%	1.20%	6.80%	-5.60%	-9.20%	-24.70%		
	% Non-elective Variance	Local	0.00%	3.50%	-8.50%	-1.30%	13.70%	-	0.00%	0.40%	-6.40%	-0.40%	4.40%	-		
	% Outpatient Variance	Local	0.00%	-8.50%	-10.80%	-5.10%	-1.90%	-34.40%	0.00%	-0.30%	-2.11%	-0.03%	5.67%	-2.29%		
RESPONSIVE - Operational Targets	Trust Theatre Utilisation	Local	90.00%	91.04%	90.73%	-	99.84%	-	90.00%	91.81%	91.79%	-	95.37%	-		
	% Daily Discharges - Pre 11am	Local	28.00%	9.45%	11.27%	8.73%	9.03%	-	28.00%	9.27%	11.34%	8.63%	8.57%	-		
	Number of Outliers (Bed Days)	Local	0	877	13	864	0	0	0	4136	218	3918	0	0		
	First DNA Rate	Local	7.00%	8.42%	8.57%	7.66%	8.81%	10.53%	7.00%	7.35%	7.38%	6.78%	7.87%	9.51%		
RESPONSIVE:18 Weeks and Other Access Indicators	% Non-admitted Closed Pathways under 18 weeks	National	95.00%	99.06%	98.74%	99.50%	99.41%	100.00%	95.00%	98.69%	98.72%	98.45%	99.18%	94.52%		
	% Admitted Closed Pathways Under 18 Weeks	National	90.00%	91.32%	90.72%	100.00%	94.86%	75.00%	90.00%	91.82%	90.96%	99.90%	96.24%	75.61%		
	% Incomplete Pathways <18 Weeks	National	92.00%	94.52%	92.59%	99.65%	98.86%	86.84%	92.00%	94.52%	92.59%	99.65%	98.86%	86.84%		
	18 weeks Pathways >=26 weeks open	Local	0	295	285	3	1	6	0	252	238	4	8	2		
	% Diagnostic Waiting List Within 6 Weeks	National	99.00%	98.21%	93.49%	100.00%	-	99.50%	99.00%	98.85%	98.95%	99.93%	-	98.72%		
RESPONSIVE: Cancer	62 Day Gp Referral to Treatment	National	85.00%	90.36%	92.31%	84.48%	100.00%	-	85.00%	90.86%	93.16%	86.15%	92.65%	-		
	62 Day Referral From Screening to Treatment	National	90.00%	87.50%	87.50%	-	-	-	90.00%	93.85%	93.65%	-	100.00%	-		
	31 Day Subsequent Surgery Treatment	National	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	99.00%	100.00%	99.00%	-	-		
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National	86.00%	97.35%	91.92%	84.48%	100.00%	-	86.00%	90.75%	93.25%	86.15%	93.75%	-		
	31 Days From Diagnosis to First Treatment	National	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.54%	99.53%	99.75%	97.62%	-		
	Two Week Wait From Referral to Date First Seen	National	93.00%	97.46%	97.34%	97.08%	100.00%	-	93.00%	97.96%	98.64%	95.31%	99.06%	-		
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National	93.00%	96.72%	96.72%	-	-	-	93.00%	95.92%	95.92%	-	-	-		
RESPONSIVE: Accident & Emergency	A and E 4 hour target	National	95.00%	91.89%	91.89%	-	-	-	95.00%	94.57%	94.57%	-	-	-		
	Time to Initial Assessment (95th Percentile)	National	00:15	00:20	00:20	-	-	-	00:15	00:20	00:20	-	-	-		
	Time to Treatment (Median)	National	01:00	00:15	00:15	-	-	-	01:00	00:19	00:19	-	-	-		
	Unplanned Re-Attendance	National	5.00%	5.13%	5.13%	-	-	-	5.00%	5.02%	5.02%	-	-	-		
	Left without being seen	National	5.00%	1.93%	1.93%	-	-	-	5.00%	2.73%	2.73%	-	-	-		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive/Operational Targets - Director of Operations

THIS

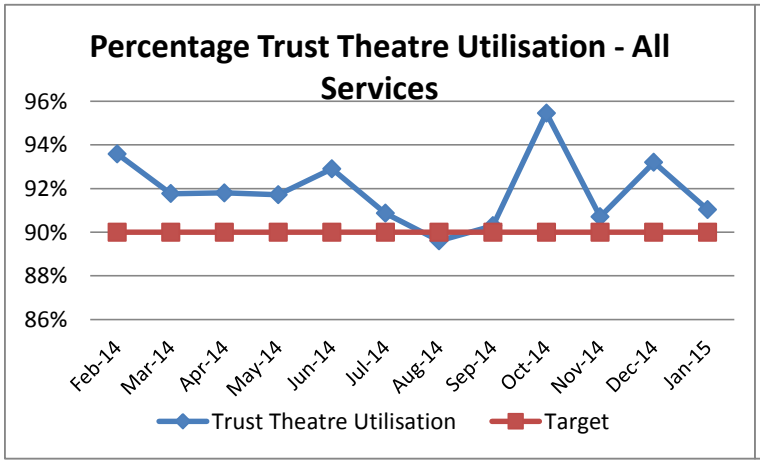
Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Trust Theatre Utilisation	90.00%	91.04%	90.73%	-	99.84%	-
Outpatient Utilisation (Attendances Per Slot)	-	-	Indicator in Development			
% Daily Discharges - Pre 11am	28.00%	9.45%	11.27%	8.73%	9.03%	-
% Daily Bed Demand - 3pm	-	-	-	-	-	-
Number of Outliers (Bed Days)	0	877	13	864	0	0
First DNA Rate	7.00%	8.42%	8.57%	7.66%	8.81%	10.53%

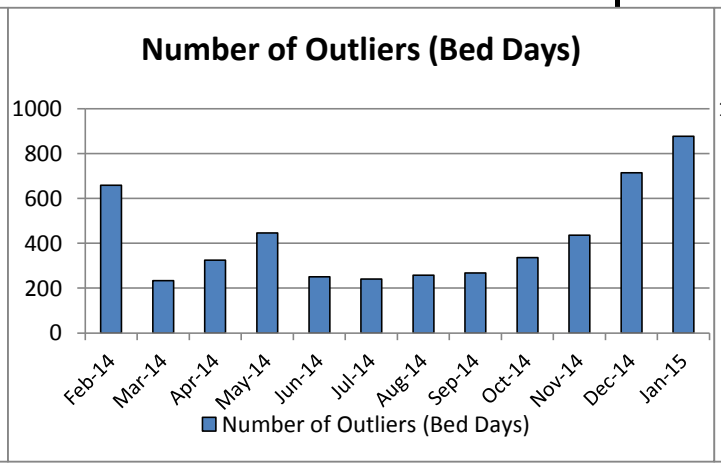
% Daily Discharges Pre 11am - discharge levelling targets require 28% of medical patients and 27% of surgical patients to be discharged before 11am. The vehicle for making this possible is Visual Hospital and Plan for Every Patient. Improvements have been seen but continued improvements are needed. A number of initiatives to improve performance have been implemented but not embedded consistently, work is on-going to achieve this and these have now become part of the Reduced LOS work stream of the PMO. Clinical Site Commanders are only just starting to come into post, so we have not yet seen the benefits of these posts. There is also a big piece of work being undertaken involving both local Social Services to further address the number of green cross pathway patients.

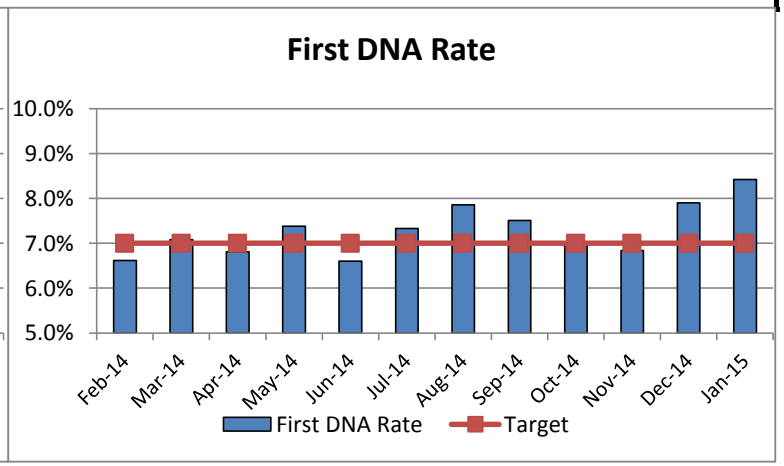
Outlier Rate (bed days) - target is no outliers. Increasing numbers of patients have outlied in month in both hospital sites due to winter pressures (this is a seasonal picture and we would expect to see it beginning to reduce from now). The work going on within the reduced LOS PMO work stream aims to address the outlier situation.

First DNA Rate - Performance dipped across all specialties in the Month of January due to the adverse weather which resulted in exceptionally high numbers of DNA and cancellations. The SMS and Interactive Voice Messaging continues to deliver a reduction in missed appointments, and patients are now able to update contact numbers at the self checking kiosks. Evening staff are to be recruited to support the extended working in OP reception, the role will include telephoning potential DNAs as an added precaution. The Trust DNA rate is 8.42 % against the same period last year of 7% . Overall the DNA rate is in line with peer Trusts.

Theatre Utilisation - The Trust is slightly above target in overall Theatre Utilisation. It is recognised that not every Specialty is achieving this target individually. The Theatre Productivity Programme is engaging with each Specialty to drive through changes required to deliver 90% per Specialty in both Elective Inpatient and Day Case Surgery.







Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive - RTT - Director of Operations

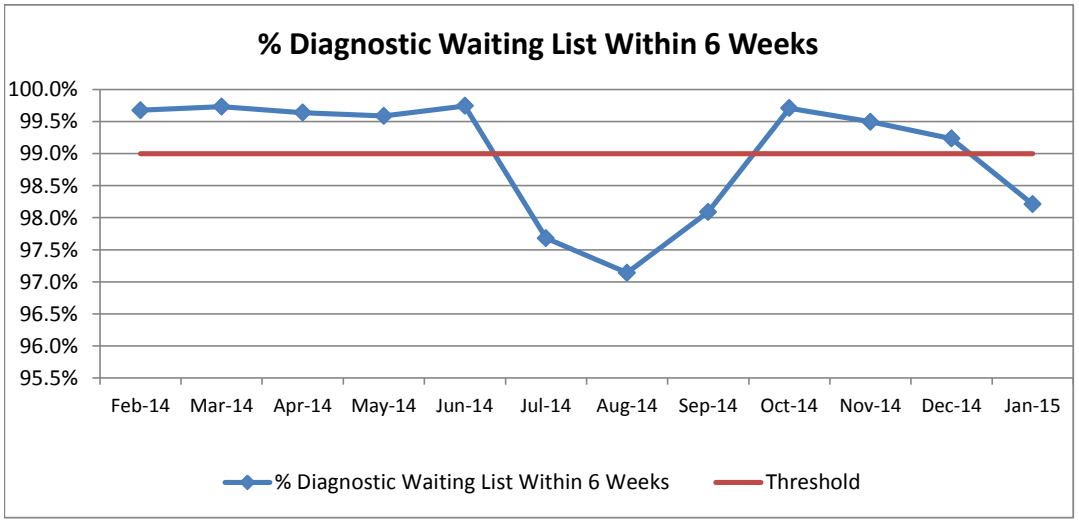
THIS

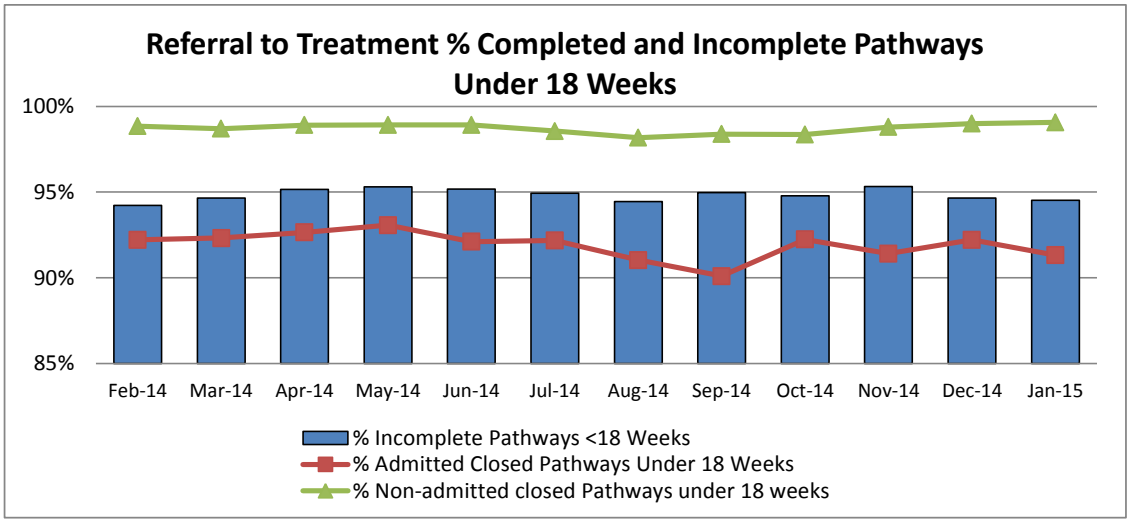
	Target	Trust	Surgical	Medical	CWF	DATS
% Non-admitted closed Pathways under 18 weeks	95.00%	99.06%	98.74%	99.50%	99.41%	100.00%
% Admitted Closed Pathways Under 18 Weeks	90.00%	91.32%	90.72%	100.00%	94.86%	75.00%
% Incomplete Pathways <18 Weeks	92.00%	94.52%	92.59%	99.65%	98.86%	86.84%
18 weeks Pathways >=26 weeks open	0	295	285	3	1	6
% Diagnostic Waiting List Within 6 Weeks	99.00%	98.21%	93.49%	100.00%	-	99.50%
% Last Minute Cancellations to Elective Surgery	0.60%	0.36%	0.63%	0.04%	0.20%	0.00%

The RTT for interventional radiology away from plan due to late surgical referrals, complex pathways & some radiology capacity issues. Plan to meet with surgery to address late referrals. Radiology capacity now back to normal. Date for improvement April 2015. For the 6 week target further additional mobile MRI scanning capacity is being procured between now & the end of the financial year. All other modalities are on track.

Endoscopy commentary – demand and local 7 day target for fast-track referrals is causing additional pressures into a stretched service . Deep dive presentation to WEB along with recovery plan which includes moving some appointments for surveillance patients to release some capacity, securing additional capacity in March, and we have secured a locum to cover a long term consultant sickness.

Cancelled Operations for Elective Procedures. The Trust is currently at 0.36% against a target of 0.6%. This is a slight drop in performance since the December 2014 report. Bed Pressures have resulted in some elective cancellations in surgery. Theatre Productivity Project is well underway and Workstreams are working on reducing DNA Rates (on day), cancellations due to pooled lists (Operation not needed) and List Overrun avoidance.





Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Two Week Wait From Referral to Date First Seen	93.00%	97.46%	97.34%	97.08%	100.00%	-
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.00%	96.72%	96.72%	-	-	-
31 Days From Diagnosis to First Treatment	96.00%	100.00%	100.00%	100.00%	100.00%	-
31 Day Subsequent Surgery Treatment	94.00%	100.00%	100.00%	100.00%	-	-
31 day wait for second or subsequent treatment drug treatments	98.00%	100.00%	100.00%	100.00%	-	-
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	86.00%	97.35%	91.92%	84.48%	100.00%	-
62 Day Gp Referral to Treatment	85.00%	90.36%	92.31%	84.48%	100.00%	-
62 Day Referral From Screening to Treatment	90.00%	87.50%	87.50%	-	-	-

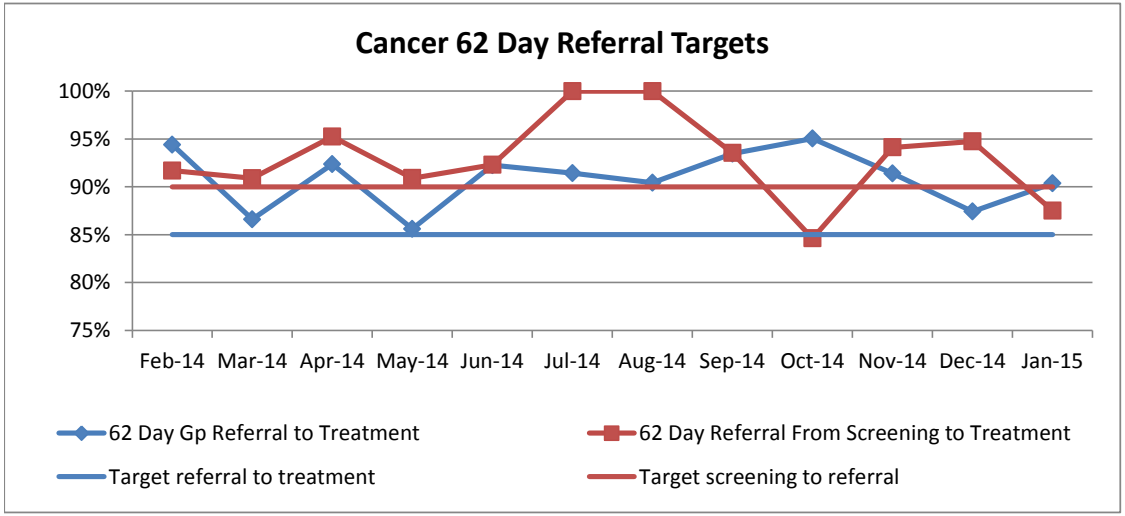
31 day Screening - In January the Trust had 1 x 0.5 breach; however the Trust only treated 4 patients in month which is the lowest number for 2 years; giving a percentage of 87.5.

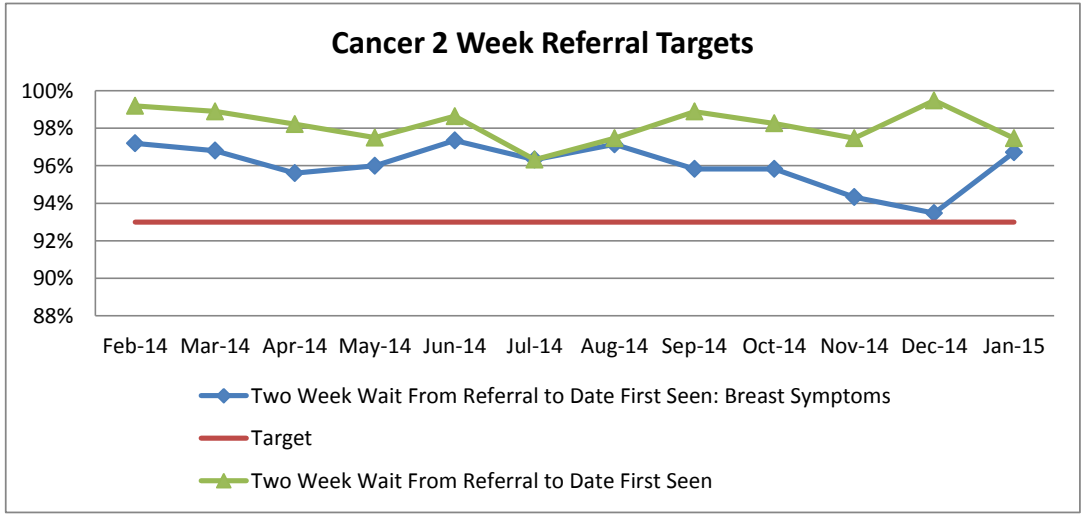
Explanation

The patient was offered a date on the 20th Nov but wanted his son to attend so was offered another date at the beginning of December. He rang the day before to cancel as he had suffered a bereavement and then asked for a date after Christmas., which has resulted in the above.

All patients are monitored very closely through their cancer pathway and discussed weekly by the cancer lead, GM and patient pathway co ordinator.

In February however we are already looking at a possible 2 breaches which will need the Trust to treat 20 patients to reach the 90% target; the reasons for these are due to patients being unfit and patient cancellation.





Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive/Accident & Emergency - Director of Operations

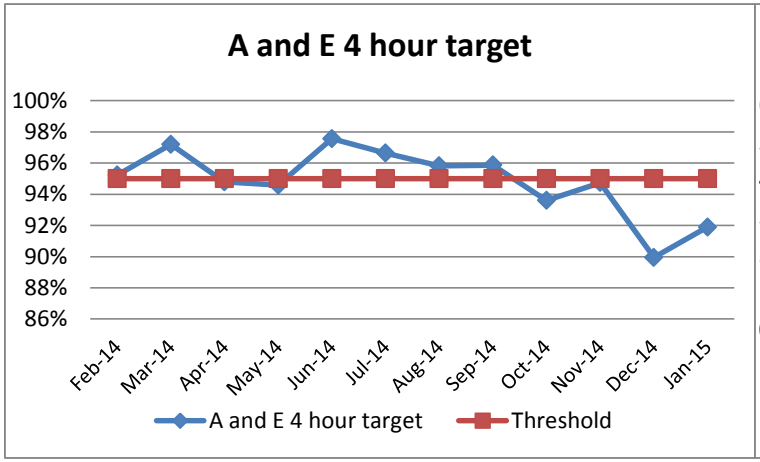
THIS

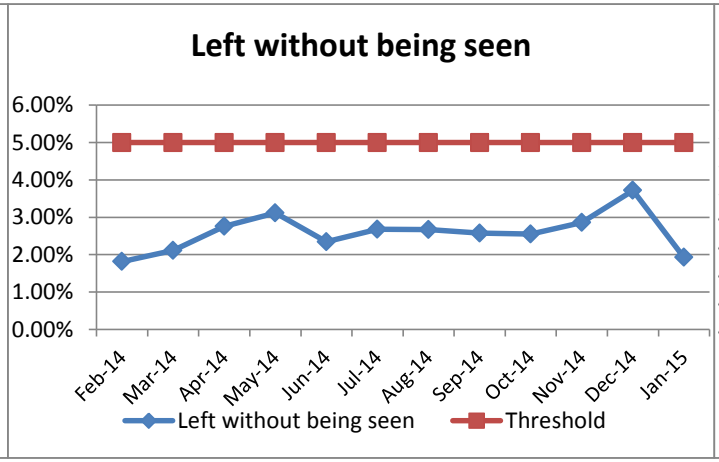
Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
A and E 4 hour target	95.00%	91.89%	91.89%	-	-	-
Time to Initial Assessment (95th Percentile)	00:15	00:20	00:20	-	-	-
Time to Treatment (Median)	01:00	00:15	00:15	-	-	-
Unplanned Re-Attendance	5.00%	5.13%	5.13%	-	-	-
Left without being seen	5.00%	1.93%	1.93%	-	-	-

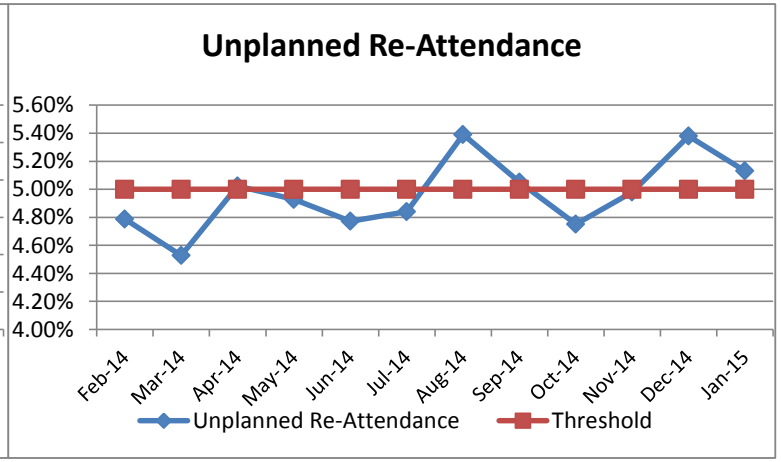
Continued increase in admissions. LOS and patients on the green cross pathway has shown a continued increase at both sites. Discharge levelling has generally not been achieved creating lengthy delays for patients waiting an inpatient bed in A & E which has an impact on their experience. It is expected that the appointment of Clinical Site Commander posts will have a significant impact on discharge levelling. Forecast as yet has improved but there remains a significant risk of not achieving the Q4 and YTD required performance. Impact of long waits in A&E for inpatient beds now seen on most of the A&E indicators. Improvement plan to be developed to ensure delivery of 4 hour for the year, A&E indicators and improvement in patient experience.

TIME TO ASSESSMENT Lack of cubicle capacity has not enabled the achievement of the 15 minute assessment. An improvement in patient flow will create that capacity necessary to achieve. FORECAST AMBER.

TIME TO TREATMENT - RAG RATING GREEN.
UNPLANNED REATTENDANCE - FORECAST GREEN. Further validation completed as data quality is an issue.
LEFT WITHOUT BEEN SEEN - FORECAST GREEN







			Report For: January 2015						Year To Date							
	Report For: January 2015	Indicator Source	Target	Trust	Surgical	Medical	CWF	DATS	Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Caring	Number of Mixed Sex Accommodation Breaches	National	0	0	0	0	0	0	0	7	0	7	0	0		
	% Complaints closed in the month within target timeframe	Local	100.00%	27.00%	27.00%	33.00%	33.00%	33.00%	100.00%	36.00%	40.00%	27.00%	37.00%	29.00%		
	Total Complaints received in the month	Monitor	-	55	25	14	10	5	0	513	242	136	84	38		
	Inpatient complaints per 1000 bed days	Monitor	-	-	-	-	-	-	-	-	-	-	-	-		
	Total Concerns in the month	Monitor	-	58	22	29	3	3	-	740	315	283	63	53		
	Number of Patients Surveyed (RTM) - (Quarterly)	Local	-	546	245	280	21	-	-	1772	725	946	101	-		
	Overall, How would you rate the care you received? (RTM)	Local	-	-	-	-	-	-	-	-	-	-	-	-		
	Have You Found Someone on the Hospital Staff to Talk to About Your Worries or Fears (RTM)	Local	-	-	-	-	-	-	-	-	-	-	-	-		
	% RTM Responses That are on or Above Target (Quarterly)	Local	74.00%	59.30%	59.30%	59.30%	70.40%	-	74.00%	66.70%	63.00%	65.40%	79.00%	-		
Caring - Friends & Family	Friends & Family Test (IP Survey) - Response Rate	CQUIN	30.00%	37.90%	40.60%	34.80%	35.00%	-	30.00%	39.80%	45.60%	35.00%	36.30%	-		
	Friends & Family Test (IP Survey) - % would recommend the Service	CQUIN	-	96.60%	98.00%	95.00%	100.00%	-	-	96.40%	97.00%	95.00%	99.00%	-		
	Friends & Family Test (IP Survey) - % would not recommend the Service	CQUIN		1.00%	1.00%	1.00%	0.00%	-		0.90%	1.00%	1.00%	1.00%	-		
	Friends & Family Test (Maternity Survey) - Response Rate	CQUIN	-	17.50%	-	-	17.50%	-	-	21.40%	-	-	21.40%	-		
	Friends & Family Test (Maternity) - % Would recommend the Service	CQUIN	-	92.40%	-	-	92.40%	-	-	92.80%	-	-	92.80%	-		
	Friends & Family Test (Maternity) - % Would not recommend the Service	CQUIN		4.00%	-	-	4.00%	-		3.60%	-	-	3.60%	-		
	Friends and Family Test A & E Survey - Response Rate	CQUIN	20.00%	12.90%	12.90%	-	-	-	20.00%	20.30%	20.30%	-	-	-		
	Friends and Family Test A & E Survey - % would recommend the Service	CQUIN	-	92.20%	92.20%	-	-	-	-	88.60%	88.60%	1.10%	-	-		
	Friends and Family Test A & E Survey - % would not recommend the Service	CQUIN		6.00%	6.00%	-	-	-		6.00%	6.00%	-	-	-		
	Percentage of non-elective inpatients 75+ screened for dementia	CQUIN	90.00%	96.10%	-	-	-	-	90.00%	96.10%	-	-	-	-		

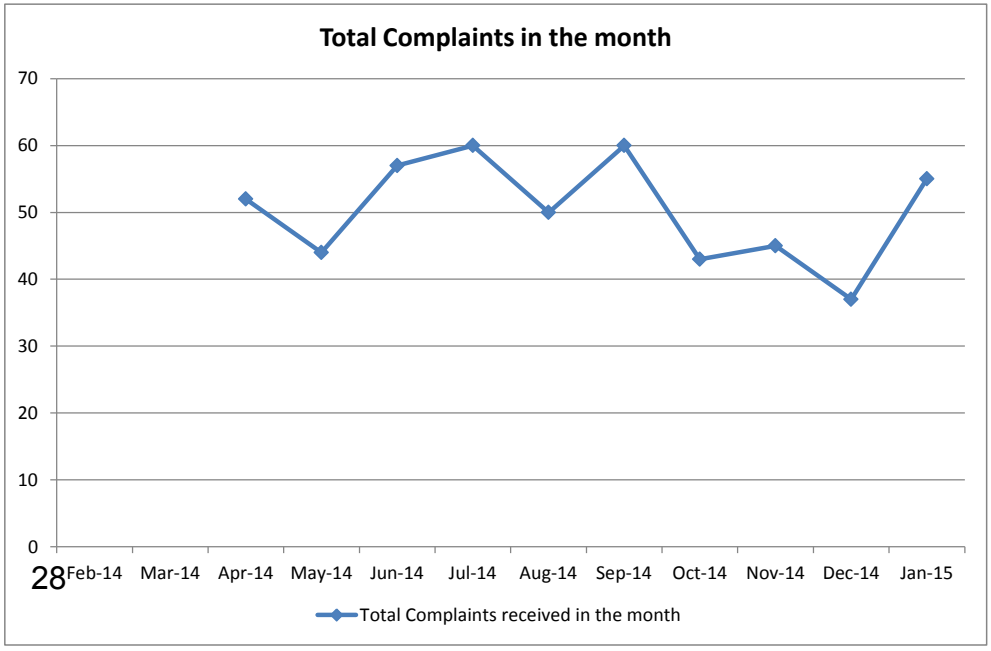
Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of Mixed Sex Accommodation Breaches	0	0	0	0	0	0
% Complaints closed in the month within target timeframe	100.00%	27.00%	27.00%	33.00%	33.00%	33.00%
Total Complaints received in the month	-	55	25	14	10	5
Inpatient complaints per 1000 bed days	-	-	-	-	-	-
Total Concerns in the month	-	58	22	29	3	3
Number of Patients Surveyed (RTM) - (Quarterly)	-	546	245	280	21	-
Overall, How would you rate the care you received? (RTM)	-	-	-	-	-	-
Have You Found Someone on the Hospital Staff to Talk to About Your Worries or Fears (RTM)	-	-	-	-	-	-
% RTM Responses That are on or Above Target (Quarterly)	74.00%	59.30%	59.30%	59.30%	70.40%	-

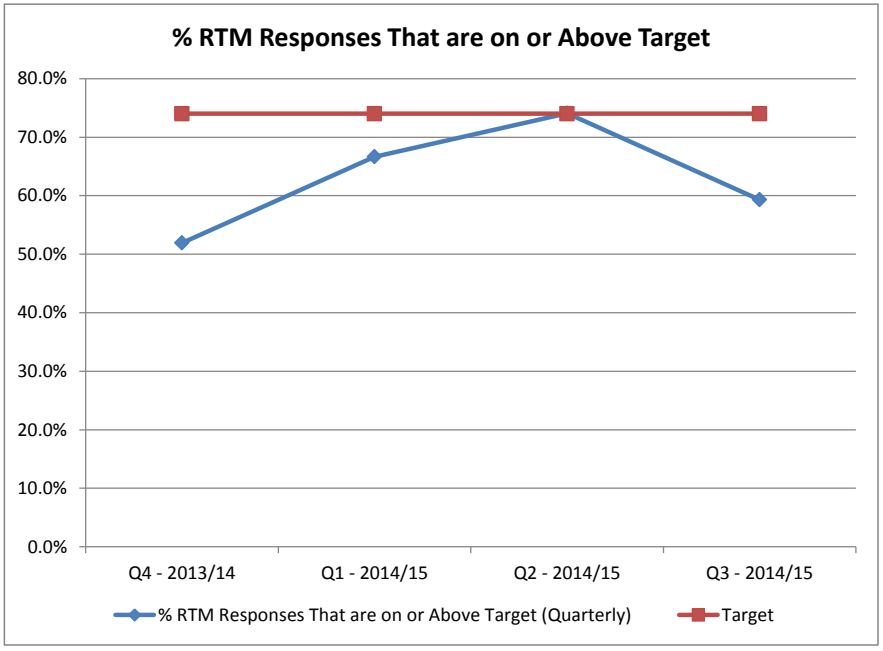
Real Time Patient Monitoring (RTPM)- PLEASE NOTE THIS IS A QUARTERLY PROCESS AND THEREFORE THIS DATA COVERS THE PERIOD OCT - DEC 2014

All Divisions are scoring green (equivalent to top 20% of Trusts nationally) for the 2 questions listed. A local target has been set for 20 of the 27 questions asked to have a RAG rated 'green' score - this equates to 74%, this has not been achieved for quarter 3. All improvement work is being monitored by the Patient Experience Group. Changes to the questions are being made to link more closely to the Patient Experience Improvement Plan

Complaints - A total of 45 complaints were closed in January compared to 65 in December. 155 cases remain open compared to 135 in December.

27% of complaints closed this month were closed within timescale. The trajectory for reducing the number of open complaints is not being achieved, weekly performance reports are now being sent to Divisions and they have been advised that performance needs to improve at a faster rate. Receipt of the first monthly Benchmark Report of our Complaints Handling carried out by the Patients Association, shows CHFT performing well in relation to the other participants for overall handling; helpfulness of staff; ease of making a complaint ; being kept informed and understanding the explanations given. CHFT had the best response in terms of feeling the truth was being told.





Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Friends & Family Test (IP Survey) - Response Rate	30.00%	37.90%	40.60%	34.80%	35.00%	-
Friends & Family Test (IP Survey) - % would recommend the Service	-	96.60%	98.00%	95.00%	100.00%	-
Friends & Family Test (IP Survey) - % would not recommend the Service	-	1.00%	1.00%	1.00%	-	-
Friends & Family Test (Maternity Survey) - Response Rate	-	17.50%	-	-	17.50%	-
Friends & Family Test (Maternity) - % Would recommend the Service	-	92.40%	-	-	92.40%	-
Friends & Family Test (Maternity) - % Would not recommend the Service	-	4.00%	-	-	4.00%	-
Friends and Family Test A & E Survey - Response Rate	20.00%	12.90%	12.90%	-	-	-
Friends and Family Test A & E Survey - % would recommend the Service	-	92.20%	92.20%	-	-	-
Friends and Family Test A & E Survey - % would not recommend the Service	-	6.00%	6.00%	-	-	-
Percentage of non-elective inpatients 75+ screened for dementia	90.00%	96.10%	-	-	-	-

The Friends and Family Test (FFT) -

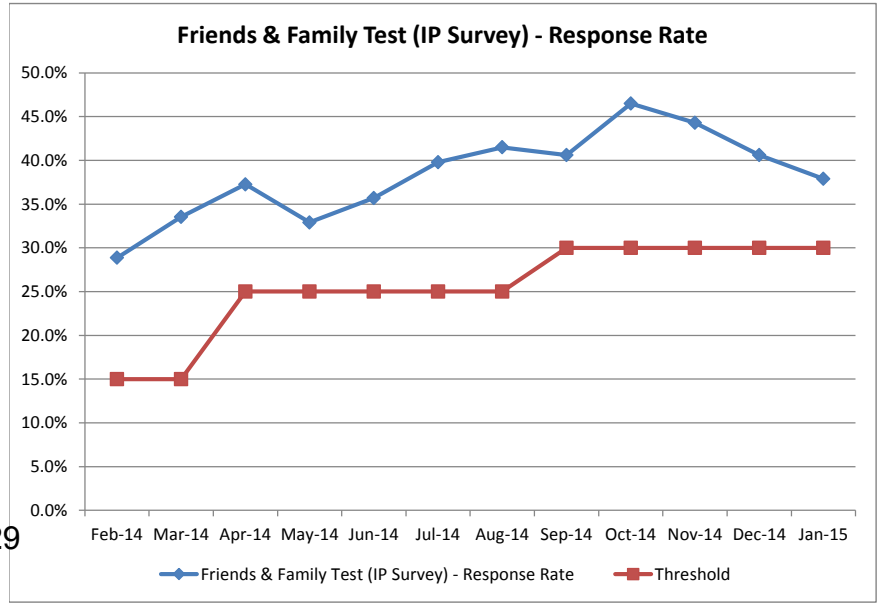
It is disappointing to note the reduction in response rate to 37.9% in January 2015, (Dec = 40.6%), with only the Surgical Division achieving the 40% stretch target.
The importance of achieving at least 40% has been reiterated to the ward staff, emphasising not only the CQUIN target, but the requirement that all patients are offered the opportunity to give feedback and the understand that the greater the response the more reliable the results.
Of note are the 9 wards which have achieved a response rate of >40% for the last 4 months (wards 8A, 8B at CRH and wards 15, 3, 10, 20, 4, 21 and 6 at HRI). Ward 8B has the highest response rate year to date, achieving 75.9%).

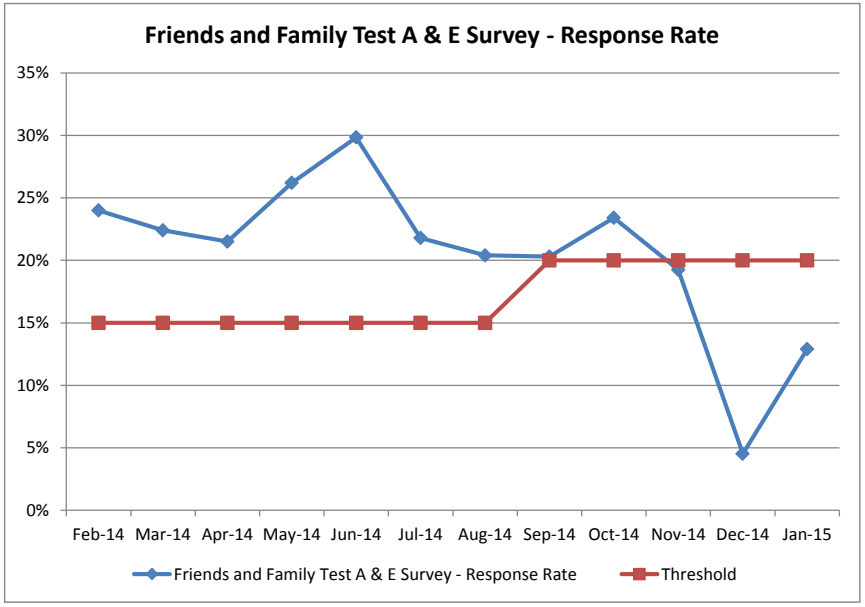
A high %age of the patients have reported that they would recommend the Trust to family and friends (96.6%) with just 1% saying they wouldn't recommend our wards.

The maternity response rate *(17.5%) is disappointing, given the significant engagement with the midwives to increase their understanding of the Test and the role they must play in promoting it. The text messaging methodology reduces the level of influence staff can play in gaining a response, it is hoped to overcome this on the postnatal wards, through a trial with tablets, asking women to complete a web based version of the survey before they go home.*

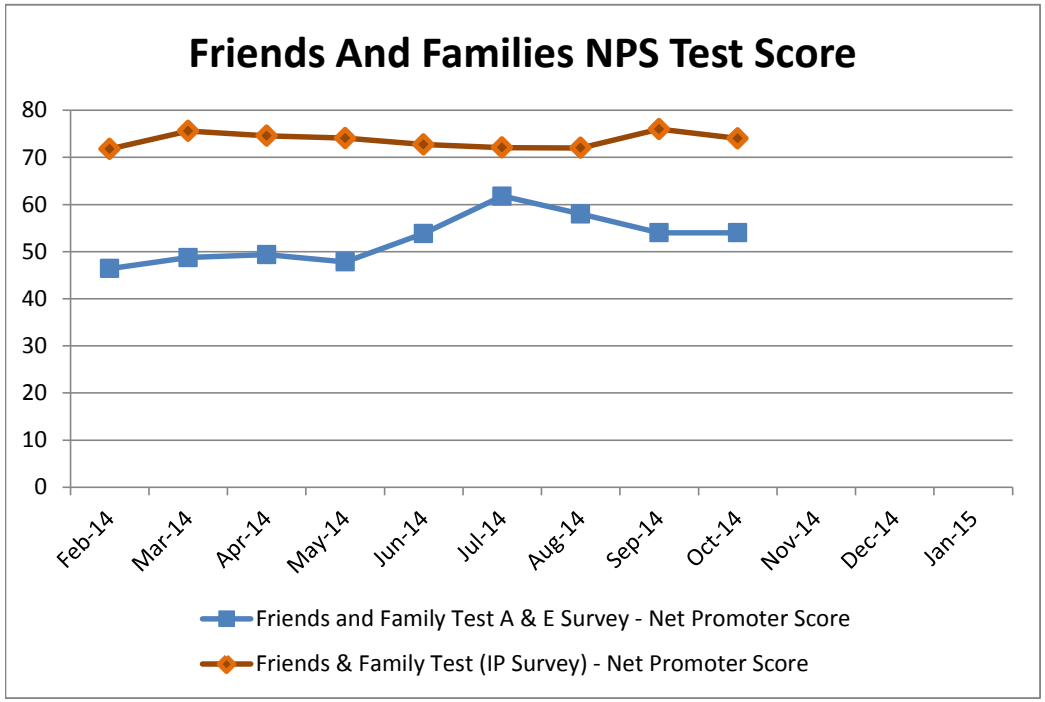
The A&E response rate *has seen some improvement this month to 12.9% from 4.5% in December 2014. However this is significantly below the 20% CQUIN target. A number of steps have been introduced, however the personal engagement from staff providing care is the most likely way of influencing a response. A response of 22.89% has been achieved for w/c 16.1.15, indicating that it is possible to achieve the 20%, however this dropped back to below 20% for the following 2 weeks. As the CQUIN is a 20% response across the quarter, there is an extreme risk of not achieving this target (current quarter to date rate = 13.7%)*

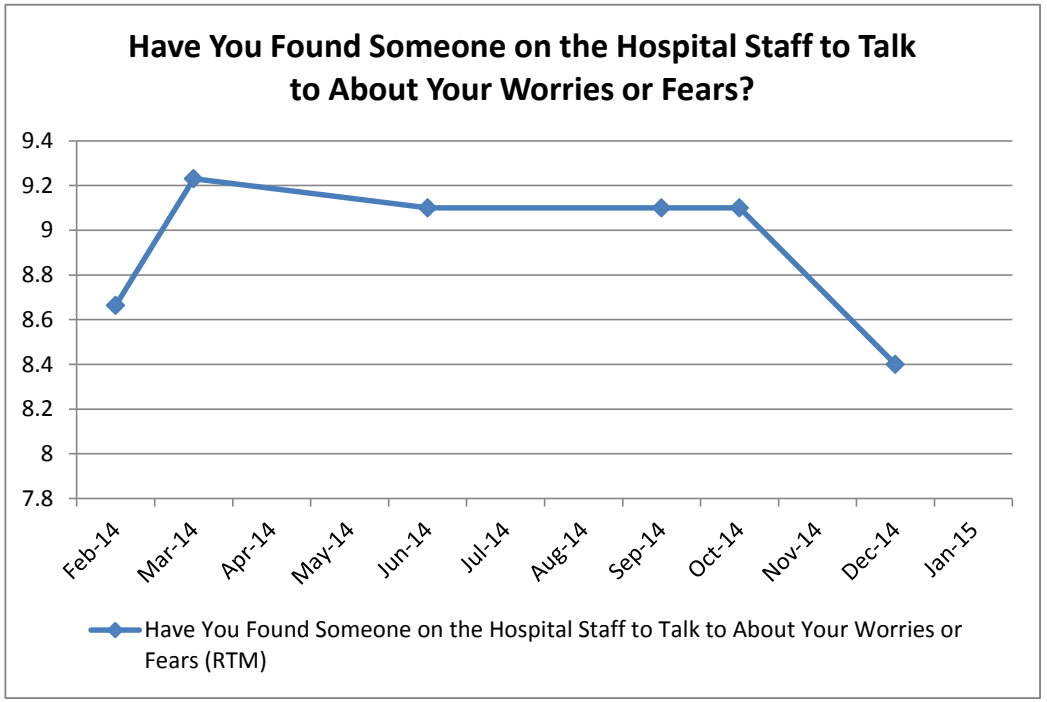
FFT is now live for both outpatients and community services

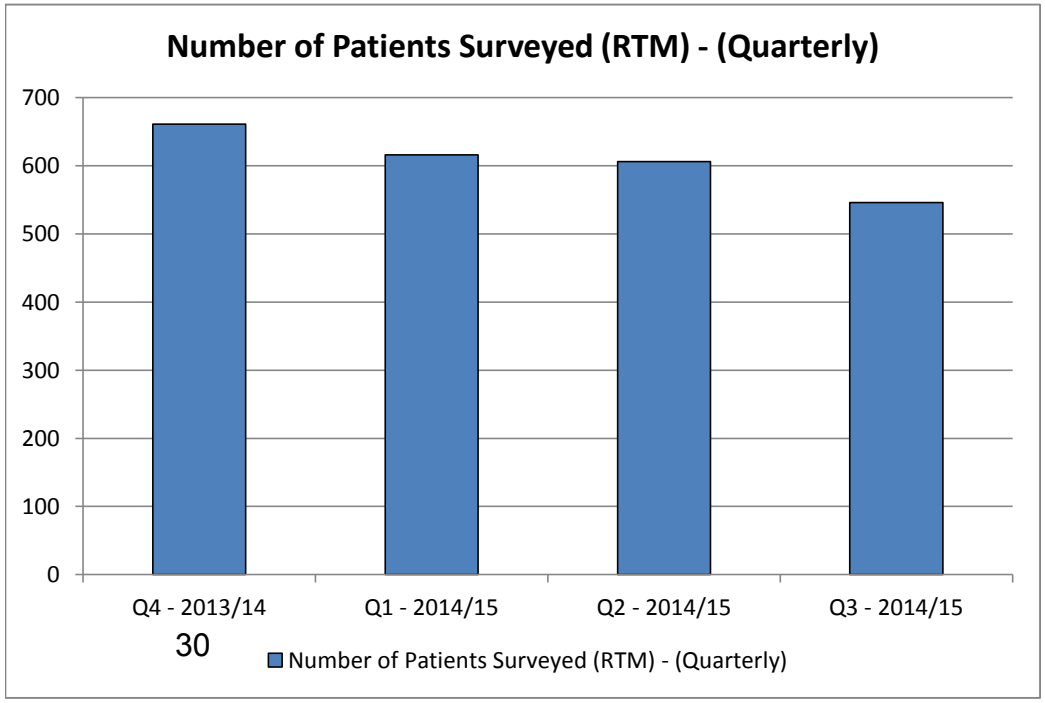


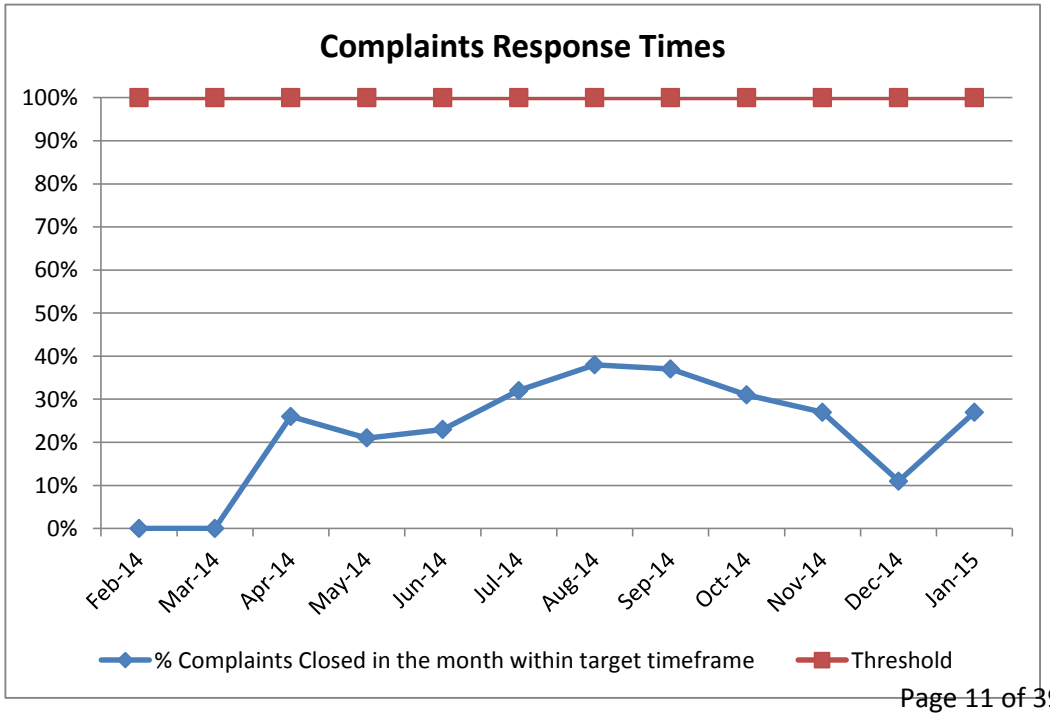


Caring - Director of Nursing









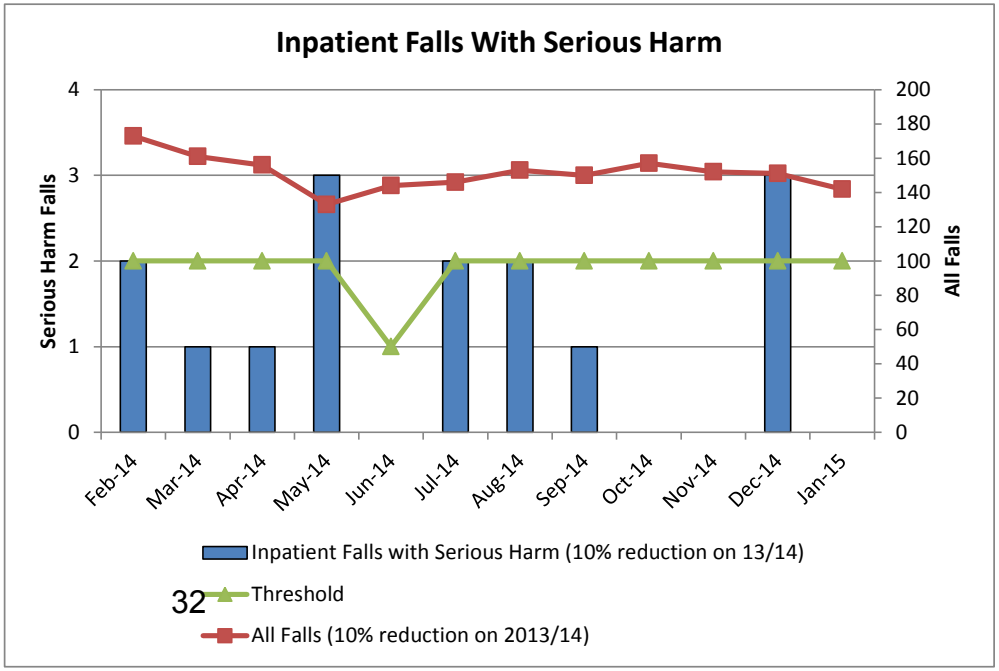
	Report For: January 2015	Indicator Source	Report For: January 2015 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Safety	Inpatient Falls with Serious Harm (10% reduction on 13/14)	Local	2	0	0	0	0	-	18	12	4	8	0	-		
	All Falls (10% reduction on 2013/14)	Local	112	142	36	105	1	-	1119	1483	309	1142	32	-		
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	11	17	3	14	0	-	108	157	59	97	1	-		
	Number of Grade 2 Pressure Ulcers Acquired at CHFT	Local	7	8	2	6	0	-	73	110	47	62	1	-		
	Number of Grade 3 Pressure Ulcers Acquired at CHFT	Local	0	9	1	8	0	-	0	45	12	33	0	-		
	Number of Grade 4 Pressure Ulcers Acquired at CHFT	Local	0	0	0	0	0	-	0	2	0	2	0	-		
Safety 2	Percentage of Completed VTE Risk Assessments	National	95.00%	95.20%	94.30%	94.80%	97.70%	100.00%	95.00%	95.30%	94.00%	95.40%	98.30%	100.00%		
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	National	100.00%	100.00%	100.00%	100.00%	-	-	100.00%	100.00%	100.00%	100.00%	100.00%	-		
	% Harm Free Care	CQUIN	95.00%	93.56%	95.40%	87.53%	100.00%	-	95.00%	93.70%	94.76%	90.88%	99.74%	-		
	Missed Doses		5.00%	8.10%	5.06%	5.15%	14.94%	-	5.00%	8.10%	5.06%	5.15%	14.94%	-		
Safety 3	Number of Patient Incidents	Monitor	-	528	154	261	99	14	0	5693	1467	2774	1094	313		
	Number of SI's	Monitor	-	13	0	13	0	0	0	71	12	55	4	0		
	Number of Incidents with Harm	Monitor	-	138	35	67	34	2	0	1324	313	723	237	44		
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		
	Serious hazards of transfusion	Local	0	1	0	0	1	0	0	6	1	0	2	3		
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	-	100.00%	-	-	-	-	-	-	-	-		
	Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	Local	100.00%	50.00%	100.00%	66.00%	50.00%	-	-	-	-	-	-	-		
	Total Duty of Candor reported within the month		-	6	3	3	0	0	-	6	3	3	0	0		
	Total Duty of Candor outstanding at the end of the month		-	3	1	2	-	-	-	3	1	2	-	-		

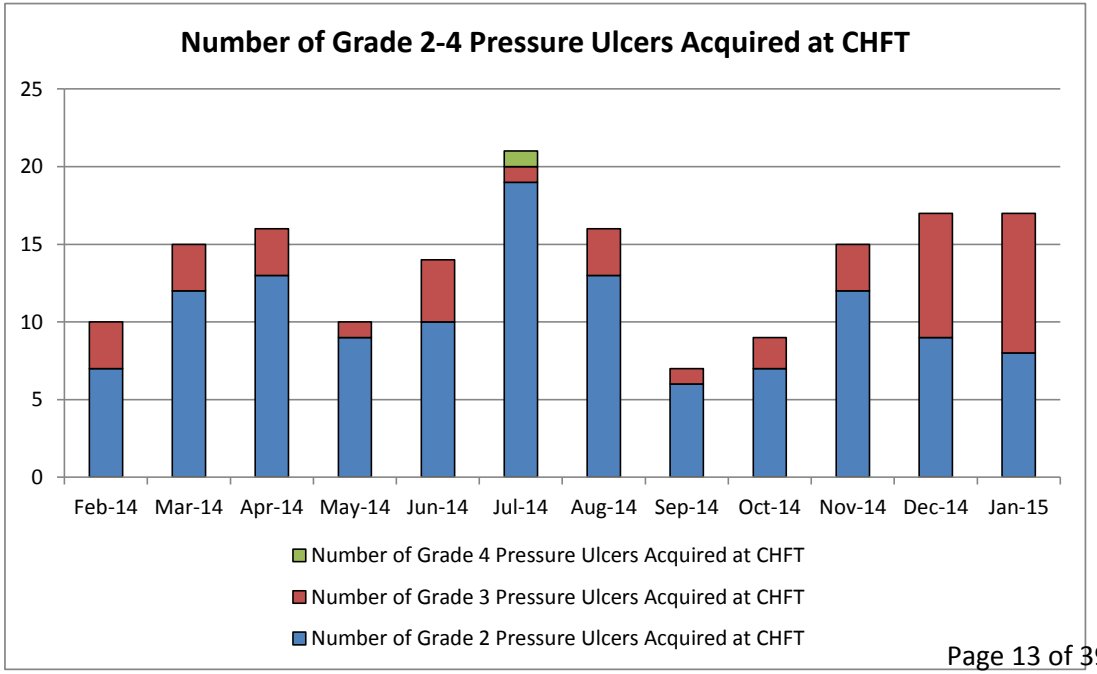
Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Inpatient Falls with Serious Harm (10% reduction on 13/14)	2	0	0	0	0	-
All Falls (10% reduction on 2013/14)	112	142	36	105	1	-
Number of Trust Pressure Ulcers Acquired at CHFT	11	17	3	14	0	-
Number of Grade 2 Pressure Ulcers Acquired at CHFT	7	8	2	6	0	-
Number of Grade 3 Pressure Ulcers Acquired at CHFT	0	9	1	8	0	-
Number of Grade 4 Pressure Ulcers Acquired at CHFT	0	0	0	0	0	-

Pressure Ulcers

This month's hospital acquired pressure ulcer incidents is above the internally set 10% improvement target. It is unlikely that the year end target will be met as the threshold for the year is 134 and at the end of December the number is 125. Targets for 2015/16 are to be agreed at the Patient Safety Group (this will be dependent on agreed CQUIN measures). A review of pressure ulcer incidents will be undertaken for November and December to identify why there has been an increase in incidents. The improvement plan includes targeted training on pressure ulcer prevention to the wards with highest levels of incidents, installation of higher specification pressure relieving mattress at HRI & the pressure ulcer group will consider an implementation plan for a new risk assessment tool.

Patient Falls - This month the surgical division have reported 33 falls; ward 19 have had 6 falls and ward 20 gave had 7. there are 95 falls reported from the medical division, with MAU at HRI and 5AD at CRH reporting 11, 6BC at HRI has reported 12. The Trust has exceeded the target with regard to the number of falls reported, however with no reported harm falls this Trust target remains under trajectory. Care bundles for falls prevention and post falls action are now in place on all wards along with the nursing care plan for reducing falls risk, training has also been provided. Audit of use was very disappointing and it has now been agreed with the Director of nursing to target some areas where risks are high and to learn what works. Initially to work with the team on ward 5 HRI who have used Safety Briefings to dramatically reduce their falls, to understand how to spread this good practice to other wards. This work will take place over the next 6 weeks.





Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Percentage of Completed VTE Risk Assessments	95.00%	95.20%	94.30%	94.80%	97.70%	100.00%
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	100.00%	100.00%	100.00%	100.00%	-	-
VTE Prophylaxis Compliance			Indicator in development			
% Harm Free Care	95.00%	93.56%	95.40%	87.53%	100.00%	-
Safeguarding Alerts made by CHFT		14	-	-	-	-
Safeguarding Alerts made against CHFT		5	-	-	-	-
Missed Doses	5.00%	8.10%	5.06%	5.15%	14.94%	-

VTE Risk Assessments - There is an on-going issue with the collection and validation of this data set, whilst there is no concern that VTE risk assessment is below target in any division a manual note pull is required at present to verify the numbers. Detailed scoping is being undertaken to include VTE risk assessment and review on to the nerve centre handover module. This will ensure junior doctors undertake the assessment & review and will allow access to a live data set so any areas of concern can be addressed.

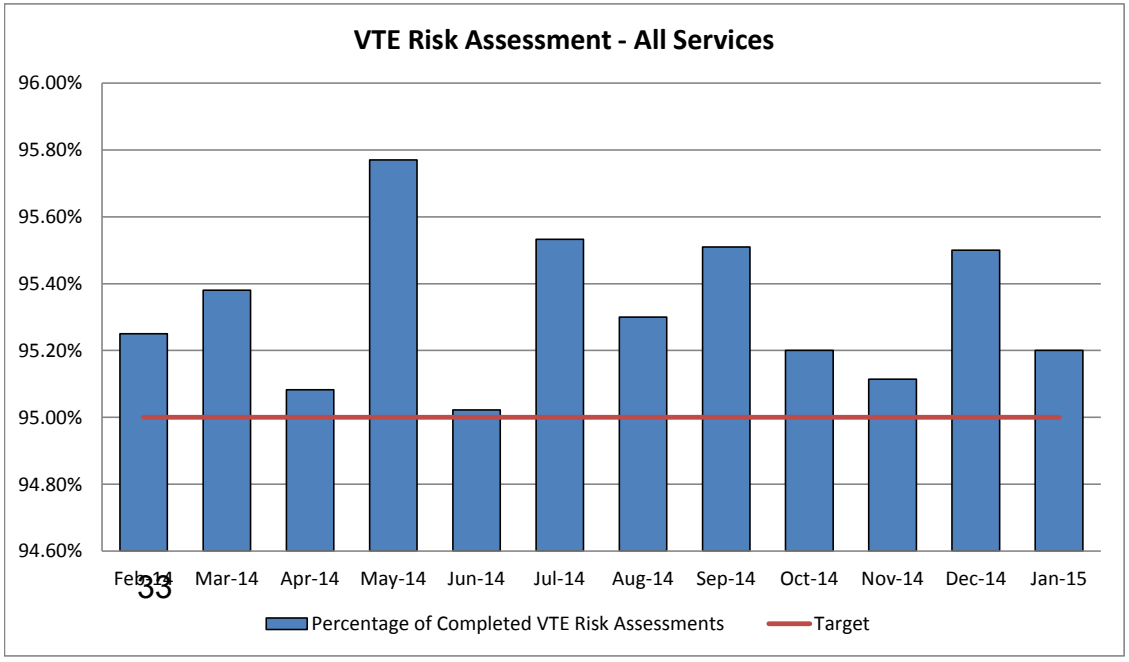
Harm Free Care - Monthly Point prevalence audits are carried out across the whole trust including community areas on the second Wednesday of each month. Improvement work is on-going on all the harm metrics captured to reduce prevalence; attempts are being made to validate the pressure ulcer metric. Because of the nature of the sampling monthly variation is to be expected. This is the final year of this CQUIN, it will move to become part of the standard Trust contract from April however the exact scope of this won't be clear until the contract is published.

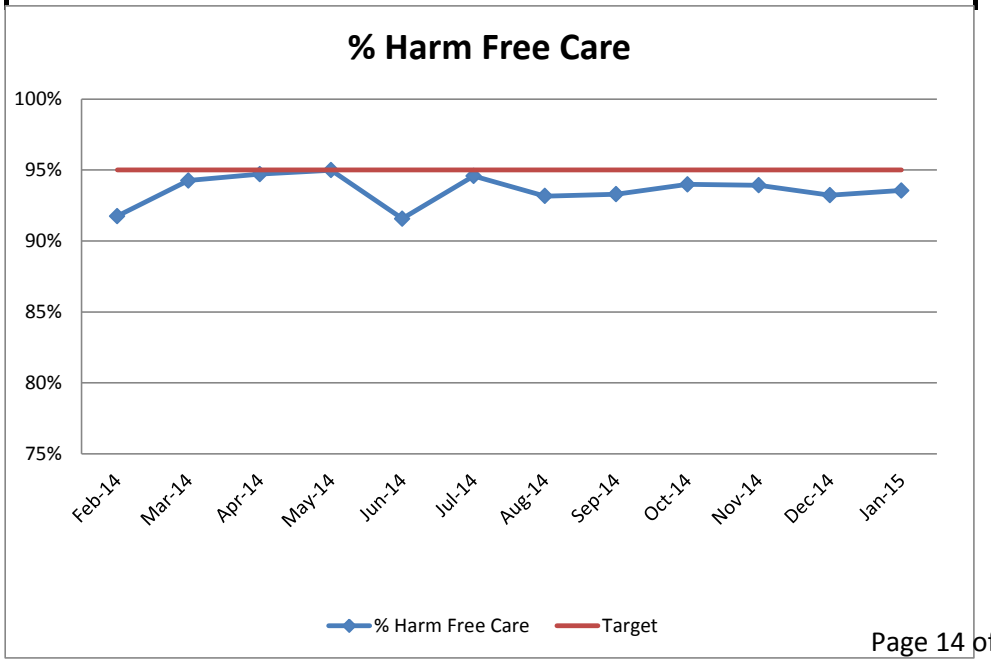
VTE RCA'S - There were 22 HAT episodes in January, all had a stage one RCA with no stage two's identified. The outstanding RCA from November has now been completed resulting in 100% compliance for stage one RCA's for 2014/15.

Safeguarding Alerts made by CHFT (against other providers)
7 – pressure ulcer / pressure damage related, 2 – medication issues, 1 – financial abuse, 1 – self neglect, 1 – delay in seeking medical advice, 1 – neglect of care needs, 1 – breach of patient confidentiality / dignity (derogatory remarks on face-book)

Safeguarding Alerts made against CHFT by other providers:
2 – 'missed' fractures, 2 – discharge issues, 1 – 'rough' handling, 1 – pressure ulcer

Missed doses – 1/4ly data collection, showed some improvement 8.1% from 9.25% in September 14. The number of missed doses due to poor record keeping has improved from 386 Sept 14 to 338 Dec 14 but remains high in comparison with 145 in June 14.Improvement work in the next quarter will focus on record keeping . From focussed investigation we know that issues around the transfer of medicines with patients moving from one ward to another is a significant cause of missed doses. Work to improve this process will form the basis for further improvement work for the next quarter.





Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS	Estates and Facilities	Corporate
Number of Patient Incidents	-	528	154	261	99	14	0	0
Number of SI's	-	13	0	13	0	0	0	0
Number of Incidents with Harm	-	138	35	67	34	2	0	0
Never Events	0	0	0	0	0	0	0	0
Percentage of SI's reported externally within timescale (2 days)	100.00%	100.00%	-	100.00%	-	-	-	-
Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	100.00%	50.00%	100.00%	66.00%	50.00%	-	-	-
Total Duty of Candor reported within the month	-	6	3	3	0	0	0	0
Total Duty of Candor outstanding at the end of the month	-	3	1	2	-	-	-	-

SI's reported to CCG: 13 serious incidents were reported to the CCG; all related to Category 3 pressure ulcers.

SI Incidents reported within 2 days: All 13 serious incidents were reported within the 48 hour timescale.

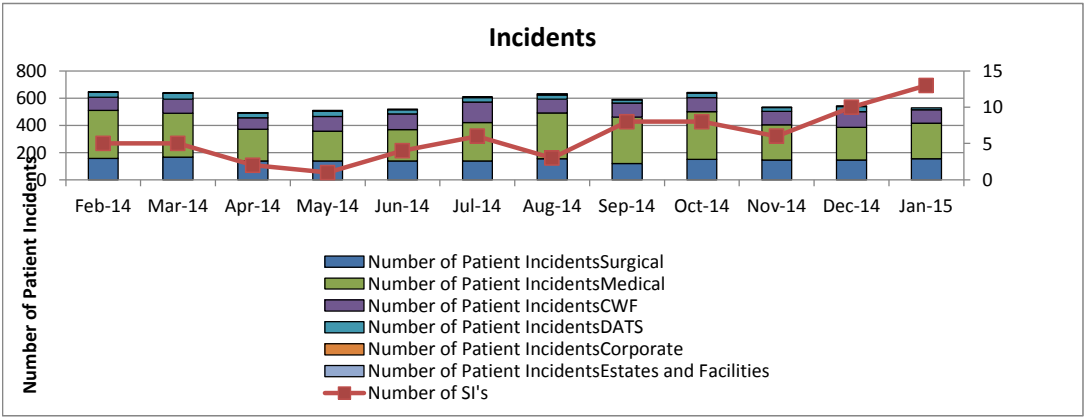
SI Incident reports submitted within timescale (45 days or within agreed extension): Of the 6 reports due for submission in January:

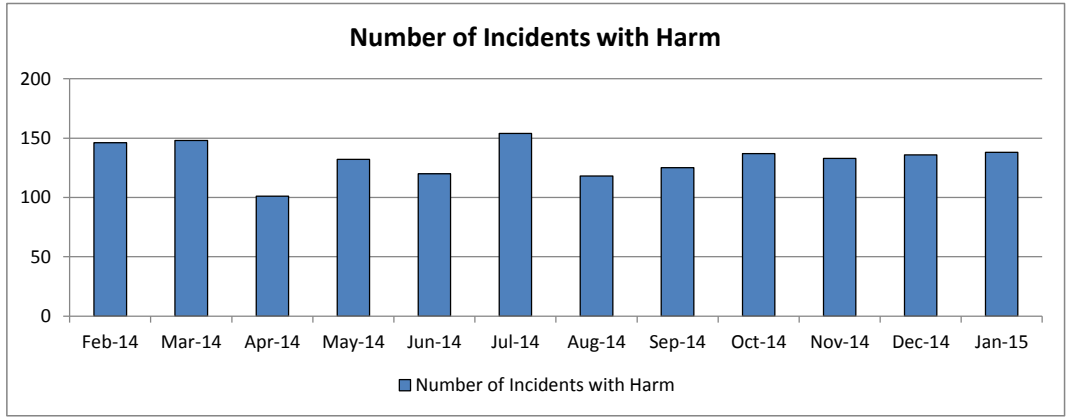
CWF - of 2, 1 was submitted 3 days late, the other was submitted on time.

Medical - of the 3 due: 1 was submitted early, the other 2 were submitted late (1 x 7 days late, 1 x 9 days late). SAS - The one due was submitted early.

SAS - The one due was submitted early.

Duty of Candour: On 27 November the Statutory Duty of Candour came into effect. From December we have been recording our compliance against this and have developed a monitoring tool to ensure this is captured. The figures for January show that there are 6 cases, of these 3 related to post 48hr C.Diff cases. DOC letters were sent for the 3 non-C.Diff cases. Confirmation was given on 5 February that DOC applied to C.Diff/MRSA and pressure ulcer cases. The monitoring of this is still in its early stages and we are continually liasing with Divisions to ensure that we are able to record the date that contact with the patient/carer was made. It is expected that recording of our compliance improves over the next month. From January 2015, the orange and serious incident registers have been sent to each Division to enable them to ensure that all reporting timescales are met.





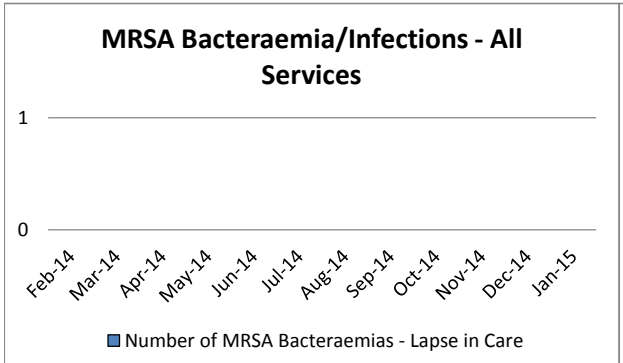
	Report For: January 2015	Indicator Source	Report For: January 2015						Year To Date						Year End Forecast	Data Quality
			Target	Trust	Surgical	Medical	CWF	DATS	Target	Trust	Surgical	Medical	CWF	DATS		
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National	0	0	0	0	0	0	0	0	0	0	0	0		
	Total Number of Clostridium Difficile Cases	National	1	3	1	2	0	0	18	22	7	13	2	0		
	Total Number of Clostridium Difficile Cases – Trust assigned	National	0	1	1	0	0	0	0	7	6	1	0	0		
	Unavoidable Number of Clostridium Difficile Cases	National	1	2	0	2	0	0	18	15	3	11	1	0		
	Number of MSSA Bacteraemias - Post 48 Hours	National	2	2	1	1	0	0	24	9	2	6	1	0		
	% Hand Hygiene Compliance	Local	95.00%	99.96%	99.91%	100.00%	100.00%	100.00%	95.00%	99.82%	99.57%	99.99%	100.00%	99.90%		
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	96.40%	95.38%	99.32%	100.00%	-	95.00%	98.00%	95.00%	99.00%	98.00%	-		
	Number of E.Coli - Post 48 Hours	Local	2	3	0	3	0	0	20	20	7	13	0	0		
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.50	1.32	-	-	-	-	1.50	0.97	-	-	-	-		
Effectiveness 2	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.54%	7.56%	5.20%	11.19%	7.57%	0.00%	7.41%	7.37%	4.75%	11.85%	6.06%	4.55%		
	Local SHMI - Relative Risk - (1yr Rolling Data)	National	100	110	-	-	-	-	100	111	-	-	-	-		
	Hospital Standardised Mortality Rate	National	100.00	106.21	-	-	-	-	-	-	-	-	-	-		
	Rebased HSMR	National	-	-	-	-	-	-	-	-	-	-	-	-		
	Crude Mortality Rate	National	1.00%	1.57%	0.52%	4.18%	0.07%	0.00%	1.14%	1.26%	0.47%	3.27%	0.12%	0.00%		
	Average Diagnosis per Coded Episode	National	4.9	4.10	3.52	5.91	2.32	3.77	4.9	4.06	3.62	5.70	2.38	3.41		
Effectiveness 3	Number of Unplanned Adult Admissions to ITU		-	36	-	-	-	-	-	482	0	0	0	0		
	No of Spells with > 2 Ward Movements	local	-	147	20	90	37			1357	202	858	297			
	% of spells with > 2 ward movements (2% Target)	local	2.00%	2.46%	1.33%	5.15%	1.36%		2.00%	2.31%	1.27%	5.14%	1.13%			
	No of Spells with > 3 Ward Movements	local	-	36	6	25	5			368	47	272	49			
	% of spells with > 3 ward movements (No Target)	local	-	0.60%	0.40%	1.43%	0.18%			0.63%	0.30%	1.63%	0.19%			
	No of Spells with > 4 Ward Movements	local	-	6	1	4	1			129	15	104	10			
	% of spells with > 4 ward movements (No Target)	local	-	0.10%	0.07%	0.23%	0.04%			0.22%	0.09%	0.62%	0.04%			
	No of Spells with > 5 Ward Movements	local	-	4	0	3	1			39	4	31	4			
	% of spells with > 5 ward movements (No Target)	local	-	0.07%	0.00%	0.17%	0.04%			0.07%	0.03%	0.19%	0.02%			
	Total Number of Spells	local	-	5978	1503	1746	2729			58829	15893	16680	26256			
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	70.00%	70.00%	-	-	-	85.00%	62.92%	62.92%	-	-	-		

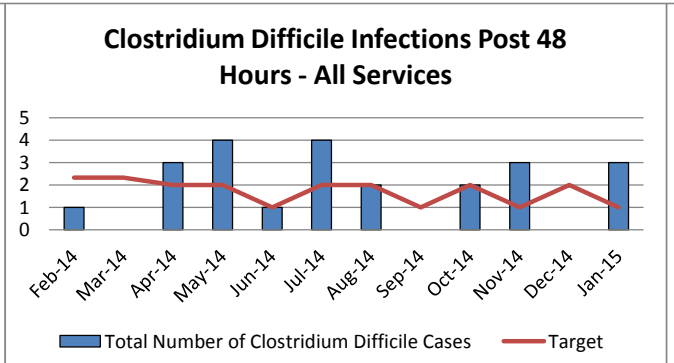
Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0
Total Number of Clostridium Difficile Cases	1	3	1	2	0	0
Total Number of Clostridium Difficile Cases – Trust assigned	0	1	1	0	0	0
Unavoidable Number of Clostridium Difficile Cases	1	2	0	2	0	0
Number of MSSA Bacteraemias - Post 48 Hours	2	2	1	1	0	0
% Hand Hygiene Compliance	95.00%	99.96%	99.91%	100.00%	100.00%	100.00%
MRSA Screening - Percentage of Inpatients Matched	95.00%	96.40%	95.38%	99.32%	100.00%	-
Number of E.Coli - Post 48 Hours	2	3	0	3	0	0
Central Line Infection rate per 1000 Central Venous Catheter days	1.50	1.32	-	-	-	-

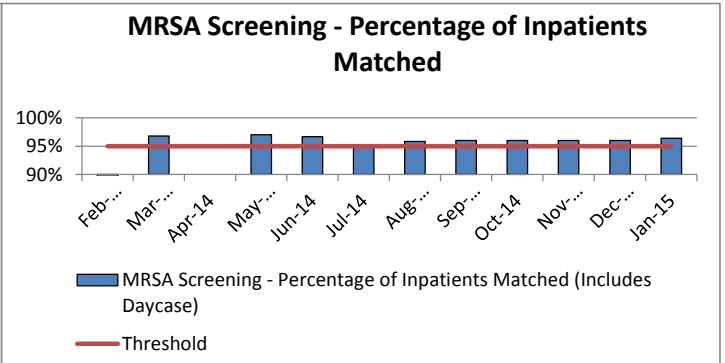
C difficile – 3 post admission cases in January with a YTD total of 25 cases against a ceiling of 18. Of these, 15 have been classed as unavoidable and 8 classed as avoidable (2 pending). The majority of cases are sporadic and could not have been prevented. The pilot of the 'nerve centre' is expected to identify patients with diarrhoea and prompt timely isolation Recent avoidable cases identified issues around cleaning and staffing. Action plans produced from each RCA for Action plans produced from each RCA for scrutiny at Infection Control Performance Board.

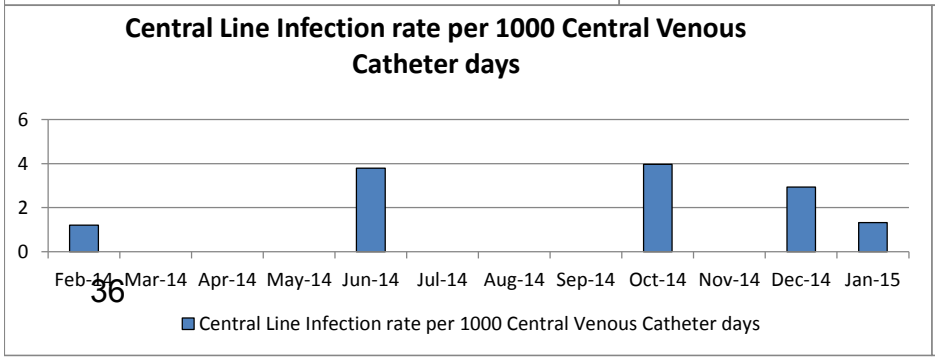
MSSA – there were two MSSA cases in January, one case was a line infection and currently being investigated by RCA. We are still on track to meet the year-end target.

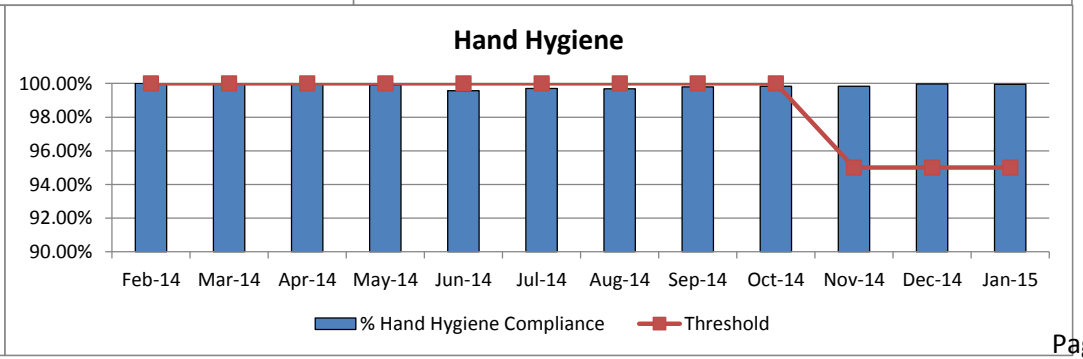
E.Coli - 3 cases in January so 20 in total this year against the target of 23. 1 cases was a relapse; 1 case was due to a respiratory infection and the other sepsis of unknown cause. Further scrutiny of cases is taking place to establish areas of learning. There is a risk this internal year-end target will not be met.











Effectiveness - Medical Director

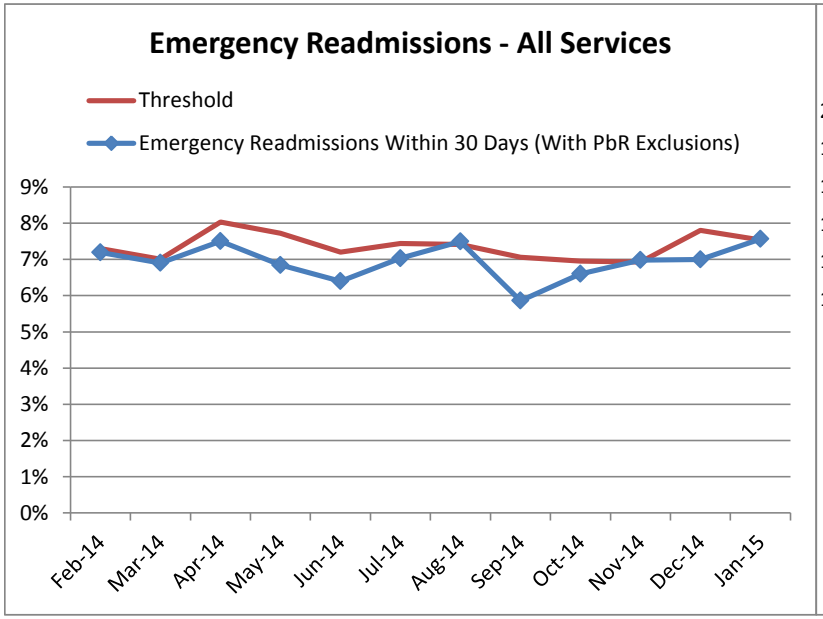
Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Emergency Readmissions Within 30 Days (With PbR Exclusions)	7.54%	7.56%	5.20%	11.19%	7.57%	0.00%
Local SHMI - Relative Risk - (1yr Rolling Data)	100	110	-	-	-	-
Hospital Standardised Mortality Rate	100	106.21	-	-	-	-
Rebased HSMR	-	-	-	-	-	-
Crude Mortality Rate	1.00%	1.57%	0.52%	4.18%	0.07%	0.00%
Average Diagnosis per Coded Episode	4.9	4.10	3.52	5.91	2.32	3.77

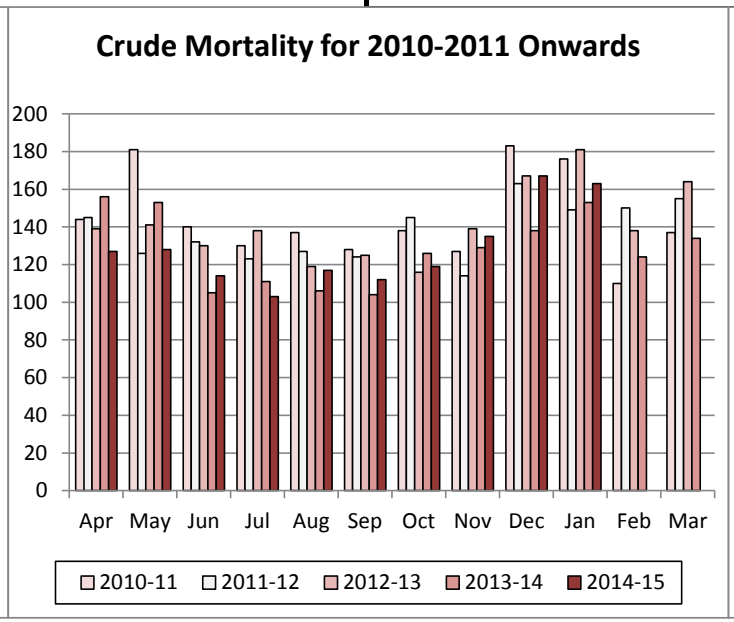
Readmissions - Readmissions target is an overall elective and emergency trust level target which takes into account the difference in patient cohort into each division. The target level varies each month and is based on the same point last year. Although whilst slightly outside the in-month target range our current YTD performance is within the target level at 7.37% against a YTD target of 7.41% . Work continues through the task and finish group to monitor and ensure focus on delivery.

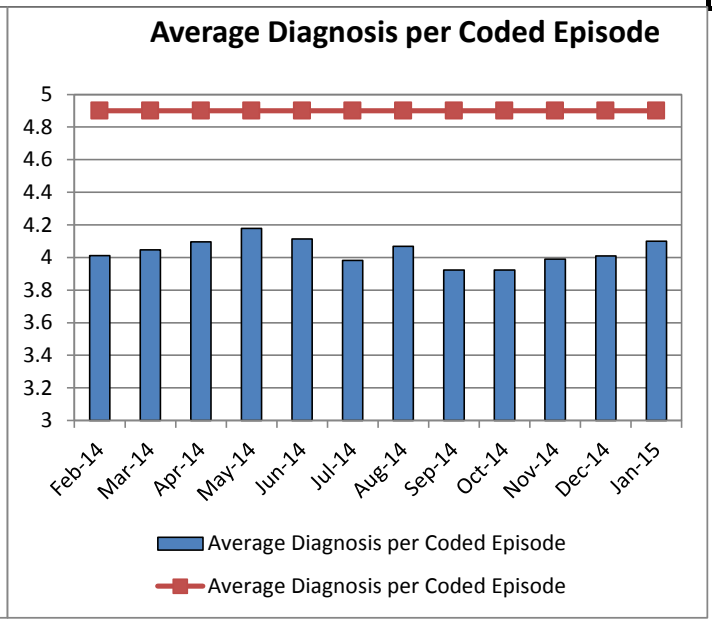
SHMI - SHMI is published quarterly, and reported as a rolling 12 month figure. The most recent released indicated a SHMI of 110 the 12 months of July 13 to June 14. This has reduced from the 111 published in April 13 - March 14. .
HSMR – This score is now coming from the Healthcare Data Evaluation (HED) system and is measured against a national average of 100. The most recent 12 months data indicates a score of 106.21. Work continues on The Care of the Acutely Ill Patient programme and the eight key themes which will help to reduce both SHMI and HSMR. These include reliable implementation of care bundles, focus on frail patients, coding and condition specific work where mortality rates appear to be outlying.

Crude Mortality - The rise in Crude mortality for Dec 14 has been noted (the highest since Dec 13) . Extra resources have been put into the mortality review process with the aim of achieving 95% compliance for all deaths to be reviewed. As of 13th February 74% had undergone review with 8 cases requiring more in depth investigation. A full report will be submitted to clinical outcomes group and Quality Committee in March 15.

Coding - Improvement work around capture of co morbidities has been taking place, initial work has focussed on the Medical division with a new proforma included in the admission documentation. This document will be in place across all admitting areas from 23rd February 2015. Performance reports will be sent into division every 2 weeks for action.







Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of Unplanned Adult Admissions to ITU	-	36	-	-	-	-
No of Spells with > 2 Ward Movements	-	147	20	90	37	-
% of spells with > 2 ward movements (2% Target)	2.00%	2.46%	1.33%	5.15%	1.36%	-
No of Spells with > 3 Ward Movements	-	36	6	25	5	-
% of spells with > 3 ward movements (No Target)	-	0.60%	0.40%	1.43%	0.18%	-
No of Spells with > 4 Ward Movements	-	6	1	4	1	-
% of spells with > 4 ward movements (No Target)	-	0.10%	0.07%	0.23%	0.04%	-
No of Spells with > 5 Ward Movements	-	4	0	3	1	-
% of spells with > 5 ward movements (No Target)	-	0.07%	0.00%	0.17%	0.04%	-
Total Number of Spells	-	5978	1503	1746	2729	-
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	70.00%	70.00%	-	-	-

Fracture Neck of Femur Target - This is away from target predominantly due to the lack of theatre capacity, and surgeons available to deliver the operations. Further work will be undertaken as part of the theatres PMO, and this methodology will be used to identify timescales.

Achieving the Target

i/ Priority given to fracture neck of femur patients when scheduling trauma lists

ii/ Careful observation of admission times and list ordering to maximize those patients operated on in 36 hours.

iii/ Use of a BPT spreadsheet to visualize compliance for all patients

iv/Trauma lists extended to 7 days a week all day, with appropriate job planning to allow this.

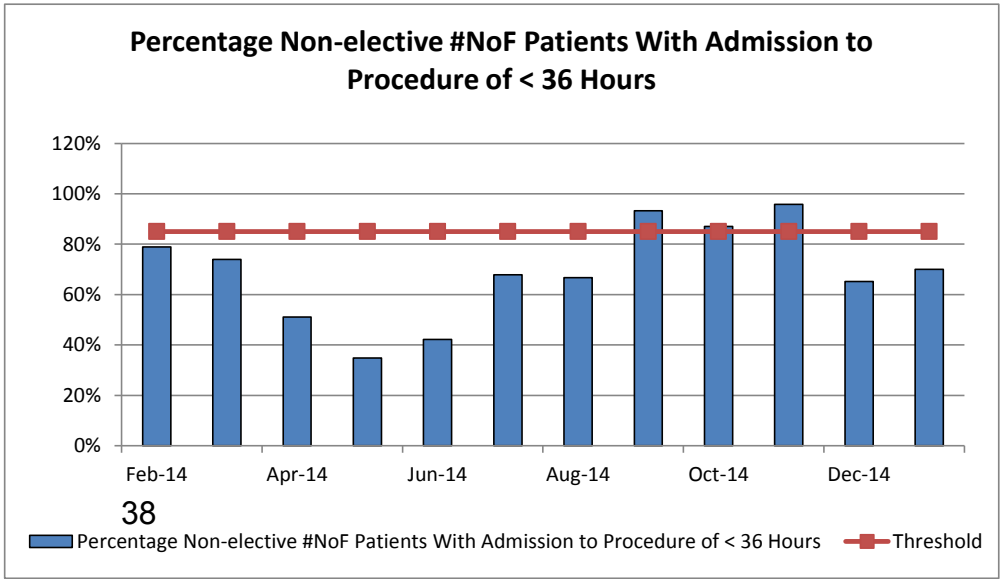
v/Trauma lists start time brought forward to 08.30

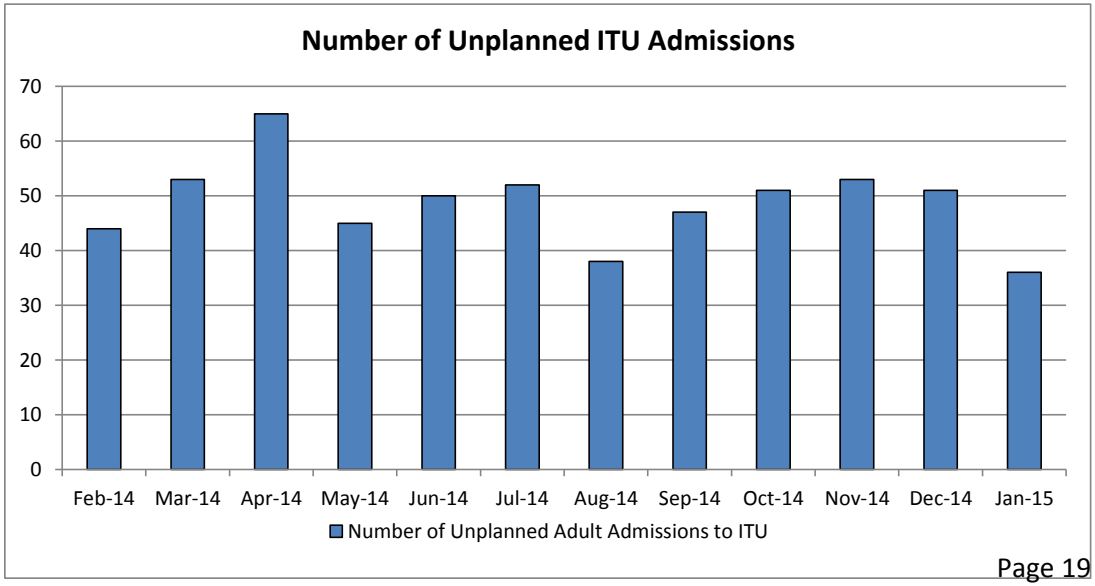
vi/ 2 anaesthetists allocated to weekday trauma list to reduce downtime

vii/ No trauma list lunch break to maximize operating time.

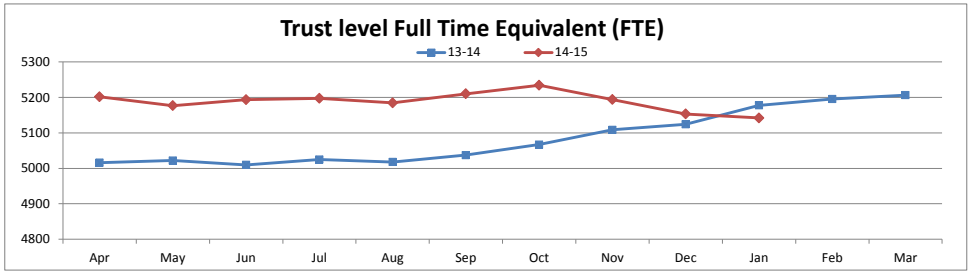
viii/ Transfer or admission of some trauma patients to CRH for surgery to increase fracture neck of femur capacity in HRI and to fill under utilized elective lists in CRH.

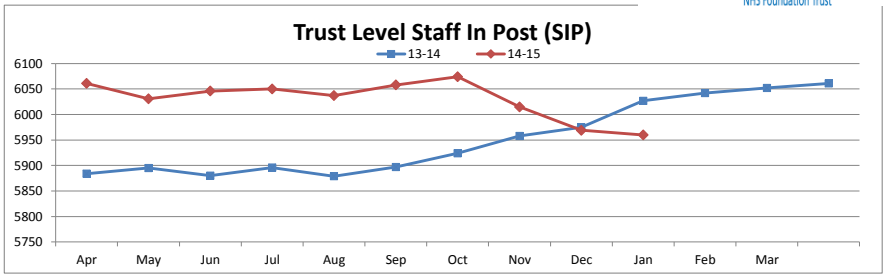
ix/ Flexible upper limb trauma operating to prioritize fracture neck of femur patients. Use of a second theatre where possible for this work.

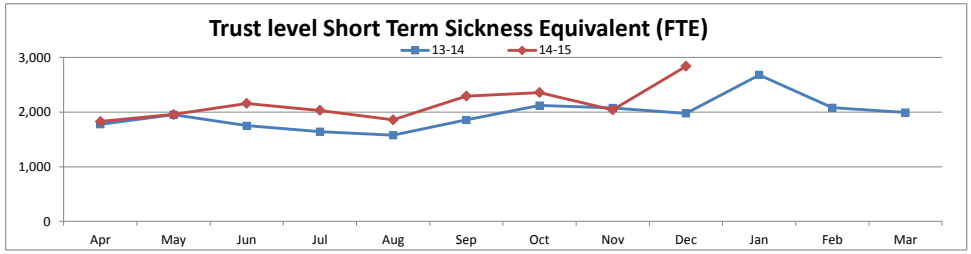


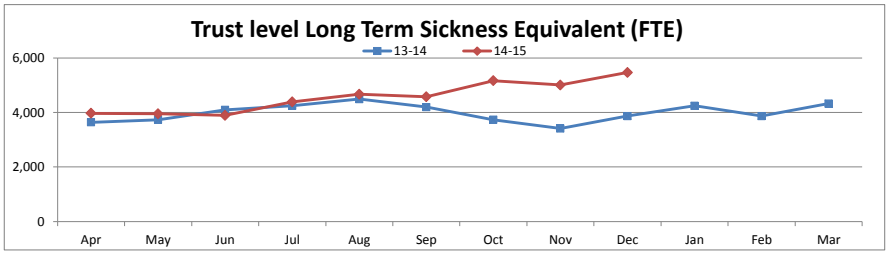


Well Led / Workforce - Director of Workforce and Organisational Development









Director Lead	Report For: January 2015	Trust Threshold	Trust Actual	Surgery	Medical	CWF	DATS	Estates	Corporate	THIS
J.H	Sickness Absence rate (%) (1 Month Behind)	4.00%	5.20%	4.40%	5.92%	6.35%	4.11%	7.09%	3.00%	3.85%
J.H	Sickness Absence rate (FTE Lost) (1 Month Behind)		8309.76	1821.77	2978.51	1570.85	808.46	644.32	262.16	223.70
J.H	FTE Days Available (1 Month Behind)		159404.43	41260.80	50365.16	24596.10	19626.00	9021.49	8868.70	5666.18
J.H	Sickness Absence rate (%) - Nursing (1 Month Behind)	4.00%	5.66%	4.61%	5.03%	7.74%	13.29%	-	2.86%	-
JH	Total Staff in Post (FTEs)		5,142.08	1,330.99	1,624.68	793.42	633.10	291.02	286.09	182.78
LH	Fire Safety Awareness	95.00%	81.00%	77.20%	70.50%	85.70%	95.80%	99.20%	83.80%	93.60%
LH	Fire Risk Assessments	100.00%	Report going to board	-	-	-	-	-	-	-
MG	Information Governance - Rolling 12 Month	100.00%	73.30%	74.70%	62.80%	71.10%	87.90%	86.80%	71.30%	92.90%
JD	Risk Training - Rolling 12 Month	100.00%	67.70%	68.90%	53.90%	72.70%	73.40%	91.20%	72.90%	86.80%
JH	Appraisal Non Medical- YTD	75.00%	44.46%	27.50%	34.20%	58.10%	49.40%	94.50%	43.20%	65.90%
JH	Appraisal - Rolling 12 Month	100.00%	72.61%	69.72%	63.64%	74.63%	78.82%	96.27%	74.29%	88.89%
DB	Appraisal Medical- YTD	100.00%	44.42%	42.40%	37.50%	47.70%	71.90%	-	100.00%	-
DB	Medical devices training	95.00%	81.00%	75.00%	76.00%	82.00%	80.00%	-	91.00%	-
JD	Safeguarding - Level 1 - Staff compliant		60.40%	61.40%	46.60%	66.60%	62.20%	86.30%	73.30%	73.50%
JD	Safeguarding - Level 2 - Staff compliant		49.60%	53.60%	57.00%	24.20%	56.70%	82.50%	54.80%	0.00%
JD	Safeguarding - Level 3 - Staff Compliant		78.90%	58.30%	82.60%	69.70%	80.00%	-	85.00%	-
JH	FFT Staff - Response Rate (Quarterly)		6.50%	-	-	-	-	-	-	-
JH	FFTStaff - Would you recommend us to your friends and family as a place to receive		81.00%	-	-	-	-	-	-	-
JH	FFT Staff - Would you recommend us to your friends and family as a place to work?		59.00%	-	-	-	-	-	-	-
JD	Hard Truths Summary Day - Nurses/Midwives (1 Month Behind)	100.00%	81.90%	83.70%	80.20%	83.10%	-	-	-	-
JD	Hard Truths Summary - Day Care Staff (1 Month Behind)	100.00%	92.40%	90.40%	98.50%	71.30%	-	-	-	-
JD	Hard Truths Summary - Night Nurses/Midwives (1 Month Behind)	100.00%	85.90%	85.20%	83.40%	91.20%	-	-	-	-
JD	Hard Truths Summary - Night Care Staff (1 Month Behind)	100.00%	119.70%	113.20%	131.80%	85.10%	-	-	-	-

Sickness Rates - A programme of work on 'high absence incidence' service areas has commenced . An internal taskforce is working to support divisional colleagues in managing attendance. The taskforce is taking a hands-on role in developing an overall approach to effective management in these service areas and in individual cases. This approach is supported by intensive briefing of colleagues with regard to how attendance impacts on our ability to deliver safe services and high quality patient care.

A line manager toolkit has been made available and further enhanced tools are being developed (the proposal is for a multi-channel approach with an extensive intranet resource package) supported by technical HR input. A programme of line manager breakthrough events are planned focusing on what improvements to how we manage and what good practice tools/resources are needed to deliver excellent attendance at work.

Data about absence is a critical part of an effective approach and information for individual service areas about their performance is available routinely. Attention is being paid to data quality and to the availability/timeliness of absence reports. Significant improvements in access to data as well as the quality of data capture and reporting will be delivered with the full implementation of ESR manager self-serve which is currently available on a pilot basis.
To help divisions manage sickness through ESR business intelligence (B.I) reports have been created which show sickness at ward levels, identify trends and provide detailed lists of all colleague's absence on an individual basis. This process has been shared with the Medical Division and will then be shared with over divisions.

Sickness FTE days lost - Is calculated by multiplying FTE against calendar days lost in current reporting month.

Fire Safety Awareness - All areas of the Trust's two hospitals have had fire assessments carried out. Other properties for which the Trust is responsible are currently being completed and should be issued shortly. Once risk assessments are issued to departments it is essential that those departments act upon this assessment, otherwise we will be in breach of our statutory duty.

81% of colleagues are trained in fire safety awareness . Although a vast improvement in the training attendance has been achieved there are still large numbers of staff who are not compliant (over 1000).

Fire Training - A revised approach to mandatory and essential skills training has been designed and this approach will help improve and sustain compliance performance.

Fire Risk Assessments - Fire Safety Awareness - 81.0% of colleagues are trained in fire safety awareness . Fire Training Handbooks are currently being distributed out to Staff and they are asked to submit the declaration form located on the Intranet.

http://nww.cht.nhs.uk/divisions/corporate/estates-and-facilities/compliance/fire/fire-training-dates/

Fire Risk Assessments - Please see attached report.

Appraisal YTD - The monthly compliance target for appraisals is 8%. All areas forecast compliance of 100% at 31 March 2015. There is strong evidence that appraisal activity is concentrated in last 3 months of performance year. Resources provided by the Workforce Development team are still being added to the intranet available toolkit. For example, appraisal planning and appraisal preparation videos are new additions.

YTD Information Governance - The monthly compliance target for Information Governance is 6%. Information Governance training compliance is measured on a rolling year basis so figures will fluctuate throughout the year. YTD Compliance is at 71% Training awareness and compliance messages are being communicated via the Trust Information Governance and Records Strategy Group which is then cascaded throughout the divisions. There will be a final push for Training uptake during January, February and March 2015 with a yearend predication of 85%.

Hard Truths - Maintaining staffing levels has remained difficult due to the fluctuating demand. The implementation of the web based staffing tool has assisted in providing increasingly accurate and informative staffing information by ward or division at any point of the month. Further work is now underway to develop an electronic format for the daily staffing review undertaken by the site co-ordinatiors to ensure reporting and escalation processes are recorded for staffing priorities.
A focus on robust recruitment continues with events at 4 local universities planned within the next two months in addition to a further recruitment event in Spain.

FFT- This Information is for quarter 2. Friends and Family Test for Staff doesn't run in quarter 3 due to the Staff Survey.

Revised new version:

		Trust Threshold	Trust Actual
Finance	Continuity of Service Risk Rating	3	3
	Operational Performance (Debt service cover)	3	2
	Cash & Balance Sheet Performance (Liquidity)	3	3
	Use of Capital	£19.05m	£17.35m
	Income and Expenditure	£2.56m	(£2.09m)
	Cost Improvement Programme (CIP)	£14.40m	£7.35m

Calderdale and Huddersfield NHS
NHS Foundation Trust

Contract income

THIS

		Year To Date Plan		Year To Date Actual		Year To Date Variance	
Division	Monitor POD	Plan YTD - Spells	Plan YTD - Value (Inc MFF) with CQUIN	Actual 1415 - Spells	Actual 1415 -Value (Inc MFF) with CQUIN	Variance - Spells	Variance - Value (Inc MFF) with CQUIN
CWF	DAYCASE	2,133	1,358,458	1,947	1,366,213	-186	7,755
	ELECTIVE	1,207	2,038,891	887	2,046,972	-320	8,081
	NON-ELECTIVE	12,422	14,650,698	12,034	14,661,842	-388	11,144
	OTHER NHS NON-TARIFF	40,640	18,364,253	37,068	17,882,364	-3,571	-481,888
	OTHER NHS TARIFF	12,815	9,398,424	12,529	9,396,207	-286	-2,218
	OUTPATIENT	33,364	5,086,971	35,160	5,173,468	1,796	86,497
CWF Total		102,582	50,897,695	99,625	50,527,064	**-2,956**	-370,630
DATs	DAYCASE	268	248,335	223	249,809	-45	1,474
	ELECTIVE	283	483,350	276	513,767	-7	30,418
	NON-ELECTIVE	5	27,028	1	12,424	-4	-14,603
	OTHER NHS NON-TARIFF	1,178,286	7,360,224	1,168,910	7,450,598	-9,376	90,374
	OTHER NHS TARIFF	50,857	4,594,672	55,393	4,696,701	4,535	102,029
	OUTPATIENT	0	0	0	0	0	0
DATs Total		1,229,699	12,713,608	1,224,803	12,923,300	**-4,896**	209,691
Medicine	DAYCASE	8,760	4,912,434	8,313	4,941,939	-447	29,505
	ELECTIVE	752	1,623,596	818	1,571,375	66	-52,221
	NON-ELECTIVE	18,109	34,525,681	17,788	34,655,178	-321	129,497
	OTHER NHS NON-TARIFF	60,771	38,822,899	58,622	36,897,565	-2,149	-1,925,334
	OTHER NHS TARIFF	9,654	2,709,131	9,275	2,580,694	-379	-128,437
	OUTPATIENT	76,713	9,907,395	77,061	9,950,687	348	43,292
Medicine Total		174,759	92,501,137	171,877	90,597,438	**-2,882**	-1,903,699
Surgery	A&E	118,441	11,698,376	119,860	11,776,077	1,419	77,701
	DAYCASE	22,821	18,316,499	23,166	18,317,982	345	1,483
	ELECTIVE	5,805	17,138,819	5,034	16,757,268	-771	-381,550
	NON-ELECTIVE	11,749	20,435,519	10,931	20,436,363	-818	843
	OTHER NHS NON-TARIFF	30,474	10,127,608	29,399	10,489,634	-1,075	362,026
	OTHER NHS TARIFF	15,382	1,399,135	14,843	1,407,936	-539	8,801
	OUTPATIENT	161,946	17,554,419	162,073	17,593,607	127	39,188
Surgery Total		366,618	96,670,375	365,306	96,778,867	**-1,312**	108,492
Corporate	OTHER NHS NON-TARIFF	0	180,695	0	180,695	0	0
Corporate Total		0	180,695	0	180,695	0	0
Ops & Facilities	OTHER NHS NON-TARIFF	0	442,078	0	442,078	0	0
Ops & Facilities Total		0	442,078	0	442,078	0	0
Central	NON-ELECTIVE	0	0	0	0	0	0
	OTHER NHS NON-TARIFF	25	240,000	64	232,220	39	-7,780
	OTHER NHS TARIFF	0	-88,575	0	-88,575	0	0
Central Total		25	151,425	64	143,645	39	-7,780
Grand Total		**1,873,683**	**253,557,012**	**1,861,675**	**251,593,087**	**-12,008**	**-1,963,925**

Trust Financial Overview as at 31st Jan 2015 - Month 10

INCOME AND EXPENDITURE COMPARED TO ORIGINAL PLAN SUBMITTED TO MONITOR IN APRIL 2014

YEAR TO DATE POSITION: M10

CLINICAL ACTIVITY

	M10 Plan	M10 Actual	Var
Elective	8,046	7,015	(1,031)
Non Elective	42,286	40,754	(1,532)
Daycase	33,983	33,649	(334)
Outpatients	272,022	274,294	2,272
A & E	118,441	119,860	1,419

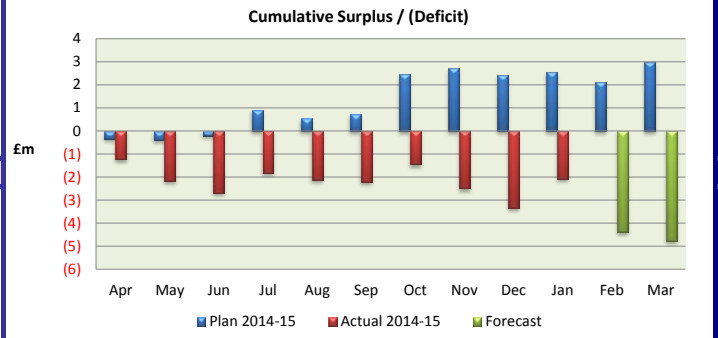
TRUST: INCOME AND EXPENDITURE

	M10 Plan	M10 Actual	Var
	£m	£m	£m
Elective	£21.28	£20.89	(£0.40)
Non Elective	£69.64	£69.77	£0.13
Daycase	£24.90	£24.88	(£0.03)
Outpatients	£32.58	£32.72	£0.13
A & E	£11.70	£11.78	£0.08
Other-NHS Clinical	£101.71	£102.74	£1.02
Other Income	£31.04	£30.96	(£0.09)
Total Income	**£292.86**	**£293.72**	**£0.85**
Pay	(£180.74)	(£183.36)	(£2.62)
Drug Costs	(£22.06)	(£24.05)	(£1.98)
Clinical Support	(£23.59)	(£25.07)	(£1.48)
Other Costs	(£33.27)	(£32.62)	£0.65
PFI Costs	(£9.60)	(£9.72)	(£0.12)
Total Expenditure	**(£269.25)**	**(£274.81)**	**(£5.56)**
EBITDA	**£23.61**	**£18.91**	**(£4.70)**
Non Operating Expenditure	(£21.05)	(£19.88)	£1.17
Deficit excl. Restructuring	**£2.56**	**(£0.97)**	**(£3.53)**
Restructuring Costs	£0.00	(£1.12)	(£1.12)
Surplus / (Deficit)	**£2.56**	**(£2.09)**	**(£4.65)**

DIVISIONS: INCOME AND EXPENDITURE

	M10 Plan	M10 Actual	Var
	£m	£m	£m
Surg & Anaes	£27.12	£24.82	(£2.30)
Medical	£24.68	£20.76	(£3.92)
CWF	£16.46	£15.92	(£0.54)
DATS	(£10.62)	(£12.05)	(£1.43)
Est & Fac	(£22.14)	(£22.22)	(£0.08)
Corporate / THIS	(£14.04)	(£15.77)	(£1.73)
Central Inc/Tech	(£18.11)	(£13.55)	£4.56
Reserves	(£0.79)	£0.00	£0.79
Surplus / (Deficit)	**£2.56**	**(£2.09)**	**(£4.65)**

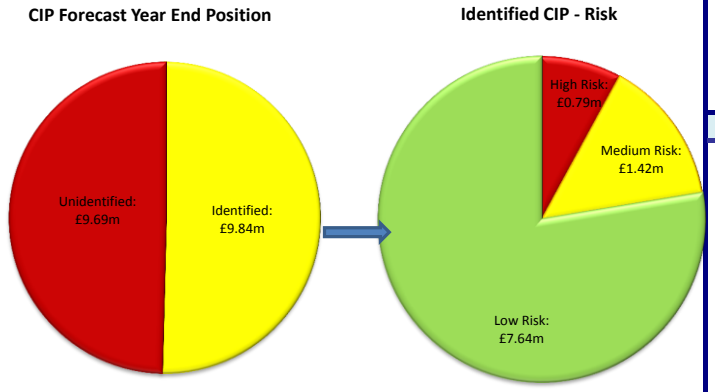
TRUST SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date: M10 Plan	Year To Date: M10 Actual	Year To Date: Var	Year End: Forecast: Plan	Year End: Forecast: Forecast	Year End: Forecast: Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	£2.56	(£2.09)	(£4.65)	£3.00	(£4.76)	(£7.76)
Capital (Re-forecast Plan)	£19.05	£17.35	£1.70	£24.31	£22.69	£1.62
Cash	£19.99	£18.56	(£1.43)	£22.71	£13.18	(£9.53)
	Plan	Actual		Plan	Forecast	
Continuity of Service Risk Rating	3	3		3	2	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £19.53m **Total Identified:** £9.84m

YEAR END 2014/15

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,676	8,460	(1,217)
Non Elective	50,642	48,801	(1,842)
Daycase	40,851	40,384	(467)
Outpatients	327,239	329,829	2,590
A & E	141,505	143,200	1,695

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£25.60	£25.12	(£0.48)
Non Elective	£83.29	£83.44	£0.15
Daycase	£29.93	£29.85	(£0.08)
Outpatients	£39.20	£39.33	£0.13
A & E	£13.98	£14.07	£0.09
Other-NHS Clinical	£122.37	£123.30	£0.93
Other Income	£37.27	£37.18	(£0.09)
Total Income	**£351.64**	**£352.29**	**£0.65**
Pay	(£217.10)	(£220.93)	(£3.83)
Drug Costs	(£26.36)	(£28.80)	(£2.44)
Clinical Support	(£28.04)	(£29.99)	(£1.95)
Other Costs	(£40.29)	(£38.72)	£1.57
PFI Costs	(£11.52)	(£11.69)	(£0.17)
Total Expenditure	**(£323.31)**	**(£330.13)**	**(£6.82)**
EBITDA	**£28.33**	**£22.16**	**(£6.17)**
Non Operating Expenditure	(£25.33)	(£23.80)	£1.53
Deficit excl. Restructuring	**£3.00**	**(£1.65)**	**(£4.65)**
Restructuring Costs	£0.00	(£3.11)	(£3.11)
Surplus / (Deficit)	**£3.00**	**(£4.76)**	**(£7.76)**

DIVISIONS: INCOME AND EXPENDITURE

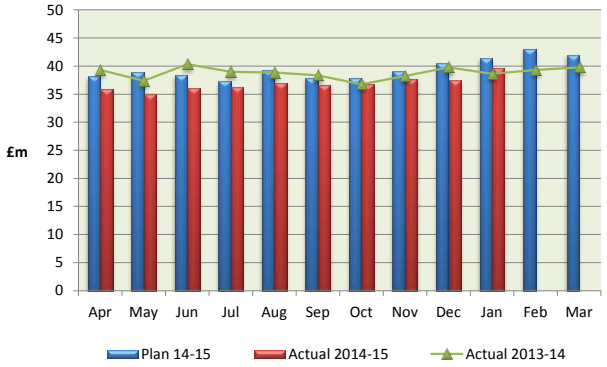
	Plan	Forecast	Var
	£m	£m	£m
Surg & Anaes	£33.11	£29.27	(£3.83)
Medical	£28.96	£24.28	(£4.68)
CWF	£19.85	£18.88	(£0.97)
DATS	(£12.19)	(£13.51)	(£1.33)
Est & Fac	(£26.71)	(£26.87)	(£0.16)
Corporate / THIS	(£16.89)	(£19.07)	(£2.18)
Central Inc/Tech	(£20.44)	(£17.61)	£2.83
Reserves	(£2.70)	(£0.14)	£2.56
Surplus / (Deficit)	**£3.00**	**(£4.76)**	**(£7.76)**

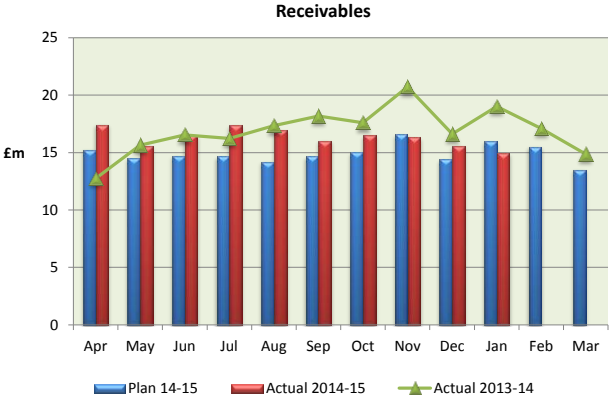
Trust Financial Overview as at 31st Jan 2015 - Month 10

CAPITAL AND CASH COMPARED TO ORIGINAL PLAN SUBMITTED TO MONITOR IN APRIL 2014

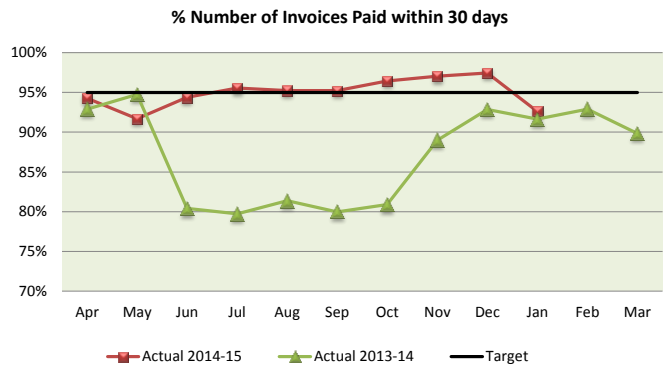
WORKING CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Payables	(£41.48)	(£39.71)	(£1.77)	
Receivables	£16.02	£14.96	£1.06	



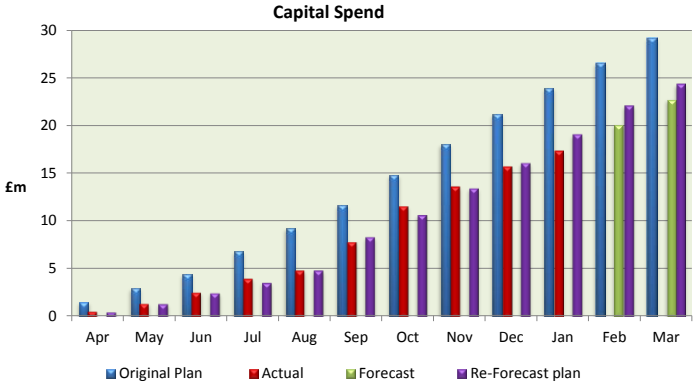


BETTER PAYMENT PRACTICE CODE



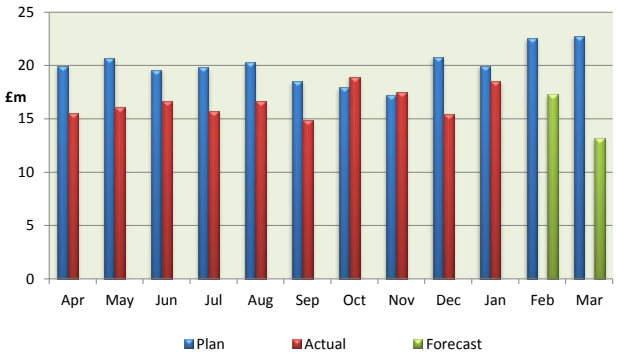
CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Capital (re-forecast plan)	£19.05	£17.35	£1.70	

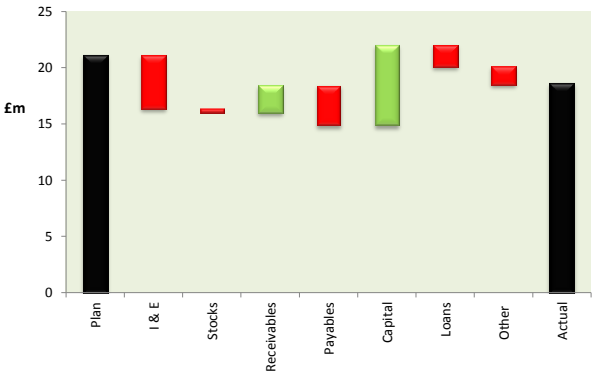


CASH

	M10 Plan £m	M10 Actual £m	Var £m	M10
Cash	£19.99	£18.56	(£1.43)	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Additional activity in month has resulted in bed capacity pressures.
- The level of income protection offered by the fixed value contract stands at £5.06m in the year to date.
- The year to date deficit is £2.09m against a planned surplus of £2.56m.
- Capital expenditure of £17.35m against revised planned £19.05m, an underspend of £1.70m (£6.55m below original plan).
- The cash balance was £18.56m, versus a planned £19.99m, £1.43m lower than planned. A level of loan funded borrowing has supported the cash required for capital investment.
- The Continuity of Service Risk Rating (CoSRR) stands at 3, although underlying performance is at level 2.
- The regulator, Monitor investigated the financial position and a turnaround process has been instigated by the Trust.

SUMMARY FORECAST

- The deficit excluding 'exceptional' restructuring costs is forecast to be £1.65m against a planned £3.0m surplus. Due to their exceptional one-off nature, restructuring costs are excluded from the calculation of the CoSRR but these payments will adversely affect the cash balance.
- The year end forecast including restructuring costs is a deficit of £4.76m. This will result in a CoSRR of 2 for the year.
- CIP schemes are forecast to deliver £9.84m against the planned £19.53m. This is a shortfall of £9.69m and will have an impact on 2015/16.
- £1.5m has been committed to extra substantive nurse staffing; additional winter expenditure has been included within the forecast position.
- £1.5m additional income to support quality investments has been received and is reflected in the year to date and forecast position.
- The revised capital forecast, is a £22.69m spend, a reduction of £1.62m from the revised plan, (£6.51m lower than original plan).
- The forecast year end cash balance is £13.18m against the planned £22.71m.

RAG KEY: (Excl: Cash)

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

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

RAG KEY - Cash:

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Community Executive Summary

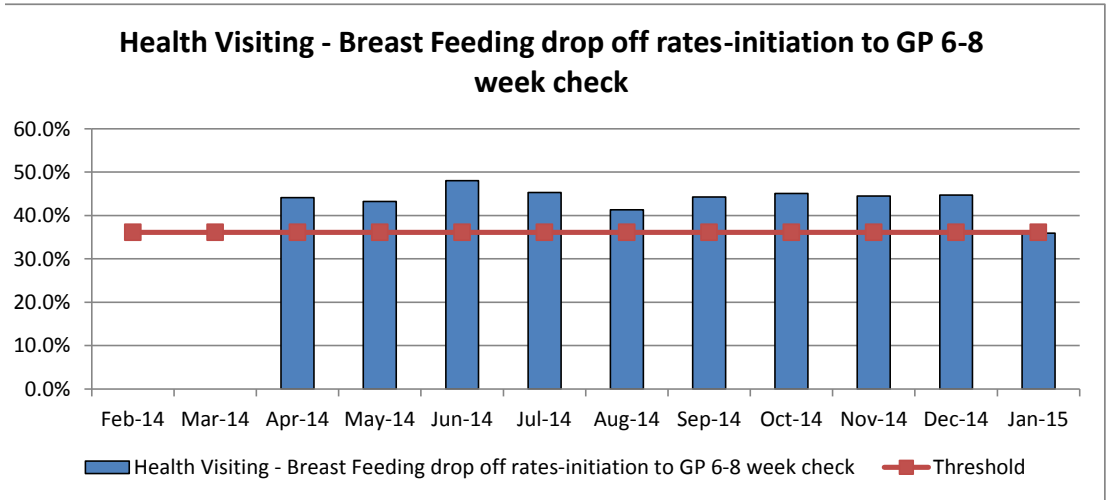
THIS

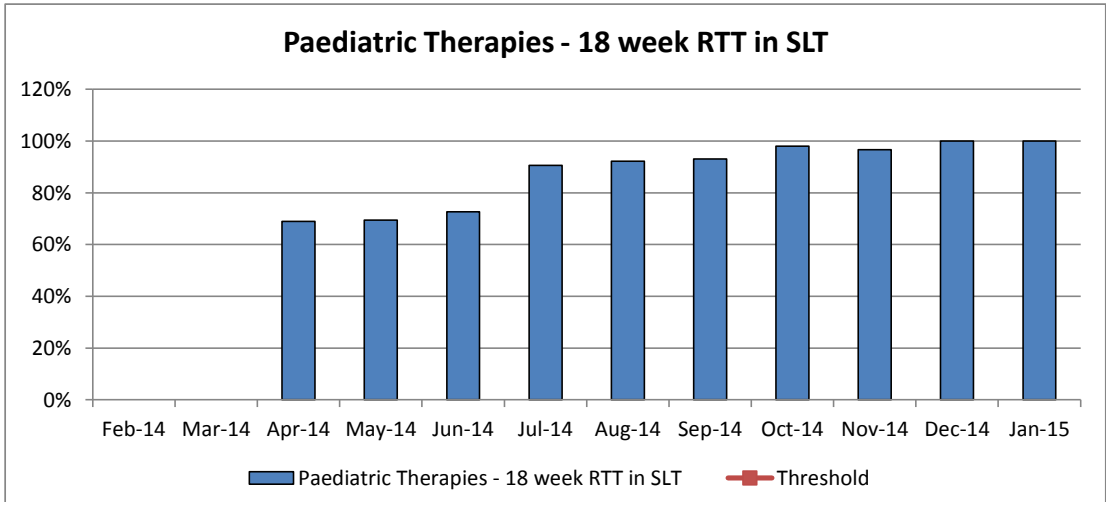
			Report For: January 2015						Year To Date							
	Report For: January 2015	Indicator Source	Target	Trust	Surgical	Medical	CWF	DATS	Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Community - CWF	Antenatal Health Visiting Contact by 32 Weeks	National	70.00%	73.00%	-	-	73.00%	-	70.00%	53.00%	-	-	53.00%	-		
	Health Visiting - Post Birth Visits within 14 days	National	70.00%	78.00%	-	-	78.00%	-	70.00%	85.00%	-	-	85.00%	-		
	Health Visiting - Breast Feeding drop off rates-initiation to GP 6-8 week check	National	36.10%	35.90%	-	-	35.90%	-	36.10%	44.40%	-	-	44.40%	-		
	Immunisations - % of 8 year old girls HPV immunised	National	90.00%	91.60%	-	-	91.60%	-	90.00%	91.00%	-	-	91.00%	-		
	Paediatric Therapies - 18 week RTT in SLT	National	95.00%	100.00%	-	-	100.00%	-	95.00%	82.98%	-	-	82.98%	-		
	Paediatric Therapies - 18 week RTT in Physiotherapy	National	95.00%	96.40%	-	-	96.40%	-	95.00%	91.20%	-	-	91.20%	-		
	Paediatric Therapies - 18 week RTT in Occupational Therapy	National	95.00%	100.00%	-	-	100.00%	-	95.00%	75.45%	-	-	75.45%	-		
	Family Nurse Partnership	Local	TBC	TBC	-	-	TBC	-	TBC	TBC	-	-	TBC	-		
Community - CWF 2	Midwifery - % Home Births	National		2.00%	-	-	2.00%	-		1.80%	-	-	1.80%	-		
	Midwifery - % of Antenatal Bookings done with 12 weeks and 6 days	National	90.00%	93.50%	-	-	93.50%	-	90.00%	92.30%	-	-	92.30%	-		
	Midwifery - % women smoking at time of delivery	National	11.90%	14.50%	-	-	14.50%	-	11.90%	11.70%	-	-	11.70%	-		
	Sexual Health - % Referrals seen within 48 Hours	Local	95.00%	96.17%	-	-	96.17%	-	95.00%		-	-		-		
	Sexual Health - % Patients offered a HIV Test	Local	100.00%	100.00%	-	-	100.00%	-	100.00%		-	-		-		
	CDU	Local	TBC	TBC	-	-	TBC	-	TBC	TBC	-	-		-		
	Communituy - Children's Nurses		TBC	TBC	-	-	TBC	-	TBC	TBC	-	-		-		
Community	Home equipment delivery < 7 days	National	100.00%	96.80%	-	96.80%	-	-	100.00%	92.30%	-	92.30%	-	-		
	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days (one month behind)	Local	10.00%	1.80%	-	1.80%	-	-	10.00%	1.40%	-	1.40%	-	-		
	% of leg ulcers healed within 12 weeks from diagnosis	Local	100.00%	96.60%	-	96.60%	-	-	100.00%	96.70%	-	96.70%	-	-		
	Number of community acquired grade 3 or 4 pressure ulcers	National	6.3	2	-	2	-	-	6.3	15	-	15	-	-		
	Community AHP - 18 week RTT Snapshot at month end	National	95.00%	85.40%	-	85.40%	-	-	95.00%	89.00%	-	89.00%	-	-		
	Percentage of Community Staff equipped with mobile device	Local	-	-	-	-	-	-	-	62.00%	-	62.00%	-	-		
	% district nursing patients with a care plan	Local	90.00%	95.79%	-	95.79%	-	-	90.00%	94.60%	-	94.60%	-	-		
	% of patients with a LTC with a Calderdale Care Plan	Local	90.00%	42.00%	-	42.00%	-	-	90.00%	57.60%	-	57.60%	-	-		
	District Nursing Performance Active caseload	Local	-	4376	-	4376	-	-	-	4234	-	4234	-	-		
	District Nursing Performance New referrals in month	Local	-	1068	-	1068	-	-	-	14397	-	14397	-	-		
	District Nursing Performance Urgent referrals seen within 4 hours	Local	80.00%	63.33%	-	63.33%	-	-	80.00%	75.30%	-	75.30%	-	-		
	District Nursing Performance Non urgent referrals seen within 2 days	Local	80.00%	52.17%	-	52.17%	-	-	80.00%	64.80%	-	64.80%	-	-		
	Community F+F Test = % Would recommend the Service	CQUIN	-	91.00%	-	91.00%	-	-	-	91.00%	-	91.00%	-	-		
	Community F+F Test = % Would NOT recommend the Service	CQUIN	-	5.00%	-	5.00%	-	-		5.00%	-	5.00%	-	-		
	Patients who died at their preferred place of choice	Local	100.00%	90.00%	-	90.00%	-	-	100.00%	94.10%	-	94.10%	-	-		
	Number of patients with a Calderdale care plan - (this is a self management plan incorporates the emergency care plan)	Local	80.00%	29.00%	-	29.00%	-	-	80.00%	37.00%	-	37.00%	-	-		

Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Antenatal Health Visiting Contact by 32 Weeks	70.00%	73.00%	-	-	73.00%	-
Health Visiting - Post Birth Visits within 14 days	70.00%	78.00%	-	-	78.00%	-
Health Visiting - Breast Feeding drop off rates-initiation to GP 6-8 week check	36.10%	35.90%	-	-	35.90%	-
Immunisations - % of 8 year old girls HPV immunised	90.00%	91.60%	-	-	91.60%	-
Paediatric Therapies - 18 week RTT in SLT	95.00%	100.00%	-	-	100.00%	-
Paediatric Therapies - 18 week RTT in Physiotherapy	95.00%	96.40%	-	-	96.40%	-
Paediatric Therapies - 18 week RTT in Occupational Therapy	95.00%	100.00%	-	-	100.00%	-
Family Nurse Partnership	TBC	TBC	-	-	TBC	-

Family Nurse Partnership (FNP)

Family Nurse Partnership indicator to be confirmed as the service reports on multiple indicators to NHS England. NHS England raised no concerns at the recent advisory board. We will narrow down to one indicator for the next report.





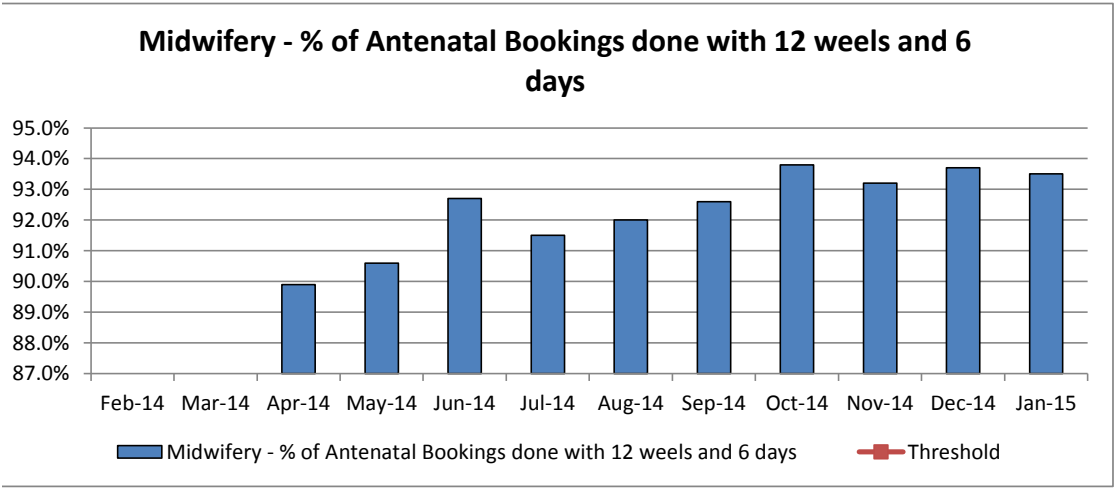
Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Midwifery - % Home Births		2.00%	-	-	2.00%	-
Midwifery - % of Antenatal Bookings done with 12 weeks and 6 days	90.00%	93.50%	-	-	93.50%	-
Midwifery - % women smoking at time of delivery	11.90%	14.50%	-	-	14.50%	-
Sexual Health - % Referrals seen within 48 Hours	95.00%	96.17%	-	-	96.17%	-
Sexual Health - % Patients offered a HIV Test	100.00%	100.00%	-	-	100.00%	-
CDU	TBC	TBC	-	-	TBC	-
Community - Children's Nurses	TBC	TBC	-	-	TBC	-

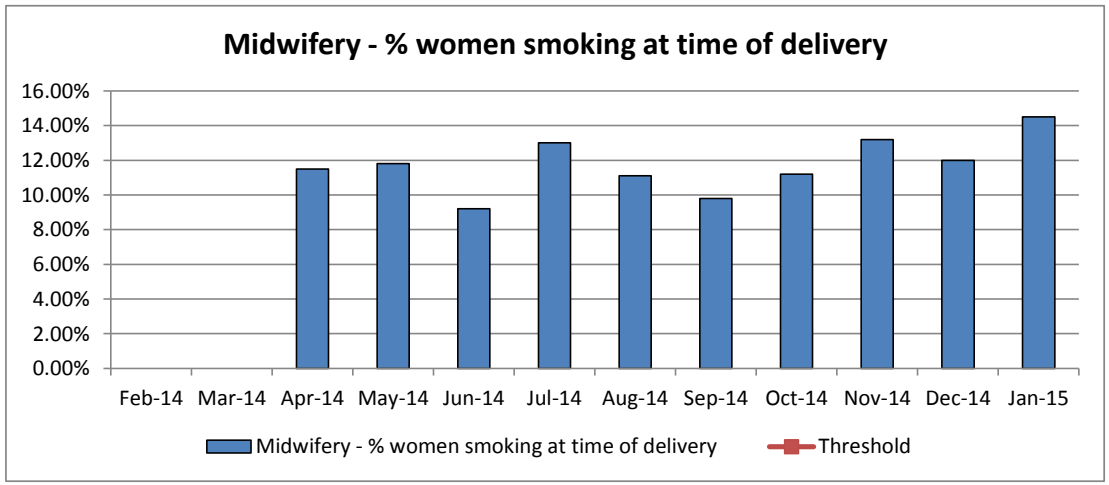
Midwifery - % women smoking at time of delivery

Relevant women being referred to a specialist service, this is expected to see a reduction in a the percentage of women smoking at delivery.

CDU - Indicator to be devised for the next report

Community - Children's Nurses - indicator to be devised for the next report





Report For: January 2015	Target	Trust	Surgical	Medical	CWF	DATS
Home equipment delivery < 7 days	100.00%	96.80%	-	96.80%	-	-
% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days (one month behind)	10.00%	1.80%	-	1.80%	-	-
% of leg ulcers healed within 12 weeks from diagnosis	100.00%	96.60%	-	96.60%	-	-
Number of community acquired grade 3 or 4 pressure ulcers	6.3	2	-	2	-	-
Community AHP - 18 week RTT Snapshot at month end	95.00%	85.40%	-	85.40%	-	-
Percentage of Community Staff equipped with mobile device	100.00%	-	-	-	-	-
% district nursing patients with a care plan	90.00%	95.79%	-	95.79%	-	-
% of patients with a LTC with a Calderdale Care Plan	90.00%	42.00%	-	42.00%	-	-
District Nursing Performance Active caseload	-	4376	-	4376	-	-
District Nursing Performance New referrals in month	-	1068	-	1068	-	-
District Nursing Performance Urgent referrals seen within 4 hours	80.00%	63.33%	-	63.33%	-	-
District Nursing Performance Non urgent referrals seen within 2 days	80.00%	52.17%	-	52.17%	-	-
Community F+F Test = % Would recommend the Service	-	91.00%	-	91.00%	-	-
Community F+F Test = % Would NOT recommend the Service	-	5.00%	-	5.00%	-	-
Patients who died at their preferred place of choice	100.00%	90.00%	-	90.00%	-	-
Number of patients with a Calderdale care plan - (this is a self management plan incorporates the emergency care plan)	80.00%	29.00%	-	29.00%	-	-

67% percent of **community staff equipped with a mobile device** - Handover and training sessions of laptops taking place. The smart phone rollout continues. The change management process for this impletion has been completed. A request has been made for further capital to complete the project. Once we have the request formalised further laptops and phones will be ordered . The plan will be that the roll out for the remaining 33% of staff receive their Kit and training by June 2015 .

% Leg ulcers healed with 12 weeks from Diagnosis - YTD 175/181 of leg ulcers diagnosed by the team were supported to heal within 12 weeks. There has been extensive work in the healing of leg ulcers and 6 patients out of 181 did not have their leg ulcer healed within 12 weeks. The target was set by the Directorate as 100 %. The next report will show the exceptions and why they have not healed .

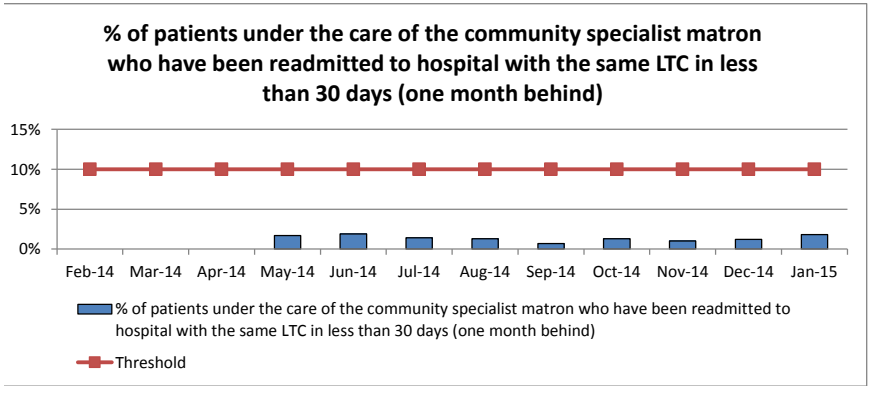
LTC Patients with a Calderdale Care Plan - Current work ongoing to validate data within the next month. The target around LTC patients and Calderdale Care plan is linked to the self -management plan and is only recorded on the community matrons caseload. Further verification of the data is required to ensure we are capturing both plans and that staff are recording correctly . Clinical S1 nurse is working with the team to improve this figure and compliance of this care plan. This will be shown on the next report .

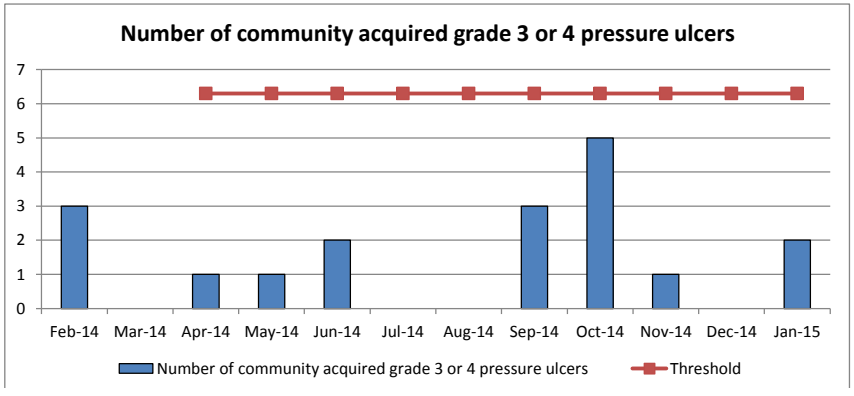
Community Friends and Family Test - Test went live in January and data collection has started**.**

District Nursing Performance target discussed at CCG contract meeting - agreed to change the criteria and how this is counted as these timescales are not valid 01/05/15

Community AHP RTT - due to Podiatry and OTAS. Podiatry have redesigned service to try and increase capacity - part of PMO scheme. Calderdale council are looking at redesigning OTAS provision - we are working with them

The patients who have died in their preferred place of choice needs further work as staff will need to check that what is recorded on the electronic record is actually what happened . The Clinical S1 is working with staff to ensure this is consistently recorded. These figures will be small any omissions will radically alter the %





CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	
Indicator Name	**Apr**	**May**	**Jun**	**Total**	**Jul**	**Aug**	**Sep**	**Total**	**Oct**	**Nov**	**Dec**	**Total**	**Jan**	**Feb**	**Mar**	**Total**	**YTD**
1.1 - Friends and Family Test - Implementation of the staff FFT across the provider from April 2014 - reporting by end of Q1 One payment at end of Q1 (£319k total)																	
Indicator 1.1 Reporting by end of Q1			YES														
1.1.1 - Friends and Family Test - Implementation of FFT across outpatient and day case department across the Trust - establish by end of Q2 and report from Q3 onwards One payment at end of Q2 (£319k total)																	
Indicator 1.2 Reporting from Q3 - Daycase (including endoscopy, day surgery and day procedures).							YES		26.3%	26.0%	25.2%						
Indicator 1.2 Reporting from Q3 - Outpatient							YES		16.7%	16.3%	11.5%						
1.1.2 - Friends and Family Test - Implementation of FFT across Community services - establish by end of Q3 and report from Q4 onwards One payment at end of Q3 (£319k total)																	
Indicator 1.1.2 Reporting from Q4											YES						
1.2 - Friends and Family - Response rate to F&F test question **Inpatient - Q1 25%, Q4 30%** **A&E - Q1 15%, Q4 20%** Two payments, end of Q1 and Q4 (£159k total)																	
Indicator 1.2 Inpatient response rate to F&F test question	37.3%	32.9%	35.7%		39.8%	41.5%	40.6%		46.5%	44.3%	40.6%						
Indicator 1.2 A&E response rate to F&F test question	21.5%	26.2%	29.8%		21.8%	20.40%	20.3%		23.4%	19.2%	4.5%						
1.3 - Friends and Family - Response rate to F&F test question **Inpatient - further improvement requirement to achive 40% in any month during Q4.** One payment, end of Q4 (£159k total)																	
Indicator 1.3 Inpatient response rate to F&F test question	37.3%	32.9%	35.7%		39.8%	41.5%	40.6%		46.5%	44.3%	40.6%						39.9%

CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
2.1 - Safety Thermometer (Quarterly payment conditional on use of thermometer in each of 3 months) Quarterly payment (£159k total)																	
The collection of data on Patient Harm using the NHS Safety Thermometer Harm Measurement Instrument. Collects Falls, Pressure Ulcers, Catheter Infection & VTE																	
Indicator. Continued use of thermometer for monthly data collection	Y	Y	Y		Y	Y	Y		Y	Y	Y						
2.2 - Safety Thermometer - Reduction in the prevalence of pressure ulcers One payment based on achievement of three consecutive months at or below required level One payment (£478k total)																	
(100% payment <4.1%, 75% payment < 4.6%, 50% payment < 5%, 0% payment if >5%)																	
Numerator: Reduction in the prevalence of pressure ulcers using thermometer	47	39	57		39	47	49		43	48	53						**422**
Denominator: Reduction in the prevalence of pressure ulcers using thermometer	1135	1119	1056		1091	1097	1059		1032	1048	1093						**9730**
Indicator. Reduction in the prevalence of pressure ulcers using thermometer	**4.14%**	**3.49%**	**5.40%**		**3.57%**	**4.28%**	**4.63%**		**4.17%**	**4.58%**	**4.85%**						**4.34%**
3.1- Dementia - Use of dementia screening tool, risk assessments, referrals for emergency admissions aged 75 and over (Target - 90% aggregate) Quarterly payment based on achievement of all three elements (£478k total)																	
Dementia Screen - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	
Numerator 1: No of Non Elec admissions of patients aged 75 and over reported as having been asked the SQUID question for case finding	461	469	456		457	441	436		468	396	396						**3980**
Demoninator 1. No. of Non Elec admissions of patients aged 75 and over, who were admitted as inpatients in an emergency minus the exclusions	494	491	472		463	457	439		503	412	412						**4143**
Indicator 1. Percentage of patients aged 75 and over admitted as inpatients who were screened for dementia	**93.3%**	**95.5%**	**96.6%**		**98.7%**	**96.5%**	**99.3%**		**93.0%**	**96.1%**	**96.1%**						**96.1%**
Dementia AMTS - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	
Numerator 2: No of Non Elec patients admitted aged 75 and above, who have scored positively on the SQUID and reported as having had a dementia diagnostic assessment. (AMTS)	76	87	65		57	81	87		70	57	80						**660**
Demoninator 2. No of Non Elective patients aged 75 and above admitted as inpatients, who have scored positively on the SQUID case finding question (figures should balance to Numerator 1)	76	87	65		57	81	87		71	58	82						**664**
Indicator 2. Percentage of patients aged 75 and over admitted as inpatients who were appropriately risk assessed	**100%**	**100%**	**100%**		**100.0%**	**100.0%**	**100.0%**		**98.6%**	**98.3%**	**97.6&%**						**99.4%**
Dementia Referral - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	

CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1 Apr	May	Jun	Q1 Total	Quarter 2 Jul	Aug	Sep	Q2 Total	Quarter 3 Oct	Nov	Dec	Q3 Total	Quarter 4 Jan	Feb	Mar	Q4 Total	YTD
Numerator 3:No of Non Elec Patients admitted aged 75 and above, who have had a positive diagnostic assessment, who are referred on for further diagnostic advice.	71	78	64		55	74	74		68	55	71						610
Denoninator 3. No of Non Elec patients aged 75 and above admitted as inpatients, who underwent a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive")	71	78	64		55	74	74		68	55	71						610
Indicator 3. Percentage of patients aged 75 and over admitted as inpatients who were appropriately referred on to GP	100%	100%	100%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%						100.0%

3.2 - Ensuring 90% of wards have 1 WTE dementia 'expert' and 75% of wards to have 1 WTE 'competent' dementia lead
Report at end of Q2 and Q4
Two payments, end of Q2 and Q4 (£159k total)

Improve the quality of care for people with dementia

Percentage of applicable wards that have at least 1 full time member of staff (or equivalent WTE) that has been trained to **'expert'** level in Dementia					**Report completed**								x% & report				
Percentage of applicable wards that have at least 1 full time member of staff (or equivalent WTE) trained to **'competent'** level in Dementia					**Report completed**								x% & report				

3.3 - Dementia - ensuring carers feel supported - Bi-annal payment on submission of qualitative summary report
Two payments, end of Q2 and Q4 (£159k total)

Indicator 3. Number of interviews carried out in month (7 required)					**Report completed**								**Report due**				
Indicator 3. Structured interviews conducted and qualitative summary of learning					**Report completed**								**Report due**				

4.1 - ASTHMA Improving management of patients presenting with Asthma in A&E
Q1 - 60%, Q2 - 65%, Q3 - 70%, Q4 - 75%
Quarterly payment (£638k total)

Num 1. Number of patients admitted with Asthma as primary diagnosis who receive the following complete care bundle either prior to discharge or within 48 hours of discharge.
i. Provided with brief intervention advice to current smokers and referral to smoking cessation clinic if patient consents
ii. Assessment of suitability and/or enrolment into a pulmonary rehabilitation programme
iii. Provided appropriate education and written information on Asthma, Self-management and medication including oxygen if relevant, to patient and/or carers)
iii. Provide appropriate education and written information on Asthma, self-management and medication including oxygen if relevant, to patient (and/or carers)
iv. Documentation that patient has demonstrated good inhaler technique
v. Patient is re-established on their optimal maintenance therapy (including bronchodilator therapy).
vi. Appropriate follow-up arrangements once discharged from hospital are documented and included in discharge summary. Evidence that patient and/or carer are informed/aware.

	Quarter 1				Quarter 2				Quarter 3				Quarter 4				
Patient age split (number <20 years and >20 years. Total 50)	**18 Children / 32 adults**				**18 Children / 32 adults**				**37 Children / 13 Adults**								
Initial Set - Peak Flow	50	50	100.0%		44	50	88.0%		42	50	84.0%						
Initial Set - Obs	50	50	100.0%		50	50	100.0%		47	50	94.0%						

CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	
Indicator Name	**Apr**	**May**	**Jun**	**Total**	**Jul**	**Aug**	**Sep**	**Total**	**Oct**	**Nov**	**Dec**	**Total**	**Jan**	**Feb**	**Mar**	**Total**	**YTD**
Salbutamol	49	50	98.0%		48	50	96.0%		46	50	92.0%						
In Time	37	50	74.0%		45	50	90.0%		36	50	72.0%						
Steroids	48	50	96.0%		50	50	100.0%		45	50	90.0%						
In Time	43	50	86.0%		45	50	90.0%		36	50	72.0%						
Second Set - Peak Flow	49	50	98.0%		47	50	94.0%		45	50	90.0%						
Second Set - Obs	48	50	96.0%		46	50	92.0%		46	50	92.0%						
Inhaler	40	50	80.0%		40	50	80.0%		36	50	72.0%						
Discharge Px	43	50	86.0%		44	50	88.0%		48	50	96.0%						
Follow Up	46	50	92.0%		46	50	92.0%		47	50	94.0%						
Bundle Complaint	**33**	**50**	**66.0%**		**36**	**50**	**72.0%**		**27**	**50**	**54.0%**						

4.2 - Pneumonia Care Bundle
Quarter 1 update report - / Quarter 2 & 3 - Quarterly reporting with no requirement / Quarter 4 - 55%)
Quarterly payment (£638k total)

Number of patients attending A&E and / or MAU with pneumonia who receive the CAP care bundle on admission to hospital.

The CAP Care Bundle reflects College of Emergency Medicines standards and BTS/Sign guidelines and includes all of the following measures:
1. Chest X-ray
2. Oxygen administration
3. CURB 65 severity score
4. Antibiotics administered.

	Quarter 1 - end of Q1		Quarter 2		Quarter 3		Quarter 4		
Chest X-Ray	**Report Completed**		**Report Completed**		**Report submitted**				
Oxygen Administration									
CURB 65 severity score									
Antibiotics administered									
Compliant with CQUIN									

5.1 - Diabetes Self Care (Q1 achieve 50% on 4 wards, Q2 achieve 50% on 6 wards, Q3+Q4 achieve 50% on 8 wards)
2 payments - end of Q2 and Q4
Two payments, end of Q2 and Q4 (£319k total)

Diabetes Self care

CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1 Apr	May	Jun	Q1 Total	Quarter 2 Jul	Aug	Sep	Q2 Total	Quarter 3 Oct	Nov	Dec	Q3 Total	Quarter 4 Jan	Feb	Mar	Q4 Total	YTD
Target RAG Rating					Report								Up to Jan				
Numerator. Number of patients supported to self care (fully compliant with bundle)		16				15				16							**47**
Denominator. Number of patients admitted to cohort wards who have insulin dependant diabetes and are competent to self-administer		20				25				20							**65**
Number of patients sampled who are admitted to cohort wards and have insulin dependant diabetes		31				37				46							**114**
Assessed to self care	31	31	100.0%		32	37	86.5%		40	46	87.0%						**103**
Care plan in place	29	31	93.5%		33	37	89.2%		40	46	87.0%						**102**
Giving own Insulin	20	31	64.5%		30	37	81.1%		38	46	82.6%						**88**
Adjusting the dose of insulin	20	31	64.5%		30	37	81.1%		37	46	80.4%						**87**
Testing own blood sugars	18	31	58.1%		22	37	59.5%		35	46	76.1%						**75**
Access to food and snacks	31	31	100.0%		37	37	100.0%		46	46	100.0%						**114**
% Diabetes patients supported to self care (fully compliant with bundle)	**80.0%**				**60.0%**				**80.0%**								**72.3%**

5.2 - Diabetes (Q1 - 60% achievement, Q2-Q4 90% achievement)
Two payments, end of Q2 and Q4 (£159k total)

Diabetes - Management of hypoglycaemia patients in A&E, CDU and MAU

Target RAG Rating																	
Numerator. Patients attending A&E, CDU or MAU with diabetic hypoglycaemia who are referred to a specialist nurse and receive written educational support	3	8	12		6	12	7		7	20	18						93
Denominator. Patients attending A&E, CDU or MAU with diabetic hypoglycaemia	4	8	12		6	12	7		7	20	18						94
% Diabetes attending A&E, CDU or MAU referred to specialist nurse	**75.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**						**98.9%**

6 - Improving Medicines Safety

Support the effective transfer of information about medicines when patients are being transferred from one provider to another following an unplanned admission to hospital

Part 6.1 - Reconciliation (Quarterly payment conditional on: Q1-3 70% target. Q4 - 80%
Quarterly payment (£319k total)

Part A: Number of e-discharges checked by Pharmacy with medicines reconciled - numerator	1060	698	639		679	676	650		730	642	645						6419
Part A: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1185	753	733		778	744	736		832	747	759						7267
Part A: Reconcilliation of medicines on admission - total	**89.5%**	**92.7%**	**87.2%**		**87.3%**	**90.9%**	**88.3%**		**87.7%**	**85.9%**	**85.0%**						**88.3%**

CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	
Indicator Name	**Apr**	**May**	**Jun**	**Total**	**Jul**	**Aug**	**Sep**	**Total**	**Oct**	**Nov**	**Dec**	**Total**	**Jan**	**Feb**	**Mar**	**Total**	**YTD**
Part 6.2 - Discharge Accuracy Checks (Quarterly payment conditional on: Q1 - 55%, Q2- 60%, Q3 - 65%, Q4 - 70% Quarterly payment (£319k total)																	
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards having their e-discharge prescription approved and reconciled against the inpatient prescription chart by a pharmacist - numerator	1185	753	733		778	744	736		832	747	759						7267
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1826	1200	1106		1141	1104	1073		1179	1057	1093						10779
Part B: Discharge Medication - total	**64.9%**	**62.8%**	**66.3%**		**68.2%**	**67.4%**	**68.6%**		**70.6%**	**70.7%**	**69.4%**						**67.4%**

7 - End of Life

Part A - introduction of care bundle on two respiratory wards
Q2 - 30% of staff to have received training, Q4 - 90%
Single payment end of Q4 (£478k total)

Implementation of care bundle in two respiratory wards					**Report completed**								Reporting Due				

Part B - Join the TRANSFORM programme
Quarter 2 - Production of driver diagram to include key measures.
Quarter 4 - Demonstration of programme achievements as evidenced by a dashboard and key measures
Two payments, end of Q2 and Q4 (£478k total)

					Report completed								Report due				

8 - Nutrition

Establish a collaborative task and finish group to scope patient, staff and visitor food provision in order to understand the current catering services across the hospital setting with a view to achievement of the Food For Life Catering Mark and Government Buying Standards where feasible.

Q2 - Baseline Report on progress YTD, including Real Time Patient Monitoring (RTPM) baseline results
Q4 - Report including RTPM demonstrating improvement work carried out
Two payments, end of Q2 and Q4 (£319k total)

Reports due highlighting progress	Report Complete				Action Plan Implemented								Report due				

Calderdale and Huddersfield NHS
NHS Foundation Trust

Monitor Indicators

THIS

Indicators	Thresholds	Weighting	January 2015	Quarter 3	Comments
Incidence of MRSA Year to Date	0	1.0	0	0	
Incidence of Clostridium Difficile Year to Date	5	1.0	3	22	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Admitted	90%	1.0	91.32%	91.95%	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Non-Admitted	95%	1.0	99.06%	98.70%	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Incomplete Pathways	92%	1.0	94.52%	95.32%	
62 Day Wait for First Treatment from Urgent GP Referral	85%	1.0	90.36%	93.33%	
62 Day Wait for First Treatment from Consultant Screening Service Referral	90%	1.0	87.50%	91.67%	
31 Day Wait for Second or Subsequent Treatment: Surgery	94%	1.0	100.00%	100.00%	
31 Day Wait for Second or Subsequent Treatment: Anti Cancer Drug Treatments	98%	1.0	100.00%	100.00%	
31 Day Wait from Diagnosis to First Treatment (All Cancers)	96%	0.5	100.00%	99.73%	
Two Week Wait From Referral to Date First Seen: All Cancers	93%	0.5	97.46%	98.41%	
Two Week Wait From Referral to Date First Seen: Symptomatic Breast Patients	93%	0.5	96.72%	94.77%	
A&E: Maximum Waiting Time of Four Hours from Arrival to Admission/Transfer/Discharge	95%	1.0	91.89%	92.74%	
Community care - referral to treatment information completeness	50%	0.5	100.00%	100.00%	
Community care - referral information completeness	50%	0.5	98.40%	98.32%	
Community care - activity information completeness	50%	0.5	100.00%	100.00%	
Overall Governance Rating			Amber-Red	Amber-Green	

Green:<1.0, Amber-Green: >=1.0, <2.0, Amber-Red: >=2.0, <4.0, Red: >4.0

FIRE SAFETY

Fire Safety Awareness – The Fire Safety handbooks are currently being distributed out to Staff – commencing with the non-compliant, then to those due in January / February. Staff will be required to complete the declaration form located on the link below when they have read and understood the handbook.

http://nww.cht.nhs.uk/divisions/corporate/estates-and-facilities/compliance/fire/fire-training-dates/

Fire Risk Assessments – Please see attached document.

Fire Alarm Activations for January 2015

CRH 9 Activations - Keith meeting Cofley after each months fire alarm figures are released to identify improvements.

HRI 4 Activations - A steam leak is causing a major problem and giving numerous faults as water gets into the fire alarm wiring. The offending leak would require a full shutdown to repair and the site would lose its heating, which is not practical at this time of year!

Acre Mill - 23 training sessions have been carried out, plus a full evacuation at Acre Mill.

Recent Incidents - A faulty light fitting caused smoke logging in the Physiotherapy Department at HRI.

Fire Risk Assessment Review/Audit 2015 CHFT

Summary of Task

A Fire Risk assessment is a live document which must be reviewed and updated in several circumstances, such if there are new task introduced into the area, should there be dramatic change in the numbers of relevant persons and most importantly on an periodic basis.

Over the last 2 years I have carried out 115 fire risk assessments. This process has included both hospital sites, several of the community premises and accommodation areas. These assessments each have a prioritised action plan. This is a huge step forward from the Trusts previous position of no suitable fire risk assessment programme.

As a former Fire safety Auditor for West Yorkshire Fire and Rescue service I have approached this process in the same way an enforcement officer would.

I am visiting each area which has a full risk assessment and ascertaining how many of the actions have been completed, how many actions have been reported and also most importantly how can we a s a Trust improve the fire risk assessment process for CHFT to ensure continued compliance, where are we failing and how can we improve.

Each department visited

- Check the usage of the department is still the same as the original assessment.
- Ensure that the numbers of relevant persons are roughly similar to the original assessment.
- Check to make sure processes haven't changed new risk haven't been introduced.
- Check the department has sufficient numbers of trained fire wardens and all staff have attended fire training in the last 12 months
- Check the fire file is being used correctly and advise.
- Update the fire file with new documentation.
- Advise either the NIC or the fire warden of any policy changes and inform them of the fire training regime and training intervals.
- Audit the fire risk assessment action plan and tour the department to see which jobs have been completed (referencing the original FRA and the photos taken at the time of the assessment.)
- Check to see if there are any new findings and develop a new action plan.
- Answer any fire safety questions.
- It is very difficult to quantify risks regarding fire safety, one departments high risk is another department's low risk.
- Identify areas where no FRA has been completed.

Update after 7 days of Auditing

- Only HRI departments and wards visited so far.
- Out of the 53 Assessment completed 31 areas have been audited.
- This equates to 58% of HRI complete.
- Of the departments visited there were a total of 207 items on the action plans combined.
- At the time of auditing 119 of these items were complete which equates to 57% of issues closed.

Initial Findings

- During this initial period 2 areas have been identified where no assessment has been carried out as the area was not either initially identified or did not exist at the time of the assessment.
- Some departments have reported jobs but can't be classed as closed as the job has still to be completed.
- All action plan jobs for the estates department have now been logged and managed.
- The progress is acceptable as a clear audit trail can be followed.
- Very few departments "haven't bothered"
- Staff on the whole are aware of the fire risk assessment.
- Staff have been very receptive to my visits.
- The fire safety awareness of staff has improved.

Conclusion

I will complete the visits in the next three weeks at the HRI and CRH, following that I will produce a review document which must be kept with the initial fire risk assessment. This review document will also include new action which must be acted upon.
This will also help us to develop a full and realistic fire risk assessment review programme, some areas need annual and some may be deferred. This can only be developed once this process has been completed.

As areas change and develop, new areas are created fire risk assessments need to be carried out.

Quantifying fire risk assessments can be very difficult and also have negative effects on progress as different departments and areas have different opinions on risk. CHFT has a very positive attitude to this situation and it is important to remember that whilst giving staff ownership of the assessment there is a robust infrastructure in place that staff can turn to for advice and assistance in making the premises safer for all users and give compliance assurance.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: FINANCIAL POSITION UPDATE - MONTH 10 - The Board is asked to approve the Month 10 narrative.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Finance and Performance Committee - 19.2.15	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Trust has delivered the year to date financial position in-line with the reforecast plan and is forecasting to achieve its year end deficit consistent with the Monitor reforecast plan. The Board is asked to review and approve the Month 10 financial position.

Main Body

Purpose:

This paper provides a narrative to accompany the monthly financial dashboard and will focus on the key messages within the year to date and forecast year end positions, making reference to 15/16 and beyond, as appropriate. This paper has previously been discussed at the Finance & Performance Committee on the 19 February 2015.

Background/Overview:

The Board of Directors is aware that the Trust submitted a re-forecast financial plan to Monitor in September 2014. The attached paper provides an up to date position of financial performance against the re-forecast plan.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to approve the Month 10 narrative.

Appendix

Attachment:

Month 10 Financial Narrative.pdf

Calderdale and Huddersfield NHS FT

Month 10, January 2015 Financial Narrative

Purpose

This paper provides a narrative to accompany the monthly financial dashboard and will focus on the key messages within the year to date and forecast year end positions, making reference to 15/16 and beyond, as appropriate. This paper has previously been discussed at the Finance & Performance Committee on the 19 February 2015.

The comparisons and reference points within this paper are consistent with the dashboard highlighting actual performance against the Reforecast plan as submitted to Monitor in September 2014 and must be seen in the context of non-achievement of the original planned surplus of £3.0m.

Executive Summary

The Trust has delivered the year to date financial position in-line with the reforecast plan and is forecasting to achieve its year end deficit consistent with the Monitor reforecast plan.

The financial headlines are detailed below with more detailed narrative supplied on the following pages.

The financial position to the end of January 2015 shows:

- A year to date deficit of £0.97m (excluding 'exceptional' restructuring costs), a favourable variance of £2.37m from the reforecast planned £3.34m deficit, driven by £1.50m quality investment by commissioners to support hard truths nursing expenditure, donated asset income of £0.4m together with over delivery of CIP of £0.50m.

- When the restructuring costs of £1.12m are included, the above favourable variance of £2.37m reduces to a favourable variance of £1.25m from the reforecast plan.

- Over delivery of CIP schemes of £7.35m against a reforecast planned level of £6.85m;

- Capital expenditure of £17.35m versus a reforecast planned level £18.30m;

- A cash balance of £18.56m against a reforecast planned position of £17.04m;

- The year to date Continuity of Service Risk Rating (CoSRR) is a level 3 in line with the reforecast plan, however this is artificially high due to the timing of the loan drawdown. The underlying CoSSR is a 2.

The forecast year end position shows:

- At an operational financial performance level, the Trust is in-line with the reforecast plan submitted to Monitor. Although the forecast deficit stands at £1.65m, as with the previous month's forecast, there are items that require adjustment to ensure the deficit is comparable to the reforecast position of a deficit of £4.29m. These adjusting items relate to non-recurrent income that total £2.60m and consist of £1.50m of Commissioner non-recurrent income for 'hard-truths' and A&E investment, £0.40m of charitable funds income and a forecast benefit of £0.70m as a result of lower than anticipated depreciation charges. These adjustments are laid out in appendix 1 and demonstrate that the forecast is equivalent in trading terms to the reforecast plan and is consistent with last month's forecast.

- When the forecast restructure costs of £3.11m are included, the Trust's position is a deficit of £4.76m against a reforecast deficit of £4.29m. This negative variance is excluded from the CoSRR calculation but becomes an un-forecast cash pressure for the Trust.

- Delivery against CIP schemes of £9.86m against a planned £9.86m.

- Capital expenditure of £22.69m versus a reforecast planned £21.32m;

- A cash balance of £13.18m against a reforecast planned position of £14.76m;

- CoSRR for the full year of level 2 in line with reforecast plan.

Activity and Capacity

- At an aggregated level, elective activity, which includes inpatient, daycase and outpatient activity, is over-performing at the end of January 2015. However, and as consistent with the prior month position, this aggregated position is masking an under-performance within inpatient and daycase work that is counter-balanced against over-performance within outpatient services. Only daycase activity is expected to reverse this position and is forecast to over-perform by the end of the year.
- Non-elective activity including A&E attendances has seen an under-performance at the end of January. The trend of emergency admissions seen in December has continued with an in-month switch of fewer short stay emergency admissions to a greater number of long stay admissions. The forecast position for the remaining part of the year is consistent with the year to date position.
- Direct access diagnostic services continue to over-perform particularly within imaging services and are forecast to over-perform by the end of the year.
- All aspects of specialist commissioned services have over-performed with the exception of SCBU which is slightly beneath the year to date reforecast planned level. The areas of high cost drugs and ICDs carry direct pass through costs that result in a nil gain within the I&E.
- Appointment Slot Issues (ASIs) are being monitored closely and remain challenging in certain specialties. The national issue of lack of availability of the Choose and Book system within January has skewed the ASI position and accounts for 50% of the increase seen.
- An elective outsourcing programme for Calderdale patients using CCG non-recurrent funding is being implemented. The cases identified for outsourcing are: 50 Orthopaedic cases and 30 General Surgery cases. We will maintain 18 week performance at aggregate CCG level however as we are targeting treatment for a higher proportion of longer waiters we have agreement from Commissioners that we may breach 18 weeks at speciality level. This will not have any negative impact on external 18 week performance.
- As referenced in Decembers report, the first weeks of January required additional, unplanned bed capacity to meet operational pressures. At the peak point, an additional 95 beds were open tapering to lower levels that resulted in an average number of additional beds of 39 within the month. As described in the previous months report, an additional £0.50m for winter costs had been provided for over and above the reforecast expenditure levels and the Trust has been able to bear these pressures without detriment to the achieving the overall reforecast financial position.
- CQUIN performance has been maintained and achieved throughout the first half of the year, however operational pressures in the later part of the year bring a risk to full achievement against the individual targets. Whilst the majority of the financial pressure is mitigated through the fixed value contracts an element of this performance standard carries an immaterial financial risk of £50k through non-delivery. This financial risk has been mitigated through the recent agreement of a year-end position with specialised commissioners.
- As previously reported the activity plans for 2015/16 based on forecast outturn, demographics and deliverable capacity were completed on 16 January and is the basis of the 2015/16 contract negotiations with commissioners. This activity plan is currently being scrutinised by Commissioners with significant queries being raised and further assurance being sought to ensure deliverability. Work continues across the Finance and Contracting teams to ensure agreement can be achieved on this plan. To re-state, this piece of work concludes that there is a potential £5m reduction in income driven by this level of activity. This amount is consistent with the protection being offered within 2014/15 by the fixed value contract arrangements.

Income

- Clinical income has over-performed within the month driven by the £1.50m quality investment by commissioners to support hard truths nursing expenditure and additional specialist commissioning and ‘out of area’ activity. The former is partially offset by pass through costs as described above and remains below contracted levels at a year to date position.
- The underperformance on activity against the main two commissioners contracted levels has resulted in a significant increase in the financial protection offered by the contract. The in-

month contract protection has increased by £0.60m leading to a cumulative financial protection of £5.06m. This is forecast to continue until the end of the year and the implication of this under-performance within 2015/16 has been highlighted above at a value of £5m based on activity and capacity plans.

- Non-clinical income remains above planned levels primarily due to charitable funded income to support the pacing room at CRH. This income has no bearing on the calculation of the risk rating and must be removed when assessing operational financial performance.
- Commercial activities, namely PMU and THIS, continue to be below reforecast plans for the year to date and forecast positions. The PMU contribution risk of £200k highlighted within the previous months report remains within the year end forecast, though this needs to be recovered.
- Smaller benefits around education and training income have also been recognised.
- There is no recognition of income relating to the sub-contracting arrangements that have been described above to secure Orthopaedic and General Surgery RTT performance. Any income that will be received will have an equal and opposite cost associated with it resulting in a £nil impact within the year end I&E position.

Expenditure

- Substantive pay costs continue to under-spend but are compensated for by the use of non-contracted pay within the areas of agency, bank, overtime and waiting list initiative payments. The substantive whole time equivalents (wte) equates to 5,176 wte against a budgeted amount of 5,502 wte resulting in vacancies against budgeted levels of 326 wte. The non-contracted pay elements have been estimated on average pay rates to be equivalent to 339 wte. Within the year to date position this results in a marginal underspend within total pay of £0.4m. This position is forecast to reverse with a year-end over-spend forecast at £1m.
- Medical workforce spend is in line with reforecast plan and recognises the continued reliance within the middle grade medical workforce within A&E and the significant spend attached to this. Specialties that have medical workforce gaps are filling with locum/agency as appropriate recognising that significant variation in cost is being experienced.
- Nursing workforce spend is in line with reforecast plan and is experiencing variability within shift fill rates. This variability is due to a combination of lower than anticipated benefits from the overseas recruitment campaign and the variability in the capability of the Trusts preferred supplier to fill shift requests. The Trust has planned further overseas recruitment visits in the final quarter of the year and has recently engaged with Thornbury nursing agency. This agency has significantly higher charge out rates than the majority of other agencies and this remains a potential financial risk for the Trust. Weekly monitoring of shift requests and fill rates is being undertaken.
- Drug expenditure is over-spending against reforecast plans but this is in the context of the specialist commission activity over-performing and is supported by additional income within these areas.
- Additional expenditure of £500k has been included within the year to date and forecast position in recognition of additional Management Consultancy and Turnaround costs. The shape and impact of these arrangements are yet to be defined and quantified within the plans for 2015/16.

Exceptional costs

- Exceptional costs of MARS have been recognised within the year to date position with additional costs forecast in relation to the VR scheme that closed at the end of January 2015. The VRS panel is in the final stages of the validation and approval process of all the applications. This process assesses each application against potential savings, value for money and quality impact assessment. A minimal level of saving (£100k) has been included within the year end forecast but the full year effect into 2015/16 will be far greater.
- Previously anticipated to be fully funded by Commissioners, these costs are now a cash outflow for the Trust with the quality investment of £1.5m as described earlier partially offsetting the impact of this by 50%.

CIP

- The year to date CIP position has over delivered against the reforecast plan by £0.50m with a high level of confidence that the year-end reforecast of £9.86m will be achieved, if not bettered.
- **The focus remains to support the rapid development of 2015/16 schemes as this remains the highest financial risk.**
- Movements have been seen within categories from the previous month forecast recognising offset by additional elements within divisional housekeeping and budgetary control.
- £0.79m of the total CIP identified for 2014/15 remains rated as high risk, the main element of this at £0.64m is the additional contribution target from the Pharmacy Manufacturing Unit.
- The non-recurrent element of this year's forecast is £3.7m with the full year effect of current year schemes into 2015/16 being valued at £6.2m.
- As described above the VR scheme closed on 31 January 2015 with c500 applications received. The 1 month pay savings will be seen in 2014/15 with the full year effect within 2015/16 not currently included within the initial view of 2015/16.
- The Turnaround Executive review on a weekly basis the PMO led workstream areas that are currently proposed for 2015/16. Not all workstreams have been fully tested but progress along the agreed business planning timeframes using the revised process of gateway review is happening. This must conclude as a matter of urgency to inform 2015/16 and beyond, strategic, operational, estates, workforce and financial plans. As a minimum, this programme must release £14m recurrent, cash savings.

Capital

- Spend to date is £0.95m under the reforecast plan but is forecast to overspend by £0.90m by the end of the year. This overspend is primarily within the areas of IT and is recognising opportunities to accelerate specific schemes from 2015/16 into the current year. Maternity EPR and the Trust wide EPR are the key drivers, with additional infrastructure spend and investment within agile working equipment to assist with the decanting of colleagues from the administration block at HRI, making up the balance.
- In addition to the IT spend, a maternity department development at CRH of £225k is included within the forecast over-spend. However, this development is funded from centrally available funds and as such has a zero cash impact for the Trust.
- The theatre refurbishment programme continues to progress and the impact of this programme has been factored in when considering the 2015/16 activity plan.
- The associated cash flows are being monitored and managed as any movements in schemes will have a timing impact within the cash position at year end and into 2015/16.
- There has been no further drawdown on the capital loan facility. Following the October loan drawdown of £7m the remaining facility of £23m is being reviewed in the overall capital review for 2015/16 and beyond.
- The recent success in securing £900k of additional, centrally available technology funds have not been forecast due to the uncertainty of timing of the cash flows. The Trust continues to seek clarification from the Department of Health as to the timing of these flows.
- The affordability and prioritisation of capital spend over the next 5 years continues. The Estates and IT teams have reviewed and re-prioritised forecast spend for 2015/16 with medical equipment currently being finalised with divisional colleagues. This may result in capital spend reducing from the initial plans of £33m to £18m with risk assessments under way to assess the impact of this.

Cash

- The cash collection of aged debt remains strong although an increase in value of the aged debt has been seen within the month by one customer relating to THIS activity. This amount of £800k has now been agreed for payment with the assistance of THIS management and will ensure the previously seen increased levels of cash in the bank and a reduction of bad debt provision will remain. A continual focus within this area remains.
- Although an in-month reduction in compliance the Trust continues to perform within the Better Payment Practice Code and has achieved a cumulative 95% against the targeted level of

95%. In light of the challenges within 2015/16 this area of compliance will be looked at as a potential source of a one-off cash benefit.

- As described above the impact of the capital programme is being monitored and managed.
- The year-end forecast cash balance and cash protection strategies will be further explored as part of the 2015/16 business planning process ensuring robust connections to I&E, capital expenditure and disinvestments. This includes alternative loans/payment profiling as appropriate.

CoSRR

- The year to date Continuity of Service Risk Rating (CoSRR) is a level 3 in line with the reforecast plan, however, as previously reported, this is artificially high due to the timing of the loan drawdown. The underlying CoSSR is a 2.
- The forecast for year-end remains a 2 and is line with the reforecast plan.
- The initial and current view of 2015/16 is a CoSRR of 1.

Other issues

- The progression of the CC2H tender continues with the response to the Invitation to Tender submitted on 30 January 2015. The Trust is conscious that this will have one of two impacts within 2015/16 of a loss £5m income or a growth in income of £30m, both with associated costs. The Trust is currently modelling the status quo but recognises that an appropriate narrative will have to be made explaining to Monitor the risk and/or the opportunity.
- The EPR full business case has been approved and the immediate capital implications have been described above. The wider financial implications are being modelled within the 2015/16 business plans.
- As described in last month's report, at the end of December 2014 the NHSLA informed the Trust of the revised levels of contributions due for CNST arrangements. Due to the changes within the methodology that include the removal of contribution discounts and based on an experienced based assessment, the Trust is facing an increase in contributions of £4m for 2015/16. This pressure will be recognised within the current 2015/16 business planning process alongside all other contract, service, workforce and estate driven pressures.

Recommendation

The Board of Directors is asked to note the contents of this report.

Keith Griffiths

Appendix 1 – Underlying trading position

	Reforecast Plan Submitted to Monitor £m	Known Adjustments					Reforecast Plan Adjusted £m	Reported at M10 £m	Variance £m
		CCG Quality Investment £m	Donated Income £m	Depreciation £m	Restructuring Costs £m	Total £m			
Year to Date M10									
EBITDA	**17.1**	**1.5**	**0.4**	**0.0**	**0.0**	**1.9**	**19.0**	**18.9**	**(0.1)**
Surplus / (Deficit) excluding restructuring costs	(3.3)	1.5	0.4	0.4	0.0	2.3	(1.0)	(1.0)	0.0
Surplus / (Deficit)	**(3.3)**	**1.5**	**0.4**	**0.4**	**(1.1)**	**1.2**	**(2.1)**	**(2.1)**	**0.0**
Year End Forecast at M10									
EBITDA	**20.3**	**1.5**	**0.4**	**0.0**	**0.0**	**1.9**	**22.2**	**22.2**	**0.0**
Surplus / (Deficit) excluding restructuring costs	(4.3)	1.5	0.4	0.7	0.0	2.6	(1.7)	(1.7)	0.0
Surplus / (Deficit)	**(4.3)**	**1.5**	**0.4**	**0.7**	**(3.1)**	**(0.5)**	**(4.8)**	**(4.8)**	**0.0**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: RISK REGISTER REPORT - The Board is asked to note the organisational risks scoring 15+.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Group	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to note organisational risks scoring 15+.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to note organisational risks scoring 15+.

Appendix

Attachment:

COMBINED RISK REGISTER REVISED - 19.2.15.pdf

RISK REGISTER REPORT

Risks as at 16 February 2015

TOP RISKS

6150 (25): Finance: breach of licence
6131 (25): Progression of service reconfiguration impact on quality and safety
4706 (25): Failure to meet CIP
2827 (20): Risk of poor patient outcomes due to dependence on middle grades
2828 (20): Risk of poor patient outcomes and experience caused by blocks in patient flow
4783 (20): HSMR & SHMI
6136 (20): Overaching risk for Infection Control
6178 (20): Modernisation Programme: conflicting priorities

RISKS WITH INCREASED SCORE

There are no risks which have increased in score.

RISKS WITH REDUCED SCORE

5937: Nursing staffing levels (reduced from 15 to 12)

The above risk now sits on their local risk register.

NEW RISKS

The following new risks have been added/have been carried over since/from the meeting:

5806 (16): Privacy & Dignity on Chemotherapy ward at HRI
6143 (16): Modernisation Programme: working with BTHT
6144 (16): Modernisation Programme: Tactical solutions

CLOSED RISKS

No risks were closed.

RISKS TO BE DISCUSSED AT NEXT RISK & COMPLIANCE COMMITTEE:

- 6216 – Failure to comply with FOI requests within statutory timescale
- All Divisions full risk registers
- Appraisal and Mandatory Training
- Paediatrics in A&E
- Safeguarding/Deprivation of Liberty

Extreme and Major Risks (15 or over)

	Risk No	Div	Dir	Dept	Opened	Status	SO	Risk Description plus Impact	Existing Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Extreme	4706	Trustwide	All Divisions	All Departments/Wards	Jun-2011	Active	Objective 2 - Keeping the Base Safe	Trust expenditure exceeds planned levels through failure to deliver Cost Improvement Programme (CIP) or budgetary overspend. The expenditure levels in 2014/15 carry forward into 2015/16 to give rise to an income an expenditure gap that is insurmountable through achievable savings levels. Potential Impact: The Trust does not generate a sufficient I&E surplus and cash to meet on-going commitments and cannot remain a viable and sustainable organisation.	The Trust appointed PWC to assist in the creation of a more robust PMO to develop, control and monitor the 14/15 and 15/16 CIP schemes. - The revised PMO approach includes external and interal support and has been built on the ideas and schemes that were previously managed within the Efficiency Programme Board. - The Trust has appointed a Turnaround Director to provide further direction and support to the PMO process under the overall leadership of the Turnaround Executive. - The Turnaround Executive meets weekly to review, challenge and escalate progression within the necessary workstreams. - Remaining Trust reserves to mitigate against shortfall in part in 2014/15. - Monthly financial reporting and forecasting to allow remedial action.	25 5 x 5	15 5 x 3	5 5 x 1	Additional, external resource will be considered based on need and specialist input identified within each workstream. - Business Planning for 2015/16 underway to capture the financial challenge and design service plans to address this.	Feb-15	Mar-16	BOD	Keith Griffiths	Chris Benham

Extreme	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: The delay in being able to progress service reconfiguration creates the risk that the Trust will not be able to address important clinical quality and safety issues Background: The Outline Business Case identified service reconfiguration proposals that would mitigate and address significant clinical and quality safety issues associated with the current configuration of services across two sites. Clinical Commissioning Groups have decided that consultation on changes in configuration of hospital services will not commence in 2014 and will be delayed to a later stage after changes have been implemented to deliver care closer to home. Impact: The delay in being able to progress service reconfiguration creates the risk that the Trust will not be able to address important clinical quality and safety issues such as: • Non-compliance with many of the standards for Children and Young People in Emergency Care settings; • Paediatric medicine and surgery are not co-located on the same hospital site; • The two hospitals in Halifax and Huddersfield do not provide the same acute services and this leads to a frequent need for inter-hospital transfers • Non-compliance with the prescribed NHS England standards such as: □ All admissions seen by a suitable consultant within 14 hours of admission, or within 6 hours between 0800-2000, except patients who are very ill, where it should be 1 hour; □ Hospital inpatients must have scheduled seven-day access to diagnostic services; □ Support services, both in the hospital and in primary, community and mental health settings, must be available seven days a week.	To address this the Trust is reviewing and assessing possible actions and critical service changes that could be progressed in the interim period, and as quickly as possible, within the required statutory and regulatory processes so as to improve the clinical, quality, safety and sustainability of services. These proposals will be submitted for consideration by the Trust Board in October 2014.	25 5 x 5	25 5 x 5	15 3 x 5	Clinical commissioning Groups have established a Hospital Board to review the OBC and consider the risks related to current model of provision. The Trust will be working with CCGs to support development of possible risk mitigation strategies by the commissioner.	Nov-2014	Mar-2015	WEB	Anna Basford	Catherine Riley
Extreme	6150	Trustwide	All Divisions	All Departments/Ma	Nov-2014	Proposed for Acceptance	Objective 2 - Keeping the Base Safe	Risk that the Trust is found to be in breach of its licence and is unable to operate as a result of the current Monitor investigation into the deterioration of the financial position	Monitor has concluded its investigation into the Trust's unplanned financial performance, The required undertakings have been agreed by the Trust and actions are in place to ensure the Trust remains compliant with these undertakings.	25 5 x 5	15 5 x 3	5 5 x 1	The Trust has instructed PWC to complete a 'Good Governance Review' for financial governance. The Trust is required to refresh the long-term business plan confirming the point at which the Trust returns to a sustainable position.	Jul-2011	Mar-16	BOD	Keith Griffiths	Chris Benham

Major	2827	Surgery & Anaesthetics	Accident and Emergency	A&E CRH / HRI	Apr-2011	Active	Objective 1 - Transforming Patient Care	Risk of poor patient outcomes, caused by dependence on locum middle grades, who at weekends and nights are the senior decision maker in the department. This quality/experience of locums is hugely variable. There have been 4 serious clinical incident in the past two years involving locum Middle grade Doctors. There is a national shortage of middle grade doctors in emergency medicine. December 2014- Risk reviewed - higher risk at present due to Speciality Doctor withdrawing from 2 weeks of nights. Also sickness within the consultant body is causing increased risk as more shifts including consultant on calls to cover. January 2015- consultant sickness reduced as one has returned to work.	- On-line ED guidelines. Senior Nurse Operationally managing the department- overview of all staff to support and advice, escalation of any issues to the on-call Consultant. - - Recruited longer term locums to improve continuity, provide improved decision making, improved supervision for junior medical staff and support to the Senior Nurse. - Recruited 4 new consultants, departmental cover from 8am until 10pm Monday to Friday. - Two SpR's now in post. - A&E Risk Management Strategy- guidelines available in each department.	20 4 x 5	20 5 x 4	16 4x 4	-Oct 2014- Workforce review completed. 2 Senior Nurses training and developing the ANP role within the departments, with a 10 year plan to increase the number to 10. - first two ACP's will complete in March 2015 at SHO level- - Business case developed to provide direct clinical care consultant cover seven days a week, this has now been approved- recruitment process commenced. Consideration being given to NHS Locum Consultants being recruited. -BC for two consultant approved, out to recruit-October 2014 - Recruitment at middle grade level ongoing. - Exploration of reconfiguration of services underway, as described in the Strategic Outline Case.-2013/14- Contingency Plan being developed to mitigate the risk of having no available Middle Grade Doctors in the OOH period, this is to be agreed with Director of Operations as this contingency is to potentially close one site in the OOH period and divert to the opposite site. December 2014- Requested Locum consultant via agency. Out to all agencies for locum Specialty Doctors. Consultants 'acting down' to provide on site cover but extremely challenging due to gaps at consultant level and Speciality Doctor level cover. January 2015- One consultant has now returned from sick leave	Apr-2015	Dec-2015	Clinical Outcomes Board	David Birkenhead	Dr Mark Davies/Mrs Bev Walker
Major	2828	Surgery & Anaesthetics	Accident and Emergency	A&E CRH / HRI	Apr-2011	Active	Objective 1 - Transforming Patient Care	Risk of poor patient outcomes and experience, caused by blocks in patient flow due to low numbers of discharges. This results in patients having prolonged waits in A&E until an appropriate bed becomes available. There is also a risk of breaching the A&E performance indicators, including the YAS turn around time. November 2014- worsening/increasing delays for patients transferring into inpatient speciality beds causing poor patient experience and blocking ED cubicles which impacts on the ability for patients to be assessed. January 2015- likelihood reduced as long waits not occurring daily.	- Senior Nurse co-ordinator to liaise with patient flow team. Use A&E escalation protocol to ensure A&E senior management aware. - Site co-ordinator to be informed to provide support/additional nursing resource. - Out of hours to contact Matron on site/on call manager. - Level discharges. - Plan for every patient which is monitored for each patient on a daily basis to reduce length of stay. - Strong multi-agency working relationships, overseen by the Urgent Care Board. -Escalation process in place- Surge and Escalation Plan	20 4 x 5	20 5 x 4	2 1 4 x 4	Strategic Outline Case aims to deliver effective, efficient responsive services.	Apr-2015	Mar-2015	CHT Capacity Group	Julie Dawes	Sajid Azeb

Major	5792	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2013	Active	Objective 1 - Transforming Patient Care	As per Risk 3793 - but specifically for Macular and Glaucoma patients with Chronic eye disease where they are dependant upon CHFT in monitoring, reviewing and assessing their eye condition at specifically times intervals. The shortage of Consultants has led to difficulties in maintaining capacity, resulting in the risk of glaucoma/macular patients missing follow ups as CHFT are unable to provide an appointment at the correct interval. This could result in harm (i.e. deterioration of sight).	- Partial Booking introduced to assist with planning of follow up appointments - Some Consultants helping by undertaking WLI and allowing their clinics to be overbooked to see the urgent cases - Advertised x 2 for Consultants with poor response now have 2 long term locum Consultants in place as of 31 August with another scheduled to start on September 11 2014 - Maternity leave cover no longer required as Consultant due to return September 2014 - Action Newton revised clinic templates - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract Refinement, Ocular Hypertension follow ups) - Explored different ways of working to assist currently (employed additional Optometrists on bank) and in the future looking to employ additional Orthoptists and Optometrists and expand their practice so that can undertake reviews of Glaucoma patients(within agreed protocols) and undertake non medical prescribing and intra-occular injections. - reviewed clinical portfolio of existing Consultants and the Cornea Specialists now taking responsibility for the patients that are most vulnerable from their chronic condition - plan to remove Specialty on C&B for out of area referrals to reduce impact on already stretched capacity	25 5 x 5	16 4 x 4	4 2 x 2	- continue to explore opportunities to involve AHPs and expand their roles with protocols and pathways and additional training for non-medical prescribing to enable the Consultants to deal with the more complex cases The risk rating will be reduced once we are assured that all the 'pending' appointments have been actioned and no patients are waiting (other than for their own choice) 12.11.14 Consultant Appointments Committee set for December 2014, with 5 Candidates shortlisted	Feb-2015	Apr-15	PCB	Julie Dawes	Melanie Addy
Major	6136	Trustwide	All Divisions	All Departments/Wards	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Infection Control The number of cases of post 48 hr C Difficile creates a risk to patient safety & experience, and could impact upon CHFT's governance rating. There has not been an outbreak, but isolated cases in different areas across both sites	Hand hygiene compliance audits Antibiotic prescribing & monitor according to Trust policy FLO audits completed Replacement of commodes to ensure that they can be effectively cleaned 24/7 cleaning available CCGs involved in C Diff RCAs to ensure learning across the health economy Standard isolation procedures, with any breaches incident reported C Difficile care plan to ensure best practice, with daily ICPN review External Review of Infection Control practice & procedures	25 5 x 5	20 5 x 4	15 5 x 3	- Share the learning from RCAs effectively - Implement the recommendations of the External Review - HPV of wards - Antibiotic ward rounds - Prompt isolation of patients	Jan-2015	Mar-2015	ICPB	David Birkenhead	Jean Robinson

Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Objective 2 - Keeping the Base Safe	The HSMR and SHMI are higher than the national average, which indicates that there are more deaths than expected, according to these methodologies	- Communications plan. - Care of the acutely ill patient programme underway underpinned by a number of workstreams, reporting to Clinical Outcomes Board - Revised plan has been implemented, a Mortality dashboard down to ward level has been developed to improve monitoring. - The Medical Division has plans for 3 diagnostic outliers: COPD, Stroke and heart failure. - Improved understanding of proxy HSMR and SHMI measures are allowing us to map closer to real time the impact of the programme.	20 4 x 5	20 4 x 5	8 4 x 2	Implement action plan by: - Implementation of Outline Business Case - Reducing mortality rates - Early recognition of our deteriorating patients - Reliable delivery of care bundles - Improving care for frail patients - Investigating the cause of outlying SHMI conditions - Improving coding - Reducing patient transfers and outlying - Improved staffing and improved handover. - Clinical commissioning Groups have established a Hospital Board to review the OBC and consider the risks related to current model of provision. The Trust will be working with CCGs to support development of possible risk mitigation strategies by the commissioner.	Jan-2015	Mar-2015	COB	David Birkenhead	Juliette Cosgrove
Major	5937	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Jan-2014	Active	Objective 2 - Keeping the Base Safe	Nurse staffing level on wards, departments and community teams falls below the Trust agreed establishments which are in line with RCN guidance of a 1 to 8 ratio during the day. Wards cannot always cover shifts adequately which may result in patients coming to harm and having a poor experience. Staff experience will also be poor which could result in low morale and job satisfaction (also known to impact on patient safety and experience). Training requirements may not be achieved due to inability to release staff for training. There may be difficulty for ward/department/team leaders/sisters achieving management function. Nurse staffing levels have been highlighted as a significant issue from a mock CQC inspection undertaken in September 2014. The concerns regarding nurse staffing levels is highlighted monthly through the Hard Truths report.	- Weekly nursing workforce meetings. - Operational meetings to review staffing requirements on a weekly basis. Every ward/department/team duty roster examined and priorities for cover agreed and actioned. - Matrons sign off duty rosters. - Frequent recruitment days to ensure a smooth process. - Hard Truths report and staffing numbers included in Board of Director report. - Daily risk, action and evaluation to ensure wards, departments and teams have sufficient staff to deliver safe effective care and experience. - Monitoring of specific patient safety outcomes.	16 4 x 4	16 4 x 4	6 2 x 3	- Develop recruitment and retention strategy. - Overseas recruitment January to March 2015. Aim to recruit 50 qualified nurses. - Develop preceptorship membership and supervision to retain staff. - Develop induction package to recruit and retain staff. - Grow the nursing workforce - OU courses, back to nursing courses. - Utilise the Calderdale framework to develop roles to support patient safety and experience. - Examine the function of the Flexible Workforce Department in order to ensure nurses are available to work as required. - Work with partners to ensure a well governed flexible workforce is available.	Jan-2015	Mar-2015	WEB	Julie Dawes	Lindsay Rudge/Jackie Murphy

Major	6130	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: Loss of income or reduction in profit related to competitive procurements There is a significant risk of the Trust losing income and market share of service provision through competitive procurements. This is caused by Greater Huddersfield CCG and Kirklees and Calderdale Local Authority decisions to undertake competitive procurement for services. Current tenders relate to: sexual health services in Calderdale and Huddersfield: anti-coagulation services in Huddersfield; school nursing services in Calderdale; a range of services in Huddersfield related to the Kirklees wide community services market testing (such as specialist nursing, podiatry, dietetics, community rehab, diabetes patient education services, intermediate care, pulmonary rehab, COPD early supported discharge, dermatology, stroke early supported discharge).	There are proactive systems in place to ensure that we are aware of risk and opportunities related to competitive procurement. We are responding and submitting tenders to secure continued service delivery. We are working collaboratively with partners such as GP Federations, Locala, Mid Yorks, and SWYPFT to determine where a decision to collaborate may give more chance of success to secure continued service delivery and support business viability (whilst ensuring this in accordance with regulatory requirements related to choice and competition). We are redesigning services to meet the specifications and offer value for money. We have used bid writers to assist us in presenting tenders.	16 4 x 4	16 4 x 4	8 2 x 4	.	Nov-2014	Dec-2014	CISC	Anna Basford	Rob Aitchison & Lisa Williams
Major	6132	Corporate	Finance	Corporate Finance	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: Reduction in elective surgery market share and volume of work undertaken by the Trust. Impact: Reduction in income that will impact on overall Trust viability. The current value of under performance against the block contract for elective surgery is £3m.	A recovery plan to increase the volume of procedures undertaken within existing capacity has been developed and is being implemented. The NHS England Elective Intensive Support Team have been contacted and the Trust has developed capacity models for elective surgery specialities as part of the 15/16 business planning process. Work is being undertaken to work with consultant surgeons to explore the potential to develop new business models that will improve the ability of the Trust to make attractive and competitive offer for elective surgery.	20 5 x 4	16 4 x 4	8 2 x 4	-The trust will develop GP and patient information to support the offer of choice and promote the services provided by the Trust. '-The PMO workstream of 'Theatre Productivity' is working with external support to identifiy productivity gains that may allow for an increased level of activity within the same capacity.	Dec-2014	Mar-2015	WEB	Mags Barnaby	Julie Barlow
Major	6027	Corporate	Finance	Corporate Finance	May-2014	Active	Objective 2 - Keeping the Base Safe	A failure to secure sufficient cash to pay for the planned Capital programme or meet ongoing commitments. The potential impact is: The Trust is unable to develop infrastructure in support of a sustainable future for the organisation.	Loan and drawdown profile agreed with the Independent Trust Financing Facility to support capital investment. Capital forecast revised further downwards in September to protect liquidiy. Robust management of working capital ongoing.	16 4 x 4	15 5 x 3	12 4 x 3	-Opportunities under review to increase CIP delivery and improve I&E position will improve cash availability. '-Awaiting outcome of applications to secure central Department of Health capital funding for technology investments. '-2015/16 Capital plans have been risk assessed and reduced. Further modelling is being undertaken as part of the 15/16 business planning process. '- Further discussions are to be had with the ITFF for forecast external cash support within the third quarter of 2015/16	Jan-2015	Mar-16	WEB	Keith Griffiths	Kirsty Archer
New Risks to be presented:																				

Major	6105	Surgery & Anaesthetics	Theatres & Operating Services	Theatres HRI	Jun-2014	Active	Objective 2 - Keeping the Base Safe	Changes in surgical technique adding pressure to an already limited laparoscopic instrument base, meaning that there is not always instrumentation available for cases. patients can experience delay and/or cancellation in extreme cases. The equipment is used at night also for urgent cases and we sometimes rely on this being returned from off-site sterilisation, and change plans at short notice. We have had some patients who had to undergo and open surgical case.	Demand drive and fast track (at a cost per tray) through Bbraun. £10k in month Borrow from CRH when the demand allows, demand at CRH is also growing on the equipment	8 x 4 = 2	15 x 5 = 3	0 x 0 = 2	on capital plan was put on hold 13/14 reduced in 14/15.	May-2015		DB	Mags Barnaby	Kathryn Aldous
Major	6191	Medical	Acute Medicine	Ward 6A CRH	Jan-2015	Proposed for Acceptance	Objective 2 - Keeping the Base Safe	Extra capacity ward area of 15 beds with no established workforce acting as medical outliers. KPI potential for poorer compliance. Patient experience may have negative feedback. Deterioration of patient	Ward based medical staff reviewing patients daily- escalation to responsible Consultant allocated to review daily as outliers Escalation of patients who become acutely unwell to return as priority to speciality bed base. Band 7 and matron reviewing ward daily	15 x 5 = 3	15 x 5 = 3	6 x 3 = 2	Daily review of staffing and patients and re-deployment of staff by matrons Reallocation of Trust staff from within the medical division to support the ward. Weekly "hotspots" escalation to flexible workforce priority for agency for this ward. Dedicated ward based Dr, allocated Consultant. Prompt recruitment of band 6 clinical post x2 for this ward, interview date 23.01.15	Jul-2011	Jan-2015	PSQB	sajid Azeb	mandy musgreave
Major	6203	Diagnostics & Therapeutic Services	Pharmacy Manufacturing Unit	PMU	Jan-2015	Proposed for Acceptance	Objective 2 - Keeping the Base Safe	The Stilmas Still producing Water for Injections is a complex, bespoke, high maintenance system. It is also obsolete and we are having to commission bespoke manufacture of spare parts. In addition as demand for manufacturing has developed it with struggle to keep up with demand. This is a critical system for sterile manufacture in particular and the loss of function will destroy the business; there are no viable alternatives to on-site manufacture of Water for Injections. Sterile manufacturing currently accounts for £2.5million of business and is our biggest high value growth area. Replacement with more appropriate plant system is the only option c£150,000	Regular maintenance and close daily monitoring.	15 x 3 = 5	15 x 3 = 5	5 x 1 = 5	Needs to be covered in business plans by 2016/17 at the latest.	Jul-2011	Feb-2016	DB		Stephen Langford
Major	5806	Medical	Integrated Medical Specialties	Ward 3 HRI	Jan-2015	Active	Objective 1 - Transforming Patient Care	A failure to maintain privacy and dignity of patients on the Chemotherapy Unit at HRI, caused by the poor environment on Ward 3, shared with the vascular surgical ward. the vascular patients and the staff from ward 3 all have to travel through the chemotherapy outpatient area to get to there ward. Resulting in the possibility of the ward area being closed down by peer review and poor patient experience.	Staff on the Unit are taking whatever action they can to maintain privacy and dignity for all the patients in this cramped environment, pending the longer term solution.	16 x 4 = 4	16 x 4 = 4	2 x 1 = 2	Ward 7, HRI is to be upgraded to accommodate Chemotherapy Day Unit and Oncology Outpatients, this will commence in April 2015 and be completed in October 2015.	Apr-2015	Mar-2015	QC	Lesley Hill	Maureen Overton
Major	6161	Surgery &	Critical Care	ICU	Dec-2014	Active	Objective 2 - Keeping the Base Safe	Existing bronchoscope is old and repairs are costly and becoming more frequent. It is cleaned and stored in the Endoscopy Department. The bronchoscope is not freely available due to the frequency of damage. Obtaining it out of hours is time consuming and takes a member of staff away from the shop floor. The Department is often left without a bronchoscope in the Department.	We never use the bronchoscope with an endotracheal tube of less than 8mm as a diameter smaller risks desheathing the bronchoscope, as has previously happened. We aim to use the bronchoscope 'in hours' to minimise the necessity of obtaining it out of hours, not always possible.	9 x 3 = 3	16 x 4 = 4	0 x 0 = 0	Purchase disposable bronchscopes to eliminate all risk factors.	Apr-2015		NA		Denise Cunningham

Major	6164	Medical	Intermediate Care and Community	All departments (Community Adult Service)	Dec-2014	Active	Objective 2 - Keeping the Base Safe	The lymphoedema service has already had one member of staff (Band 5) resign who leaves the service on 9/01/15 The Clinical Nurse Specialist (band 7) has resigned and leaves her post 20/02/15 ThRisk to service delivery due to band 5 staff nurse leaving the team. 5 clinic sessions lost per week as a result as there is no one to cover the clinics. This will have a financial impact on the Trust as the service is commissioned on an SLA agreement and payment is attached to attendances. The service is unsustainable with a single practitioner due to the demand on the service. is will result in there being no lymphoedema service as both staff members will have left by the 20/02/15	Discussions with managers to identify priorities for notice period to notify stakeholders and patients of the loss of service We have met to look at the catergories of patients that are seen within this service .The complex head and neck breast and Gynae we are asking whether in the short term Bradford could support . The lower lymphoedema can be managed by District nurse and supported by Tissue viability . There are 2 Dns that have completed the key assessor and triage new patients however we need pathways otherwise these patients will breach 18 week target .Back fill for the community nurse will be required .	25 5 x 5	16 4 x 4	0 0 x 0	Awaiting out come of actions	Jul-2011		NA	mandy Gibbons-Phelan	Tracy Green

Modernisation Programme Risks:																				

Major	6143	Corporate	THIS	Modernisation Programme	Nov-2014	Active	Objective 1 - Transforming Patient Care	Risk 12. There is added complexity in working with Bradford Teaching Hospitals who are being named as a beneficiary of the procurement. This may affect the deployment timescale and delay any associated benefit. There could also be increased costs as a result of the delays.	regular discussions with senior management at Bradford Trust; inclusion of the implications of working with Bradford (during procurement; during implementation and post implementation) in all negotiations with potential suppliers.	16 4 x 4	16 4 x 4	4 4 x 1	Mitigation. 1) The legal team are formulating an MOU between the two Trusts which will form the basis of a contract. 2) There is an option to receive a managed service with off site hosting which may be considered post contract award. Update 4/2/15 - Ongoing	May-2015	Apr-2015	WEB	Mandy Griffin	Dave Lang & Cindy Fedell
Major	6144	Corporate	THIS	Modernisation Programme	Nov-2014	Active	Objective 1 - Transforming Patient Care	Risk 13. The tactical solutions fail to realise benefit in the period prior to EPR go live due to delay and resource constraints	programme and project structures use of formal methodologies (MSP and PRINCE2)	16 4 x 4	16 4 x 4	9 3 x 3	Mitigation 1) Better monitoring arrangements are in place for the tactical deployments. 2) Additional resources have been committed to assist with the management and coordination of the tactical deployments. update : November 2014 : some projects delayed; but priority being given to those with best ROI. Proper controls now in place. Risk rating unchanged until evidence of effectiveness. Update 4/2/15 - Ongoing	May-2015	Apr-2015	WEB	Mandy Griffin	Emma Livesley
Major	6145	Corporate	THIS	Modernisation Programme	Nov-2014	Active	Objective 2 - Keeping the Base Safe	Risk 14. A failure to safely deliver clinical services due to the complexity of locally hosting and managing an EPR system creating service disruption in Bradford Teaching Hospitals and the possibility of a financial penalty to CHFT as a result of arrangements. Links to risk 6160	the procurement process - specifically identifying the operational requirements (performance standards), and considering all options for system support.	20 5 x 4	20 5 x 4	1 1 x 1	mitigation 1) To ensure that THIS has adequate skills and expertise in house in order to provide a guaranteed service. 2) Locally host the solution and have external management of the application. 3) Have the solution remotely hosted by the vendor and managed by them in the early years. 4) The contract with the supplier and the MOU with Bradford is used to deflect potential penalties on CHFT.	May-2015	Feb-2015	WEB	Mandy Griffin	Dave Lang

Trust Risk Profile as at 16 February 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)					= 6027 – Failure to meet Capital programme
Likely (4)				= 5792 – Shortage of Consultants in Opthalmology > 5806 – Privacy and Dignity on Chemotherapy Ward, HRI > 6143 – Modernisation Programme: working with BTHT > 6144 – Modernisation Programme: Failure to realise benefits = 6130 = Loss of income/reduction in profit related to competitive procedures = 6132 = Reduction in elective surgery market share and volume of work	= 2827 – Dependence on middle grade locums in A&E = 2828 – Blocks in patient flow in A&E = 6136 – Infection Control
Highly Likely (5)				= 4783 – HSMR & SHMI	= 6150 – Breach of Monitor licence = 6131 – Progression of service reconfiguration impact on quality and safety = 4706 – Failure to meet CIP

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: DRAFT BOARD ASSURANCE FRAMEWORK - The Board is asked to receive and approve the Draft 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: Board of Directors / Weekly Executive Board	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board Assurance Framework (BAF) is a strategic document that the Board uses to to obtain assurance on the achievement of the organisation's principal objectives. Over the last four months work has been done to develop the BAF and the latest ddraft is presented to the Board for review.

Main Body

Purpose:

At its workshop in October the Board of Directors discussed the Trust's risk management approach and arrangements. A programme of work was agreed to develop the risk register and risk reporting arrangements alongside the development of an improved BAF and independent support sought to help deliver this work. The draft BAF is presented to the Board for comment.

Background/Overview:

Following the Board workshop, a further workshop was held with the executive directors to identify the key risks to the delivery of the Trust's strategic objectives. This risk horizon is attached for information. Following this meetings have been held with each of the directors to go through the detail of the risks, the mitigating actions and to score the risks.

The Issue:

The current version of the 2014/15 BAF is presented for comment. There is a glitch in the excel files that shows the date a month ahead. This will be sorted by the final version.

Next Steps:

Further work is required to agree the date when the Board believe the target risk score should be achieved. Work is also being done on the detail behind the summary - and is available for Board members to review at this stage. The detail will be presented along with the final BAF at the March meeting.
Following the Board meeting in January, there is work being done to identify the specific strategic risks relating to the decision to progress with the electronic patient record. These will go to Risk and Compliance Group prior to presentation to the Board.
A draft BAF is also being developed for 2015/16 along wtih a refresh of the strategy on a page for review by the Board in March.

Recommendations:

The Board is asked to receive and comment on the Draft Board Assurance Framework.

Appendix

Attachment:

New BAF 14-15 Issue 8.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

THE BOARD OF DIRECTORS
Board Assurance Framework
2014/15

Date **26-Mar-15**

This version of the BAF identifies the following significant risks of failure to achieve the corporate objectives:

	Today's score S x L
1. A failure to achieve good clinical outcomes and compassionate care, caused by inertia to transform the way we work, may result in unintended harm to patients (severe permanent harm or death). **(Clinical outcomes and compassionate care).**	5 x 3 = 15
2. A failure of sufficient clinical leaders to inspire and facilitate change, caused by a lack of engagement, may result in unintended harm to patients (severe permanent harm or death). **(Clinical leadership).**	4 x 4 = 16
3. A failure to deploy sufficient, talented staff, caused by an inability to attract, recruit, motivate, train, reward and develop them, may result in unintended harm to patients (severe permanent harm or death). **(Safe staffing).**	4 x 4 = 16
4. A failure to remain financially sustainable a caused by national austerity and slow transformation may result in unplanned financial deficit (and Special Administration). **(Financial resilience).**	5 x 5 = 25
5. A failure to compete vigorously, caused by being too focussed internally, may result in missed opportunities to retain or acquire activity, talent, capital, services (losses of £1-£5M). **(Competitive forces).**	4 x 4 = 16
6. A failure to obtain stakeholder commitment to initiate change political uncertainty and commissioners' own priorities may result in an exacerbation of all significant risks (may result in regulatory escalation and Special Administration). **(Community and two site strategy).**	5 x 5 = 25
7. - UNDER CONSTRUCTION - EPR Risk	

The following pages set out the initial work to characterise the assurance framework over each risk.

Plan on a page 2014-15.

Calderdale and Huddersfield NHS
NHS Foundation Trust

We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding, compassionate care which transforms the welfare of the communities we serve.

We put the patient first

Our patients and our staff will be able to describe what our vision and mission means to them. We will treat our patients, staff and partners in a way that we would be expected to be treated ourselves. We will use our resources (financial, human and estate) as a driver for change, rather than as a constraint.	We will improve access to care for patients and prioritise their safety, thereby also ensuring our regulatory compliance. We will improve real time patient information being at hand for us and our partners to provide the best and seemless care.	We will improve patient outcomes and experience through active and strategic collaboration within and outwide CHFT.

We go see

TRANSFORMING CARE	KEEPING THE BASE SAFE	IMPROVEMENT & INNOVATION THROUGH STRATEGIC ALLIANCE
1. We're rolling out the Courage to Put the Patient First lean action plan. (LH, MB)	6. We're implementing action plans for both the Urgent Care Board and the Care of the Acutely Ill patient. (MB).	11. We're working with stakeholders including CCGs / HWB / NHS England to gain support for consultation to begin on the case for change (AB)
2. We're implementing the Colleague Engagement Plan (LH)	7. We're actively seeking a partner to modernise our IM & T systems and install an Electronic Patient Record. (JR)	We're working in collaboration with partners to improves services such as:
3. We're developing state of the art outpatient services at Acre Mill. (LH)	8. We're reviewing and making changes to governance (VP)	12. Bariatric surgery with Mid Yorks; (AB)
4. We're working to deliver the Trust's Efficiency Programme Board (EPB) activity for 2013-15 (MB)	9. We're implementing a Health & Safety action plan to make sure we have safe and suitable premises (LH)	13. Sexual health services with Mid Yorks and Locala; (AB)
5. We're modernising and prioritising our approach to patient engagement and compliants handling. (JD)	10. We're improving our commercial intelligence about future commissioning risks / opportunities. (AB)	14. Psychiatric liaison services with South West Yorks Partnership (AB).

We work together to get results

We do the must dos

Significant risk register 14-15

Line	Objective we could fail	Risk of failure to achieve objective that we face now	Exec Lead	Impact x likelihood (max 5 x 5) today	Acceptable score	Target date	Our assurance oversight
1	Transforming care	A failure to achieve good clinical outcomes and compassionate care caused by inertia to transform the way we work, may result in unintended harm to patients (severe permanent harm or death). **(Clinical outcomes and compassionate care).**	JD	5 x 3 = 15	3 x 3 = 9		Quality Committee
2	Keeping the base safe	A failure of sufficient clinical leaders to inspire and facilitate change caused by a lack of engagement may result in unintended harm to patients (severe permanent harm or death). **(Clinical leadership).**	DB	4 x 4 = 16	3 x 3 = 6		Remuneration Committee
3	Keeping the base safe	A failure to deploy sufficient, talented staff caused by an inability to attract, recruit, motivate, train, reward and develop them, may result in unintended harm to patients (severe permanent harm or death). **(Safe staffing).**	JD	4 x 4 = 16	3 x 3 = 9		Quality Committee
4	Keeping the base safe	A failure to remain financially sustainable caused by national austerity and slow transformation may result in unplanned financial deficit (and Special Administration). (**Financial resilience**).	KG	5 x 5 = 25	3 x 4 = 12		Audit Committee
5	Keeping the base safe	A failure to compete vigorously caused by being too focussed internally may result in missed opportunities to retain or acquire activity, talent, capital, services (losses of £1-£5M). **(Competitive forces).**	AB	4 x 4 = 16	3 x 3 = 9		Finance & Performance
6	Improvement & innovation	A failure to obtain stakeholder commitment to initiate change political uncertainty and commissioners' own priorities may result in an exacerbation of all significant risks (may result in regulatory escalation and Special Administration). **(Community and two site strategy).**	AB	5 x 5 = 25	3 x 5 = 15		Board

Board assurance framework summary for 14-15 corporate objectives

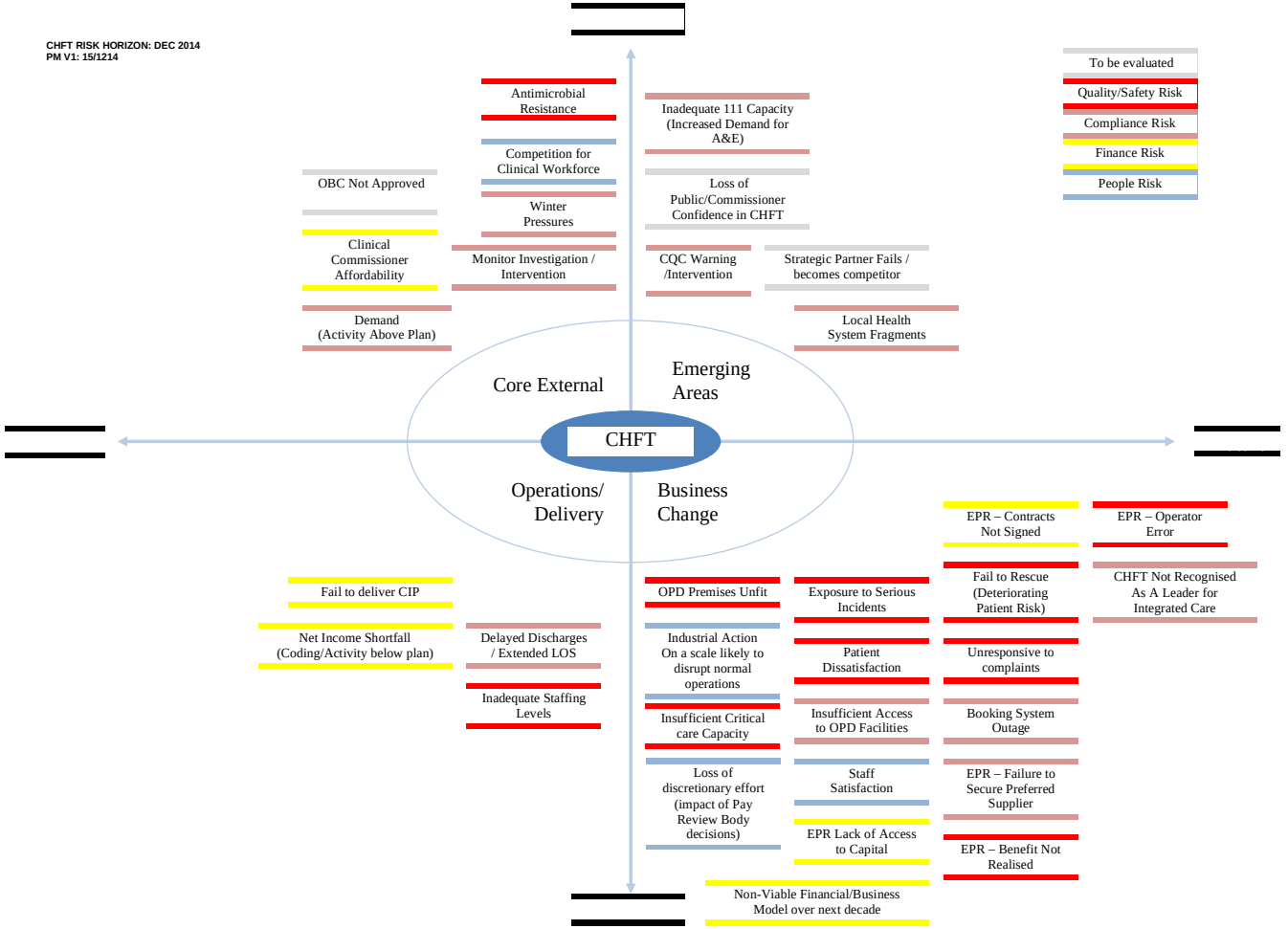
Calderdale and Huddersfield NHS
NHS Foundation Trust

	Corp obj	Risk name	Primary Lead	Secondary Lead ?	Initial score S x L	Today's score S x L	Acceptable S x L	Target date Board to determine	Committee oversight	The risk of failure….	Caused by…	Which could result in…
1	Transforming care	Clinical outcomes and compassionate care	JD	KB	4 x 5 = 20	5 x 3 = 15	3 x 3 = 9		Quality Committee	A failure to achieve good clinical outcomes and compassionate care	inertia to transform the way we work	unintended harm to patients (severe permanent harm or death).
2	Keeping the base safe	Clinical leadership	DB	JD	0	4 x 4 = 16	3 x 3 = 6		Remuneration Committee	A failure of sufficient clinical leaders to inspire and facilitate change	a lack of engagement	unintended harm to patients (severe permanent harm or death).
3	Keeping the base safe	Safe staffing	JD	KB	0	4 x 4 = 16	3 x 3 = 9		Quality Committee	A failure to deploy sufficient, talented staff	an inability to attract, recruit, retain, reward and develop them	unintended harm to patients (severe permanent harm or death).
4	Keeping the base safe	Financial resilience	KG	AB	5 x 3 = 15	5 x 5 = 25	3 x 4 = 12		Audit Committee	A failure to remain financially sustainable	national austerity and slow transformation	unplanned financial deficit (and Special Administration). (Financial resilience).
5	Keeping the base safe	Competitive forces	AB	KG	0	4 x 4 = 16	3 x 3 = 9		Finance & Performance	A failure to compete vigorously	being too focussed internally	missed opportunities to retain or acquire activity, talent, capital, services (losses of £1-£5M).
6	Improvement & innovation	Community and two site strategy	AB	AB	5 x 5 = 25	5 x 5 = 25	3 x 5 = 15		Board	A failure to obtain stakeholder commitment to initiate change	political uncertainty and commissioners' own priorities	an exacerbation of all other significant risks (may result in regulatory escalation and Special Administration).

An overview of how risk relates to strategy at Calderdale and Huddersfield NHS FT 14-15

	Risk categories	Relationship to Trust strategy	Approaches we use to control the risk	Example tools we use to gain confidence that risks are controlled to an acceptable level	Which significant risks fall into each category ?
i	Preventable, undesirable, operational risks. (Routinely fed into Datix on the front line).	There is no strategic benefit from taking these risks. We may prevent or cost-efficiently minimize their occurrence.	Prevention: Culture. Internal control systems. Detection: Proactive identification and mitigation of risk in proportion to threat level.	Mission & value statements. Policy, procedure, training, segregation of duties; restricted access; defined levels of authorisation; record keeping; reporting. Risk maps and registers. Strategic risk register (identifies risks scored 15+) Board assurance framework. Internal audit & clinical audit. Conversation and other communication.	1. Clinical outcomes and compassionate care. 2. Clinical leadership. 3. Safe staffing
ii	Strategy execution risks, which the Trust accepts as a result of the Board's strategic choices.	Taking these risks is essential for achieving strategic objectives. We may reduce the likelihood and impact in cost-efficient ways.	Detection: Risk monitoring linked to strategy review meetings and resource allocation. Contingency: Cost and time reserves to support problem solving.	Risk horizon scanning workshops. 'Delphi' method of expert review to agree a risk score. Risk 'heat map'. Strategic risk register (identifies risks scored 15+) Board assurance framework. Expert review of planning assumptions. Select Committees (ie an assurance committee meeting for a select purpose, to examine one topic in greater detail). Conversation and other communication.	5. Competitive forces 6. Community and two site strategy 7. Modernisation / EPR
iii	External risks which are hard to predict or manage, because although we may influence the environment, we cannot control it.	We cannot control the occurrence of such risks, but can prepare for them and thus reduce the impact.	Contingency: Escalation procedures. Emergency response planning. Contingency planning. Insurance.	What if ?' scenario workshops. Give due regard to high impact, low probability events ('HILPs'). Risk 'heat map'. Strategic risk register (identifies risks scored 15+) Board assurance framework. Conversation and other communication.	6. Community and two site strategy. 4. Financial resilience.

Calderdale and Huddersfield NHS
NHS Foundation Trust



Audit trail from workshop December 2014 with Exec Team, showing how concerns relate to significant risks and BAF

Quality/Safety Risk
Compliance Risk
Finance Risk
People Risk
To be evaluated

Line	Core external risks identified	Our response under the risk policy	Link to one of our 7 significant risks	Reference to the BAF (non-exhaustive)
1	Antimicrobial Resistance	Take control; modify by prescribing guidelines	Clinical outcomes and compassionate care	Risk 1 control 5.
2	Winter Pressures	Take control; modify by contingency planning	Clinical outcomes and compassionate care	Risk 1 control 1
3	Monitor Investigation / Intervention	This is negative assurance that confirms weak control	Financial resilience	Risk 4 control 2
4	Demand (Activity Above Plan)	Avoid by reducing activity or modify by taking control by contingency	Financial resilience	Risk 4 control 2
5	Clinical Commissioner Affordability	Avoid by reducing activity or modify by taking control by contingency	Financial resilience	Risk 4 control 2
6	Competition for Clinical Workforce	Avoid by stopping activity / transfer by contracting / modify by taking control by contingencies	Safe staffing	Risk 3 controls 3,4,5
7	OBC Not Approved	Modify by taking control by contingencies	Community and two site strategy	Risk 6 controls 1-6
	Operations / delivery risks identified (internal and now)			
8	Inadequate Staffing Levels	Transfer by contracting / modify by taking control by prevention & contingencies	Safe staffing	Risk 3 controls 1,2,3,4
9	Delayed Discharges / Extended LOS	Modify by taking control by prevention and detection	Clinical outcomes and compassionate care	Risk 1, controls 4,5,6
10	Net Income Shortfall (Coding/Activity below plan)	Modify by taking control by detection and contingencies	Financial resilience	Risk 4 control 2
11	Fail to deliver CIP	Modify by taking control by prevention, detection & contingency	Financial resilience	Risk 4 controls 1,2,3,4,5,6
	Business change (internal but future)			
12	OPD Premises Unfit	Avoid by stopping the activity / modify by taking control by prevention, detection	Competitive forces	Risk 5 control 4
13	Insufficient Critical care Capacity	Modify by taking control by prevention, detection and contingencies	Clinical outcomes and compassionate care	Risk 1 control 1
14	Patient Dissatisfaction	This is negative assurance that confirms weak control	Clinical outcomes and compassionate care	Risk 1 control 1
15	Exposure to Serious Incidents	Modify by taking control by prevention and detection	Clinical outcomes and compassionate care	Risk 1 control 4
16	Unresponsive to complaints	This is negative assurance that confirms weak control	Clinical outcomes and compassionate care	Risk 1 control 1,2,6
17	Fail to Rescue (Deteriorating Patient Risk)	Modify by taking control by prevention and detection	Clinical outcomes and compassionate care	Risk 1 control 1,4,5,6
18	EPR – Operator Error	Modify by taking control by prevention and detection	Clinical outcomes and compassionate care Modernation / EPR	Risk 1 control 6 Risk 7
19	EPR – Benefit Not Realised	Modify by taking control by prevention; detection and contingency	Clinical outcomes and compassionate care Modernisation / EPR	Risk 1 control 6 Risk 7
20	Insufficient Access to OPD Facilities	Modify by taking control by prevention and detection	Clinical outcomes and compassionate care	Risk 1, controls 5
21	Booking System Outage	Modify by taking control and contingency planning	Clinical outcomes and compassionate care	Risk 1 control 6
22	CHFT Not Recognised As A Leader for Integrated Care	This would be negative assurance that confirms weak control	Clinical outcomes and compassionate care	Risk 1 control 1
23	EPR – Failure to Secure Preferred Supplier	Transfer by contracting	Clinical outcomes and compassionate care Modernisation / EPR	Risk 1 control 6 Risk 7
24	Non-Viable Financial/Business Model over next decade	Modify by taking control by preventing; detecting and contingency	Financial resilience	Risk 4 controls 1-6
25	EPR Lack of Access to Capital	Transfer by contracting	Modernisation / EPR	Risk 7
26	EPR – Contracts Not Signed	Transfer by contracting	Modernisation / EPR	Risk 7
27	Staff Satisfaction	Modify by taking control by reventing and detecting	Clinical leadership	Risk 2 control 1
28	Industrial Action On a scale likely to disrupt normal operations	Modify by taking control by contingency planning	Clinical outcomes and compassionate care Competitive forces	Risk 1 control 1 Risk 5 control 4
29	Loss of discretionary effort (impact of Pay Review Body decisions)	Modify by taking control by prevention and detection	Clinical leadership	Risk 2 control 1
	Emerging areas (external and future)			
30	Inadequate 111 Capacity (Increased Demand for A&E)	Modify by taking control by contingency planning	Clinical outcomes and compassionate care Competitive forces	Risk 1 control 1 Risk 5 control 4
31	CQC Warning /Intervention	This is negative assurance that confirms weak control	Clinical outcomes and compassionate care	Risk 1 control 1
32	Local Health System Fragments	Modify by taking control by contingency planning	Clinical outcomes and compassionate care Competitive forces	Risk 1 control 1 Risk 5 control 4
33	Loss of Public/Commissioner Confidence in CHFT	Modify by taking control by prevention and detection	Community and 2 sites	Risk 6 control 3
34	Strategic Partner Fails / becomes competitor	Modify by taking control by prevention and detection Seek and take a chance	Competitive forces -	Risk 5 controls 2,3,4, 5 -

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Assistant Director of Infection Prevention Control
Date: Thursday, 26th February 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Monthly DIPC report - Monthly DIPC Report - Report on the position of Healthcare Associated Infections	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: WEB	
Governance Requirements: Improving Patient Experience - reducing HCAI	
Sustainability Implications: None	

Executive Summary

Summary:

The DIPC report provides a monthly update on the current position of HCAI in the Trust and highlights areas of concern

Main Body

Purpose:

To keep the Board informed

Background/Overview:

Monthly update of the Trust position on Infection Prevention and Control

The Issue:

As per the report

Next Steps:

Report to be taken to the Infection Control Performance Board

Recommendations:

For the Board to note the content

Appendix

Attachment:

Monthly DIPC Report February 2015.pdf

Report from the Director of Infection Prevention and Control to the Weekly Executive Board February 2015

Performance targets

Indicator	Month agreed target	Current month (January)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	0	**1**	One case has been assigned the trust
C.difficile (trust assigned)	2	**3**	18	**22**	7 avoidable 15 unavoidable
MSSA bacteraemia (post admission)	1	**2**	15	**9**	One case was a line infection and currently being investigated by RCA
E.coli bacteraemia (post admission)	2	**3**	23	**20**	Further scrutiny of cases is taking place to establish areas of learning. There is a risk the internal year-end target will not be met.
MRSA screening (electives) December validated data	95%	**96.4%**	95%	**94.93%**	Compliance has improved in December

Quality Indicators

Indicator	Month agreed target	Current month (January)	YTD agreed target	YTD performance	Comments
MRSA screening (emergency)		90.5%		84.8%	
Central line associated blood stream infections (Rate per 1000 cvc days)	1.5	1.32	1.5	0.97	There was one central line infections in January and being investigated using RCA investigation.
Isolation breaches		35		202	Increased isolation breaches mainly due to D&V taking priority over MRSA. All were monitored by IPCT
ANTT Competency assessments (doctors)			95%	**66.5%**	Plan to provide mandatory training for all junior doctors

ANTT Competency assessments (nurses)			95%	**73.3%**	with a fixed time frame for assessment and to re-train the ward based key trainers
Blood cultures Competency assessments (Drs)				1%	Significant decrease in competency assessments is due to the changeover of doctors. Training to be provided as above with ANTT training
Blood cultures Competency assessments (RN)				53.4%	
Cleanliness	Not set	97.46%		97.4%	
Hand hygiene	95%	100%	95%	99.83%	
Frontline Ownership Audits (% performed)		46%			The majority of areas where audits were not performed were the outpatients departments. OPD managers contacted

Clostridium difficile

3 post admission cases in January with the YTD total of 25 cases (an additional 3 cases in February) against a ceiling of 18. Of these, 15 have been classed as unavoidable and 8 classed as avoidable (2 pending).

- The majority of cases are sporadic and could not have been prevented.
- The pilot of the 'nerve centre' is expected to identify patients with diarrhoea and prompt timely isolation.
- Recent avoidable cases identified issues around cleaning and staffing.
- Action plans produced from each RCA for scrutiny at Infection Control Performance Board.

The 2015-16 objective has been set with a ceiling target of 21 cases. The table below summarises the cases in January.

Date and place of patient	**Summary of case**	**Key issues identified from RCA**
02.01.15 HICU	Admitted to SAU on 26th December and transferred to ICU following repair of perforated gastric ulcer. Treated for intra-abdominal sepsis with IV Tazocin. Commenced enteral feeding on 30th December and developed loose stools.	• RCA meeting concluded this was an avoidable case • Potential cross transmission from another case • Delay in sampling
14.01.15 C6C	Admitted on 4th December to CMAU falling a fall. Transferred to C6C on 5th December. Developed swallowing problems	• RCA meeting concluded this was an unavoidable case • Delay in isolation • Delay in diagnosis due to

	and required NG feeding. On regular laxatives. Developed pneumonia and treated with IV Tazocin	poor labelling of sample • Inappropriate use of laxatives • Not treated for C.difficile infection – classed as colonisation
19.01.15 C5D	Admitted on 27th December and treated for a chest sepsis. He received 14 days of IV antibiotics which was justified based on clinical condition. Had bowel prep on two occasions for investigations of malaena.	• RCA meeting concluded this was an unavoidable case • Delay in isolation • Missed opportunities to sample or discuss episodes of loose stools with infection control

The two charts below have been taken from the HCAI Yorkshire and Humber Quarterly Report from PHE. The first chart below shows the quarterly rate per 100,000 bed days over the last four years (up to Q3 this year)

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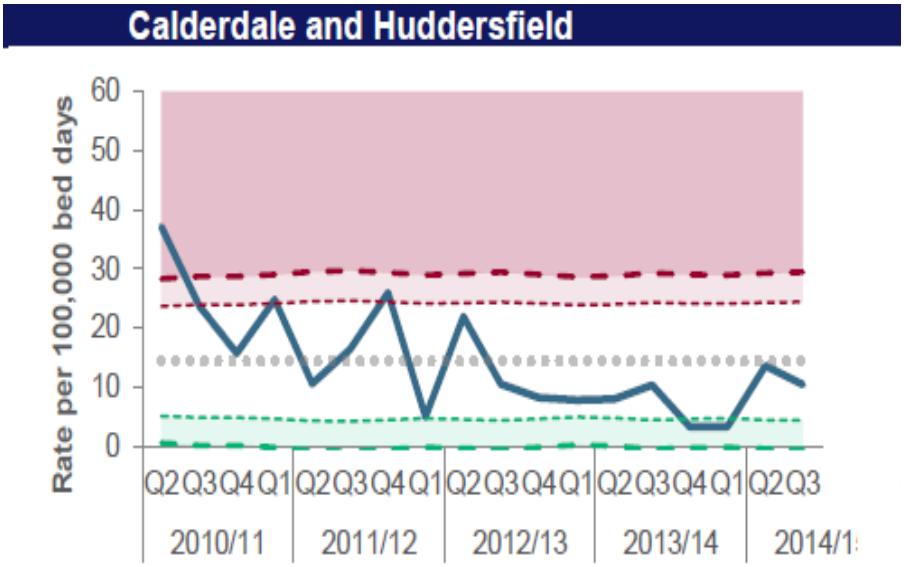
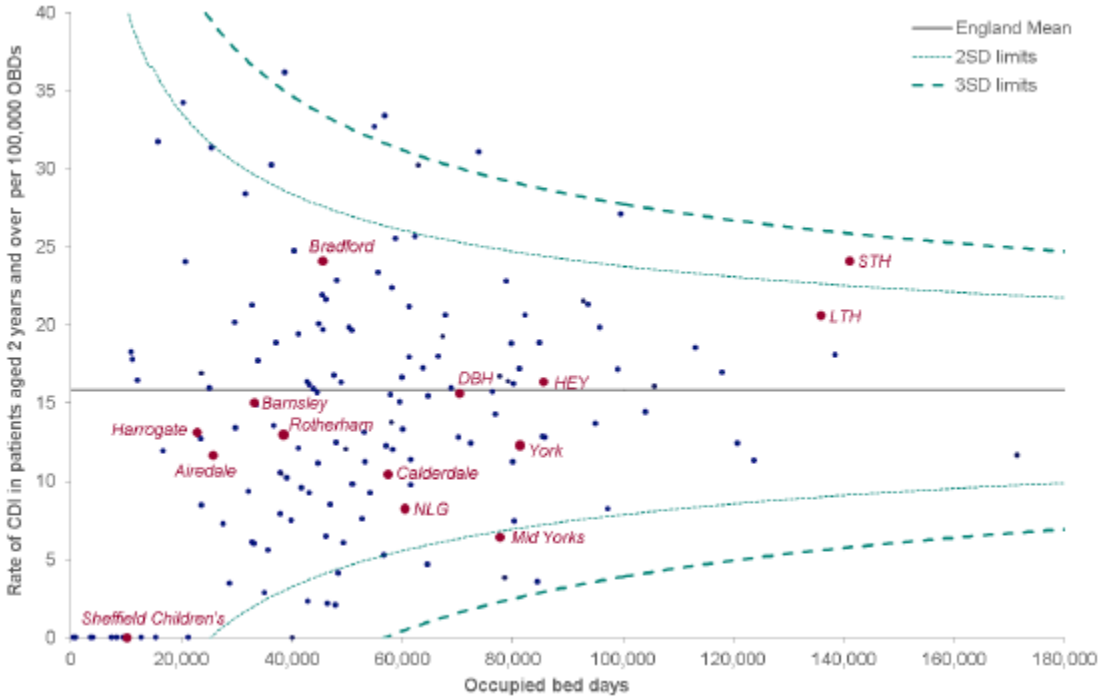


The second chart shows the trust apportioned cases per 100,000 bed days for all acute trusts in England from July to September 2014. Points represent all acute trusts in England with the trusts in the Yorkshire and Humber Region identified. The dashed lines represent control limits at 2 and 3 standard deviations around the national mean.

July to September 2014



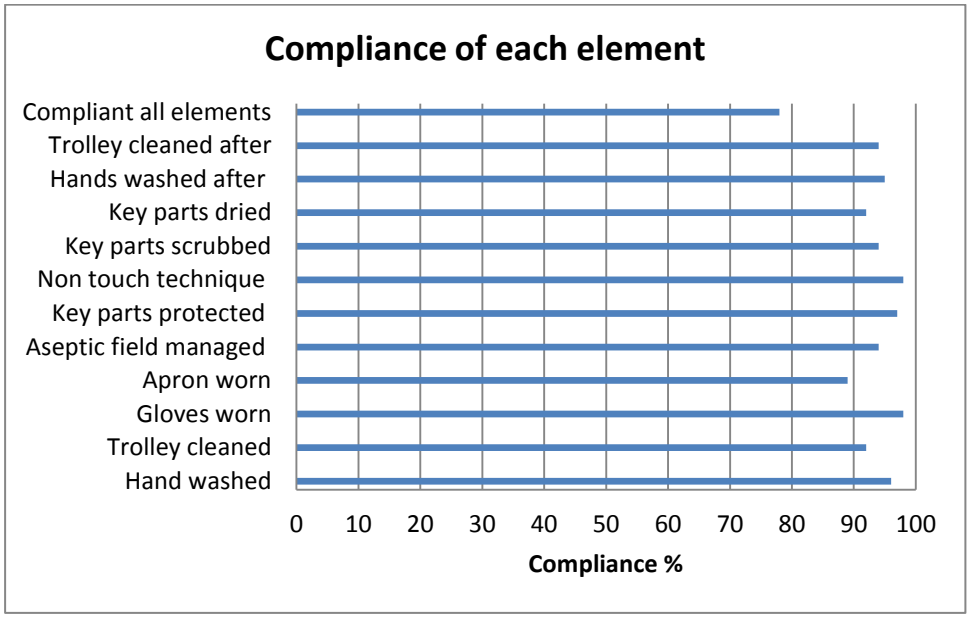
Areas of Concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during January were 35 compared to 24 in December. Of the 35 isolation breaches in January,
    - 20 were at CRH and 15 were at HRI
    - 31 were on medical wards, of these, 14 were on the MAUs
    - 4 were on surgical wards
- **Norovirus** – HRI wards 4 and 5 were closed to admissions due to Norovirus during January for 5 days on ward 4 and 10 days on ward 5 with a total of 60 lost bed days. The norovirus strain this year has seen prolonged periods of symptoms up to 5-7 days,
- **Hospital acquired MRSA** - in January, there was 3 cases identified; 2 on medical wards and one in critical care. There have been a total of 26 cases of hospital acquired MRSA since April.

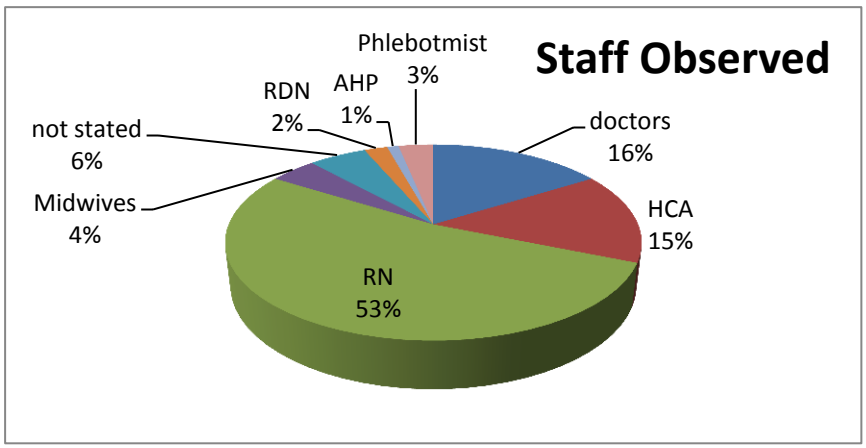
Miscellaneous

- **Influenza** – the flu vaccine campaign has been extended to the end of February
- **Aseptic Non-touch Technique (ANTT) Audit –** an annual audit of observed practice of ANTT was performed in December with a total of 93 observations. A full report will be shared with clinical teams. The key facts are highlighted in the charts below

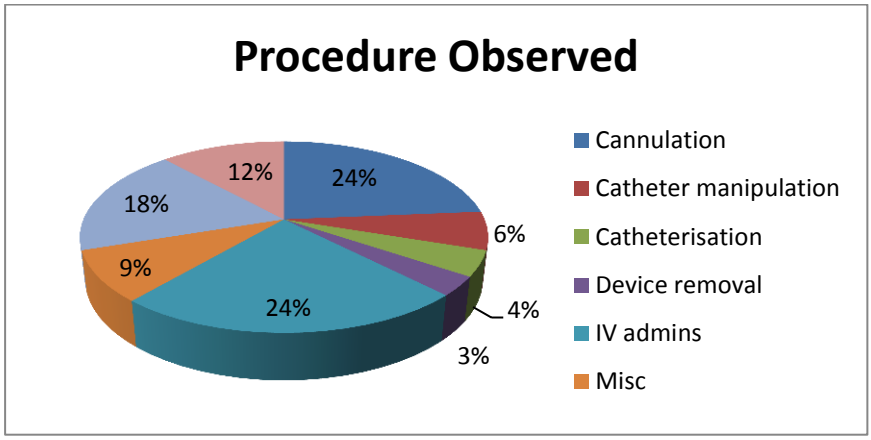
    - ***78% compliance with all elements of ANTT***



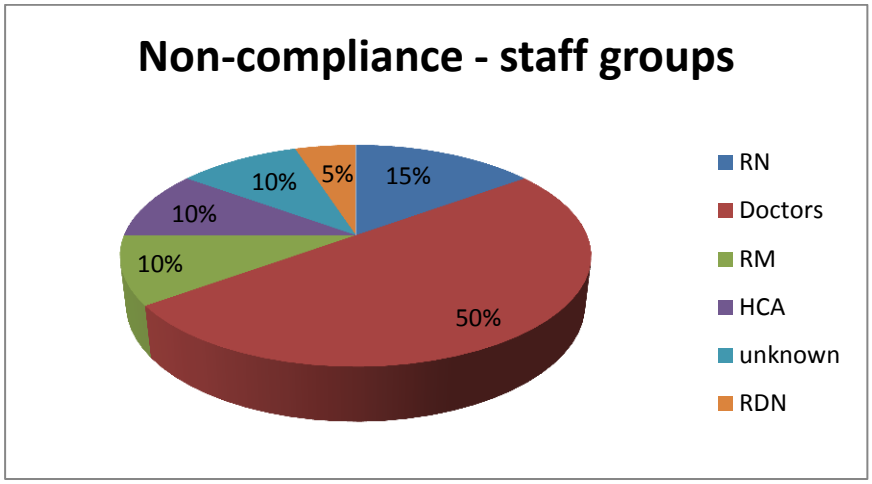
- ***Staff groups observed***



- ***Procedures observed***



- ***Non-compliant staff (in one or more elements of the ANTT process)***



Quality Improvement Audits

- Five Quality Improvement Audits were performed in January
  - CRH Neurophysiology – Scored Green (97%)
  - HRI ward 3 – Scored Green
  - CRH DPU – Scored Green (91%)
    - Damage noted to chairs in the waiting area
    - Some dust noted in cupboards in the dirty utility
  - HRI ward 21 – Scored Amber (89%)
    - Plaster and paintwork damage noted to fixtures, fittings and walls (jobs logged with estates)
    - Dusty air vents
  - CRH ward 2CD – awaiting report

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Stephanie Jones, PA to Director of Nursing
Date: Thursday, 26th February 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Adult and Children Safeguarding Annual Report 2013-2014 - The Adult and Children Safeguarding Annual Report provides an overview of the work that has taken place over the past year with regards to safeguarding children and adults.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Adult and Children Safeguarding Annual report was received by the Trust's Safeguarding Committee on 2 February 2015, where it was agreed.	
Governance Requirements: In line with local and national guidance the Annual Safeguarding report provides assurance that the organisation is discharging its safeguarding responsibilities.	
Sustainability Implications: None	

Executive Summary

Summary:

The Safeguarding Annual Report provides an overview of the safeguarding work that has been undertaken over the past year in order to ensure our services are fit for purpose and meet the needs of the Communities we serve.

Main Body

Purpose:

See attached report

Background/Overview:

See attached report

The Issue:

See attached report

Next Steps:

See attached report

Recommendations:

It is recommended that the Board of Directors note the content of this Annual Report.

Appendix

Attachment:

CHFT SAFEGUARDING ANNUAL REPORT 2013-2014 FINAL - February 2015.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Annual Safeguarding Report 2013 – 2014

Author: **Karen Hemsworth, Associate Director Safeguarding Children and Vulnerable Adults**

December 2014

Foreword

I am pleased to introduce Calderdale and Huddersfield NHS Foundation Trust's Annual Safeguarding Report for 2013/14.

The Trust's pledge to safeguarding remains a key priority and over the past year this has been evidenced through staff's dedication to ensuring that the quality of services that we deliver are safe and meet the needs of our services users. A number of National reports on patient Safety and Quality and the publication of a number of SCR's have helped us shape our thinking and as a result, update our vision for the Trust;

'We will work with partner organisations to understand the individual needs of patients, and together, deliver outstanding compassionate care which transforms the welfare of the communities we serve'.

The Trust's Safeguarding Team have continued to support and empower staff in working with people who are experiencing or have experienced abuse and neglect, in order to ensure that they continue to develop the necessary skills and competences to fulfil their safeguarding responsibilities, whatever their role.

Work with our partners across the Calderdale and Kirklees footprint, has gained momentum over the past year, in order to protect children and adults at risk from abuse and to collectively ensure that all organisations are discharging their safeguarding responsibilities.

In particular, over the past year, the importance of ensuring that safeguarding is at the heart of everything we all do has been brought into spotlight with national reports published on Jimmy Savile "Giving Victims a Voice" and Mid Staffordshire NHS Trust's Public Inquiry.

Safeguarding truly is everyone's business across the Trust and is integral to our work, whatever our role. Whilst we continue to embrace the changes and challenges that lay ahead, it is important that we remain focused on providing quality services that keep children and adults at risk safe.

Introduction

The purpose of this report is to provide the Trust Board with an overview of safeguarding activity within the organisation over the past year, outlining key achievements and challenges. The report provides accurate and current information about the efficiency and effectiveness of our internal systems and processes in order to demonstrate the status of compliance with our statutory safeguarding obligations. It 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.

Calderdale and Huddersfield NHS Foundation Trust (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, requiring services to work effectively together to prevent harm and intervene only when harm, neglect, or abuse is suspected. Changes, re-organisation, and uncertainty can create risks to Safeguarding arrangements. It is therefore vital that Safeguarding standards are maintained and continue to improve, and, accountability remains clear and unambiguous. With this is mind it is critical that safeguarding remains a key priority and staff are fully supported in delivering safe and quality services.

Whilst historically safeguarding children policy and practice has been more established within **all organisations**, during the past year there has been good progress in implementing Safeguarding Adult Policy and Practice across the Trust, however, it must be acknowledged that there is still much work to be done, both within the Trust and collectively across the partnership.

It is crucial that safeguarding becomes embedded in practice and in everything we all do, as opposed to there being a culture where 'safeguarding' is seen as being someone else's responsibility. If we are to learn lessons and ensure quality and safe services, staff across all organisations have to be skilled, competent and supported in taking ownership and responsibility for dealing with issues that arise.

The Changing Face of Safeguarding: A National Context

(i) Children

Safeguarding activities in Health and Social Care organisations such as Calderdale and Huddersfield NHS Foundation Trust NHS are regulated by the Care Quality Commission (CQC). They make sure that the care people receive meets Essential Standards of Quality and Safety whilst respecting their dignity and protecting their rights. Regulation 11 of the Health & Social Care Act 2008 ensures that people who use services are safeguarded from abuse. The Children Act 2004 and Working Together to Safeguard Children 2013 set out how agencies work together to protect children.

Useful links

Working together to safeguard children 2013

http://nww.cht.nhs.uk/divisions/trust-wide-information/safeguarding-index-new/safeguarding-children

In addition a national panel of independent experts has been established to ensure that lessons are learned from Serious Case Reviews (SCRs). The panel provides advice to Local Safeguarding Children Boards (LSCBs) about the application of SCR criteria and the requirement to publish reports. The Working Together guidance makes clear that LSCBs should have regard to the panel's advice when making decisions about SCRs and clarifies the essential roles of local agencies – including health services and the police – in keeping children safe and promoting the welfare of children in need.

(ii) Adults

This year the NHS Commissioning Board also published Safeguarding Vulnerable People in the Reformed NHS (2013), an accountability and assurance framework for Safeguarding. The framework complements the revised statutory guidance.

Useful links

Safeguarding vulnerable people in the reformed NHS

http://nww.cht.nhs.uk/divisions/trust-wide-information/safeguarding-index-new/safeguarding-adults

Care Act 2014

The Care Act puts in place the legal changes necessary to implement the 2012 White Paper 'Caring for our future' and will change how social care law works, prioritising people's well-being, needs and goals, highlighting the importance of preventing and reducing needs, promoting independence and putting people more in control of their care. Most of the changes will come into effect from April 2015 covering a range of matters including adult safeguarding.

The Care Act aims to provide a clearer legal framework for adult safeguarding by putting safeguarding adult's boards on a statutory footing, making safeguarding enquiries a corporate duty for councils, and making serious case reviews mandatory when certain triggering situations have occurred and partners believe that safeguarding failures have been implicated. In addition duties will be placed on relevant agencies to co-operate over the supply of information and a duty of candour will be placed on providers about failings in hospital and care settings with creation of a new offence of supplying false or misleading information in the case of information they are legally obliged to provide.

Further briefing on the Care Act and practice implications will be available on the intranet and in the Spring Safeguarding Newsletter.

Useful links

Statutory guidance for the Act has been published:

https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

(iii) Domestic Abuse

In March 2013 the Government extended the definition of domestic violence and abuse to include young people aged 16 and 17 and includes wording to capture coercive control.

Domestic Violence Protection Orders saw the new power introduced by the Crime and Security Act 2010 to enable the police to put in place protection for victims in the immediate aftermath of a domestic abuse incident. The DV disclosure scheme (Claire's Law') introduces a framework with recognised and consent processes to enable the police to

disclose to the public, information about previous violent offending where this may help to protect a potential victim.

(iv) Giving Victims a Voice & the Francis Inquiry Reports

In early 2013 the reports in to sexual allegations made against Jimmy Savile and the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry were published. Whilst both reports are different in their nature; one is of prolific sexual abuse of children and young people over a significant time period by a high profile celebrity, and the other is first and foremost of appalling suffering of many patients that was primarily caused by a serious failure on the part of a provider NHS Trust Board; what both reports have in common is the recording and description of unprecedented failings by agencies for early identification or timely responses to reports of abuse (including neglect) and failure to act in a timely or robust manner once such allegations had been made. Both reports include failings on behalf of NHS organisations to ensure that the care people received met essential standards of quality and safety whilst respecting their dignity and protecting their rights; thus ensuring that people who use services are safeguarded from abuse.

From a safeguarding perspective both reports reiterate the continuing need for all NHS health and social care employees to be professionally curious and directly ask patients questions about abuse and neglect, to act upon suspected or reported abuse and to ensure robust safety plans are in place escalating concerns with tenacity, whilst respecting patients' human rights and demonstrating the candour expected of public organisations.

Work has taken place over the past year to ensure that the culture of learning and lessons learned from Mid Staffordshire becomes shared and developed in all the Trust's strategies.

With regard to the Savile inquiries, the Trust has had the opportunity to review current arrangements and a Visiting VIP and Visiting Media Policy has now been developed and highlighted across the organisation. More recently, a number of new allegations relating to Savile and NHS settings have come to light; one relating to a predecessor organisation of CHFT, and the Trust is currently investigating this incident.

Useful links

Giving victims a voice. Joint report into sexual allegations made against Jimmy Savile.

http://www.nspcc.org.uk/news-and-views/our-news/child-protection-news/13-01-11-yewtree-report/yewtree-report-pdf_wdf93652.pdf

The Mid Staffordshire NHS Foundation Trust Public Inquiry
http://www.midstaffspublicinquiry.com
Policies for Visiting VIP's and Visiting Media can be found at;
http://nww.cht.nhs.uk/index.php?id=4914#P

(v) Prevent Strategy

April saw the 2013/14 NHS contract being amended to include the 'PREVENT' strategy for providers of services.

The Government's counter-terrorism strategy is known as CONTEST. PREVENT is part of CONTEST, and it's aim is to stop people becoming terrorists or supporting terrorism. The strategy promotes collaboration and co-operation among public organisations. The health service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients. The aim of PREVENT is to stop people from becoming terrorists or supporting terrorism. Three national objectives have been identified for the Prevent strategy:

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

The health sector contribution to PREVENT; focuses primarily on Objectives 2 and 3 (DoH, 2011).

Useful links
Prevent strategy - Channel: Protecting vulnerable people from being drawn into terrorism
http://nww.cht.nhs.uk/divisions/trust-wide-information/safeguarding-index-new/prevent-agenda

(vi) The Information Governance (Caldicott 2) was published in 2013 'Information; To share or not to share' it's aim being to promote a more balanced approach between protection of patient information and the use and sharing of information to improve patient care. It links closely to recommendations from the Francis Report regarding the development of a more open culture of transparency within the NHS, the duty of candour and stronger support for staff who speak out about care concerns and also recommendations from a number of SCR's.

Useful links

Caldicott 2:

http://nwww.cht.nhs.uk/divisions/trust-wide-information/saefguarding-index-newsletters/

Safeguarding: Progress over 2013/14

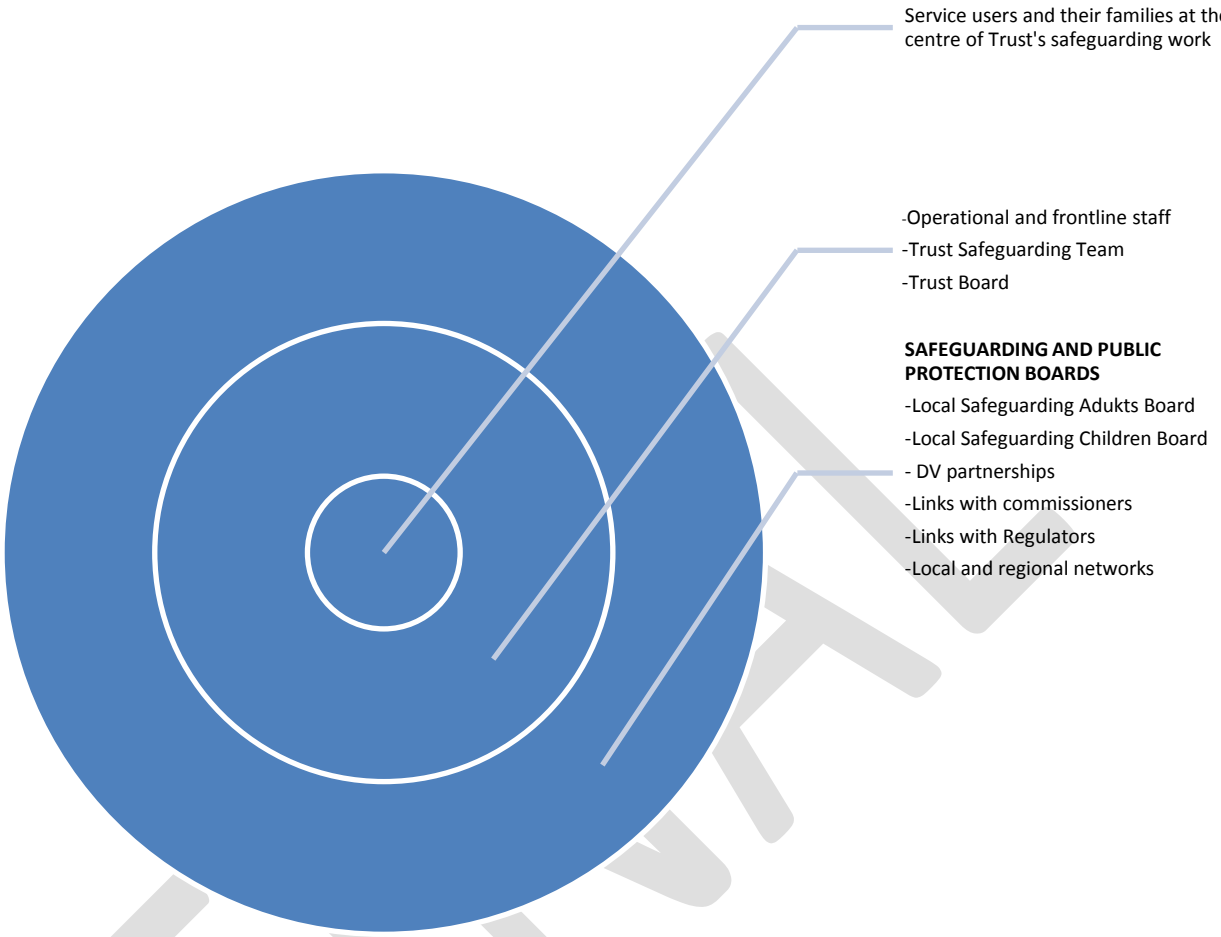
Achievements

The Safeguarding Team, and staff across the Trust, have worked hard over the past year to deliver the Trust's 2013/14 objectives from a safeguarding perspective and to ensure that the organisation fulfils its statutory safeguarding responsibilities including;

- The development of a robust and reliable safeguarding framework that will monitor compliance against both strategic and operational safeguarding functioning within CHFT, whilst ensuring that strategic change does not impact negatively on safeguarding processes.

- Ensuring high levels of compliance and best practice.

If we are improve outcomes for vulnerable groups and keep people safe from harm, it is essential that safeguarding becomes everyone's responsibility and part of everyone's practice, whatever their role. CHFT will therefore continue to support staff to embrace their responsibilities so that safeguarding becomes embedded in practice.



The Trust Safeguarding Team

The Trust has a dedicated Safeguarding Team who provides safeguarding advice and support across the workforce. The team sits corporately within CHFT and is led by the Associate Director for Safeguarding, who provides a strategic steer, in order to ensure that the organisation is complaint with its safeguarding responsibilities. Regular reports and updates to the Trust's Safeguarding Committee, to the Trust Board, Quality Boards and engagement with the Local Safeguarding Boards (LSCB'S), ensure that our approach is open and transparent. The team provides the organisations linkage to the Local Safeguarding Boards; namely Local Safeguarding Children Boards (LSCB), Local Safeguarding Adult Boards (LSAB) as well as other strategic partnerships. The Team is proactively engaged in multiagency working to enhance relationships, develop strategies and strengthen processes to ensure that the people to whom the Trust provides services

and the communities in which it works are safeguarded from abuse and that early intervention is available to assist vulnerable children and adults.

Lines of accountability

Director of Nursing

Associate Director for Safeguarding (Safeguarding Team Administrator)

Looked After Children's Team	*Named Nurse*	*Named Nurse (acute)*
Designated LAC Nurse)	*(Adults)*	*Named Nurse(community)*
Specialist LAC Nurse		*Named Midwife*
LAC Administrator		*Paediatric Liaison*

How have we developed and strengthened partnerships?

Collaborative work with partners continues to be at the heart of everything we do.
Child and adult safeguarding has continued to be a priority within CHFT over the last year, with significant developments being made to strengthen and develop partnerships across the health and social care economy. The Associate Director for Safeguarding has continued to provide a strategic steer within the organisation with regard to safeguarding and continues to work closely with the Safeguarding Children and Adult Board's and across the strategic partnership. CHFT works with four safeguarding boards (across the Kirklees and Calderdale footprint), the Associate Director for Safeguarding representing CHFT on all four boards and holding the position of Vice Chair of both safeguarding boards in Kirklees. Regular meetings with lead safeguarding personnel within health and social care, both from an adult and children's perspective, as well as regular meetings with safeguarding leads within the Clinical Commissioning Groups, have strengthened working relationships and ensured effective communication and information sharing. Work continues to develop wider links across the region.

How do we quality assure safeguarding work and work with partner agencies in safeguarding and promoting the welfare of vulnerable adults and challenge any areas of practice needing improvement?

We have worked hard to ensure strong and effective partnerships and working arrangements both at an operational and strategic level.

Within the Trust, clear reporting mechanisms are in place for feedback from all board meetings about safeguarding practice and developments. The Trust **has continued to engage and work with the safeguarding boards and all its current** subgroups, ensuring representation and effective contributions in order to take work forward, this has included contributions to the board's development day and agreement of board priorities and the 2013/14 work plan.

How have we ensured effective communication and engagement with staff and the public in respect of the work of the Trust and the wider safeguarding agenda?

Internal lines of accountability and internal structures within the Trust have been strengthened to ensure the organisation has a clear process in place for communicating with staff and ensuring they are engaged with the work of the board. Engagement with service users is critical and involving them in the development of future services within local communities is a priority. Learning from experience and from complaints and incidents is crucial if we are to embrace a culture of openness and transparency. Within CHFT we continue to move forward in relation to feedback following complaints, staff survey, suggestion schemes etc and we have a strong and effective membership council made up of local people, patients, carers, staff from partner organisations and staff employed by the Trust.
The Trust's vision is "Your Care, Our Concern". This vision is at the heart of everything we do and our successes in achieving high quality care for all our patients.

How have we ensured continuous improvement in the efficiency and effectiveness of our safeguarding work?

Over the past year **governance arrangements** around safeguarding within the Trust have been reviewed. Lines of accountability and responsibility have been established and all internal policies and procedures have been reviewed to reflect changes within health and social care, as well as Local and National Policy, and they can be accessed via the Safeguarding icon on the intranet.

The **Integrated Safeguarding Children and Adults Committee** formed in 2012, continues to take a strategic overview of the safeguarding arrangements within the Trust, and to

provide updates to the Trust Board on a regular basis. The Terms of Reference and divisional representation on these groups has been reviewed in 2014 to ensure that divisions are appropriately engaged and represented. It has continued to provide a forum to bring together key senior safeguarding professionals and other senior managers across Calderdale and Huddersfield Foundation Trust to ensure the organisation's safeguarding responsibilities' are being discharged effectively. It provides a bridge between the Safeguarding Boards, and all areas of service within the Trust, in order to be assured safeguarding responsibilities are being fulfilled and risks identified and managed appropriately. It also considers the implications of national policy on local practice and oversees the safeguarding work programme and priority areas for action, as well as providing regular updates to both commissioners and to the Safeguarding Board. This has also been strengthened this year by the identification of a link from the safeguarding team who now attends the divisional Patient Safety and Quality Groups on a quarterly basis in order to improve communication and information sharing. Two safeguarding operational groups (children and adults), represented by divisions, continue to monitor safeguarding practice at an operational level and provide a forum for monitoring and progress and sharing information and specialist guidance and support, thus ensuring that safeguarding becomes embedded throughout the entire breadth and depth of the organisation. Over this last year discussions have taken place with divisions and they have been asked to review their representation at these groups in order to ensure they are represented appropriately and in order to improve communication and engagement. **Clear links with the CCG's have been established with the Designated Safeguarding Leads within the CCG being formal members of the Committee and as such having an overview of the current position within the organisation.**

Monitoring and Assurance

Section 11 Audits. The Section 11 audits and subsequent challenge events, as well as our assurances to commissioners, have provided a vehicle for demonstrating CHFT's level of compliance and effectiveness with regard to our safeguarding responsibilities. **Section 11 of the Children Act 2004 places a statutory duty** on organisations, and individuals, to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children and all agencies are required to submit an annual self assessment to the Safeguarding Children Board. The Safeguarding Team submitted the Section 11 self assessment and associated evidence to Calderdale Safeguarding Children Board in Spring 2014 and no issues with compliance were identified.

Analytical reports for the purpose of Serious Case Reviews (SCR's) are quality assured and challenged, where necessary, by the safeguarding team and evidence that recommendations from SCR's have been implemented is closely monitored internally by the Trusts Safeguarding Committee and externally by commissioners and the Safeguarding Boards.

The Safeguarding Team's annual work programme continues to be overseen by the Trust's Safeguarding Committee, which is chaired by the Associate Director for Safeguarding within the Trust and has senior membership from across the divisions, as well as from commissioning. The Committee provides regular reports to the Board of Directors for assurance.

The Safeguarding Team provide frontline staff with additional advice and support in complex and high risk situations, as well as being an escalation point for situations that require resolution and intervention to improve outcomes for service users and their families.
CHFT has a clear learning from experience policy which outlines the procedure to follow when something goes wrong or could potentially go wrong, and how we ensure that we learn lessons from these events to improve the service we provide.
Risk management, or governance and safety, are integral to everything we do and the Trust has an organisational framework which provides a robust, systematic approach through all levels of the organisation.

How have we raised the profile of safeguarding policy and procedures and to ensure that effective multi-agency and single agency training in relation to safeguarding is delivered, with a measurement of outcomes on practice being embedded across agencies?

Policy - Significant work has taken place over the last year to review and update all our policies and procedures to ensure they reflect local and national guidance.

Training - The last year has seen an improvement in the uptake of safeguarding training. A series of internal master classes and bespoke training has also been delivered to support the workforce. The **training strategy** has been reviewed and updated and clear target groups have been set, outlining the levels of training for specific staff groups. In line with the intercollegiate document 2014 it is now a requirement that the Trust Board receive safeguarding training, specific to their responsibilities, this was delivered in October 2014. The Trust's safeguarding training plan continues to be under constant review and is

accessible to staff in order to ensure they develop the necessary skills and competencies to safeguard patients/service users and their families. This has included **different learning opportunities** continuing to be available from taught courses, e learning, and access to multi agency training as well as specific training by specific professional bodies.

- Level 1 safeguarding – delivered via written updates and briefings across the workforce in the form of the safeguarding newsletter which is circulated twice a year. It not only gives relevant information to meet the criteria for level 1 training, but it also supports levels 2 and 3 training - **Currently at 100%.**

- Level 2 training (Adults and Children) **The current position has seen an increase from 47.8% to 51.3%** (As of quarter 3)

- Level 3 training (children) **The current position has seen an increase from 75.0% to 79.3%** (As of quarter 3)

- More **in depth safeguarding adults training sessions** have been developed for 2014 aimed at those involved in the safeguarding adult's process and this has been supported by a 2 day vulnerable adults programmed delivered by other senior nurses across the Trust . Further work is planned for the coming year to ensure there is a clear focus and coordinated approach to safeguarding adult's training, in particular, in relation to MCA and DOLS.

- **Master classes** have been developed and delivered throughout 2014 covering a range of different issues from learning from SCR's to changes in policy and practice.

- **E learning** Safeguarding Level 2 (children and adults) has been developed and is now available.

- **All training programmes have been reviewed** in order **to meet the requirements of the diverse workforce but at the same time** in line with statutory requirements.

Prevent - Has now become part of the new NHS contract and all health providers are required to provide assurances about how it is being implemented. Significant work has taken place over the past year to support implementation of the PREVENT Strategy. Progress to date includes:

- an internal policy reflecting statutory requirements has been developed and ratified
- an internal Prevent group has been established to oversee implementation
- Prevent leads within divisions have been identified and have undertaken a 2 day accredited Department of Health (DH)/Home Office (HO) train the trainers course which will enable them to deliver a specific internal training package (this training is stand alone and cannot be incorporated into existing risk, safeguarding or mandatory training).
- Training dates for the rest of the year have been circulated across the Trust
- Monthly assurance to commissioners and NHS England about progress continues
- Whilst all staff have to attend this training over time, key staff who have to be prioritised are community staff, A&E staff, managers and chaplains.

Other work has included;

- Child Protection Information Sharing System (CP-IS)

  What is CP-IS?

  The **Child Protection – Information Sharing** (CP-IS) project is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings nationally. CP-IS will share information for those children who are subject to a Child Protection Plan (CCP), Looked after Children (LAC) and any pregnant woman whose unborn child has a pre-birth protection plan.

  The Trust has established an Operational Group with key membership from Health Informatics Service (THIS), Safeguarding, the Emergency Department (ED) and Paediatrics; Working collaboratively with Calderdale Local Authority. The agreed staff members for inclusion within the operating systems are ED Consultants, Paediatricians, Safeguarding Team, Paediatric Nurse Practitioners and Band 6/7 ED Nurses.

  On a higher level the Trust has been involved with the national Stakeholder Engagement Group (SEG) which involves contributing towards and reviewing guidance and implementation and communication materials. Internally working

with the ED software supplier, THIS, Intersystems (Integration Engine) and the Health & Social Care Information Centre (HSCIC) to develop the technical solution.

Due to the high profile coverage of the CP-IS, the Trust has taken active steps to ensure key staff members have been effectively informed of the continued developments within the programme. This has involved the use of a staff letter, utilising an online training video which incorporates the Trust process, with access being monitored via weekly audit reports.

Working alongside Data Quality and the Information Governance Teams, an agreed mechanism for increasing successful first time patient matches has been introduced. The patient information leaflet is to be adapted to incorporate the central guidance which complies with the requirements of the Data Protection Act.

The standard operating procedures (SOP) have been developed and agreed at operational level to detail current practice, followed by future practice in line with the CP-IS going live.

Standard implementation has commenced within the Trust with the installation of the Summary Care Record application (SCRa) on desktop within the lead areas. Smartcards have been authorised and issued to the approved staff groups.

Due to CHFT's high involvement with the process Trust representation was in attendance at the first National CP-IS Conference as guest speakers, being recognised as an exemplar site.

The proposed Business Go-Live date should be achieved early March 2015, followed by a deployment verification period of two weeks for monitoring and issue resolution.

The future landscape consists of implementation within all paediatric and maternity services. On further discussion, the long term national plans are to consider applying the process within adult safeguarding.

- Development of Intranet pages to facilitate easier access to safeguarding information. The safeguarding icon is now clearly visible on the Trust's intranet pages. Work

continues to develop the content of the safeguarding pages in order to make it easier for staff to access up to date safeguarding information. A recent screen saver has also been developed to remind the workforce that safeguarding is 'everybody's business' and asks 'do you know your responsibilities?'

- Publication of the safeguarding newsletter in April 2014 and October 2014.

- A number of reflective learning sessions have been delivered to specific teams in order to encourage reflection and learning from specific cases.

- Further work has taken place to develop safeguarding links across the organisation, with further work planned for 2014. Work has continued to develop the role of the safeguarding link/champion and workshops have been delivered for staff both from an adult and child perspective. Engagement is integral to taking the safeguarding agenda forward and raising awareness. Further training is planned imminently for all band 6 and 7 nurses.

- Safeguarding supervision continues to be delivered across the organisation in order to support and empower staff in their roles.

- Safeguarding Team Development to ensure a more focused approach across the Trust.

- Significant work has taken place with the Risk Department. This has included work to determine safeguarding adult thresholds; work continues in order to strengthen this area further, in particular in relation to how this information is presented and analysed so that it can inform practice.

- CHFT continues to engage with partners and contribute to the 4 Local Safeguarding Boards and their work streams, working closely with partners across the health and social care footprint. Further work is required to ensure the workforce contributes and engages more in the work of the Safeguarding Board sub groups.

- **See ME and Care Campaign in Kirklees**. In 2014 the Trust contributed to a campaign led by Kirklees. **See ME and Care"**, aimed primarily at health and social care professionals, but is relevant to all partners. The campaign was all about putting **"yourself in others shoes"** and thinking about the level of care you give and see and

whether this is how you would like yourself or those you care for to be treated. The campaign encouraged staff to notice and question bad practice, either by reporting it to their managers, challenging their colleagues or by using existing protocols in place.

- CHFT have worked with and continue to work with the 4 Safeguarding Boards across Kirklees and Calderdale to further develop the safeguarding performance framework. This forms the basis of the assurance process across the partnership and monitors progress and effectiveness of practice and procedures. It ensures the performance approach to vulnerable children and adults reflects the emerging government policy and requirements.

- CHFT have worked with partners to develop guidance for when pressure ulcers should be reported as a safeguarding adult alert and staff have been briefed about when they need to consider this in relation to safeguarding adult procedures.

- Promoting dignity in care has continued to be promoted and to be a key component on our preventive approach to abuse.

- OFSTED. The unannounced inspection of children's services in Calderdale in June 2013 continued to be judged as inadequate, and children's social care continue to be under a Direction Notice from the Secretary of State which sets both pace and direction for change. This continues to be coordinated by an Improvement Board, of which CHFT are represented and progress continues to be closely monitored. CHFT continues to be a strong partner in contributing to the improvement journey.

- The Trust has worked jointly with other agencies to review safeguarding processes including the development of a Multi-Agency Safeguarding Screening and tasking team (MASSTT) in Calderdale. The Safeguarding Team are currently working with Kirklees in relation to their development of a MASH. MAST operates borough wide and is the first contact point for all new referrals regarding children and young people. The service comprises a multi-agency team of social care staff, early intervention, police and health colleagues.

- The Trust continues to engage with partners with regard to Multi-Agency Risk Assessment Conferences (MARACs) for high risk cases of domestic abuse. This has included the development of a DV pathway in A/E which has proved to be successful.

- Child Sexual Exploitation. The Trust has worked closely with all partners on this important agenda both at an operational and strategic level. Guidance for staff has been developed and widely circulated and issues relating to, child sexual exploitation has been incorporated into all training and supervision as a matter of course. Working with the Local Safeguarding Board, police and other partners, clear pathways and information tools have been developed and implemented. The Safeguarding Team and wider workforce continue to work with partners to identify and work with this vulnerable group. Further work is ongoing to explore 'flagging' young people subject to CSE in unscheduled settings such as A&E.

- MCA and DOLS. Work has been undertaken over the past year to raise awareness of Mental Capacity and Deprivation of Liberty. It has been incorporated into the Trust's training and supervision program and staff have been briefed via the Trust's safeguarding newsletter. However, it is noted that further work is required and the new year will see a new approach to awareness raising with regard to this impartment issue with a series of visits to the ward to support staff in their day to day work and make it 'more real for them'.

- **Supervision**

  Both **individual and group supervision** has been developed further and uptake is closely monitored. Target groups have been established identifying the type and frequency of supervision and are outlined in the safeguarding supervision policy. The team are planning to undertake a supervision audit in the coming year to better understand working practices & gaps re; provision

  - 89% for Health Visitors and School, Nurses
  - 100% for **specialist** midwives
  - 32% for paediatric consultants

  The uptake of **overall** safeguarding children's supervision across the **total** workforce has fallen slightly in the last quarter from 49%, to 37% but this may be due to the fact that some teams are not recording or providing information with regard to peer group supervision that is taking place. Whilst overall the **uptake remains encouraging** and engagement with supervision from a community perspective remains good, further work

is required to ensure staff within the hospital setting becomes more engaged in the process. Work is underway to address this with divisional leads.

Significant developments have also taken place in relation to **safeguarding supervision for adults** over the last quarter, with 18 group sessions taking place over the latter half of the year and 12 individuals accessing formal intensive supervision around specific cases. Work is also now underway to develop reflective learning sessions, whereby groups of staff can reflect on specific cases in order to learn lessons and inform future practice.

- **Audit**

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

  - Referrals audit
  - Supervision audit
  - EDIS audit

  Internal Audit of safeguarding within the Trust earlier in the year gave full assurance for all safeguarding policies and procedure and significant assurance overall with regard to governance arrangements. Work is underway in particular to improve divisional engagement at the strategic and operational safeguarding meetings and to improve recording of safeguarding incidents on Datix. The action plan will be monitored at the Trusts' Safeguarding Committee.

Reviews and Lessons Learned

Over the last year the Trust has contributed to a Domestic Homicide Review (DHR). DHR's were established on a statutory basis in 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This has highlighted for the Trust the importance of embedding the full domestic abuse definition which includes family members, embedding questions about abuse in all services and increasing the notion of professional curiosity relating to suspected or potential abuse where full disclosure has not been made. Domestic abuse has been incorporated into safeguarding training and significant work has taken place to strengthen engagement with the MARAC process (Multi Agency Risk Assessment Conference). In particular, much work has taken place to develop a Domestic Abuse

Pathway within Accident and Emergency. The Trust is currently working with Kirklees in relation to two further cases.

Useful Links

Further information can be found on the safeguarding pages on the Trust's intranet

http://nww.cht.nhs.uk/divisions/trust-wide-information/safeguarding-index/domestic-abuse

- **Serious case reviews**

The Trust has worked with, and continues to work with the Local Safeguarding Children Board and Local Safeguarding Adult Board across Kirklees and Calderdale in respect of a number of serious case reviews. These are currently on-going and the recommendations and actions emerging from these reviews will be closely monitored and will inform future practice, so that we can provide assurances across the partnership that lessons have been learned. Kirklees Safeguarding Adults Board has recently published a SCR which has resulted in extensive learning in relation to dementia care and all partners are currently working to improve the care pathway for this vulnerable group and the services that are provided to them and their families. Calderdale Safeguarding Adults Board published a SCR earlier in the year where the key learning focused on better information sharing and communication between agencies. Both Kirklees and Calderdale Safeguarding Children Boards will be publishing the findings of their SCR's in the New Year.

Local Picture

Calderdale and Kirklees Safeguarding Adults Boards

The increase of alerts from within Adult Health and Social Care across both Calderdale and Kirklees reflects the work that has gone on to raise the profile of safeguarding. Neglect continues to be the main category of abuse which is followed by physical abuse and financial abuse. The alleged victims were predominantly white. Adult Social Care remains the highest referral source, with the highest percentage of alleged perpetrator's coming from social care, followed by family members.

	2011/12	2012/13
Number of Alerts; *Calderdale* *Kirklees*	 527 2627	 707 2675

'Alerts' are expressions of concern about an adult reported to the council and not all will need investigating as a safeguarding adult referral. More details about the number of adults referred and the categorisation can be found by accessing the link below;

Useful Links

For Further information check out CSAB and KSAB Annual reports which can be found at ;

http://www.calderdale.gov.uk/socialcare/safeguardingadults/

http://www.kirklees.gov.uk/community/careSupport/keepingSafe/safeguardingAdults.aspx

Calderdale and Kirklees Safeguarding Children Boards

The overall trend of recent years continues to show an increase in numbers of children subject to child protection plans, with the emotional abuse and neglect continuing to be predominantly the highest categories of abuse.

	2013	2014
Number of children subject to a child protection plan ; *Calderdale* *Kirklees*	 335 391	 266 346

Whilst the numbers of contacts to children's social care remain high, the numbers of referrals for early help remain relatively low, with the number of CAF's being initiated continuing to be relatively low across all agencies and work is currently underway to explore this further.

Useful Links

For further information check out the Calderdale and Kirklees Safeguarding Children Board Annual reports which can be found at;

http://calderdale-scb.org.uk/

http://www.kirkleessafeguardingchildren.co.uk

Looked After Children

'Looked After Child' is a generic term introduced in the Children Act 1989 to describe children and young people subject to care orders (placed into care of local authorities by order of a court) and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live within foster homes, residential placements or with family members (connected carer's).

Evidence from research shows that looked after children and young people, share many of the same health risks and problems as their peers; but often to a greater degree. They can have greater challenges such as discord within their own families, frequent changes of home or school, and lack of access to the support and advice of trusted adults. Children often enter the care system with a worse level of health than their peers, in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect. Longer term outcomes for looked after children remain worse than their peers. (Ref DH 2009.)

Looked after children face greater challenges than their peers, and suffer long term health, social and educational challenges, and outcomes as compared to the general population. These children are particularly vulnerable.

The health element of the Looked After Children's service in Calderdale sits with CHFT; the service in Kirklees sits with LOCALA.

To date there is a national upward trend with regard to children who are looked after. Currently there are 326 children who are looked after in Calderdale.

Useful links

Full statistical reports can be accessed via this link:
http://www.education.gov.uk/cgi-bin/rsgateway/search.pl?cat=3&subcat=3_1&q1=Search

Check out the LAC health annual report which can be accessed on the Truss's intranet pages

http://nww.cht.nhs.uk/divisions/trust-wide-information/safeguarding-index-new/safeguarding-children

Conclusion

Safeguarding is everyone's responsibility and should be part of everyone's practice, whatever their role. The roles are advisory and supportive and it is important that the workforce take responsibility for safeguarding within their own area of work and know what to do if they are concerned that someone is at risk of harm.

The landscape within health and social care is changing rapidly in relation to safeguarding and development work will continue over the next months to ensure CHFT provides a safeguarding service that is fit for purpose. It is essential that everyone within CHFT continues to embrace their responsibilities so that safeguarding becomes embedded in practice if we are to improve outcomes for vulnerable groups and keep people safe from harm.

Karen Hemsworth
MA Child Protection, BSc (Hons) HV, RSCN, RM, RGN.
Associate Director for Safeguarding Adults and Children

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: QUALITY COMMITTEE MINUTES - 27.1.15 - The Board is asked to receive a verbal update from the Quality Committee held on 24.2.15 and the minutes held on 27.1.15.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive a verbal update from the Quality Committee held on 24.2.15 and the minutes held on 27.1.15.

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 a verbal update from the Quality Committee held on 24.2.15 and the minutes held on 27.1.15.

Appendix

Attachment:

Minutes QC 27 01 15 - draft.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the QUALITY COMMITTEE MEETING held on Tuesday 27 January 2015 in Discussion Room 2, Huddersfield Royal Infirmary, commencing at 3pm

PRESENT

Jeremy Pease, Non-Executive Director (Chair)
David Birkenhead, Medical Director
Jackie Murphy, Deputy Director of Nursing
Jan Wilson, Non-Executive Director
Julie Dawes, Executive Director of Nursing
Julie O'Riordan, Divisional Director, Surgery and Anaesthetics Division
Juliette Cosgrove, Assistant Director to Medical and Nursing Director
Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities
Linda Patterson, Non-Executive Director
Lindsay Rudge, Associate Director of Nursing, Medical Division
Lynn Moore, Membership Council
Mags Barnaby, Interim Director of Operations (from 3.50pm)
Sal Uka, Divisional Director, DATS Division

IN ATTENDANCE

Stephanie Jones, PA (Minutes)
Joyce Ayre, Senior Clinical Midwifery Manager (for Item 6.2)
Helen Marshal, General Manager, Risk Management
Elaine Brotherton, Patient Safety and Quality Lead, CWF Division (for Item 6.2)
Christine Bentley, Matron, Estates and Facilities (for Item 6.2)

Item

1/01/15 WELCOME AND INTRODUCTIONS

The chair welcomed members to the meeting.

2/01/15 APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER

Apologies for absence were received from:
Anne-Marie Henshaw, Associate Nurse Director, CWF Division/Head of Midwifery
Claire Gruszka, Patient Safety Risk Manager
Julie Hull, Executive Director of Workforce and Development
Keith Griffiths, Executive Director of Nursing
Kristina Arnold, Assistant Divisional Director, CWF Division
Martin DeBono, Divisional Director, CWF Division
Victoria Pickles, Company Secretary
Ashwin Verma, Divisional Director, Medical Division

3/01/15 MINUTES OF THE MEETING HELD ON TUESDAY 16 DECEMBER 2014

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

4/01/15 ACTION LOG (Items due this month)

All items on the action log due this month were discussed under the main agenda.

5/01/15 MATTERS ARISING

5.1 Data on Patient Dying in Hospital
The chair presented data detailing the percentage of patients who died in hospital and how this compares with other Trusts. However the work that consultant Mary Keily has done on the Care of the Dying, which will be presented to the Board of Directors on 29 January 2015, has superceded this information. The chair requested that Mary be invited to a future Committee meeting to give a short presentation.

ACTION: Stephanie Jones to invite Mary Kiely to the next Quality Committee.

5.2 Update on vacancies in Pharmacy & extended opening hours
The Divisional Director for DATS reported that vacancies have been filled and training is still ongoing. The department cannot provide extended opening hours beyond normal closing times at present as they are trying to cover the extra capacity wards during normal opening hours. Review of staffing is ongoing.

06/01/1 CQC PREPARATION AND ACTION PLAN

6.1 CQC Action Plan
The Assistant Director to the Nursing and Medical Directors' presented the action plan in preparation for the Trust's Care Quality Commission (CQC) impending inspection.

It was noted all Divisions have commenced a self-assessment process to assess their services against the 5 domains and how they compare to the CQC ratings of *outstanding, good, requires improvement and inadequate.* For any service that requires improvement or inadequate an action plan will be developed and monitored through the divisional process. A shared network drive has been established which will hold evidence for each division that will inform both the internal self-assessment process and can also be used as evidence for the formal CQC visit. Any themes and trends pulled from the self-assessments will be looked at in more detail.

Consideration has been given to the Communication Plan and the Comms team are arranging to visit other Trusts that have received awards for good communications to see what lessons can be learnt.

The chair commented that from the action plan it is clear to see there is a lot of transactional functions in place (i.e. policies etc.), but queried whether are staff able to clearly articulate what, for example, the risk management policy is about. The Assistant Director to the Nursing and Medical Directors' agreed to take all comments away and build into the work being done and pick up the links.

The Committee **received** the CQC action plan and **noted** the work to date and plans for

moving forward.

ACTION: A further update report on the action plan will be received by the Committee in February 2015. The chair suggested that it should be rag rated.

6.2 Divisional CQC Self-assessments
The Committee received the divisional CQC self-assessments:

Estates and Facilities
Matron Christine Bentley presented the CQC self-assessment for the Estates and Facilities Division.

The self-assessment tool was discussed with each head of service, who considered what evidence they could use to populate the proforma.

The following was noted:
- SABs; not currently monitored
- Safeguarding training: staff understand the process of how to report, but are not confident all are aware what to do.
- Mandatory training / PDRs: doing well
- PAMs: premises assurance model working progress.
- Caring: trying to delve deep

DATS
The Divisional Director presented the CQC self-assessment for the DATS Division and the following was noted:

Against *safety* and *effectiveness* the Division reported a mixture of green and amber status. To support those areas of amber status action plans have been developed in order to move them to green going forward.

Current reporting status against the 5 domains:
Safety: mixture of green and amber status
Effectiveness: mixture of green and amber status
Caring: all areas reporting green status.
Responsive: all areas reporting green status.
Well led: all areas reporting green status.

CWF
Elaine Brotherton was in attendance to present the CQC self-assessment for the CWF Division. The Division reviewed the mock inspection and from the self-assessment exercise pockets of green and amber were identified across all the domains. Actions are ongoing to address the amber areas and will be discussed with the Directorates and led by the Division.

Current reporting status against the 5 domains:
Safety: all areas reporting amber status
Effectiveness: mixture of amber and green status
Responsive: mixture of amber and green status
Caring: all areas reporting green status
Well led: mixture of amber and green status

Medical Division
The Associate Director of Nursing, Medical Division, presented the CQC self-assessment for the Division.

Following the mock inspection the Division populated and progressed the issues raised in the report within a Divisional action plan and a number of immediate actions were taken to mitigate risks identified. Overall, the Division have rated the self-assessment as 'requires improvement'. This will be open to review by individual Directorates over the next month based on the ongoing evidence gathering against the 5 CQC domains

Current reporting status against the 5 domains:
Safety: all areas reporting amber status
Effectiveness: mixture of amber and green status
Caring: all areas reporting amber status
Responsive: all areas reporting amber status
Well led: mixture of amber and green status

Surgery & Anaesthetics Division
The Associate Director of Nursing, Surgery and Anaesthetics Division, presented the CQC self-assessment for the Division.

The Division's process of self-assessment was similar to the other Divisions. The following areas were highlighted as areas of concern:
- paediatrics in A&E
- patient and public involvement – consideration to be given to how this is worked strategically
- mandatory training to be reviewed
- consent: piece of work needs to be done around this

Current reporting status against the 5 domains:
Safety: mixture of amber and green status
Effectiveness: mixture of amber and green status
Caring: most areas reporting green status
Responsive: mixture of amber and green status
Well led: mixture of amber and green status

7/01/15 RESPONSIVE

7.1 Integrated Performance Report
During December the Trust saw a further increase in urgent and emergency activity and all capacity was opened. The additional activity has put pressure on the A&E departments which led to a reduction in performance against the 4 hour target. For December the Trust delivered 89.4%, which meant the target for Q3 has not been met.

Additional beds have put further pressures on nurse staffing levels and bank and agency staff have been used to bring these levels up.

Improvement has been seen with the access to diagnosis within 6 weeks target. This should be delivered for the year by the year end.

The Trust is behind on some of the quality indicators. This includes the number of falls,

although those with serious injury have reduced.

SHMI is 111, with the unrebased HSMR at 102.41.

8/01/15 SAFETY

8.1 Serious Untoward Incident Report and Register
The Director of Nursing presented the Serious Incident report and register for the week ending 16 January 2015, which detailed the current position of all open serious incidents.

Slippage on the 48 day timescale for completion of incidents was noted, however work is ongoing to get this back on target. A rise in grade 3 pressure ulcers had been seen and it was thought the number of extra patients in hospital at the time may have been a contributing factor.

The following was noted from the report:
- 17 new serious incidents had been reported to the CCG (all are category 3 pressure ulcers). 6 of these were reported late (i.e. over the 48hour reporting timescale)
- 5 reports have been submitted to the CCG (1x 4 days late, 1 x 6 days late, 1 x 8 days late and 2 were early).
- 3 reports that were due to be submitted in December 2014 have yet to be submitted or requests for extension of time have been made.

The Committee **received** and **noted** the content of the report and the work being done to ensure serious incidents are investigated within the 48 day timescale.

8.2 Patient Safety Group Update
The Executive Director of Nursing reported that the Patient Safety Group meeting scheduled to take place in January 2014 was cancelled due to 'Perfect Week'. A full update report on the work of the Patient Safety Group would be submitted to the Quality Committee in February 2015.

9/01/15 COMPLIANCE

9.1 Corporate Risk Register
The Director of Nursing presented the Risk Register and confirmed the register is working progress. The Risk Management team and the Divisions are continuing to receive support from the work commissioned from Paul Moore (Independent Risk Consultant)

The register includes all the Trust's risks scoring 15 or above.

The Trust's current top risks are:
- 6131 (25): Progression of service reconfiguration impact on quality and safety
- 4706 (25): Failure to meet CIP (recently increased from 20 to 25)
- 6150 (25): Finance: breach of licence

- 2827 (20): Risk of poor patient outcomes due to dependence on middle grades
- 2828 (20): Risk of poor patient outcomes and experience caused by blocks in patient flow
- 4783 (20): HSMR & SHMI
- 6136 (20): Overarching risk for Infection Control

It was noted that consideration will need to be given over the risk against CQC self-assessment.

The Committee **received** and **noted** the content of the risk register that will be monitored by the Risk and Compliance Group.

9.2 Draft Risk Management Policy

The Director of Nursing presented the draft Risk Management Policy, which had previously been received by the Risk and Compliance Group in January 2015.

The chair commented that although the content of the report was fine, there were inconsistency with the language used and this would need to be addressed before it is submitted to the Board of Directors.

It was noted the policy will be received by the Weekly Executive Board (WEB) on the 29 January 2015.

ACTION: The Director of Nursing to feed back the amendments required on the policy to Claire Gruszka ready for submission to the Board of Directors in February for final approval.

9.3 Update on CQUINS

The Assistant Director to the Nursing and Medical Directors' gave a verbal update position on CQUINS. For Q4 there are 3 areas of risk, these being:

- **Friends and Family (A&E);** The Surgical and Anaesthetic Division are taking action on this. The target won't be achieved for December 2014, but hopefully will be back on track for January 2015.
- **Safety Thermometer;** a challenge target was set for this CQUIN of 4.1, currently for Q4 it. stands at 4.16. Despite being really close the Trust will only receive 75% payment.
- **Management of hypergleamic patients in A&E**; this relates to a small number of patient. It is unlikely this target will be achieved, but this cannot be confirmed until the data is in. It should be noted that despite the likelihood of this target not being achieve no patients came to any harm.

For 2015/16 there will be 3 new national targets:
- kidney injury
- sepsis (high risk patients)
- emergency pathways

Friends and Family and Safety Thermometer will be part of the 2015/16 contract.

Local CQUINS that have been agreed to be carried forward are:
- pneumonia
- diabetes inpatient (self-management)
- medicines reconciliation (was two CQUINS but will be combined into one for 2015/16)
- end of life (was two CQUINS but will be combined into one for 2015/16)
- nutrition and hospital food – this has been a great success for 2014/15

Asthma will be discontinued. A local CQUIN on smoking cessation has been asked to be considered.

ACTION: A paper on local CQUINs will be brought back to the Committee in April 2015 by the Assistant Director to the Nursing and Medical Director.

10/01/15 EFFECTIVENESS

10.1 Clinical Effectiveness and Outcomes Group

The Medical Director presented the report from the Clinical Outcomes Group. The following was noted from the report

- Mortality: SHMI for the last quarter stands at 110. December saw the highest crude mortality with a 160 deaths in total. The mortality reviews will be completed by the end of February 2015.

ACTION: The Chair requested the analysis from the mortality reviews from December 2014 be received by the Committee in March 2015.

- more metrics for Divisions and CAIP
- 'Nerve Centre' is being implemented with pilot wards commencing the process in February 2015. Once integrated it is planned other wards will be integrated quicker.
- Frailty; a measure tool has been produced. Scope of work has been discussed and action plan will be presented to Outcomes Working Group in February 2015.
- Courage to put the patient first; new challenge – capacity issues getting right patient in the right bed. Non- Executive Director Linda Patterson queried whether we records patient moves. The Director of Nursing confirmed, from March 2015, this data will be included in the Integrated Performance Report of 3 moves or more.
- The Director of Nursing confirmed a Visible Leadership paper had been submitted to the Weekly Executive Board (WEB) and the recommendations from this report should be in place by March 2015.

Coding: updated paper on coding received as part of 10.3 of the agenda.

The Committee **received** and **noted** the content of the report and the risks to delivery that were highlighted

10.2 Research and Development six monthly report

The Medical Director presented the six monthly report on Research and Development. CHFT is a partner organisation of the Clinical Research Network. The Trust received £813,791 of funding for 2014/15 from the National Institute for Health Research which goes towards supporting research study across the Trust. R&D funding can increase or decrease each year depending on performance and delivery. The funding for 2015/16 has not yet been confirmed.

The Trust target recruitment for 2014/15 is 1,342 participants; at the end of December 2014 the Trust had achieved 81% as a proportion of its locally agreed target. The lack of a broad portfolio in research is a challenge for the Trust. Dr Lynn Terrrett has been appointed as a Clinical Lead in R&D who is specifically tasked to work with clinicians to broaden the research base in areas not currently research active. The appointment of a clinical research lead for Nursing and Applied Health Care has been appointed (jointly funded with the University of Huddersfield) and it is intended that this role will create opportunities for research grant submissions and training.

The Research and Development Strategy was agreed and a working action plan has been

developed. Some of the workstreams identified are underway to meet the goals outlined within the action plan.

ACTION: The Quality Committee **received** and **noted** the content of the report. The Committee requested a further report be received in July 2015, but any issues in the meantime should be escalated to the Committee.

10.3 Update on Clinical Coding

The Medical Director presented an update report on Clinical Coding. The report had been requested and presented to the Finance and Performance Committee to update on the work carried out by the Clinical Coding team and progress made in improving the quality of clinical coding within the Trust following the recommendations made by Price Waterhouse Cooper (PWC) in 2014.

In December 2013, PWC were commissioned to carry out a detailed benchmarking exercise at speciality level. There report was signed off in August 2014. It identified a number of areas of improvement and confirmed that in order to improve the quality of coding, full engagement was required across the end to end process from clinician to coder. An action plan was developed on the back of the report and since the report has been signed off the CCISG has continued to progress the improvement of clinical coding across the Trust, paying specific attention to the areas identified within the report.

The Medical Director reported that increased focus work on co-morbidities is being addressed to ensure co-morbidities are reported more accurately.

The Quality Committee **received** and **noted** the content of the report and felt assured that **progress** made with the planned work going forward.

11/01/15 WELL LED ORGANISATION

11.1 Well Led Organisation Group

A brief report was received from the Well Led Organisation Group following the cancellation of the last meeting in January due to 'Perfect Week'. Going forward the work of the group will now be led by Julie Hull, Director of Workforce and Organisational Development.

It was noted the focus of the meeting scheduled to take place in February will be to consider/agree the arrangements for taking forward the results of the 2014 NHS Staff Survey and Staff Friends and Family Test, the approach to colleague Health and Wellbeing and progress checking the development of the Well Led data report.

12/01/15 CARING

12.1 Patient Experience and Caring Group

The Assistant Director to the Nursing and Medical Directors' reported that the Patient Experience Group in January 2015 was cancelled due to 'Perfect Week'.

A brief verbal update was received and it was noted that complaints improved on their trajectory by reducing the number of open complaints, but unfortunately despite a lot of work with the Divisional teams, this did not reduce the overall trajectory. Improvement has been seen in the quality of the response letters, but the timeliness of getting a complaint through the process is still a concern, however constant work is ongoing to improve this. The Director of Nursing felt the lack of attention to actioning a complaint within the timeframe was a cultural issue and although some improvements are being seen, complaints are not

being processed in a timely manner. The chair queried where the improvement will be documented and the Director of Nursing confirmed that this information is detailed within the Integrated Performance Report under the Well Led section.

The Quality Committee **received** and **noted** the verbal update and the Chair agreed to make the Board of Directors aware of the ongoing concern that complaints are not processed within the agreed timeframe.

13/01/15 HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE

13.1 Operational Health and Safety group minutes

The minutes from the Operational Health and Safety group were received for information.

The Director of Estates and Facilities, Planning and Performance updated on the following areas:

- ongoing issues with fire training and staff must be encouraged to attend.
- Fire risk assessment audit is being carried out, from which an action plan will be developed and driven by the Estates and Facilities Division, but with divisional involvement.
- COSH: staff should be reminded of the importance of health and safety around COSH
- Medical devices training / critical training: figures have dipped and need to be brought back up again
- Operational Committee: continues to progress and work well.

14/01/15 MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS

The Committee agreed the following items would be highlighted to the Board of Directors:
- CQC preparedness (Well Led / mandatory training)
- Paeds in A&E
- Complaints; concern over number not dealt with within timeframe
- R&D Strategy; in context of current position

15/01/15 ITEMS TO NOTE

15.1 Quality Committee Work Plan
The Committee received the work plan for 2014/15.

16/01/15 ANY OTHER BUSINESS

16.1 Update on Perfect Week
The Interim Director of Operations gave a verbal update on the outcome of 'Perfect Week' which took place between 7th to 13th January 2015.

The aim of 'Perfect Week' was to provide safe and timely patient care. The result saw some improvement seen in relation to timely care; which was evidenced by the A&E target during the week in question. The lower attendance figure in A&E was thought to have been the driver to improve the target.

Some of the issues identified were:
- patients arriving in assessments areas do not have time limits and there were a number of

stories that patients spend a long time in these areas
- complex wards: not enough therapy staff to give dedicated therapy i.e. stroke, complex care etc . It was noted therapy for stroke patients has been an issue for some time and an update report on stroke would be received by the Committee in March.

It was noted a full report on the outcomes from the 'Perfect Week' would be received by the Weekly Executive Board (WEB) at its meeting on 29 January 2015, but it was unsure where it will sit overall whether it be via a sub-committee of the Quality Committee (i.e. Well Led Group).

ACTION: The Chair requested that it should come back to the Quality Committee as a full paper. Many of the actions from the report will be across all divisions.

17/01/15 DATE AND TIME OF NEXT MEETING

Tuesday 24 February 2015
3pm – 5pm
Discussion Room 2, HRI

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: STRATEGIC HEALTH AND SAFETY COMMITTEE MINUTES - 27.1.15 - The Board is asked to note the contents of the minutes from the Strategic Health and Safety Committee held on 27.1.15.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to note the contents of the minutes from the Strategic Health and Safety Committee held on 27.1.15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to note the contents of the minutes from the Strategic Health and Safety Committee held on 27.1.15.

Appendix

Attachment:

Strategic Health and Safety Committee Minutes - 27 01 15 Final.pdf

Calderdale & Huddersfield NHS Foundation Trust
Strategic Health & Safety Committee
Minutes
27th January 2015

Present: J Wilson – NED (Chair)
L Hill – Executive Director, Planning, Performance, Estates & Facilities
Mike Culshaw – Director, Pharmacy
Jason Eddleston – Deputy Director of Workforce & OD
Julie Barlow – Assistant Divisional Director, Surgery & Anaesthetics
David McGarrigan – Associate Director, Estates & Facilities
Darran Jessett – Health & Safety Advisor
Heather Kirk – Emergency Planning Officer

In Attendance: Karen Bates

Lesley Hill asked that Carole Gorman arrange the dates of the Strategic Health & Safety Committee for 2015.

Action: 2701-01 – CG to arrange the dates of the Committee for 2015.

1. Apologies: Ashwin Verma

2. Minutes from previous meeting held on 23rd December 2014.
The Medical Device Management Policy was signed off with a note to amend the dates. The minutes were agreed as an accurate record of the meeting.

3. Actions from the previous meeting – nothing to report.

4. Policies

a) COSHH – Mike Culshaw updated the group.

- A request has gone out to Divisions for nominations for Staff to become Divisional Representatives to work with the COSHH Strategy Group
- SYPOL are to be invited to carry out refresher training for the Strategy Group and Divisional Representative. The training should take place as soon as possible as CQC will focus on COSHH.
- The database is currently up to date and the Divisional Representatives are to maintain it and act as a middle man between the Strategy Group and Divisions.
- Concerns are that there will be a lot of Staff updating the database and there is no designated Admin. Support to monitor it.

Action: 2701-02 – The COSHH Strategy Group to decide on an Admin. Function.

COSHH Policy – Mike Culshaw distributed a copy of the draft Policy to the group and asked for comments.

Comments were made regarding the Duties and Responsibilities, and that Assistant Divisional Directors and General Managers need inserting between Trust Directors and

Matrons. Mike Culshaw agreed to take a template paragraph from any other Policy. Community Staff will require a paragraph due to transporting COSHH products and taking them into patient's homes.

Action: 2701-03 – Mike Culshaw to insert a paragraph for ADD's, General Managers and also a paragraph for Community Staff.

Discussions were held on the awareness of COSHH being communicated to Staff, it was agreed that all Staff are expected to read the Policy, Team Briefs will draw attention to Staff, also additional communications including pop-ups, screensavers and Trust News.

Lesley Hill requested that the Policy be complete by the next meeting to sign off and then take to WEB.

Action: 2701-04 – Mike Culshaw to complete the Policy by the April meeting.

Discussions took place on Training for Staff, Darran Jessett added that COSHH forms part of the current IOSHH Health & Safety Training and Awareness of COSHH will also be included in the 1 day (Tier 4) Health & Safety Training.

Action: 2701-05 – Darren Jessett to ensure that COSHH Awareness is linked to the Tier 4 Training.

Lesley Hill thanked Mike for the update and added that if he needed any help to contact her.

b) Emergency Planning – Heather Kirk updated the group.

Heather Kirk explained that currently there are a suite of documents relating to Emergency Planning and that she is working on merging the documents into one user friendly version. The Policy will require input from the Clinical Divisions, and Heather will resurrect the Resilience Forum to review the Policy. Other Organisations and Community will be included in the Policy. Heather will also ensure that Command and Control mirrors the on-call rota.
Suggestions were made for the Resilience Forum to walk the site to ensure that locations used are known to all and are appropriate for needs.

Action: 2701-06 – Heather Kirk to finish the Policy by the April Meeting.

5. Escalated Issues from the Operational Health & Safety Committee.

a) West Yorkshire Audit Consortium – Discussions were held on the Terrier income coming from Estates and a paper received from the Audit Consortium. David McGarrigan agreed to look at the Terrier Report with Tom Donaghey.

Action: 2701-07 – David McGarrigan to review the Terrier Report with Tom Donaghey.

b) Medical Devices Training Figures – Lesley Hill raised concerns on attendance at the Medical Devices Training Sessions, the issues have been to WEB and are currently on the Performance Report.

6. Health & Safety Update

David McGarrigan updated the group.

- The Health & Safety Policy is now on the Intranet
- The training sessions are now carried out by NHS Property Services and the 1st session was carried out last week.
- Dates for the 2015 Health & Safety Training courses are to be put on the Intranet and also sent to Divisional Secretaries.

Action: 2701-08 – Darran Jessett to arrange the dates for the 2015 to go on the Intranet and to Divisional Secretaries.

- Tier 2 training is to be condensed into 1 day training for Senior Managers.
- Tier 3 IOSHH Training is currently running with 4 day training and David McGarrigan and Property Services are looking to condense this into 2 days. There will be a certificate at the end of the 2 day session, but not accredited to IOSHH.
- Operational Health & Safety Committee attendees continue to bring issues to the meetings, but there are current issues with Union Representatives.

Action: 2701-09 – Jason Eddleston to check the nominees from the main Unions.

7. Any Other Business

Lesley Hill reported that the Directors On-Call is being extended and will commence in April 2015. Training will also be arranged for the new on-call staff. Lesley will bring the flow chart for the group to gain an understanding of the rota.

Action: 2701-10 – Lesley Hill to bring a copy of a flow chart of the on-call rota.

8. Date and Time of Next Meeting – Thursday 2nd April 2015 2.00 - 3.30 pm in Discussion Room 2, The Learning Centre, HRI.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: AUDIT AND RISK COMMITTEE - DRAFT MINUTES - 20.1.15 - The Board is asked to receive and note the contents of the Draft Audit and Risk Committee Minutes from the meeting held on 20.1.15.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the contents of the Draft Audit and Risk Committee Minutes from the meeting held on 20.1.15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive and note the contents of the Draft Audit and Risk Committee Minutes from the meeting held on 20.1.15.

Appendix

Attachment:

Draft ARC minutes 20.1.15.pdf

APP A

Minutes of the Audit and Risk Committee Meeting held on Tuesday 20 January 2015 in Acre Mill, 3rd Floor commencing at 10:45pm

PRESENT

Peter Roberts	Chair, Non-Executive
Phil Oldfield,	Non-Executive Director
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Nigel Bell	Head of Internal Audit
Chris Benham	Deputy Director of Finance
Chris Boyne	Internal Audit Manager
Jillian Burrows	Senior Manager, KPMG
Keith Griffiths	Executive Director of Finance
Adele Jowett	Local Counterfraud Specialist
Victoria Pickles	Company Secretary
Trevor Rees	External Audit – KPMG (for items 1-10)
Kathy Bray	Board Secretary (minutes)

OBSERVERS

Andy Chittenden	Coscienza Company Re: Board Assurance Framework
Dave Thomas	Turnaround Director

Item

1/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Julie Dawes, Executive Director of Nursing
Peter Middleton, Membership Councillor
Juliette Cosgrove, Assistant Director – MD Office

2/15 MINUTES OF THE MEETING HELD ON 27 OCTOBER 2014

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

3/15 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

4/15 MATTERS ARISING FROM THE MINUTES AND ACTION LOG

58/14 Tour de France: The Executive Director of Finance reported that £200k had been received as income against the £300k costs incurred by the Trust in planning for the Tour. Thanks were given to the Clinical Commissioning Group.
STATUS: Closed

74/14 Internal Audit Follow-up Audits : The Internal Audit Manager provided a report showing the progress against implementation of the recommendations from previous audits. This would be brought regularly to the Audit and Risk Committee for review in the future.

5/15 GOVERNANCE REPORT

The Company Secretary presented the report which brought together a number of governance items for discussion by the Committee.

a. Update on the development of the Board Assurance Framework and Risk Register -The Company Secretary advised the Committee on the work being undertaken by Andy Chittenden to develop the Board Assurance Framework following the Board Workshop held in October. It was noted that the Company Secretary and Executive Director of Nursing and

Operations were undertaking further work on the draft version, to refine the document, along with the help of Executive Directors. It was expected that the work would be completed and submitted to the Board in February.

b. New governance arrangements in relation to Turnaround and Cost Improvement Planning - The Committee noted that Dave Thomas had been appointed as Turnaround Director. The Terms of Reference for the Turnaround Executive group had been circulated with the papers. It was noted that the Turnaround Executive would meet on a weekly basis and would report into the Finance and Performance Committee.

c. Nominations Committee – The Terms of Reference for the Nominations Committee – Executives was discussed. It was noted that these would be submitted to the Board for approval at the meeting on the 29 January 2015.

d. Register of Declarations of Interest - The Company Secretary reported that the Declarations of Interest for Staff, Membership Councillors and Board of Directors was received for information.

e. Audit and Risk Committee Work Plan - The Committee approved the contents of the updated Audit and Risk Committee work plan.

6/15 REVIEW OF LOSSES AND SPECIAL PAYMENTS

In accordance with the Standing Financial Instructions, the Deputy Director of Finance presented the losses and special payments for the period 1 October to 31 December 2014. In summary there had been 13 payments for damages or costs under public / employer's liability totalling £28,000. There were no areas of concern to escalate to the Board.

The Committee **received** the report.

7/15 REVIEW OF WAVING OF STANDING ORDERS

The Deputy Director of Finance presented a report detailing the waving of standing orders for the period 1 October to 31 December 2014. During the quarter there had been four instances requiring a waiver of standing orders at a total cost of £122,063.50. Additionally 1 amendment to an earlier single source tender was made during the quarter at a value of £14,780.00.
There were 9 tenders over the quarter, the value of spend was £14,162,192.38.
There were no areas of concern to escalate to the Board.

The Committee **received** the report.

The External Auditors asked whether the PWC work should be shown on the Waiving of Standing Orders and the Deputy Director of Finance agreed to look into this matter.

ACTION: CB

8/14 GUIDANCE FOR NHS FOUNDATION TRUSTS ON PRODUCING THEIR 2014/15 ANNUAL REPORTS AND ACCOUNTS

The Company Secretary reported that this document had been brought to the Audit and Risk Committee for them to understand the guidance in relation to the production of the Annual Report and Accounts. It was noted that a meeting with authors of the annual report had been arranged for the beginning of February and a timeline had been drawn up. It was suggested that an executive summary of the document would be helpful and the External Auditors agreed to look into this further.
The Deputy Director of Finance reported that there were no new accounting systems or major changes to the Board disclosures required.

9/15 REPORT ON CURRENT REGULATORY COMPLIANCE ISSUES

The Executive Director of Finance updated the Committee on the discussions held with Monitor and it was noted that this would be publicly communicated following Monitor's decision which was expected w/c 26 January 2015. The Committee heard that a system-wide meeting had been arranged by Monitor for the 12 February to discuss the transformation of local health services with commissioners.

The Deputy Director of Finance advised that the Trust had been selected, along with a number of other Foundation Trusts, to be involved in the annual Costing and Coding Audit being undertaken by Capita.

10/15 INTERNAL AUDIT

a. PROGRESS REPORT

The Internal Audit Manager reported that since the last Audit & Risk Committee in October 2014 the following reports had been issued to and discussed with management.

Report No	Report	Opinion
CH09/2015	Estates Property Income	Limited
CH11/2015	E Rostering	Significant
CH12/2015	IG Toolkit	Significant
CH13/2015	Financial Ledger	Full
CH14/2015	Bank Nurse and Agency	Significant
CH15/2015	Outline Business Case – Risk Management	Significant

The reports with limited assurance were discussed in detail:-

CH09/2015 Estates Property Income

This report concluded with an overall limited opinion. THe Committee were asked to note that at the point that the Trust requested this review there was already an awareness of many of the issues covered in the review and steps had already been taken step to address these. The review provided an overview of the challenges facing the new team. Key issues included:

- The mechanisms to identify third parties that use Trust properties and to ensure that appropriate income streams are always derived as a result of these arrangements required significant strengthening.
- The Property records were not up to date or complete. A walk around of all Trust property would be required to see which property is occupied and by whom. This should then form part of an annual review to ensure all records are correct and charges are made appropriately.
- Lease agreements were not in place in respect of a number Trust properties occupied by other organisations.

It was noted that the follow-up would be brought back to a future Audit and Risk Committee Meeting and Jan Wilson reported that the progress would also be monitored via the Strategic Health and Safety Committee.

The Committee noted that a further draft report had been circulated to some Committee

Members the previous day or was tabled at the meeting for other members:

- **CH10/2015 CIP and Budgetary Control**

The report had been given a limited assurance.
The Committee were reminded that the Audit and Risk Committee had requested this audit be undertaken.

The review had concluded with an overall limited opinion. It was noted that the Trust was currently significantly tightening the governance structures in place around the CIP to ensure that the Efficiency Programme Board, Executives and other management leads are working as effectively as possible to deliver savings.

The review confirmed that the targets signed off by the Board had proven to be overly optimistic. The Trust needs to ensure that plans to deliver savings are subject to appropriate operational challenge and scrutiny at the earliest point possible Further work was needed to ensure that all staff and managers at the Trust are actively seeking to contribute to cost improvement efforts.

The review also noted that less than half (£4.13m) of the October 2014 CIP forecast figure of £8.54m was described as 'low risk.' The report strongly recommended that all reported headline CIP figures must be reported in the context of the risk of achievability. Members noted the report and expressed concerns that the overall limited opinion may be generous with regard to certain aspects of the CIP Programme.

It was agreed that further discussions would take place outside the Audit and Risk Committee and would be taken forward by the Prof. Peter Roberts, Audit and Risk Committee Chair, Keith Griffiths, Executive Director of Finance, Philip Oldfield, Non-Executive Director/Finance and Performance Committee Chair and Dave Thomas, Turnaround Director.

Committee members thanked Internal Audit for their work on the OBC and CIP, given the short notice and the addition of these audits to the programme.

b. INTERAL AUDIT ANNUAL REPORT
The Head of Internal Audit presented the Annual Report for information. It was noted that the Consortium had been successful this year in securing additional work from Leeds, York and three Leeds CCGs. Work was underway to develop a marketing strategy and further information would be brought back to the Committee in approximately 6 months' time.

11/15 LOCAL COUNTER FRAUD UPDATE

a. LOCAL COUNTER FRAUD SPECIALIST PROGRESS REPORT
The Local Counter Fraud Specialist (LCFS) presented the progress report and highlighted the work undertaken by the counter fraud service over the previous quarter. She highlighted the number of Awareness Talks which had taken place which had resulted in an increase in calls. She also reported that following inspection, a system for reviewing fraud policies had been put in place and to date two policies had been reviewed.
The Committee **received** the report and thanked the LCFS for her work.

b. A SUMMARY OF THE NHS PROTECT INTELLIGENCE REPORT
Salient points from the report were noted. The LCFS advised that Payroll fraud was the most prevalent type of non-patient fraud reported to NHS Protect in the previous calendar year. It was noted that the National Fraud Initiative benchmarking data would be available later in the year and it was possible that this would identify further areas of work.

The Chair suggested that an article be put in the Trust News to bring counter fraud issues to the attention of all staff.

The Committee **received** the report.

12/15 EXTERNAL AUDIT

a. TECHNICAL UPDATE

The External Auditor highlighted the following areas of the Technical Update to the Committee:

- Audit Institute Seminar Invitations – to all Audit and Risk Committee Members.
  The Chair advised that the Trust took part in the Leadership Academy. It was suggested that a request be made for information to be fed back to the Trust and it became a two-way process and learning from elsewhere be obtained by the Trust.

The Committee **received** the report.

b. ISA700/AUDIT PLAN

The Senior Manager, KPMG advised that examples of the long form audit report which had been adopted by Monitor for use in the coming year had been tabled to the Committee for information. The Deputy Director of Finance agreed to identify controls in place to confirm that there will be no material areas of risk and this will be brought to the Audit and Risk Committee at the next meeting.

ACTION: CBe – April 2015 ARC Agenda Item

13/15 ITEMS TO RECEIVE AND NOTE

a. Quality Committee minutes

The Audit and Risk Committee received the minutes of the Quality Committee meetings held on 28 October 2014, 25 November 2014 and 16 December 2014.

b. Risk & Compliance Group Minutes

The Audit and Risk Committee received the minutes of the Risk and Compliance Group meeting held on 10 November 2014.

14/15 ANY OTHER BUSINESS

There were no other items of business.

15/15 MATTERS TO BE REPORTED TO THE BOARD OR OTHER COMMITTEES

The Chair reported that he would not be attending the Board of Directors Meeting on the 29 January 2015 and nominated Phil Oldfield to report back. It was agreed that the following items would be highlighted to the Board:

- Tour De France
- Governance Report
- Internal Audit Report – Estates, CIP and Outline Business Case.
- LCFS – Dissemination of NHS Protect Summary
- Audit Plan

16/15 DATE AND TIME OF NEXT MEETING

Tuesday 21 April 2015, at 10.45 am, in Acre Mill, 3rd Floor Meeting Room.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: MEMBERSHIP COUNCIL - DRAFT MINUTES - 20.1.15 - The Board is asked to receive and note the contents of the draft Membership Council Minutes from the meeting held on 20.1.15.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the contents of the draft Membership Council Minutes from the meeting held on 20.1.15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive and note the contents of the draft Membership Council Minutes from the meeting held on 20.1.15.

Appendix

Attachment:

DRAFT - MINS - MC - 20 1 15.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL MEMBERS MEETING HELD ON TUESDAY 20 JANUARY 2015 IN THE BOARDROOM, HRI

PRESENT:

Andrew Haigh	Chair
Wayne Clarke	Public elected – Constituency 2
Dianne Hughes	Public elected – Constituency 3
Liz Schofield	Reserve Register – Constituency 4
Marlene Chambers	Public elected – Constituency 4
George Richardson	Public elected – Constituency 5
Johanna Turner	Public elected – Constituency 6
Lynn Moore	Public elected – Constituency 7
Andrew Sykes	Public elected – Constituency 8
Jennifer Beaumont	Public elected – Constituency 8
Mary Kiely	Staff elected – Constituency 9
Avril Henson	Staff-elected – Constituency 10
Eileen Hamer	Staff-elected – Constituency 11
Chris Bentley	Staff-elected – Constituency 13
John Playle	Nominated Stakeholder – Uni. of Hudds.
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
Hilary Richards	Nominated Stakeholder – Kirklees Metropolitan Council

IN ATTENDANCE:

Kathy Bray	Board Secretary
Julie Dawes	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance - (for part of meeting)
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities – (for part of meeting)
Melanie Johnson	General Manager – CGSU – (for part of meeting)
Ruth Mason	Associate Director of Engagement & Inclusion
Phil Oldfield	Non-Executive Director
Jeremy Pease	Non-Executive Director
Victoria Pickles	Company Secretary
John Rayner	Director of The Health Informatics Service - (for part of meeting)
Dr Alistair Morris	Clinical Director for Modernisation – (for part of meeting)

1/15 APOLOGIES:

Apologies for absence were received from:

Martin Urmston	Public elected – Constituency 1
Joan Taylor	Public elected – Constituency 1
Linda Wild	Reserve register – Constituency 2
Peter Middleton	Public elected – Constituency 3
Grenville Horsfall	Public elected – Constituency 5
Brian Richardson	Public elected – Constituency 6
Kate Wileman	Public elected – Constituency 7

Liz Farnell	Staff-elected – Constituency 12
Dawn Stephenson	Nominated Stakeholder – SWYPFT
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
Janice Boucher	Nominated Stakeholder - Locala
Owen Williams	Chief Executive
David Birkenhead	Executive Medical Director
Julie Hull	Executive Director of Workforce & Organisational Development

The Chair welcomed all Membership Councillors, Jeremy Pease and Phil Oldfield, Non-Executive Directors together with other attendees present.

2/15 ELECTRONIC PATIENT RECORDS

John Rayner, Director of The Health Informatics Service, together with Dr Alistair Morris, Clinical Director for Modernisation gave a presentation on the developments around implementation of Electronic Patient Records.

It was noted that following the update provided to the Membership Council in July 2014 a great amount of work had been undertaken and the Trust was now at the final stages of the procurement process, having selected a preferred supplier. The introduction of an electronic patient record would help the Trust to achieve the Government directive of all acute trusts being 'paper light' by 2018.

The benefits to patient care and implications of electronic patient records were highlighted within the presentation and this included:-

- Patient portal – all information on the system would belong to the patient and could be shared with their GPs etc.
- Admissions – There seamless information from A/E to the ward on admission.
- Care plans – EPR would auto-populate and release time for direct nursing care
- Path Lab/Ward Rounds – Clinical information available re. tests carried out available faster. Reduced inappropriate and duplication of testing.
- Observations on Wards – Immediate observations undertaken with alerts being raised automatically on deteriorating patients.
- E-Prescribing – Reduced prescribing errors and missed doses. Electronic clinical support checks. Right time, right patient, right drug.
- Discharge – Tailored patient education information available. System would populate discharge summaries/drugs. Risk of readmission reduced. Ability to notify wider health economy. Automatic Outpatient Appointment letters. System able to identify preventative measures ie. patient weight increases/heart failure risks. Patient able to share portal information with family, A/E staff, GPs or other clinicians.

Discussion took place regarding the training requirements for staff in using the system. It was envisaged that members of staff would each undergo between 8 – 12 hours of training. It was noted that at present all case notes were being scanned as part of the electronic document management system project. It was intended that the EPR system would go live in May 2016.

The Chairman advised that this system was to be introduced in the Trust in conjunction with Bradford Teaching Hospitals. CHFT would be the lead organisation, but the contract provided for other organisations to join in and thereby increase the financial benefits to the Trust.

It was noted that both Boards would make a decision in their private Board of Directors Meetings to be held on Thursday 29 January 2015. It was noted that the Trust would need to assure itself about affordability with patient safety and quality being a very high consideration.

3/15 MINUTES OF THE LAST MEETING – 6 NOVEMBER 2014

The minutes of the last meeting held on 6 November 2014 were approved as an accurate record.

4/15 MATTERS ARISING

a. AGM AND HEALTHFAIR AND MEDIA COVERAGE

The Associate Director of Engagement and Inclusion wished to thank Liz Schofield for helping with the judging of the Healthfair.

It was noted that conversations had begun on the 2015 AGM and Healthfair and the feasibility of the judging for Celebrating Success taking place within the Healthfair was being investigated. This would offer the opportunity to the public to see the innovative work taking place in the Trust.

b. LEARNING TOGETHER

The Associate Director of Engagement and Inclusion reported that 200 business cards had been ordered and it was hoped that these would be received and distributed at the February DRG Meetings.

It was agreed that Care of the Acutely Ill Patient Programme would be brought to a future Membership Council Development Session.

ACTION: RM

c. PRINTING OF PAPERS

The Associate Director of Engagement and Inclusion reminded the Membership Council of the email correspondence exchanged regarding printing of papers. The Trust was mindful of the costs of paper and the government directive for all Trusts to be paper light by 2018. Any members requiring paper copies were asked to let the Board Secretary know.

5/15 TRUST FINANCIAL AND SERVICE PERFORMANCE

Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities and Keith Griffiths, Executive Director of Finance presented the Performance and Finance reports as at the end of December 2014 together with information regarding January 2015 where available. The key issues of concern were noted:-

PERFORMANCE REPORT

a. A/E ACTIVITY – The Trust had seen an increase in A/E attendances through December and January. As was reported nationally, the Trust had found this challenging as more activity had been delivered than planned, resulting in the A/E 4 hour target being breached. The Trust had achieved 89.4% for December set against the national target of 95%.

b. PERFECT WEEK – It was noted that the perfect week held 7 to 13 January had been run with partner organisations. The week had involved Gold Command arrangements enabling all staff to focus on the care given to patients and ensure a smooth pathway of care.

The week had identified a number of areas where improvement to patient flow could be made and these had been built into an action plan to take forward. This included the creation of a dedicated 'bed team' from the cleaning staff who could be called by the wards to implement rapid cleaning and turnaround of beds to be ready for patients. This had led to improvements in patient flow with A/E 4 hour waiting being reduced. The figure as at the beginning of January was 94.8% year to date.

Bob Metcalfe reaffirmed the learning and improvements identified and hoped that these would continue into the future. Ruth Mason agreed to circulate the information on feedback from the week.

ACTION: RM

c. NURSE STAFFING – Work was underway to recruit more nurses. It was noted that a number of nurses from Spain had recently been recruited and further vacancies were still to be filled.

d. MORTALITY FIGURES – Work was underway regarding coding and pathways as part of the Care of the Acutely Ill Patient initiative. It was noted that the project had been refocused and would continue for a further 6 months to ensure that improvements have been delivered.

e. FRACTURED NECK OF FEMUR – Unfortunately due to pressures within the Trust the on ly 65% had been achieved against a target of 85% in December after a period of improved performance. Work was underway to review and improve the January position.

FINANCE REPORT

Keith Griffiths presented the finance report as at 30 November 2014 (Month 8).

The main points highlighted from the report were:-

- The year to date Income & Expenditure position for Month 8 is a deficit of £2.50m, against a planned surplus of £2.73m.
- The cash position at the end of November 2014 is £17.53m, in line with plan. This incorporates £7.0m of loan funded borrowing.
- Capital spend to date of £13.34m, in line with plan.

- The Monitor 'Continuity of Service Risk Rating' (CoSRR) is 3 at the end of November 2014 against a plan of 3.
- The underlying CoSRR is at level 2, the rating is boosted in the short term by the impact of the timing of the loan drawdown.

Key Points and Risks

- Year end forecast in line with reforecast deficit of £4.30m.
- CIP schemes to deliver £8.92m, £10.61m behind plan.
- Capital forecast to spend £21.46m.
- Forecast year end cash balance of £11.94m.
- Reserves utilised against CIP shortfall, after nursing investment.
- Winter pressures.
- CoSRR of 2.

The up to date position with Monitor was discussed in the private session with the Chair prior to the Membership Council meeting.

6/15 CHAIRMAN'S REPORT

a. MC DEVELOPMENT SESSION 3.12.14 – It was noted that the last MC Development Session, along with the Festive Buffet had been held on 3.12.14 at Blackley. Mel Johnston had given an update on the Quality Accounts at that session and had been invited to attend the meeting today to give a further update.

b. CHAIR'S INFORMATION EXCHANGE MEETING – 5.1.15 – The minutes of the meeting held on the 5 January 2015 were received and it was noted that certain items had been discussed within the informal part of the meeting.

The issues discussed at the Chair's Information Exchange included:-

- Voluntary Redundancy Schemes
- Outline Business Case
- Care Closer to Home Community Services Tender
- Saville Enquiry

c. FREEDOM OF SPEECH (WHISTLEBLOWING) POLICY

The Chairman reminded the Membership Councillors of the anonymous letter received by the Membership Council and Non-Executive Directors just before Christmas. It was noted that the concerns raised in the letter largely reflected the risk register presented to the November Board of Directors Meeting. All issues were being investigated.

Arrangements had been made for the Membership Council to discuss this further with the Non-Executive Directors at the MC/NED Informal Workshop to be held on the 12 February 2015. The Chairman reported that the policy had therefore been circulated for information.

7/15 CONSTITUTION

a. MEMBERSHIP COUNCIL REGISTER

The updated register of members was received for information.

b. 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.

c. AMENDMENT TO THE MODEL ELECTION RULES RE: ELECTRONIC VOTING

The amendment to the Model Election Rules as proposed by Monitor had been circulated for adoption by the Trust in readiness for the 2015 Elections. This would offer the opportunity for members to opt to vote electronically if they wished to. All present approved the amendment to the Constitution.

RESOLVED: Approved
ACTION: KB – amend Constitution on website

8/15 QUALITY ACCOUNTS

Mel Johnson gave a verbal presentation which updated the Membership Council on the planning for 2015-16 and progress against the priorities identified the previous year. It was noted that general public opinion on the 2015/16 priorities would be obtained through the next issue of the Foundation News which was to be published shortly. It was reported that IV Antibiotics had been carried forward from last year.

The 6 areas of voting within the 3 categories were:-

Safety

- Safe Medication
- Sepsis (new CQUIN in April)

Patient Experience

- Food
- Noise at Night

Patient Effectiveness

- Complaints Process
- Discharges – Information exchange/communication updates

It was agreed that the outcome of the consultation would be fed back to the Membership Council.

ACTION: MJ

9/15 ELECTION TIMETABLE 2015

The proposed timetable for the 2015 elections starting 1 June to 17 September 2015 was approved. Any changes were requested to be notified as soon as possible to the Associate Director of Engagement and Inclusion/Board Secretary.

10/14 ADDITIONAL INFORMATION

The following information was received and noted:

a. Updated Membership Council Calendar 2015.

11/14 ANY OTHER BUSINESS

a. MC TRAINING SESSION – "HOLDING TO ACCOUNT"

The Associate Director of Engagement and Inclusion reminded the Membership Council of the next training session to be held on the afternoon of Tuesday 27 January 2015 in the Learning Centre, HRI.

12/14 DATE AND TIME OF NEXT MEETING

Wednesday 8 April 2015 in the Large Training Room, Learning Centre, Calderdale Royal Hospital commencing at 4.00 pm

The Chair thanked everyone for their contribution and closed the meeting at 6.00 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th February 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: RISK MANAGEMENT POLICY - The Board is asked to approve the Risk Management Policy	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Committee, Quality Committee, Weekly Executive Board	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Risk Management Policy

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 Risk Management Policy.

Appendix

Attachment:

Risk Management Policy (3) (2).pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Risk Management Policy

Version 1

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

Document Summary Table	
Unique Identifier Number	G/101/2015
Status	Approved
Version	1 (previously formed part of the Governance Strategy)
Implementation Date	February 2015
Current/Last Review Dates	
Next Formal Review	February 2016
Sponsor	Director of Nursing
Author	Risk Manager/Company Secretary
Where available	Trust Intranet
Target audience	All Staff

Ratifying Committees	
Name of Ratifying committee	
Board of Directors	26 February 2015

Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Risk & Compliance Committee	Director of Nursing/Assistant Director	13 January 2015
Quality Committee	Non-Executive Director	27 January 2015
Weekly Executive of Directors	Chief Execuitve/Chair	29 January 2014

Other Stakeholders Consulted	
Stakeholders who were consulted on this document	

Does this document map to other Regulatory requirements?	
Regulator details	*Regulator standards/numbers etc*

Document Version Control	
Version no	*Details of review/alterations, rationale for document etc*
1	The Risk Management Strategy used to form part of the Trusts Governance Strategy. The Risk process has been removed from this to form its own policy.

CONTENTS

Appendices

Key Points for Staff

- The primary purpose of risk management is to:

    - Reduce harm for patients, staff, visitors or contractors;
    - Continuously improve patient experience, safety and quality performance.
    - Promote the success of Calderdale & Huddersfield NHS Foundation Trust ("CHFT");
    - Protect everything of value to the Trust (such as reputation, market share, exemplary clinical outcomes);

- When identifying risk we anticipate what could stop us from achieving our objectives or goals. To help identify areas of risk we look at our historical performance and trends, previous events, current challenges, and needs of people who use our services as well as thinking about future scenarios or potential outcomes that could help or hinder the delivery of our strategy. We are all required to be open, honest, think ahead and take an active part in identifying risk.

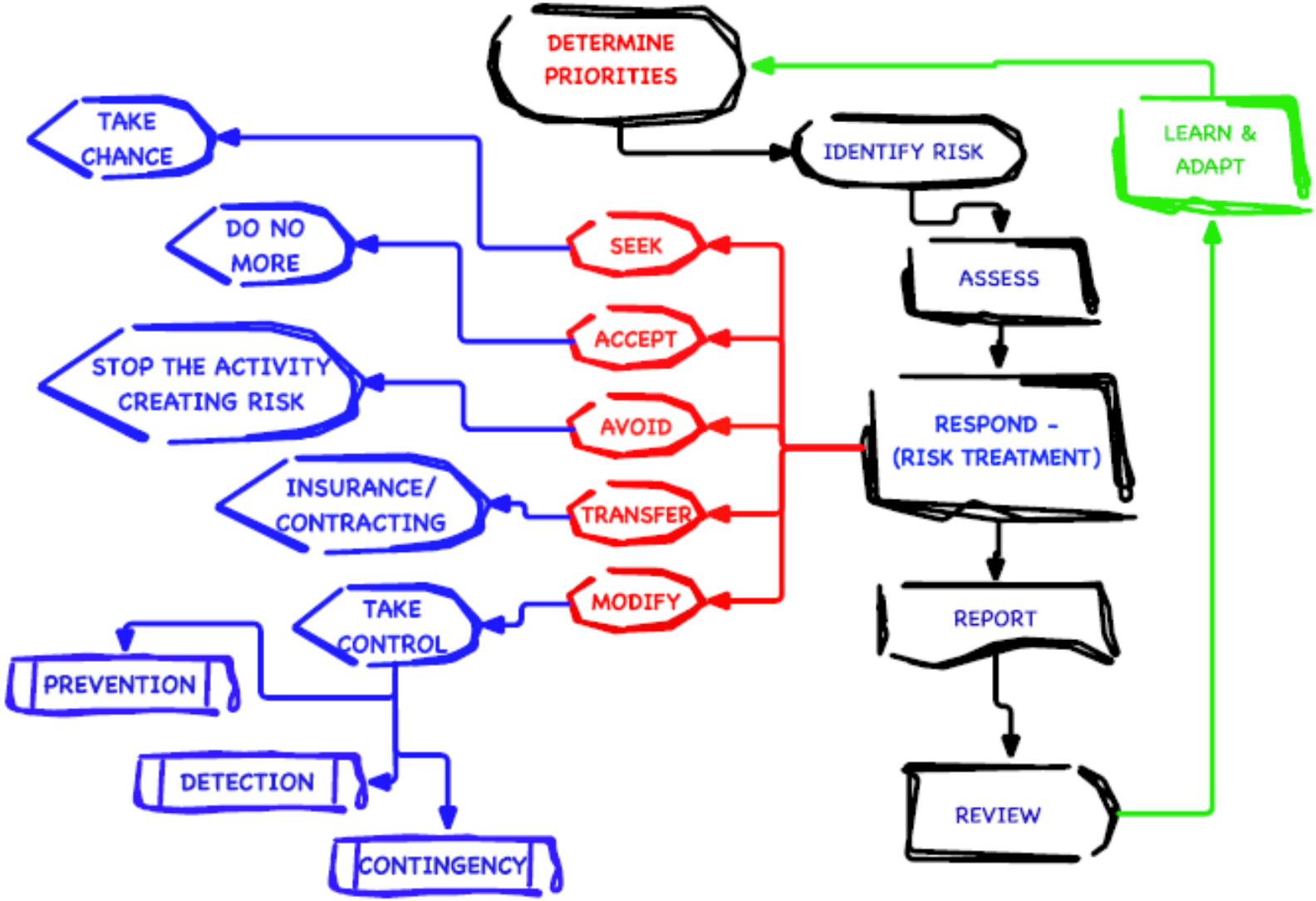
- Risk analysis involves estimating the severity (the impact the risk has on the Trust and people in our care) and likelihood (the probability of that impact happening). The scores are multiplied to give an overall risk rating. The risk rating is used to determine risk management priorities and monitor acceptable amounts of risk. Colleagues are required to challenge constructively any assumptions made regarding severity and likelihood, and to strive to ensure risk is kept within agreed tolerance.

- Risk is treated proactively using a combination of prevention, detection and contingency controls. **Prevention** controls ensure activities are performed in a certain way and typically involve policies, clinical or operational procedures, guidelines, training or computer systems. **Detection** controls alert management to any deficiencies preventing risk and typically involves performance monitoring, audits, alarms or tests. **Contingency** controls are designed to allow the Trust to recover from a failure to manage risk and allow the Trust to continue to function albeit in a modified way. Colleagues are required to understand and implement all controls designed to manage risk at the Trust.

- Organisational learning is reflected in the Trust's ability to continuously reduce the frequency of the same adverse event (incident, complaint or claim), and continuously improve performance. Controls are monitored and continuously improved as part of an open and learning culture.

- Risk management is everyone's responsibility. This policy applies to all Trust employees, contractors or volunteers working at the Trust.

At a Glance: The Risk Management Process



1. Introduction

This document is the policy for the management of risk at CHFT. Risk management is an integral component of the Trust's Quality Governance Framework. By complying with the organisational arrangements described in this document, services will ensure the effective identification, assessment and control of risk thereby promoting and supporting the achievement of objectives.

The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). Risk management includes identifying and assessing risks and responding to them in an effective and resilient manner.

At all times the Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

The Trust's governance framework will be supported by an effective risk management system that delivers continuous improvements in safety and quality, and maximises opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

2. Aims/Objective

The overall purpose of risk management at the Trust is to:

1. **Reduce the level of exposure to harm for patients, colleagues or visitors** by proactively identifying and managing personal risk to a level as low as reasonably practicable
2. **Continuously improve performance** by proactively adapting, remaining resilient to changing circumstances or events, and learning.
3. **Promote success and protect everything of value** to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income

The Trust will establish an effective risk management system which ensures that:

- All risks that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust are proactively identified and managed well
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff
- Controls are put in place, effective in their design and application to manage risks, and risk treatment is understood by those expected to

apply control

- All staff have a responsibility to comply with controls, whilst the operation of controls is monitored by management
- Gaps in control are rectified
- Management are held to account for the effective operation of controls
- Assurances are reviewed regularly and acted on
- Staff continuously learn and adapt to improve safety, quality and performance
- Risk management systems and processes are embedded locally across divisional teams and in corporate services including business planning, service development, financial planning, project and programme management and education.

The Trust will achieve this by:

- Developing and driving a clear strategy to meet patient needs
- Actively engaging openly with patients and the public, colleagues and stakeholders
- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process
- Ensuring that regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations
- Providing training to keep risk under prudent control
- Investigating thoroughly, learning and acting on defects in care
- Liaising with enforcing authorities, regulators and assessors
- Effective oversight of risk management through team and committee structures
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings
- Effective reporting and arrangements to hold staff to account

3. Scope of this Policy

Risk management is everyone's responsibility. This Policy applies to all employees, contractors and volunteers. All employees will co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. These are summarised under specific and generic responsibilities in Section 4 below.

Effective employee engagement is vital to our success and vision to provide care all of us would recommend to family and friends. Our values and behaviours set out "*the way we do things around here*" and these guide our work.

Our vision is :

We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding compassionate care which transforms the welfare of the communities we serve.

Our guiding behaviours are:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

By wholeheartedly embracing our values and behaviours in all risk management activity, this policy supports high performance and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organisation.

4. Roles and Responsibilities

In order to achieve the aims of this policy the following roles, accountabilities and responsibilities apply:

Specific Duties & Responsibilities

The **Chief Executive** has overall accountability to the Board of Directors for effective risk management. The Chief Executive is responsible for ensuring priorities are determined and communicated, risk is identified and managed in accordance with the Board's appetite for taking risk.

The **Director of Nursing,** on behalf of the Chief Executive, is the Board lead for risk management processes across the Trust. They shall, on behalf of the Board, implement and maintain an effective system of risk management. The Director of Nursing is responsible for:

(i) risk management policy development;
(ii) developing and communicating the Board's appetite for taking risk;
(iii) establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these; and
(iv) monitoring the management of risk across divisions. In the event of unsatisfactory compliance with the risk management process or unacceptable risk exposure, the Director of Nursing will escalate the matter to a relevant Executive Director for their immediate attention and action.

All Executive, Clinical, Divisional and other Directors have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They shall intervene robustly to ensure teams within their sphere of control follow the risk management process. In addition, Executive Directors, Clinical and all other Directors will also be responsible,

where required, for the provision of specialist advice to the Board of Directors. This acknowledges that all Directors are subject matter experts and have specific responsibilities for interpreting and applying national policy, legislation and regulations in respect of their specific areas of expertise.

Head of Risk & Governance - has day-to-day responsibility for risk management process, quality governance and safety management. They will report to the Director of Nursing for:

(i) the development of risk management policy;
(ii) administration of risk management systems;
(iii) oversight of risk exposures facing the business;
(iv) provision of risk management training and support to divisions; and
(v) the maintenance of the corporate risk/safety management plan. They will be responsible for the maintenance and reporting of the Corporate Risk register and carry out sufficient checks within and across divisions to monitor the management of risk alongside the Board's appetite for taking risk. They will be responsible for the effectiveness of the Risk Register system, a governance system on which the Board depend, taking whatever action is necessary with colleagues, or the system Vendor, to ensure its effectiveness, validity, data quality and data completeness. The Head of Risk & Governance will take the lead in triangulating lessons for learning ensuring defective arrangements, alerts or changes in practice are conveyed to front line teams promptly and acted upon.

Company Secretary – is the lead officer for the Board Assurance Framework ("BAF") supported by the Executive Directors and is responsible for the co-ordination and the updating of the BAF, ensuring that the information is reported appropriately. They shall also be responsible for ensuring that the BAF and risk register are aligned.

Generic Duties and Responsibilities

See table below:

Main Duties	Board of Directors	Executive Director	Divisional & Clinical Director	Other Managers	All Employees
Strategy & Policy	• Determine the Trust's vision, mission and values • Set corporate strategy • Provide leadership	• Develop and oversee the implementation of strategic plans • Develop and communicate corporate objectives • Proactively anticipate risk • Provide leadership and guidance to employees, business partners and stakeholders	• Develop and Implement Clinical Strategy • Alignment of divisional objectives to Trust strategy	• Alignment of team/personal objectives to Trust strategy	• Deliver personal objectives • Abide by ***Trust values and behaviours***
Organise	• Establish an effective risk management system • Establish and keep under review the Board's appetite for taking risk • Focus on material risk and proactive anticipation of future risk	• Develop & apply Risk Management Process • Accept and allocate ownership for risk • Share ownership for cross-enterprise risk	• Apply Risk Management Process • Accept and allocate ownership for risk • Proactively anticipate risk • Provide leadership and guidance	• Apply Risk Management Process • Accept and allocate ownership for risk • Proactively anticipate risk • Provide leadership and guidance	• Follow Risk Management Process • Accept ownership for risk
Plan & Control	• Decide what opportunities, present or future, the Board wants to pursue and what risks it is willing to take in developing the opportunities selected Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks • Decide whether or not a risk can be accepted • Simultaneously drive the business forward whilst making decisions which keep risk under prudent control	• Design, apply and monitor the operation of controls to ensure the achievement of objectives and promote organisational success • Ensure failure does not disable – contingencies are in place and tested for all reasonably foreseeable situations • Allocate, structure and prioritise resources within and across divisions or directorates so that risk is managed in accordance with the Board's risk appetite.	• Design and apply controls to manage risk in line with the Board's appetite for taking risk • Prepare risk management mitigation plans • Ensure adequate emergency preparedness and contingencies for foreseeable disruptive events • Manage resources to optimum effect • Develop policies, guidelines, procedures and standards to govern the management of risk locally	• Design and apply controls to manage risk in line with the Board's appetite for taking risk • Remain alert to risk • Manage resources to optimum effect • Develop and implement risk management plans	• Undertake and keep up to date with mandatory training and other relevant training • Follow policies, clinical standards and relevant procedures • Act on lessons for learning
Monitor	• Keep under review material risk exposures that are not accepted by the Board at each formal meeting	• Challenge, support, supervise and hold colleagues to account for performance and continuous improvement	• Monitor the operation of controls and address identified gaps in control	• Supervise the work of others to ensure controls are applied correctly	• Report concerns, defects, adverse events or failures to contain risk adequately.
Audit	• Determine Audit priorities using a risk-based approach • Take account of reports from the Audit Committee	• Determine Audit Priorities using a risk-based approach • Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues • Account for control of risk to the Audit Committee where required	• Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues • Account for control of risk to the Audit Committee where required • Undertake appropriate inspection/checks of controls for safety critical procedures	• Cooperate fully and assist Internal Audit, • Challenge recommendations if they are not agreed • Develop and implement changes in practice within the timescales agreed • Report when concluded.	• Cooperate with Internal Audit and act on their findings • Carry out instructions based on agreed audit recommendations
Review	• Effectively hold those responsible for managing risk to account for performance and continuous improvement. • Take decisions	• Report to the Board all material risks and significant gaps in control	• Report to the Board all material risks and significant gaps in control • Escalate risk in accordance with this Policy • Ensure all risks are reviewed correctly		

5. Risk Management Process

Step 1: Determine Priorities

Risk is defined as anything that is stopping or could prevent the Trust from providing safe and sustainable clinical services, and from being successful (for a summary of key terms used in this document see Appendix 1). The Board of Directors and Senior Management will be clear about objectives for each service and express these in specific, measurable, achievable ways with clear timescales for delivery.

Step 2: Identify Risk

Evaluating what is stopping, or anticipating what could prevent the Trust from achieving stated objectives/strategic priorities, annual plans, financial plans, delivering safe clinical services will identify risk. Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats. The identification of risk is an ongoing process and is never static, but is particularly aligned to the annual planning process and compliance requirements. Staff may draw on a systematic consideration of reasonably foreseeable failures alongside incident trends, complaints, claims, patient/staff surveys, observations, formal notices, audits, clinical benchmarks or national reports to identify risk. This list is not exhaustive. In order to do this the Board of Directors, senior leaders and divisional teams will identify what is uncertain, consider how it may be caused and what impact it may have on the objective and service.

Step 3: Assess Risk

Estimate the magnitude of a risk by multiplying the severity of impact by the likelihood of the risk occurring. Be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to calculating residual risk and risk scoring matrix guidance is provided in appendices 2 and 3.

Step 4: Respond to the Risk

There are a number of different options for responding to a risk[1]. These options are referred to as risk treatment strategies. The main options most likely to be used include:

- **Seek** - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk.*
- **Accept** - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).

- **Avoid** - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. *Staff must take advice from the Executive Team before entering into any risk transfer arrangement*.
- **Modify** - this strategy involves specific controls designed to change either the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust. For this reason, we expand on the nature of control as follows:

The following three types of control are used to modify risk:

(i) **Prevention/Treatment** - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre-procedure checks etc.

(ii) **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, complaints, performance reports, audits

(iii) **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency controls are designed to maintain resilience.

A combination of all 3 types of control is usually required to keep risk under prudent control.

Step 5: Report Risk

All risks must be recorded on the Risk Register. It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the Corporate Risk Register. Risks which score 12 or higher must be brought to the attention of the Head of Risk and Governance for escalation to the appropriate committee for consideration and potential inclusion on the Corporate Risk Register. The Corporate Risk Register prioritises risk, populated from risk assessments carried out both at a strategic and operational level. Key outputs from the risk management system will be reported to relevant staff/committees depending on the residual risk score as follows:

- ≥15 – each formal meeting of the Board of Directors
- ≥10 – [Relevant] Committee of the Board of Directors as part of the Committee's annual work plan
- ≥8 – Specialty/Divisional /Departmental Governance meeting at least quarterly
- ≥≤6 – Ward/Departmental Management at least annually

The BAF is the document that holds all risks which may prevent the achievement of the Trust's strategic objectives. All risks from the BAF are presented to the Board, via the Executive Board. All other Board committees

may make recommendations for including or amending strategic or significant risks. Containing only high level risk, this document is brought to the attention of the Board at each of its public meetings

The **Board of Directors** will also receive summary reports at each formal meeting to inform them of all material risk, the nature of controls and action plans. The risk profile will be part of the Chief Executive's report and cover as a minimum the risk source, description of the risk, the residual risk, main controls, date of review and risk owner.

The **Risk & Compliance Group is a sub-committee of the Quality Committee.** It will receive reports to monitor the quality, completeness and utilisation of risk registers, and also to oversee of the distribution of risk across the Trust. Reports will cover the risk description, the residual risk (exposure after control), main controls, date of review and risk owner.

Divisions will have access to the Risk Register and receive system generated Divisional specific reports in order to review the identification of risks within their wards, departments and specialties, and check that adequate controls are in place and actions are being implemented.

The Executive Team will be informed by the Director of Nursing (or relevant Executive Director) of any new significant risk arising at the first meeting opportunity.

The Audit and Risk Committee will scrutinise assurances on the entire risk management system to ensure it remains fit for purpose and, at the Committee's discretion, will examine assurances on the operation of controls for all significant risk exposures or any other risk of interest to the Committee.

Urgent Escalation - in the event of a significant risk arising out with meetings of the above, the risk will be thoroughly assessed, reviewed by the relevant Clinical Director, Associate Director of Nursing, Divisional Manager and Executive Director and reported to the Chief Executive (or their deputy) within 24 hours of becoming aware of the risk. The Chief Executive, with support from relevant members of the Executive Team and advisors, will determine the most appropriate course of action to manage the risk. The Chief Executive will assign responsibility to a relevant Executive Director for the management of the risk and the development of mitigation plans. The risk will be formally reviewed by the Executive Team at their next weekly meeting.

Step 6: Review Risk

Risks will be reviewed at a frequency proportional to the residual risk. Discretion regarding the frequency of review is permitted. As a guideline it is suggested, as a minimum, risk is reviewed as follows:

- ≥15 – at least monthly
- ≥10 – at least quarterly
- ≥8 – at least bi-annually

- ≤6 – annually.

The Committees of the Board

The totality of the Trust's risk governance infrastructure includes the oversight provided by Board committees in their risk-related roles. Committees of the Board of Directors play a vital role in effective risk management and will apply the following principles to enable the Board to keep risk under prudent control at all times:

a) oversee and advise the Board on current risk exposures and future risks to the Trust's strategy;
b) oversee risk appetite and tolerance for those areas under the Committees purview;
c) address risk and strategy simultaneously taking into account assurance on the operation of control, the current and prospective macro-economic, public policy and financial environment;
d) challenge the Trust's analysis and assessment of risk;
e) advise the Board on risk treatment and strategy;
f) oversee due diligence appraisal of any proposed strategic transactions involving acquisition, merger or disposal;
g) evaluate risk management capability;
h) examine risks associated with emerging regulatory, corporate governance and industry best practices; and
i) consult experts to optimise risk treatment where necessary.

6. Training

Risks may be identified proactively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:

a) Risk Register
The Risk Register provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto the risk register.

b) Risk Management Training
This document recognises that training will be required to effectively manage risks in line with the process set out above. Details of all Trust training programmes are set out in the Training Needs Analysis which can be found in the Mandatory Training Policy and associated documents.

i) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive training and/or briefings on the risk

management process by the Risk & Governance Manager. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.

ii) All staff will receive an introduction to the Risk Management Process briefing as part of the Corporate Induction programme.

iii) Additional training will be provided through an e-learning programme.

iv) Divisional, Ward and Departmental managers will have further more detailed risk management process training incorporating how to use the Risk Register database before access to the database is enabled.

v) Staff designated to regularly undertake Root Cause Analysis will have the opportunity to undertake Root Cause Analysis training.

7. Equality Impact Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their age, race, faith, culture, gender, sexuality, marital status or disability.

8. Monitoring and Audit

The following indicators will form the Key Performance Indicators by which the effectiveness of the Risk Management Process will be evaluated:-

- All verified significant risks are reported to the Board of Directors at each formal meeting of the Board
- All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of a Committee of the Board
- The risk profiles (for risks ≥10) for all divisions are reviewed by the Patient Safety Committee, at a frequency determined by the Patient Safety Committee, as part of a rolling programme of reviews
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and ≥80% of risks are within review date and none are overdue for review by 6 or more months.

Compliance with the above will be monitored by the Head of Risk & Governance, reviewed by the Director of Nursing and reported within an annual report submitted to the Quality Committee.

The following mechanisms will be used to monitor compliance with the requirements of this document:

- Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting
- Evidence of review of significant risk exposure by the Risk & Compliance Group at each formal meeting of the Group
- Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit and Risk Committee (risk identification, assessment, control, monitoring and reviews).

9. Associated Documents/Further Reading

This policy/procedure should be read in accordance with the following Trust policies, procedures and guidance:

- Incident Reporting and Management policy
- Complaints policy
- Major Incident policy
- Blood Transfusion policy
- Capability policy
- Consent Policy
- Falls Prevention and Management policy
- Fire Policy
- Freedom of speech/Whistleblowing policy
- Health and Safety policy
- Induction policy
- Infection Control policies
- Information Governance Strategy and associated policies
- Mandatory Training Policy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Personal Development Review
- Policy on the Appointment of Medical locums
- Policy for Developing Policies
- Policy on the implementation of NICE guidelines
- Promoting Good Health at Work Policy
- Race Equality Scheme

Moore P., A. (2013) *Countering the Biggest Risk Of All: attempting to govern uncertainty in healthcare management*. London. Good Governance Institute

Chapman R., J. (2012) *Simple tools and techniques for enterprise risk*

Audit Commission (2009) *Taking it on Trust: a review of how boards of NHS Trusts get their assurance*. London. Audit Commission

BSI (2008) *Risk Management - Code of Practice*. BS 31100:2008. London. British Standard International

NPSA (2004) *Seven Steps to Patient Safety*. London. NPSA

DH (2003) *Building the Assurance Framework: A Practical Guide for NHS Boards*. London. Department of Health

DH (2000) *An Organisation with a Memory*. London. HSMO

Appendix 1

Glossary of Terms used within Policy

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

Board Assurance Framework	A document setting out material risk and assurances on the operation of controls to manage those risks	**Risk**	Effect of uncertainty on objectives
Control	An intervention used to manage risk	**Risk acceptance**	Informed decision to take a particular risk
Exposure	Extent to which the organisation is subject to an event	**Risk aggregation**	Process to combine individual risks to obtain more complete understanding of risk
Hazard	Anything that has potential for harm	**Risk analysis**	Process to comprehend the nature of risk and to determine the level of risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	**Risk appetite**	Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate
Inherent risk	Exposure arising from a specific risk before any intervention to manage it	**Risk assessment**	Overall process of risk identification, risk analysis and risk evaluation
Level of Risk	Overall magnitude of a risk. It can be significant, high, moderate, low or very low.	**Risk avoidance**	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Material Risk	Most significant risks or those on which the Board or equivalent focuses	**Risk management**	Coordinated activities to direct and control the organisation with regard to risk
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	**Risk owner**	Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
Operational Risk	The risk of loss or gain, resulting from internal processes, people and systems or from external events	**Risk Register**	A record of information about identified risks.
Programme Risk	Risk associated with transforming strategy into solutions via a collection of projects	**Target Risk**	A level of risk being planned for
Residual risk	Current risk. The risk remaining after risk treatment		

Appendix 2

Calculating Residual Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring. This calculation will produce a **Residual Risk Score** that refers to **the amount of risk remaining after treatment**. The Trust uses a standard 5 x 5 scoring matrix set out below:

SEVERITY INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Severity
Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood
Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

Differing Risk Scenarios
In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register**.

Appendix 3

Risk Grading

SCORE	Incident / Risk Grade (NPSA Cat.)	Level of Risk	Communicated to and overseen by	Investigation Level
15 - 25	Catastrophic	SIGNIFICANT	Alert Chief Nurse Reported to Board of Directors	SI Procedures RCA – 45 days (Board notification)
10-14	Major	HIGH	Alert Clinical Director Reported to Risk Management Committee	Divisional RCA – 28 days
8 - 9	Moderate	MEDIUM	Inform Divisional Manager Overseen at Divisional Level	Directorate Analysis – 28 days
4-6	Minor	LOW	Inform Ward/Departmental Manager Oversee at Ward/Departmental Level	Ward/Department Analysis – 10 Days
1-3	None	VERY LOW	Ward/Departmental Management	Ward/Department Analysis – 10 Days

5X5 MATRIX

X	LIKELIHOOD				
		1	2	3	4
IMPACT	1	1	2	3	4
	2	2	2	6	8
	3	3	6	9	12
	4	4	8	12	16
	5	5	10	15	20