Calderdale and Huddersfield NHS
NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 3 November 2016 from 9:00 am

Venue: Boardroom, Huddersfield Royal Infirmary HD3 3EA

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Lynn Moore	Chair	**VERBAL**	**Note**
2	**Apologies for absence:**	Chair	**VERBAL**	**Note**
3	**Declaration of interests**	All	**VERBAL**	**Receive**
4	**Minutes of the previous meeting** held on 29 September 2016	Chair	**APP A**	**Approve**
5	**Matters arising and review of the Action Log**	Chair	**APP B**	**Review**
6	**Patient/Staff Story: Bev Walker, Associate Director for Urgent Care re SAFER Programme**	Chair	**Presentation**	**Note**
7	**Chairman's Report** a. Board to Board Meeting with Mid Yorkshire FT – 24.10.16 b. Appointment of Executive Director of Finance c. CCGs' Decision	Chair	**VERBAL**	**Note**
8	**Chief Executive's Report:** a. West Yorkshire Accelerator Zone b. STP	Chief Executive	**VERBAL**	**Note**
Transforming and improving patient care				
9	Right Care, Right Time, Right Place update	Director of Transformation and Partnerships	**VERBAL**	**Note**
Keeping the base safe				
10	Risk Register report	Executive Director of Nursing	**APP C**	**Approve**
11	Board Assurance Framework report	Company Secretary	**APP D**	**Approve**
12	Risk Appetite Statement	Executive Director of Nursing	**APP E**	**Approve**

13	Performance Management Framework – update on pilot	Chief Operating Officer	**APP F**	**Note**
14	Governance report - Annual review of Non-Executive Director roles - Review of Board of Directors terms of reference - Standing Financial Instructions review - Single Oversight Framework - Well Led Governance Review	Company Secretary	**APP G**	**Approve**
15	Review of progress against strategy	Company Secretary	**APP H**	**Approve**
16	Care of the Acutely Ill Report	Executive Medical Director	**APP I**	**Approve**
17	Nursing and Midwifery Safe Staffing - Hard Truths Report	Executive Director of Nursing	**APP J**	**Approve**
18	DIPC Quarterly Report	Executive Medical Director	**APP K**	**Approve**
19	Health and Safety Annual Report	Executive Director of PPEF	**APP L**	**Approve**
20	Integrated Performance Report - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Finance	Chief Operating Officer “ Director of Nursing Director of Nursing Executive Medical Director Executive Director of W&OD Executive Director of Finance	**APP M**	**Approve**
Financial Sustainability				
21	Month 6 – 2016 – Financial Narrative	Executive Director of Finance	**APP N**	**Approve**
A workforce for the future – no items				
22	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of		**APP O**	**Receive**

	27.9.16 and verbal update from meeting of 31.10.16 ▪ Finance and Performance Committee – minutes of 26.9.16 and verbal update from meeting 1.11.16 ▪ Audit and Risk Committee – draft minutes from meeting 18.10.16 ▪ Workforce Well Led Committee draft minutes – 19.10.16 ▪ BOD/MC Joint AGM draft Minutes – 15.9.16			
Date and time of next meeting Thursday 1 December 2016 commencing at 9.00 am **Venue: Board Room, Sub-Basement, Huddersfield Royal Infirmary HD3 3EA**				

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 29.9.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 29 September 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 29 September 2016.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 29 September 2016.

Appendix

Attachment:

draft BOD MINS - PUBLIC - 29.9.16.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 29 September 2016 in the Board Room, Huddersfield Royal Infirmary.

PRESENT

Andrew Haigh	Chairman
Helen Barker	Chief Operating Officer
David Birkenhead	Executive Medical Director
Brendan Brown	Executive Director of Nursing
Lesley Hill	Executive Director of Planning, Estates and Facilities
Karen Heaton	Non-Executive Director
Richard Hopkin	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director
Ian Warren	Executive Director of Workforce & OD
Owen Williams	Chief Executive

IN ATTENDANCE

Gary Boothby	Deputy Director of Finance
Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Director of The Health Informatics Service
Victoria Pickles	Company Secretary
Anne-Marie Henshaw	Head of Midwifery (for item 6 – Patient Story)
Gail Wright	Deputy Head of Midwifery (for item 6 – Patient Story)

OBSERVERS

Alexander Andrews	Shadowing Chief Executive
Jason Eddleston	Deputy Director of Workforce & OD (for item 5 – Staff Survey)
Brian Moore	Membership Councillor

134/16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting, with a particular welcome to Dr Linda Patterson who had returned from sabbatical leave that month and to Ian Warren who had commenced as Executive Director of Workforce and OD on the 1 August 2016.

135/16 APOLOGIES FOR ABSENCE

Apologies were received from:
Dr David Anderson, Non-Executive Director
Phil Oldfield, Non-Executive Director
Keith Griffiths. Executive Director of Finance

136/16 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

137/16 MINUTES OF THE MEETING HELD ON 28 JULY 2016

The minutes of the meeting were approved as a correct record with the amendment to the risk register (item 124/16) to state that 'there were no risks with reduced scores'.

138/16 MATTERS ARISING FROM THE MINUTES / ACTION LOG
125/16 STAFF SURVEY ACTION PLAN – UPDATED REPORT

The Chief Executive had invited Jason Eddleston to the meeting for this item. Thanks were given to Jason for his help in supporting colleagues in preparing the Action Plan as well as the Board for their input and visibility into this piece of work.

The paper provided an update from Director leads on the progress implementing the Workforce Race Equality Scheme (WRES) and staff survey action plan was received. The progress report described actions taken and RAG rated status of each action area. The RAG ratings had been determined by the respective action lead. The current status of the overall plan (25 actions) was as follows:-

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

Discussion took place about the importance of this work and the Board's visibility in driving this forward. It was noted that the feedback from the Staff Survey which had been launched earlier that week would be included within the Action Plan.

Discussion took place about how feedback would be communicated throughout the Trust and it was noted that this would be through the networks available and could also be included in the Board discussions with staff once the Leadership Walk-rounds were re-launched in November.

OUTCOME: The Board RECEIVED AND NOTED the updated Action Plan.

There were no other items outstanding on the Action Log.

139/16 PATIENT / STAFF STORY – MONICA'S STORY

Anne-Marie Henshaw, Associate Director of Nursing and Head of Midwifery and Gail Wright, Deputy Head of Midwifery presented "Monica's Story'. The story was intended to give the Board a flavour of the work undertaken within the Midwifery Unit in balancing the Trust guidance/NICE guidelines and the wishes of the patient.

'Monica's story' told of a woman who was due to have her first baby. Initially there were no risk factors or complications and a water birth at Calderdale Birth Centre had been booked. At 36 weeks tests showed that the baby was breech. The risks were explained but the Mother declined an external cephalic version and elective caesarean section and wished to continue with the birthing plan.

The story told how using multi-professional working, breaking down barriers between midwives and other professionals to deliver safe and personalised care for women and their babies benefitted patients. This along with safe care based on a relationship of mutual trust and respect of the woman's decisions ensured that a patient's decision would be based on unbiased advice and information.

The outcome of the 'story' was that this joint working had ensured that the mother had safely delivered her baby with a water birth delivery.

The learning from this emphasised the importance of developing a safety culture aligned to the five year forward view for maternity care and the importance of embedding the core trust and professional values across teams.

Discussion took place regarding the implementation of the Maternity EPR system and whether such a story would be captured on the EPR system. It was noted that

initially the maternity system was formulaic but now that amendments had been made there was opportunity for free text to be added which allowed multi-disciplinary team input.

Discussion took place regarding the level of risk involved and percentage of patients who fall into the multi-disciplinary team (MDT) process. It was noted that MDT meetings are held fortnightly with around 3-5 cases being reviewed at each session.

The Chairman thanked Anne-Marie and Gail for their informative presentation.

140/16 CHAIRMAN'S REPORT

a. Chair/CE NHS Provider Meeting – 21.9.16

The Chairman reported on the meeting held on 21.9.16. The key issues discussed included:-

- Sustainability and Tranformation Plans (STPs) and Governance being driven up the agenda
- Ed Smith, Chair NHS Improvement highlighted five key areas – money (the published national deficit of £580m needs to be met), planning, STPs, Single Oversight Framework and leadership.

Other issues discussed included Diversity on Boards, the importance of preventative care for long term future of NHS and Brexit implications on NHS, regulatory changes and workforce.

Prof Roberts reported that similar discussions had been held at the HFMA Conference and agreed to circulated the information presented at the Conference around finances.

ACTION: Prof. Peter Roberts

b. Joint BOD/MC Annual General Meeting – 15.9.16

The Chairman confirmed that the Annual General Meeting had gone well and thanked everyone involved, particularly the Health Informatics Staff for their displays around developments in Information Technology.

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

141/16 CHIEF EXECUTIVE'S REPORT

The Chief Executive updated the Board on the national financial context. It was noted that NHS England and NHS Improvement were working together but the challenge for 70 Clinical Commissioning Groups (CCGs) declaring a deficit (of which 40 were greater than 1% of turnover, amounting to some £95m off plan).

It was noted that local discussions were being held with the CCGs to help with the challenges ahead and the need for the Trust to meet control totals.

OUTCOME: The Board **NOTED** the update from the Chief Executive.

142/16 RIGHT CARE, RIGHT TIME, RIGHT PLACE - CONSULTATION UPDATE

The Chief Executive and Director of Transformation and Partnerships informed the Board that the Joint Overview and Scrutiny Committee feedback on the consultation had been published and would be discussed at the public meeting on 30 September 2016. It was noted that a decision from the CCG was awaited on the afternoon of the 20 October 2016 when the Board could then discuss the next steps.

The Board asked that personal thanks be given to Catherine Riley, Assistant Director of Strategic Planning for her work in helping support the Overview and Scrutiny

Committee in the scrutiny process.

ACTION: Chief Executive

It was agreed that a special Board Meeting/telephone conference would be arranged and confirmed with the Board within the next few days.

ACTION: Company/Board Secretary

OUTCOME: The Board NOTED the update on the Right Care, Right Time, Right Place consultation.

UPDATE: Following the meeting the special Board Meeting was arranged for Thursday 20 October at 5pm.

143/16 RISK REGISTER

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

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

Risks with increased score

There were none with an increased score.

Risks with reduced scores

- 4783 (16): Outlier on mortality levels, reduced from score of 20 due to progress with understanding the cause of mortality.
- 6658 (16): Patient flow risk reduced from score of 20 due to progress with discharge planning.
- 6723 (12): Cost improvement delivery risk score reduced from 20 and now managed within divisional risk register.

New risks

One new risk has been added to the Corporate Risk Register in September 2016, risk 6841 EPR operational readiness.

Closed risks

There were no closed risks.

General discussion took place regarding the grading of risks and the granular information available on the system before decisions are made, particularly when down-grade a risk.

The Chairman commented on the staffing and recruitment risks. The Executive Director of Workforce and OD advised that work was underway within the Divisions and Well Led Committee to look at alternative methods of recruitment and retention. This was also reinforced by the Executive Director of Nursing and Executive Medical Director. It was agreed that the Trust had further work to do to improve the processes for recruiting to posts to ensure a speedier process and review of retention methods.

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

144/16

BOARD ASSURANCE FRAMEWORK

The Company Secretary reported that, as agreed at the Board meeting in July, the

Board Assurance Framework had been reviewed to assess whether there was any amendment required to the Trust's strategic risks as a result of the changing NHS landscape and the challenges facing the Trust.

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

There had been no new or closed risks.

The Company Secretary reported that while the risk scoring remained the same there had been some adjustment made to the assurances and the actions have been updated to reflect the current position. References to the corporate risk register had also been updated.

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

ACTION: VP – November BOD

The Executive Medical Director reported that discussions had taken place with NHS Improvement regarding 7 Day Working and it was noted that the Trust did not have confidence in making substantive progress until the outcome of the consultation was known.

OUTCOME: The Board **APPROVED** the recommendation that the BAF remain under review and **AGREED** to receive a further version at the meeting in November.

145/16 EMERGENCY PREPAREDNESS RESILIENCE RESPONSE (EPRR)

The Executive Director of Planning, Performance Estates and Facilities presented the EPRR Report and explained that there was an annual requirement to self-assess against national standards for emergency preparedness and business continuity.

It was noted that the overview, analysis and assessment of this year's standards against current EPRR portfolio practice is that there are significant pieces of work required. The compliance level would be Substantial with the caveat of fully implementing the associated improvement plan. The issues related to:-

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

It was noted that this was a self-assessment process and although it was acknowledged that this had been a good piece of work, Prof Roberts suggested that the team might find it helpful to ask for help from the Internal Audit Team or other body to help test the plan for the future and give full assurance.

OUTCOME: The Board **APPROVED** the EPRR report and action plan.

146/16 **QUARTERLY QUALITY REPORT – Q1**

The Executive Director of Nursing gave a powerpoint presentation of the key areas to report for Q1. It was noted that this data had now been superceded by Q2 and the highlights for Q2 would be brought to the November Board of Directors Meeting.

The Summary for Q1 2016-17 was discussed and the following highlights were noted. The Board recognised that details were also included in the Full Integrated Performance Report which was available to Board members and sub-committees:-

Indicator	Target	Q4 2015-16	Q1 2016-17
HSMR	100 per Quarter	105.06	113.94
SHMI	100	111.3	113.88
A&E within 4Hr Performance (Incl. CH)	95%	90.07%	94.10%
% VTE Risk Assessments	95%	95.2%	95.1%
MRSA	0	0	0
C. Difficile	6	8	6
Friends and Family Response Rate (Inpatient)	28%	31.3%	32.8%
Friends and Family Response Rate (A&E)	14%	9.5%	14.5%
EMSA	0	5	0
Staff Sickness (YTD)	< 4.00% - Green 4.01 -4.5 Amber >4.5% Red	4.69%	4.45%

ACTION: November Board of Directors Agenda.

Discussion took place around the 'safe domain'. The Chairman reported that the Membership Council had raised the lack of progress in consistently applying bundles particularly around sepsis screening on admission. It was agreed that the Quality Committee would be asked to do a 'deep dive' around compliance with the sepsis bundle to give the Board greater assurance around the delivery of bundles.

ACTION: Company Secretary

Other issues discussed included:-

SAFE

- Falls Prevention – lead now in place and falls now part of a wider piece of work on reducing harm.
- Safety Huddles – Supported by Improvement Academy on Ward 19, HRI and Ward 6BC, CRH - being rolled out further as part of a CQUIN.
- Record Keeping – 92% compliance with CRAS audit standards, though variable across wards.
- Medicines Management – Self administration medication collaborative established to support patients in managing their medication from home to hospital.
- Maternity – Maternity Action plan now in place following CQC inspection.

EFFECTIVE

- Mortality – key priority areas identified are reliability of clinical care for respiratory, stroke and elderly patients, recognizing and responding to deteriorating patients and timely antibiotics for patients with sepsis. The Board requested a deep-dive be undertaken by the Quality Committee.
- Care Bundle Implementation – some improvement noted in compliance with asthma bundle and acute kidney infection bundle.
- Reducing Hospital Acquired Infection – 0 cases of MRSA bactereamia had been reported since Q2 2015/16. It was agreed that a communications message would be circulated.
- Hospital Out of Hours – launched with nursing team and rolling out positively.
- End of Life – significant work undertaken although further work underway with CCG to be able to respond to patients wishes on end of life care
- Stroke – improvements in stroke pathway delivered – still concerns about some elements of the pathway.
- Coding – Improved position noted.

EXPERIENCE

- Improving the Patient Experience – 4 quality improvement projects in development around children's voice, effective care on a busy surgical ward, maternity patient experience, developing new measures of feedback for community services

RESPONSIVE

- Incidents, Complaints, Claims – Improvements in sharing of learning from adverse events via Patient Safety Quality Board and Quality Committee and with divisions for claims. All divisions developing complaints response time improvement plans. Details received.
- Appointment Slot Issues – improvement in the number of referrals awaiting appointment – work on going in higher risk areas.

WELL LED

- Safe Staffing – roster efficiency tool introduced to support safe staffing levels and roster efficiency approval for overseas recruitment campaign for nursing staff.
- Sickness and Absence – improved position in some areas however more work on going where there are areas of greater variability.
- 7 day services – progress in General Surgery towards a more Consultant delivered 7 day service. Further work required.

The Board were requested to give feedback to the Executive Director of Nursing on the level of information required as it was appreciated that this information was also supplied to other committees in other formats. It was suggested that it might be helpful to receive benchmarking information with other organisations in the future and it was agreed that this would be pursued.

ACTION: Executive Director of Nursing

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

147/16 CQC REPORT AND NEXT STEPS

The Executive Director of Nursing reported that the paper was to update the Board on the proposals to manage the CQC inspection report recommendations. It also provided an overview of the stages within the CQC process and described the current position for CHFT and details of the actions taking place.

OUTCOME: The Board **RECEIVED** the report and approved the recommendations made.

148/16 GOVERNANCE REPORT

The Company Secretary reported that this report brought together a number of items that evidenced or strengthened the corporate governance arrangements and systems of internal control within the Trust. This included:-

1. Review of Board of Directors meeting dates

In line with the revised performance management arrangements, the Board agreed to move its meeting to the first Thursday in the month (action 109/16).

The Board is AGREED the revised meeting dates attached in the Appendix

2. Board Workplan

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

The Board CONSIDERED AND AGREED the items allocated for the meetings and AGREED that there were no further items they would like to add for the forthcoming year.

3. Use of Trust Seal

Five documents had been sealed since the last report to the Board in June 2016 and a copy of the register of sealing was attached for information in the paper. These were in relation to:-

- Integrated Sexual Health Services Contract (Calderdale)
- Works to install a key fob system
- Variation to the contract for Calderdale Royal Hospital
- Speech and Language Therapy Contract extension (Calderdale)
- Variation to Pennine Property Partnership Contract

The Board RATIFIED the sealings.

4. Board of Directors Attendance Register

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

The Board NOTED AND AGREED the attendance register presented.

5. Board of Directors Declaration of Interest Register

The Board of Director's Declaration of Interest Register was presented.
Board members were asked to confirm that their entry on the Register was correct. It was noted that this publication would be uploaded to the Trust public website.
Outside the meeting three amendments were received from Non-Executive Directors.
It was noted that NHS England were consulting on the Code of Declaration Policy and a report with recommendations would be made by the Company Secretary to the Audit and Risk Committee on 18 October 2016.

ACTION: Company Secretary

6. Q1 Response from NHS Improvement

The Trust received feedback from NHS Improvement in relation to the Q1 2016/17 submission.

The Board RECEIVED AND NOTED the Q1feedback

149/16 SINGLE OVERSIGHT FRAMEWORK

The Company Secretary reported that with effect from 1 October 2016, NHS Improvement would be using the Single Oversight Framework to monitor and oversee all providers (both Foundation Trusts and NHS Trusts). The framework was also intended to identify where providers may benefit from or require improvement support across a range of areas.

The Board noted the five themes described within the new oversight framework and, where the information is available, the way in which the Trust will be assessed against these themes:-

1 Quality of Care
2 Finance and use of Resources
3 Operational performance
4 Strategic change
5 Leadership and improvement capability

The paper also described the segmentation process whereby NHS Improvement will identify the level of support and oversight for each Trust.

It was noted that the Integrated Board Report will incorporate reporting on the new SOF from October 2016 and further updates as to its implementation by NHS Improvement will be brought to the Board as they are released. The list of trust segmentation is likely to be published in November. It was anticipated that the Trust would be 'level 3'.

The Board RECEIVED and NOTED the revised arrangements.

150/16 SAFEGUARDING UPDATE – ADULTS AND CHILDREN

The Executive Director of Nursing presented the Safeguarding Update to the Board which covered the period April 2016 to September 2016. The report described the commitment and pledge to ensure Safeguarding Adults and Children remain a key Trust priority.

The key issues highlighted in the report were noted.

Dr Patterson asked whether the Trust should consider additional resources and the Executive Director of Nursing assured the Board that work with partners to review workload and training at ward level to change practice was underway.

The Board RECEIVED and NOTED the Safeguarding Update

151/16 INTEGRATED PERFORMANCE REPORT

The Chairman requested that now the Board were receiving a shorter version of the IPR, consideration should be given to ensure that sub-committees receive the relevant information for them to be able to drill down in areas as appropriate to individual sub-committees.

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

- Performance in August remained positive overall with the Safe domain moving to a green position and no domains red. Within the regulator KPIs, 2 indicators remain red; C Difficile and the Emergency Care Standard. Other KPIs to note are Friends and Family, SHMI, Complaints Closed and Patients Admitted to a Stroke Ward within 4 hours.
- The Carter dashboard was a balanced picture, with 8 indicators deteriorating

and 8 improving of those deteriorating complaints is a second month downward trend with vacancies improving for the 3rd month.
- The Divisional Performance Review Process continues to embed, with greater focus on actions to secure recovery and support with more complex issues.
- The new Single Oversight Framework (as noted above) has recently been published and is included in this month's Board papers and as it becomes established the IPR will be updated to reflect the reporting requirements.

The Board noted the discussions and information received as part of the Quality Report for Q1.

OUTCOME: The Board **RECEIVED** the Integrated Board Report and **NOTED** the key areas of performance for August 2016.

152/16 MONTH 4/5 FINANCIAL NARRATIVE

Finance

In the absence of the Executive Director of Finance, the Deputy Director of Finance reported the key financial performance areas. It was noted that the different reporting of the monthly narrative compared to the Integrated Performance Report was due to the timing of receipt of the STF:

The year to date financial position stands at a deficit of £8.19m, a favourable variance of £2.0m from the planned £10.20m, of which £1.88m is purely a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The underlying position is a £0.12m favourable variance from year to date plan.

In month, clinical activity has seen another strong month as was the case through quarter one, rebounding from the flatter July performance. This drives an overall income position at Month 5 which is £3.82m above planned levels in the year to date, an increase of £2.10m from Month 4 (£1.06m due to STF timing, £1.04m underlying performance improvement in August). The in-month over-performance in clinical income is seen across planned inpatient and non-elective admissions as well as outpatients, critical care and A&E attendances. However, as has been the case in recent months, to deliver activity and access standards the Trust continues to rely heavily upon agency staffing. Total agency spend in month was £2.17m, a slight fall for the third month in succession but remaining above the NHSI trajectory and a significant draw on pressured cash resources.

- EBITDA of £2.12m, a favourable variance of £1.68m from the plan.
- Of this operating performance £1.88m is driven by a timing difference on the accrual of Strategic Transformation Funding versus the planned quarterly profile.
- A bottom line deficit of £8.19m, a £2.00m favourable variance from plan.
- Delivery of CIP of £4.98m against the planned level of £3.58m.
- Contingency reserves of £0.99m have been released against pressures.
- Capital expenditure of £6.50m, this is below the planned level of £7.98m.
- A cash balance of £4.56m, this is above the planned level of £1.95m, supported by borrowing.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

OUTCOME: The Board **APPROVED** the Month 4/5 financial narrative and **NOTED** the continued financial challenges.

153/16 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

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

Quality Committee
The Chair of the Quality Committee reported the items discussed at the meeting held on 27.9.16:

- Presentation received from Organ Donation Team - Arrangements were being made for this group to report quarterly to the Quality Committee.
- Health and Safety – Issue of staff using equipment which they have not been trained was a risk highlighted. An Action Plan had been developed and was being reviewed by the Executive Director of Nursing and Executive Director of PPEF.
- Vanguard Presentation (Self-Management Work) – It was agreed that the Quality Committee was not the forum to review issues and had requested links with the Executive Board to monitor this in the future. An update on supported self-management would be received at a future Quality Committee.

OUTCOME: The Board **RECEIVED** the update and **the minutes of the meeting held on 26.7.16 and 23.8.16.**

Finance and Performance Committee
On behalf of the Chair of the Finance and Performance Committee Richard Hopkin reported the items discussed at the meeting held on 26.9.16:

- Reforecasting procedures examined
- IPR quarterly deep dive
- Agreed routine agenda themes – July 'cash and cash management' August 'procurement'

OUTCOME: The Board RECEIVED the update and the minutes of the meeting held on 26.7.16 and 23.8.16.

Audit and Risk Committee
OUTCOME: The Board RECEIVED minutes from the meeting held 21.7.16

Membership Council Draft Minutes – 6.7.16
OUTCOME: The Board RECEIVED minutes from the meeting held on 6.7.16 and noted that this would be ratified by the Membership Council at its next meeting on the 9 November 2016.

Nomination and Remuneration Committee (Membership Council) Minutes – 21.7.16
OUTCOME: The Board RECEIVED minutes from the meeting held on 21.7.16 and noted that a further meeting was scheduled for 18 October 2016.

154/16 DATE AND TIME OF NEXT MEETING
Thursday 3 November 2016 commencing at 9.00 am in the Boardroom, Sub-basement, Huddersfield Royal Infirmary.

The Chair closed the public meeting at 4:15pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - November 2016 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 November 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 November 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT** Update on pilot to be brought in February 2016.	COO	**25.2.16** Report received. Likely implementation to be July 2016. **29.9.16** Feedback to be brought to November meeting	~~29.9.16~~ 03.11.16		
33/16 25.2.16	**QUARTERLY QUALITY REPORT** The Board agreed that the level of detail being reported to the Board should be reviewed by the Quality Committee. Juliette Cosgrove agreed to ascertain the level of information required for the various sub-committees and make recommendations accordingly.	DoN	Initial review of information across all Quality metrics complete. Refreshed presentation of Quarterly quality report to commence in December 2016.	1.12.16		
94/16 26.5.16	**STAFF SURVEY ACTION PLAN** Concern was expressed that some timelines would be difficult to achieve and it was agreed that work should be undertaken to aim towards the timeline but it was acknowledged that some may require additional time. It was agreed that feedback on the progress from all workstreams would be brought to the BOD in September 2016.	All	**29.9.16** Discussion took place about the importance of this work and the Board's visibility in driving this forward. It was noted that the feedback from the Staff Survey which had been launched earlier that week would be included within the Action Plan.			29.9.16
106/16 30.6.16	**RISK REGISTER – IMPACT OF RECENT REFERENDUM** The question of whether the long term effects of the results of the EU referendum had any implications such as staff recruitment/vacancies and increased drug costs were required to be included on the Risk			3.11.16		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 November 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	Register in the future. The Chief Executive acknowledged that the Trust was alert to the issues, would monitor the situation and once the Trust was fully aware of the issues would escalate as appropriate. The Board agreed that this position should be reviewed again in November 2016 and any material risk included in the Risk Register.					
121/16 28.7.16	**SUSTAINABILITY AND TRANSFORMATION PLAN** The Board recognised that this work is complex and is moving at speed and there was a need to ensure that the Board was properly engaged in the development of the plan. It was agreed to provide a further update at the meeting in September.	OW/AB				29.9.16 (Private agenda)
144/16 29.9.16	**BOARD ASSURANCE FRAMEWORK** It was recommended and agreed that the BAF remain under review and be brought to the Board in November following the submission of the STP and the decision by the Clinical Commissioning Group Governing Bodies as to whether to progress the service reconfiguration proposals.	VP		3.11.16		
146/16 29.9.16	**QUARTERLY QUALITY REPORT – Q1** The Board were requested to give feedback to the		**18.10.16** Benchmarking information to be included in reports going forward.			3.11.16

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 1 November 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	Executive Director of Nursing on the level of information required as it was appreciated that this information was also supplied to other committees. It was suggested that it might be helpful to receive benchmarking information with other organisations in the future and it was agreed that this would be pursued.		**29.9.16** Discussion took place around the 'safe domain'. The chairman reported that the Membership Council had raised our inability to get bundles consistently applied particularly around sepsis screening on admission. It was agreed that the Quality Committee would be asked to do a 'deep dive' around compliance with the sepsis bundle to give the Board greater assurance around the delivery of bundles.			
140/16 a.	**CHAIR/CE NHS PROVIDER MEETING – 21.9.16** The Chairman gave an update on the discussions at this meeting. Prof Roberts reported that similar discussions had been held at the HFMA Conference and agreed to circulated the information around finances.		**19.10.16** Information circulated.			19.10.16
142/16	**RCRTRP – CONSULTATION UPDATE** The Board asked that personal thanks be given to Catherine Riley, Assistant Director of Strategic Planning for her work in helping support the committee on the consultation feedback.		**6.10.16** Letter sent from the Chairman.			6.10.16
162/16	**RCRTRP – CONSULTATION UPDATE** It was agreed that a special Board Meeting/telephone conference would be arranged and confirmed with the Board within the next few days.		**5.10.16** Tele-conference arranged for 20.10.16 – 5.00 pm			5.10.16
148/16	**GOVERNANCE REPORT – DECLARATION OF**					18.10.16

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 1 November 2016 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	INTERESTS It was noted that NHS England were consulting on the Code of Declaration Policy and a report with recommendations would be made by the Company Secretary to the Audit and Risk Committee on 18 October 2016.					

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Corporate Risk Register - This paper presents to the Board the corporate risk register as at October 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Risk and Compliance Group reviewed the risk register on 11 October 2016.	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

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

Background/Overview:

The CRR is presented on a monthly basis to ensure that the Board of Directors are aware of all current risks facing the Trust and is a key part of the Trust's risk management system.

On a monthly basis the Risk and Compliance Group consider all risks that may potentially be deemed a corporate risk, with those with a risk score of 15 or more, prior to these being presented to the Board.

The Issue:

The attached paper includes:

i. A summary of the Trust risk profile as at October 2016 which identifies the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks.

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

There are 3 new risks this month:

Risk 6822 Sepsis Cquin
Risk 5863 Falls risk
Risk 6829 Pharmacy Aseptic Unit

There are two risks that have been removed from the corporate risk register in the last month which are now being managed within divisional risk registers, risk 6594, not acting on radiology results and risk 6299, the risk relating to failure of high risk medical devices. Further detail is given in the attached paper.

Work is taking place to identify a risk relating to the implications of Brexit on the Trust and if this risk is deemed significant it will be presented in the next corporate risk register presented to the Board of Directors.

Next Steps:

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

Recommendations:

Board members are requested to:

I. Consider, challenge and confirm that potential significant risks within the Corporate Risk Register are being appropriately managed

ii. Approve the current risks on the risk register.
iii. Advise on any further risk treatment required

Appendix

Attachment:

Corporate Risk Register combined.pdf

CORPORATE RISK REGISTER REPORT

Risks as at 21 October 2016

TOP RISKS

6131 (20): Progression of service reconfiguration impact on quality and safety
2827 (20): Over-reliance on middle grade doctors in A&E
6345 (20): Staffing risk, nursing and medical
6503(20): Delivery of Electronic Patient Record Programme
6721 (20): Non delivery of 2016/17 financial plan
6722 (20): Cash flow risk
5806 (20): Urgent estates schemes not undertaken

RISKS WITH INCREASED SCORE

Risk 5806 has increased the risk score from 16 to 20.

RISKS WITH REDUCED SCORE

There are two risks that have been removed from the corporate risk register in the last month and are being managed within divisional risk registers:

- Risk 6594 – the risk relating to not acting on radiology results has been reduced to a score of 12 following the results of a recent audit providing assurance regarding the revised process and discussion at the Diagnostic and Therapeutics Patient Safety Quality Board. The first audit confirmed all urgent radiology results were opened by the relevant medical secretary team within a set period of time.

- Risk 6299 – the risk relating to failure of high risk medical devices has been reduced from to a score of 12 due to improved levels of planned preventative maintenance.

NEW RISKS

The following three new risks were agreed at the 11 October 2016 Risk and Compliance Group meeting for addition to the corporate risk register:

- Risk 6822 - risk of not meeting sepsis CQUIN for 2016/16 –risk score of 16.

- Risk 5862 - risk of patient falls - risk score of 16

- Risk 6829 - Pharmacy Aseptic Unit – risk score of 15.

CLOSED RISKS

None

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	May 2016	June 2016	July 2016	September 2016	October 2016
		Strategic Risks						
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme - transformation	Director of THIS (MG)	20 =	20 =	20 =	20 =	20 =
		Safety and Quality Risks						
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	20 =	20 =	20 =	20 =	20=
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20=	20=	20=	↓16	16 =
2827	Developing Our workforce	Over –reliance on middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20
6822	**Keeping the Base Safe**	**Not meeting sepsis CQUIN**	**Medical Director (DB)**	**-**	**-**	**-**	**-**	**!16**
5862	**Keeping the Base Safe**	**Risk of falls with harm**	**Director of Nursing**	**-**	**-**	**-**	**-**	**!16**
6829	**Keeping the Base Safe**	**Aspetic Pharmacy Unit production**	**Director of Nursing**	**-**	**-**	**-**	**-**	**!15**
6841	Keeping the Base Safe	Not being able to go live with the Electronic Patient Record – operational readiness	Chief Operating Officer (HB)	-	-	-	15!	15=
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=16	=16	=16	=16	↑20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD	=16	=16	=16	=16	=16
6694	Keeping the base safe	Divisional Governance arrangements	Director of Nursing (BB)	=16	=16	=16	=16	=16
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	!15	=15	=15	=15	=15
6753	Keeping the base safe	Inappropriate access to person identifiable information	Director of THIS (MG)	-	-	16!	=16	=16

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	May 2016	June 2016	July 2016	September 2016	October 2016
		Financial Risks						
6721	Financial sustainability	Non delivery of 2016/17 financial plan	Director of Finance (KG)	!20	=20	=20	=20	=20
6722	Financial sustainability	Cash flow risk	Director of Finance (KG)	!15	20↑	=20	=20	=20
6723	Financial sustainability	Capital programme	Director of Finance (KG)	!20	=20	=20	↓16	16 =
		Performance and Regulation Risks						
6658	Keeping the base safe	Inefficient patient flow	Chief Operating Officer (HB)	=20	=20	=20	↓16	16=
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Director of Workforce (IW)	=15	=15		=15	=15
		People Risks						
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce (IW)	=20	=20		=20	=20

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

Trust Risk Profile as at 21 October 2016

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6693 - Failure to comply with monitor staffing cap = 6715 - Poor quality / incomplete documentation	= 6345 - Staffing risk, nursing and medical = 6131 - service reconfiguration	
Likely (4)				↓ 4783 Outlier on mortality levels ↓ 6658 Inefficient patient flow = 6300 Clinical, operational and estates risks outcome = 6594 Radiology risk/ diagnostic tests = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 6694 Divisional governance arrangements = 6753 Inappropraite access to patient identifiable data = 6723 capital programme ! 5862 Falls risk ! 6822 CQUIN sepsis	= 2827 Over reliance on middle grade doctors in A&E = 6503 Non delivery of EPR programme = 6721 Not delivering 2016/17 financial plan ↑ 5806 Urgent estate work not completed
Possible (3)					= 6299 Medical Device failure levels = 6722 Cash Flow risk = 6814 EPR operational readiness ! 6829 Pharmacy Aseptic Unit
Unlikely (2)					
Rare (1)					

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

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CORPORATE RISK REGISTER

Oct-16

The Health Informatics Service
Informing Healthcare

Significant risks - risk score of 15+

Risk No	Div	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6131	Corporate	Oct-2014	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	15 5 x 3	The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks. A change in consultant recruitment process (that commenced during January 2016) will reduce time to appointment. **October 2016 update** Commissioner approval on 20.10.16. for development to full business case.	Oct-2016	Oct-2016	WEB	Anna Basford	Catherine Riley
2827	Medical	Apr-2011	Developing our workforce	There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff.	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time **October 2016 Update:** 2 Substantive consultants have resigned. Senior Clinical fellow appointed to Consultant level position. Currently 10 on consultant rota. One additional Specialty Doctor has been recruited	Jan-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

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

5806	Estates & Facilities	May-2015	Keeping the base safe	There is a risk that the urgent Estates schemes (see below) cannot be undertaken due to insufficient resources, resulting in,the potential closure of some areas which will mean the stopping of patient care, suspension of vital services, with delays and stoppage of treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. - Flooring: in ICU at HRI, Ward 19, CCU CRH- a lips and trips hazard - Windows: Ward 6 at HRI and all elevations of the hospital, A&E Resus,creating potential of closure to services from water affecting core services - Theatres / Environment ; HRI Main, DSU and Theatre 6 and CRH Theatres creating potential for inability to treat patients so missing national targets and affecting patient care - HRI road surfaces, pipework, second water main, aseptic unit improvements with potential to close the entire hospital - Staff Residences Saville Court and Dryclough Close Properties (fire and utilities compliance) - Trust wide roofs which need repairs and edge protection. Without this there is a danger of falling from heights, water closing wards and services, and eclectic failures. - Air Handling Units to prevent any failures in ventilation with a high risk of closing theatre 6, A&E and ICU - Medical Gas Plant to prevent all gas and air from becoming unavailable to all of HRI - Structural as we cannot drill any more large holes into HRI floors without a risk of creating the collapse of floors, and the need for an entire new building - Medical Air Plant to ensure the safe supply	Each of the risks above has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	The lack of funding is the main gap in control. Also the time it takes to deliver some of the repairs required. In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.	16 4 x 4	20 5 x 4	6 3 x 2	Aug 16 Capital programme to be agreed. Aug 16 Quote obtain for a wireless nurse call system in ICU Sept 16 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The level of risk to the servcies at HRI is increasing as the number of major building risks increases. **October 2016** The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The level of risk to the services at HRI is increasing as the number of major building risks increases	Oct-2016	Mar-2018	RC	Lesley Hill	Paul Gilling / Chris Davies

6503	Corporate	Dec-2015	Transforming and improving patient care	RISK of: non - delivery of Electronic Patient Record Programme due to failure to deliver the transformation associated with not achieving the key deliverables around timescales, engagement and financial targets causing CRB to not be realised, significant cost overruns which ultimately could make the programme unsustainable. The Trust along with its partners BTHFT (Bradford Teaching Hospitals Foundation Trust) and Cerner are implementing an EPR system that will enable service transformation whilst improving patient safety and patient and clinician experience. This is a summary risk, EPR risks escalated at Transformation Group will be brought to R&C by exception. This will impact on patient care, safety and patient experience and mean the expected financial benefits of EPR programme will not be realised.	A Well-developed Governance Structure in place underpinned by a contract between CHFT and Cerner and a partnership agreement between CHFT and BTHFT. Management of EPR programme risks using Best Practice MSP (Managing Successful Programmes) methodology and EPR specific risk register Executive sponsorship of the programme with CEO's chairing the Transformation Board Separate assurance process in place Clinical engagement from divisions Clearly identified and protected funding as identified in the Full Business Case. All Risk and issues are recorded on the programme risk and issue register and managed by the EPR Risk Review Board.	- Further divisional engagement required - A more in depth understanding of the transformational change is required within the clinical divisions. The impact on activity during go live will be significant and the changes in processes post go live will be equally significant. An understanding, acceptance and support will be essential to success. - Financial offsetting for 16/17 to mitigate against the reduction in activity during go live and short term post go live. - Sign off the Operational Readiness plan by division - Lack of divisional engagement in some areas as raised at the EPR Operational Group.	20	5 x 4	20	5 x 4	5	5 x 1	Continual monitoring of actual programme risk and issues log - Any risks escalated to the Transformation Board brought to this committee - Access to the full EPR Risk Log will be made available to R&C group via the Cerner Portal if required, any escalations from transformation group will be brought to R&C by the programme leads Sept Update: Upon review, and in order to ensure patient safety, a decision has been made to plan for a launch/go-live next year, this plan will also include the decision to separate the go-live. This decision will allow more time to engage and train staff, deliver the technical solutions that will support EPR and more thoroughly test the system and its data. This will help to mitigate some of the contributory factors outlined in this risk. Octobers update will be able to include some new indicative timescales and mitigation plans. **October Update:** As referenced above, we are now coming out of the re-planning phase after tabling a number of options at Transformation Board. The programme is following an incremental plan that will provide an indicative go-live period following successful testing during trial load 3 (November/December). Failure to meet the exit criteria will show the need for a trial load 4 resulting in a later go live date.	Nov-2016	Sep-2017	RC	Mandy Griffin	Mandy Griffin
6721	Corporate	May-2016	Keeping the base safe	The Trust is planning to deliver a £16.1m deficit in 2016/17. There is a risk that the Trust fails to achieve its financial plans for 2016/16 due to: - clinical activity and therefore income being below planned levels - income shortfall due to commissioner affordability - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - non receipt of Sustainability and Transformation Funding due to performance - failure to deliver cost improvements - expenditure in excess of budgeted levels - agency expenditure and premia in excess of planned and Monitor ceiling level	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach	Further work ongoing to tighten controls around use of agency staffing. For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement. Agency spend must be reduced considerably if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding.	20	5 x 4	20	5 x 4	15	5 x 3	**October update:** At Month 6, the year end forecast position is to deliver the planned £16.1m deficit. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit. Divisional financial recovery plans and additional savings plans must be implemented to ensure delivery of the Trust's forecast financial position. The Trust's expenditure on agency staffing has been under close scrutiny by the regulator. A revised forecast trajectory to reduce agency spend through the remainder of the year was submitted in-month based on operational actions. The Trust must drive the necessary reductions in agency expenditure whilst striving to maintain safe staffing levels and deliver standards and access targets. Against the £14m CIP target the risk profile has been reviewed and £1.37m of schemes remain as high risk. In addition, the new EPR system brings heightened risk of lost productivity through the implementation phase. The new Junior Doctors contract, commissioner affordability challenges and the costs of addressing CQC recommendations may also bring additional unplanned pressure .	Nov-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

6722	Corporate	May-2016	Keeping the base safe	Risk that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as going concern.	* Agreed £5m capital loan from Independent Trust Financing Facility received in April 2016 * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from Monitor * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Working capital loan facility in place (at 3.5% interest rate) for £13.1 m to support cash in advance of progression of revenue support loan (at 1.5% interest rate)	Distressed cash support through "Revenue Support Loan" not yet formally approved by NHS Improvement.	15 5 x 3	20 5 x 4	15 5 x 3	To progress application, subject to NHSI support, for distressed funding through Revenue Support **October update:** Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Further action is being taken to maximise collection of receivables and the profile of cash management has been raised at Divisional level and agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner. Cash continues to be a high risk due to the knock on impact of I&E risks; the ongoing reliance on availability of commissioner cash funding; and the fine balance required in managing working capital.	Sep-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer
6753	Corporate	Jun-2016	Keeping the base safe	The Risk of:- Inappropriate access to PID and CHFT Organisational data on some Trust PC's. This risk is increased by the inability to audit access either pre or post any incident. Due to :-Data being saved under Web-station log ins on communal PCs and associated network drives (wards etc) Resulting in:-Breach of confidentiality of patient or staff internally and organisational risk from a CHFT data breach.	- Only trust staff can access the PCs under the web-station login - Only PC's that are a member of a specified group will allow the use of web-station login - Policy mandates that no Data (especially PID) to be saved to local drives - Reduction of generic logons where possible (low impact) - Sophos encryption of disk drives for encrypted local disk data	- Process to wipe the local drive on web-station PCs daily (Begin Comms after audit) - Removal of generic logons through roll out of single sign-on/VDI (Oct 2016) - Password for web-station does not change (currently set in 2010) every 3 months as per other user accounts - Ability to save information to shared network drives associated with web-station account. This information is accessible by all who use the account. - Not all PC's have Sophos Encryption installed (Ongoing)	16 4 x 4	16 4 x 4	4 4 x 1	Clarity around the extent of the problem through audit of PCs and network saved data - End of July 2016 - Understand potential completion dates for SSO and VDI - October 2016 Sept Update - Short term - Unprotected PC's have been encrypted. Longer term - SSO/VDI hardware is in place, Configuration is underway, Ward 3 at CRH will be the initial test area in October. Roll out will commence in November. **October Update** As above, no further mitigation to the risk until VDI/SSO is rolled out from November.	Nov-2016	Dec-2016	RC	Mandy Griffin	Rob Birkett
6822	Medical	Aug-2016	Keeping the base safe	CQUIN target at risk of not being met for 2016/17 based on current compliance for screening for sepsis, time to antibiotic and review after 72 hours and risk of non - compliance in line with new NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of joined up working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treated within the hour and all of the sepsis 6 requirements	Sepsis CQUIN matron employed Awareness and new controls for ward areas Divisional plan, medical leads identified in all divisions -Improvement action plan in place, improvements seen in data for Q2 -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign to be launched ASAP, introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards NICE guidelines - Cerner currently testing qSOFA and new NICE cut offs	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of joined up working between nursing and medical colleagues Compliance with NICE guidelines - sepsis matron to seek clarity and confirm compliance and noncompliance and add in improvement action plan if needed	15 5 x 3	16 4 x 4	12 4 x 3	Sepsis matron to set immediate controls for ward staff Deep dive into the causes of sepsis and barriers to implementing clinical standards to be presented at Quality Committee 31.10.16. Details action plan to be developed by 18 November 2016 by deputy associate divisional nurse.	Nov-2016	Mar-2017	PSQB	David Birkenhead	Tracy Fennell

5862	Medical	Aug-2013	Keeping the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings.	Insufficient uptake of education and training of nursing staff, particularly in equipment. Staffing levels due to vacancies and sickness. Inconsistent clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12 4 x 3	16 4 x 4	9 3 x 3	Spread of falls improvement work and further staff education and training. Safety huddles to be embedded on all in patient areas with the co-operation of the whole multi -disciplinary team. Continue to undertake RCA on harm falls and ensuring learning is embedded. Embed falls 5 across all areas and monitor quality improvements against this. .	Nov-2016	Mar-2017	PSQB	Brendan Brown	Maggie Shepley
4783	Corporate	Aug-2011	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	2 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine and Complex Medicine which will give guidance on areas of further improvement. Action plans for these areas being developed based on preliminary report findings. Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. August reviews of July deaths (using new process) compliance 70% - highest since Feb'15 Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised Aug 2015 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Final reports from Royal College of Physicians awaited (expected June 2016) Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Mortality case notes review may not pick up all factors relating to preventability Coding improvement work not yet complete Improvement to standardised clinical care not yet consistent. To be completed by Dec 15 Care bundles not reliably commenced and completed	20 4 x 5	16 4 x 4	12 4 x 3	To complete the work in progress - CQUINS to be monitored by the Trust - External review of data and plan to take place - assistance from Prof Mohammed (Bradford) August update: Further information received with increased risks to mortality. Action plan reviewed and presented to WEB. PMO approach to be adopted for reliable implementation of care bundles Sept update: Compliance with mortality reviews for last month significantly increased. August update The CQC inspection report referenced the work on going within the organisation in relation to mortality and has said that we must continue with the work we are doing to reduce avoidable mortality. We have received the final report from the Respiratory ISR and will commence a plan to deliver the actions. September update A new mortality review process will be implemented which will lead to a consultant led review into each death. Progress continues to be made with the management of sepsis and a lead nurse has commenced in post **October update** The action plans for the elderly and respiratory invited service reviews (ISR's) will be presented to the Medical Director this month. Dates for the stroke ISR have been agreed.	Nov-2016	Mar-2017	COB	David Birkenhead	Juliette Cosgrove

6598	Corporate	Jan-2016	Keeping the base safe	There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation. Further essential skills subjects are been identified and added to the list with increasing frequency. This obviously not only extends the period of time the roll out project will take but also leads to a re-prioritisation exercise around establishing which are the key priority essential skills to focus on first.	There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject (the project timeline extends until February 2017). Compliance measurement will be enabled as each TA is set although this is a lengthy process within the confines of the current Learning Management System. The business plan to commission an alternate learning management system has been approved therefore the tendering process is underway. The Education and Learning Group (ELG) has recently been established and any new requests for addition to the essential skills list need to be approved by this group which should help apply some control to the content of the list.	1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. A manual system to facilitate the actions above will be require1/ Essential skills training data held is inconsistent and patchy.	16 4 x 4	16 4 x 4	12 4 x 3	**October Update** It has been recognised that the list of essential skills (currently in excess of 40) needs a refresh with a view to significantly reducing this number. The list has therefore been forwarded as requested to the director of nursing for review. The outcome is awaited. September Update Essential Skills emphasis is currently on aspects identified within the CQC report, mostly in relation to maternity. These are now priority actions which has led to delays in the progress of other planned essential skills work.	Oct-2016	Dec-2016	NA	Ian Warren,	Pamela Wood

6658	Medical	Mar-2016	Keeping the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity & capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20	4 x 5	16	4 x 4	9	3 x 3	July Update Safer patient flow programme fully operational with clear governance arrangements including monthly reporting to WEB to ensure full organisational awareness and ownership. Process to cross check patients with a long wait in A&E and outliers within the mortality review process. As per the bed plan a further 14 bed reduction on the HRI site which, with current demand is requiring more focused patient flow team input September 16 Update Single transfer of care list in place and finalised with agency partners meaning that there is consistent prioritisation of discharge planning. Integrated the discharge and social care teams on both sites. New process in SAS and Medicine for matron reviews every morning identifying and actioning discharge planning. Associate Director in place focusing on urgent care and safer flow. Active participants in the NHS I Improvement Programme for Emergency Care. **October 2016** Continued progress on SAFER Programme improvement work. CHFT part of the WYATT Accelerator Zone- to deliver the ECS 95% standard. This is about system resilience, improved patient flow, creating capacity by improved discharge with social care involvement.	Dec-2016	Mar-2017	BOD	COO Helen Barker	Bev Walker

6300	Trustwide	May-2015	Keeping the base safe	As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services.	- System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being held to monitor progress with the action plans chaired by the Chief Executive - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, has been conducted	The inspection report has shown us to be in the "requires improvement" category An action plan is being developed but not yet approved	16 4 x 4	16 4 x 4	8 4 x 2	CQC compliance Steering Group - Implementation CQC compliance action plan - CQC Operational Group - Further embedding of CQC assurance into the Divisions and Corporate Governance structures September update Governance arrangements for the oversight of the improvement plan are being approved by the Trust Board in September. A Quality Summit is planned for October. the Trust is confident that most actions are achievable in the short to medium term but still has some actions that will require service transformation **October update** the action plan has been reviewed at the Trust Board meeting in September. Core service improvement plans are also in development and expected to be completed at the end of October. the report from the RCOG relating to maternity services is due in month. Quality summit held 17.10.16.	Nov-2016	Mar-2017	WEB	Brendan Brown	Juliette Cosgrove
6694	Trustwide	Mar-2016	Keeping the base safe	Risk that the divisional governance structures are not sufficiently standardised and mature to provide assurance on quality and safety due to inconsistent divisional governance systems and processes and lack of application of agreed terms of reference and divisional and directorate Patient Safety Quality Boards (PSQB) resulting in The Quality Committee having a lack of assurance on quality and safety at divisional and directorate governance level	Divisional PSQB terms of reference used for each divisional PSQB. Supplementary governance manager resource within divisions.Quarterly quality and safety report from divisional PSQB to quality committee and hoc reports to Quality committee on specific quality issues eg, Stroke, # Neck of Femur Action plan in place to deliver improvements	Consistent application of PSQB terms of reference at Divisional and Directorate level.Variable quality quarterly PSQB reports to Quality Committee.Varied model of governance support into and within Divisions. Varying structures and processes for quality governance at Directorate and Speciality level.	16 4 x 4	16 4 x 4	8 4 x 2	Review of governance support to divisions Application of standardised governance approach to PSQBs September update The CQC issued a requirement notice to ensure that divisional governance arrangement continue to be improved. A plan is in place to deliver the improvements. **October update** The Director of Nursing has met with 3 divisions to understand where some of the gaps are and to agree specific areas of improvement. Actions continue to be implemented.	Nov-2016	Dec-2016	QC	Director of Nursing Julie Dawes	Juliette Cosgrove

6596	Corporate	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16	4 x 4	16	4 x 4	8	4 x 2	1. Capacity - recruitment taken place for dedicated investigation resource in Governance and risk team - final stages of recruitment process being completed 1. Ongoing delivery of Effective Investigation Training Course (1 day, monthly) 2. Greater identification and sharing of learning from each SI, sharing within PSQBs and across division through reporting and SI review group September update The CQC in their published report stated that we must train more investigators in the use of RCA tools and techniques, a plan is in place to deliver the required actions. **October update** There remains concerns about the timeliness of reports but the quality is improving. a business case is being developed to recruit staff with specialised investigation expertise.	Oct-2016	Dec-2016	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove
6723	Corporate	May-2016	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2016/17 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. There is a risk that NHS Improvement will not approve the Trust's capital programme for 2016/17 due to national funding pressure also resulting a failure to develop infrastructure for the organisation.	Agreed £5m capital loan from Independent Trust Financing Facility (ITFF) received in April 2016 to support capital programme, specifically the Electronic Patient Record (EPR) investment. Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Discussed with NHS Improvement and planned for distressed cash support.	Approval of distressed cash support awaited.	20	5 x 4	15	5 x 3	12	4 x 3	**October update:** No negative feedback has been received from NHSI on the £28.2m investment programme following a comprehensive deep dive return that was submitted in June and as such the Trust is proceeding with its capital plans. This investment remains reliant upon cash loans, currently supported through a working capital facility at an interest rate of 3.5%.	Sep-2016	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

6829	Family & Specialist Services	Aug-2016	Keeping the base safe	The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately 50,000 pa ready to administer injectable medicines with short expiry dates for direct patient care. Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service on behalf of NHSE. Critical findings would be reported to the MHRA who have statutory authority (under the Medicines Act 1968) to close the unit if it does not comply with the national standards. The 20 year old HRI unit is a maximum life-span up to the end of 2018.capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards. Resulting in the lack of availability of high risk critical injectable medicines for urgent patient care.Non-compliance with national standards with significant risk to patients if unresolved.	Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. Self-audits of the unit External Audits of the units undertaken by the Quality Control Service on behalf of NHSE every 18 months. Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance.	If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance 'rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.	15	3 x 5 = 15	3 x 5 = 15	0	3 x 0 = 0	The procurement of manufactured ready to administer injectable medicines when available from commercial suppliers. The first phase will be the procurement of dose- banded chemotherapy as soon as regional procurement contracts have been approved. This will create some capacity. The business case for the future provision of Aseptic Dispensing Services to be produced by November 2016 with a view to consideration and approval by the Commercial Investment Strategy Group taking into account commercial procurement of some products. If the business case is approved then the risk will be reduced. The target risk of 0 will be achieved on completion of the refurbishment of the CRH unit.	Nov-2016	Dec-2018	DB	Brendan Brown	Mike Culshaw

6841	Corporate	Sep-2016	Keeping the base safe	Risk of: Not being able to go live with the Electronic Patient Record due to: PRE GO LIVE: lack of operational readiness: unable to extend clinics, inability to maintain safe patient flow Workforce not yet trained and confident in the EPR system, and lack of basic IT skills as not currently required within staff role. Worsening staffing levels (see risk 6345), vacancies, sickness. Lack of colleague ownership and engagement for the EPR at all levels of the organisation. The potential un-availability of suitable IT equipment in all areas of the Hospitals that need access to EPR. CUT OVER: ILack of clear processes that are documented, communicated and resourced in order to carry out paper monitoring of patients through the go-live period. Productivity and efficiency may reduce as colleagues defer to paper systems. POST GO LIVE: Inability to use the system effectively once the extended support mechanisms start to reduce following Early Live Support. Lack of confidence of the system due to any quality and/or performance issues. Efficiency and productivity may reduce due to inexperience of using the system Inability to report against regulatory standards **Resulting in R**eputational damage, financial impact, impact at every point of patient care (appointments, patient flow, records, MDT s,	Pre go-live - A robust governance structure is in place to support the implementation of the EPR, including EPR specific risk register reviewed at weekly EPR meeting. - Weekly EPR operational board with direct escalation to WEB (and sponsoring group) - 90/60/30 day plans will aid control - 1:1 consultant plan Cut over: - Strong cut over plan with a developed support structure for BAU post ELS. - Command and control arrangements for cut over (Gold, Silver, Bronze) Post go-live: - gap	1. Training – need to monitor uptake of EPR training (EPR team and divisions by mid-September 2016) 2. Need to identify capacity and activity gaps through divisional operational readiness reporting 3. Number of EPR Friends/effectiveness of EPR friends.	15 5 x 3	15 5 x 3	10 5 x 2	Engagement and operational readiness sign off closer to go live date via operational readiness checklist and EPR passport. Closely monitor progress around training and staff feedback following the sessions. Further work with the divisions to clearly communicate the operational groups expectations and measure progress through the divisions reporting back to the ops group. **October update:** Decision on go live due mid- November.N26	Oct-2016	Sep-2017	RC	Helen Barker	Mandy Griffin

6715	Corporate	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation for when deterioration occurs, poor communication and multidisciplinary working.	Monthly clinical record audits (CRAS) with feed back available form ward to board A further qualitative audit is undertaken monthly by Matrons that includes patient understanding . Medical audits are undertaken Analysis and action planning is managed through divisional patient safety and quality board A multi professional clinical documentation group meets bi monthly to ensure new documentation is ratified, standards on documentation are addressed. This group also receives reports and audits with regard to documentation and identifies to the divisions areas (teams, wards departments) of concern as well as any specific areas of concern within a specific standard. Clinical records group monitors performance, highlighting best and worst performing wards and action plans are developed and managed through the divisions, including specific areas for improvement.	The number of audits undertaken can be low Unable to audit to allow and act on findings in real time The discharge documentation is under going review Fluid balance is being reviewed, the evidence base is being examined by the Deputy Director of Nursing	20	4 x 5	15	3 x 5	8	4 x 2	The Trust is developing an electronic patient record that will enable reports to be run in real time, audits can be undertaken by the ward or department lead when they deem it necessary (daily, weekly, monthly) There are alerts and stops within the system to prevent the user skipping documentation. September Update The work described above continues with the documentation sub-group meeting regularly to work on improvement. Last months CRAS audits demonstrated overall improvement. 27 medical record audits took place which demonstrated sustained improvement in recording co-morbidity, however compliance in annotating the record remains poor;; performance management is being addressed through divisional PSQB's. The Matrons audits demonstrate a low return in medicine at HRI. Further work is required to ensure care plans are personalised; this is being led through the Associate Nurse Directors. The overall CRAS audit shows sustained improvement in infection control and patient experience. Falls documentation remains an issue, however the falls collaborative are currently scoping the documentation therefore performance is unlikely to improve until change occurs. **October Update** There is recognition that the improvement work required will take time to embed and therefore the CRAS audits have been suspended until January 2017. The revised falls documentation will be tested on wards 6 and 7 at Calderdale Royal Hospital, over this period compliance with the documentation will be audited. The Matrons will also continue to work with teams to make improvement with the fluid balance charts	Feb-2017	Mar-2017	QC	Brendan Brown	Jackie Murphy

6693	Corporate	Mar-2016	Keeping the base safe	Risk Of: Failure to comply with the Monitor cap rules. Due to: Bed capacity – The Trust has opened a significant number of additional beds in response to service pressures requiring safe staffing levels. No. of vacancies in the workforce – The Trust has a high number of vacancies across its workforce resulting in the requirement to engage agency staff (including national shortages). Resulting in: High usage of externally sourced agency workers, utilising agency that breaches the cap rate and in circumstances uses off-framework agencies. Regulator sanction – The Trust receiving a regulatory sanction given the number of breaches the Trust currently reports against the Monitor agency cap. Safety risk – The Trust is unable to fill vacant posts (Medical, Nursing, AHP, A&C) resulting in the risk of patient safety, quality and care.	The Trust collects weekly information on the number of breaches of the Monitor cap and reports this through to Monitor. Assurance via Finance and Performance and Well- led Group The Trust has performed a number of challenge sessions to review all existing long term breaches of the Monitor cap. Following this one-off exercise the Trust has sought to integrate this review/challenge into the existing Divisional Business Meetings. An exercise has been carried out to write a letter to all agencies (across all staff groups) requiring agencies to comply with the Monitor cap imposed. Nursing - The Trust has a centralised escalation process in place for the authorisation of requests to secure agency workers for Nursing staff (qualified and non-qualified), through to Nursing Director. The Trust has rich information on the Nursing workforce, covering bank, overtime and agency as a monitoring tool for spend/bookings. Medical – Exec authorisation of requests to secure agency workers/locums AHP's – Exec authorisation of requests to secure agency workers Admin & Clerical – Exec authorisation of requests to secure agency workers	Reportable breaches are currently signed off at Director level though the Trust could further raise the awareness and action by including this information within a report to the Executive Board. Robust escalation and management information for all non-Nursing staff groups. Routine divisional review of agency spend.	15 3 x 5	15 3 x 5	9 3 x 3	**October update:** A further paper to the Weekly Executive Board re;gaps in controls and a directive from the Exec Board about absolute compliance with the agency cap and framework compliance guidance. The Safe Staffing Utilisation and Efficient Programme (NHS-I SMART Plan) signed off by Board, workstreams identified to be implemented from within Divisions and by Corporate leads. A Programme Board will be established to provide governance, support and structure to Trust wide initiatives to improve and embed a consistent model for medical, nursing, midwifery and AHP workforce utilisation and efficiency and subsequent reduction in the reliance on medical locums and overall use of agency medical and non-medical workforce. I.T. system implementation is scheduled to modernise the processes around job planning, Rostering and booking of flexible and interim workforce ensuring this is done through the most cost effective measures. Embed an improved communications strategy to enhance the Trust's recruitment potential and retention across all staff groups. Key leads will engage with agencies to ensure all agency/interim staff is engaged only where absolutely necessary and via the most cost effective route for the Trust, i.e. Brookson's Direct Engagement Model. Pay rates and commission rates are being renegotiated with each agency. All mid-long term agency staff contracts are to be reviewed and renegotiated where possible. All Divisions are responsible for keeping an action log / task list to ensure all possible action is being undertaken to negate the need for a mid/long term agency workforce. Increase and optimise the availability of bank staff whilst simultaneously modernising access to the bank booking system. Sickness and Absence Management policies are to be reviewed with a view to improving Trust wide sickness levels and return to work initiatives. The wider NHS-I SMART Plan addresses a number of initiatives designed to improve upon the Trust's recruitment and retention strategy including; reviewing skill mix, embedding a rolling programme of HCA recruitment, advertising for Bank Doctor vacancies and other local, national and international initiatives. NHS Improvement agency spend diagnostic tool is regularly reviewed and updated.	Nov-2016	Dec-2016	WLG	Ian Warren,	Mark Borrington, Programme Manager

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: BOARD ASSURANCE FRAMEWORK - The Board is asked to approve the update to the Board Assurance Framework	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

As agreed at the Board meeting in September, the Board Assurance Framework has been reviewed to assess whether there is any amendment required to the Trust's strategic risks as a result of the changing NHS landscape and the challenges facing the Trust.
- One risk (004) has increased
- There are no new risks
- There are no closed risks

Main Body

Purpose:

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

Background/Overview:

Please see attached

The Issue:

Following discussion at the Board meeting in September, the HSMR risk (001) has been reviewed however the score will not be reduced until further improvement in the HSMR has been seen. The 7-day services risk (004) has been increased from 12 to 15. This increase in score reflects the fact that we are unlikely to achieve the required standards by end of March. The single oversight framework also uses compliance with 7-day services as one of its metrics.

Next Steps:

It is proposed that the BAF comes back to the Board in February for its next formal review.

Recommendations:

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

Appendix

Attachment:

BAF update for Board November 2016.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2016/17

Contents:

compassionate care

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

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

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING Initial	Current	Target
1.1516	Quality Committee	Executive Medical Director	**Risk** Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI. **Impact** - Inaccurate reporting of preventable deaths - Increased regulatory scrutiny as become CQC outlier - Inability to learn lessons - Increased risk of litigation and negative publicity. - Possible increase in complaints and litigation	• Safety thermometer in use on wards • Safety huddles being implemented • Mortality review process redesigned and rolled out with clinical leads appointed to address the gaps in capacity / capability to undertake reviews • Tighter process in place in relation to SI reporting and investigation • Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) • Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan • Mortality dashboard analyses data to specific areas • Monitoring key coding indicators and actions in place to track coding issues • Nervecentre roll out across the Trust • Ongoing work to improve the care of frail patients • Implementation of care bundles • Mortality reviews in respiratory and stroke not showing any themes • Three level 2 reviewers trained • Work with GP lead on post-discharge deaths within 30 days	<u>First line</u> Mortality dashboard in divisions Mortality reviews provide themes to improve standards of care Coding review putting Trust in upper quartile for some areas Mortality Surveillance Group established <u>Second line</u> Care of the Acutely Ill patient report to Board PSQB reports to Quality Committee Mortality review updates to Quality Committee <u>Third line</u> HSMR has fallen to 108.6. Predicting modest further reductions Independent review of cases by Professor Mohammed	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. Mortality reviews not yet undertaken consistently. Carried out for 40% of all deaths. Job plans for 2017/18 will include requirement to undertake mortality reviews	• SHMI position remains high 113	5x4 = 20	5x4 = 20	4x4 = 16

Action	Timescales	Lead
Awaiting review of mortality review guidance to implement process further	November	JC
~~Phase 1 roll out of Hospital @ Night~~	COMPLETE	~~SU~~
Post-discharge deaths wtihin 30 days work being carried out	December	DB
Job plans for 2017/18 being developed	March	DB

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

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

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

Action	**Timescales**	**Lead**
~~Awaiting outcome of consultation. Participate in JOSC meetings.~~	COMPLETE	~~ALL~~
Particpation in JOSC meeting	16 November 2016	AB
Develop understanding of FB requirements with CCG / NHSI / NHS E	November	AB

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

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
4.1516	Quality Committee	Executive Medical Director	**Risk** Inability to deliver appropriate services over seven days resulting in poor patient experience, greater length of stay and reduced quality of care. **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Working group set up and workshop held with senior colleagues to develop plan • Perfect week learning shared • Governance systems and performance indicators in place • Part of the West Yorkshire early implementers • Capacity brought in to support programme • New gastro rota implemented	First line Improvement in performance against some key indicators including pre 12 o'clock discharge and reduction in outliers Second line Integrated Board report Benchmarked against four key Keogh standards Paper received at WEB Third line Independent review of mortality cases by Professor Mohammed Visit from NHS Improvement Medical Director gave positive feedback	• Gap analysis and action plan to be followed up • National consultant contract negotiations outcomes awaited • Capacity to deliver 7 day service action plan • Medicine action plan to be implemented	• Included within new Single Oversight Framework. Need to understand metric measured and impact on Trust • Scope for futher implementation limited without service reconfiguration or additional investment	**Initial** 5x3 = 15	**Current** 5x3 = 15	**Target** 2x3 = 6
Action					**Timescales**			**Lead**		
7 day service action plan to be finalised ~~Hospital @ Night phase 1 roll out~~					~~October / November~~ April COMPLETE			SU		
Links to risk register: No corporate (>15) risks										

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

Action	Timescales	Lead
Communications and Engagement plan to be implemented	Ongoing starting in September	MG
Training plan to be completed and delivered	~~September~~ March	MG
Go-live date to be agreed	November	MG

Links to risk register:
Risk 6503 - Non delivery of EPR
Risk 6841 - EPR go-live

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

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

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

TRUST GOAL: 2 KEEPING THE BASE SAFE

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

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

Links to risk register:

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

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

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

Links to risk register:
Risk 6694 Divisional governance

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

Action	**Timescales**	**Lead**
Well Led Governance Review action plan to be implemented	~~September~~	COMPLETE
Development of 16/17 CIP schemes to be completed	~~September~~ paper at F&P Committee 31.10.16	COMPLETE
Awaiting outcome of CQC report to identify any further actions to be addressed	~~August~~RECEIVED	BB
CQC response implementation plan to be delivered	March	BB
Assessment of impact of Single Oversight Framework to be presented to Board	October	COMPLETE

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

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

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

Links to risk register:
Risk 6658 - Patient flow

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

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

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

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

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

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

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

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

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

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

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

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

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY

Ref	OWNER		RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE &	GAPS IN CONTROL	GAPS IN ASSURANCE	RATING		
								Initial	Current	Target
17.1516	Board of Directors	Director of Transformation and Partnerships	**Risk** Failure to progress and agree a five year strategic plan across the local health economy **Impact** - financial sustainability - viability of certain services - inability to compete or collaborate with other WY acute trusts	• PRM process • Roundtable discussions introduced including Monitor, CCGs and NHS England • EY appointed to develop 5 year plan. 5 Year Strategic Plan completed at end December 2015 and updated in January 2016 to take account of 16/17 planning guidance. Plan approved by Trust Board in January 2016. • Public consultation completed	First line WEB assessment of direction of travel Second line Board scrutiny and approval of 5 Year Plan. Hospital Services Programme Board discussions to ensure plan aligned with local health economy plans - this has enabled CCGs in January to confirm decision to commence public consultation on future configuration of hospital services. Third line PRM meetings with NHS Improvement and Roundtable discussions with CCGs. NHS I oversight of strategy development process. NHSE assurance of CCG processes and readiness to commence public consultation. Third party assurance of consultation process.		CCG Decision taken 20 October. Awaiting JOSC meeting on 16/11. Need to identify requirements from NHS E / NHS I for full business case.	4x5 = 20	3x5 = 15	2x5 = 10

Action	Timescales	Lead
Particpation in JOSC meeting	16 November	AB
Develop understanding of FB requirements with CCG / NHSI / NHS E	November	AB

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

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY									
Ref	**OWNER**		**RISK DESCRIPTION**	**KEY CONTROLS**	**POSITIVE ASSURANCE &**	**GAPS IN CONTROL**	**GAPS IN ASSURANCE**	**RATING**	
19.1617	Board of Directors	Director of Finance	**Risk** Failure to maintain a cash flow position so that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash. resulting in external scrutiny, significant reputational damage and possible inability to function as going concern **Impact** - financial sustainability - external scrutiny - reputational damage - ability to continue as a going concern	* Agreed £5m capital loan from Independent Trust Financing Facility received in April 2016 * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from Monitor * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Working capital loan facility in place (at 3.5% interest rate) for £13.1 m to support cash in advance of progression of revenue support loan (at 1.5% interest rate) * Profile of cash management is being raised at Divisional level * Agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner.	First line WEB financial performance report Cash Management Committee Second line Finance and Performance Committee reports Third line Bi-monthly PRM with NHS Improvement	Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Cash continues to be a high risk due to the knock on impact of I&E risks and the fine balance required in managing working capital	Distressed cash support through "Revenue Support Loan" not yet formally approved by NHS Improvement	Initial 5x3 = 15	Current 5x4=20	Target 5x3=15

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

Links to risks register:
Risk 6722- Cash management

ACRONYM LIST

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

INITIALS LIST

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Risk Appetite Statement - To present for approval the Trust's risk appetite statement.	
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 Group 13 September 2016 Audit and Risk Committee 18 October 2016	
Governance Requirements: N/A for specific risks - the risk appetite will help ensure the Trust has a clear framework within which it considers risk management against an agreed risk appetite statement.	
Sustainability Implications: None	

Executive Summary

Summary:

The Trust's first risk appetite statement is presented to the Board of Directors for approval, defining the element and type of risk that the Trust is willing to consider in pursuit of delivery against it's strategic objectives.

Main Body

Purpose:

Since the financial crash of 2008, increasingly organisations are using risk appetites as a fundamental part of effective corporate governance. Auditors of NHS services are increasingly advocating the use of a risk appetite in public services in the NHS, a reflection of a more mature risk management system within an organisation. Public sector guidance on risk appetite , the Orange Book from the Treasury, has been in place since 2004. This supports well-managed risk taking, recognising that innovation and opportunities to improve public services requires risks taking, as long as those risk can be well managed.

The risk appetite statement has been developed following a workshop with Board members in July and is enclosed for review and approval by the Board of Directors.

Background/Overview:

This is the first formal paper to the Board of Directors on risk appetite following on from a Board workshop in July 2016.

The risk appetite has been shared with the Risk and Compliance Group on 13 September. It was reviewed by the Audit and Risk Committee at its meeting on 18 October 2016 and has been recommended to the Board of Directors for approval.

The Issue:

An organisation’s risk appetite is defined as the amount and type of risk that the organisation is willing to take in the pursuit of it’s strategic objectives. The risk appetite can help the Trust by enabling the organisation to take decisions based on an understanding of the risks involved and communicating expectations for risk taking to managers.

The Trust has developed it’s first risk appetite using the matrix for NHS organisations developed by the Good Governance Institute. This is commonly used by NHS organisations as a framework for the risk appetite statement.

Next Steps:

Following Board approval, work will take place to communicate the risk appetite to staff and embed it throughout the organisation. It will also be a key reference document in discussions regarding the risks on the Board Assurance Framework and corporate risk register, ensuring these are in line with the Trust's risk appetite.

The risk appetite will be presented to the Board of Directors for approval on an annual basis, or sooner if circumstances require.

The Audit and Risk Committee will review the risk appetite on a 6 monthly basis.

Recommendations:

The Board of Directors is asked to approve the risk appetite statement.

Appendix

Attachment:

Risk appetite attachment for board 3 11 16 pdf.pdf

RISK APPETITE October 2016

Risk Category	This means	Risk Level Appetite	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to deliver high quality patient care (despite greater inherent risk).	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial and Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**
Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**

Commercial	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.	**SEEK**	**SIGNIFICANT**
Quality Innovation and Improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**

*For definitions of risk level and risk appetite see next page which details Good Governance Institute definitions

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal (ALARP)** (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Performance Management Framework Review - The Board is asked to note the progress made with the implementation of the Performance Management Framework Review	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Not applicable	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Trust implemented a new performance framework at the beginning of 16/17 with weekly performance meetings to review in month delivery and a monthly PRM with each Division; 6 rounds of Divisional Performance Review meetings have now taken place.

Early roll out was challenging due to data publication and submission timelines which have now been amended. The new style Divisional Performance Review meetings provide a single performance forum between the Division and the Directors covering all aspects of financial and non-financial performance within a single conversation. They provide a forum for scrutiny of the recovery plans in areas of poor performance ensuring they are sufficient and timely plus they also provide a forum for discussion of complex issues highlighted by the either the Division or Executives and, where required, support is agreed.

Review of effectiveness has taken place after each round and changes implemented accordingly as described in the paper and the new Single Oversight Framework is being reviewed to ensure they continue to develop to respond to this.

Internal Audit have been commissioned to undertake a review of the implementation of the PMF across Divisions this will include an assessment of the improvement in IPR completeness given the new timeline and flow chart. In addition we will now progress to the implementation of the PRM process for corporate departments.

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 progress made with the implementation of the Performance Management Framework Review

Appendix

Attachment:

PMF review Nov 16.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEETING TITLE: Board of Directors	**REPORT AUTHOR: Peter Keogh**
DATE OF MEETING: 3rd November 2016	**SPONSORING DIRECTOR: Helen Barker**
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUM(S) WHERE PAPER HAS BEEN DISCUSSED: N/A	

EXECUTIVE SUMMARY:

The Trust implemented a new performance framework at the beginning of 16/17 with weekly performance meetings to review in month delivery and a monthly PRM with each Division; 6 rounds of Divisional Performance Review meetings have now taken place.

Early roll out was challenging due to data publication and submission timelines which have now been amended. The new style Divisional Performance Review meetings provide a single performance forum between the Division and the Directors covering all aspects of financial and non-financial performance within a single conversation. They provide a forum for scrutiny of the recovery plans in areas of poor performance ensuring they are sufficient and timely plus they also provide a forum for discussion of complex issues highlighted by the either the Division or Executives and, where required, support is agreed.

Review of effectiveness has taken place after each round and changes implemented accordingly as described in the paper and the new Single Oversight Framework is being reviewed to ensure they continue to develop to respond to this.

Internal Audit have been commissioned to undertake a review of the implementation of the PMF across Divisions this will include an assessment of the improvement in IPR completeness given the new timeline and flow chart. In addition we will now progress to the implementation of the PRM process for corporate departments.

RECOMMENDATION:
To note progress with the implementation of the Performance Management Framework

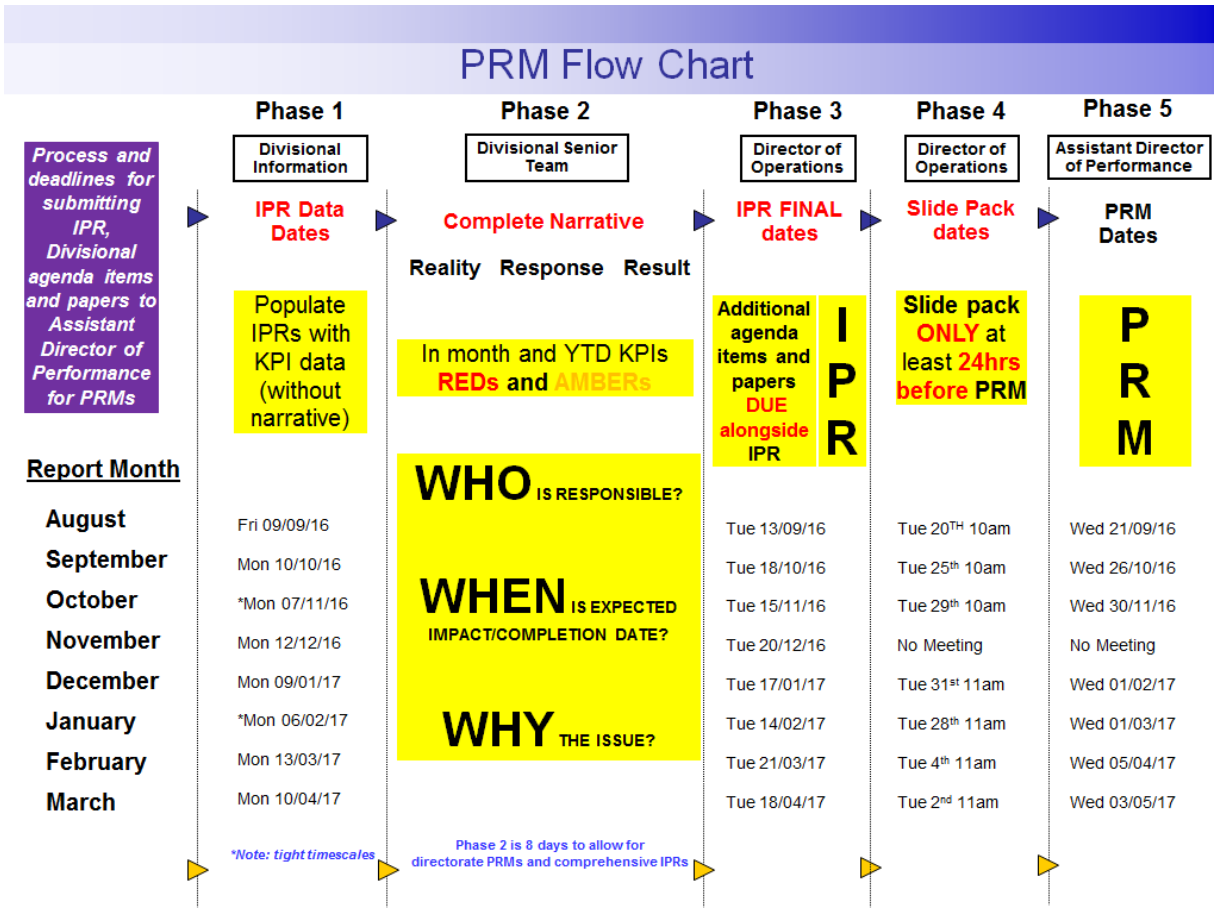
Performance Management Framework Review

1) Background

The Trust implemented a new performance framework at the beginning of 16/17 with weekly performance meetings to review in month delivery and a monthly PRM with each Division; 6 rounds of Divisional Performance Review meetings have now taken place.

Early roll out of the PRM was challenging as the dates between publication and submission did not allow the Divisions to replicate the model with Directorates however, as agreed with the Board, from October onwards there is new timetable that gives the Divisions 8 days from data publication to IPR submission which then feeds into the Performance WEB and subsequent Board and its sub committees.

A flow chart (example below) has been issued to each division highlighting key submission dates for IPRs, agenda items and additional papers for PRMs plus dates for slide packs which provide a more rounded document on overall Divisional business and facilitates a structured flow to the meetings. This was fully implemented in October and the quality and timeliness of papers was much improved.



2) Weekly Performance Meetings

These have matured over the past 6months with the data flow more robust and additional items continue to be added as appropriate. Early warnings of issues are highlighted and actions taken by the relevant attendee and issues of concern are formally escalated the following day to the Executive Board.

3) Performance Review Meetings (PRMs)

The new style Divisional Performance Review meetings have now been in place since May and provide a single performance forum between the Division and the Directors covering all aspects of financial and non-financial performance within a single conversation. They provide a forum for scrutiny of the recovery plans in areas of poor performance ensuring they are sufficient and timely plus they also provide a forum for discussion of complex issues highlighted by the either the Division or Executives and, where required, support is agreed.

New Divisional IPRs have been developed which now provide data at Directorate level and these have been formatting using the 3Rs principle in relation to actions and accountabilities.

4) Agendas

The following standard agenda items occur for each division:

- Update on actions from previous Meeting
- Quality and Performance Exception Report – Further actions required
- Workforce, including agency plans and spend
- Activity, Contracting and Commissioning
- Finance
- Update on action plans
- Risk Register

These are further augmented by divisional items plus any other current issues deemed necessary by the Executive team.

5) Key Themes

One area that it is hoped will reduce following the introduction of the new timeline is the amount of time spent in PRMs discussing the previous month's performance and action plans to bring results back in line. The narratives in the IPR should give assurance on actions to improve performance.

In recent months the following areas have regularly appeared on PRM agendas:

- Emergency Care Standard
- % Hospital Initiated Outpatient Cancellations
- Agency staffing
- Appraisals
- Sickness
- Complaints
- CQUIN – Sepsis
- % PPH
- Financial recovery plan and CIP delivery
- #NoF 36 Hours to Surgery
- Cancer D38

KPIs

- Stroke Imaging
- Locala and KPI development
- MSK pathway
- Critical Care planning
- Theatre diagnostic report and action plan

More strategic

There have been some recurrent or significant issues that have not been resolved adequately through PRMs with several additional and subject specific meetings taking place. This is in line with the agreed Performance Review Framework and has been viewed positively by Divisional teams.

6) Key changes

The weekly performance pack continues to develop, most recently activity has been added to allow for proactive tracking, in month of activity both undertaken and booked.

For PRMs there is now greater focus on the submission of additional papers alongside the initial IPR to ensure adequate time for Directors to review which, in turn, makes best use of the PRM. There have been some small changes to the PRM presentation deck including the introduction of Risk Register summaries and most recently good news stories.

Divisions now receive a formal letter post review ensuring the key elements of the review are documented, actions are clear and accountable officers are clarified. This is circulated to all the Directors.

The Directors confirm agenda items electronically following the circulation of the packs but now have a pre-meet before each PRM to discuss collectively and agree subject leads. Following a discussion at a recent Directors time out a meeting now takes place after the four Divisional PRMs where themes are discussed and areas for internal ‘Go Sees’ are agreed.

A more robust process has been developed to ensure action plans following reviews are signed off formally at Divisional and Director Level with exception reports provided monthly as relevant to the Division. The final sign off will include a review of evidence both documentary and by visiting areas.

7) Single Oversight Framework

Moving forward the structure of PRMs will further develop to ensure they align with the Single Oversight Framework and wider planning agenda including the following themes as reflected in NHS Improvement's 2020 Objectives:

- Quality of care (safe, effective, caring, responsive)
- Finance and use of resources
- Operational performance
- Strategic change: delivering the strategic changes set out in the 5YFV, with a particular focus on contribution to sustainability and transformation plans (STPs).
- Leadership and improvement capability (well-led)

8) Next Steps

Internal Audit have been commissioned to undertake a review of the implementation of the PMF across Divisions this will include an assessment of the improvement in IPR completeness given the new timeline and flow chart. In addition we will now progress to the implementation of the PRM process for corporate departments.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - NOVEMBER 2016 - This report brings together a number of governance items for review and approval by the Board.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:
1. Annual Review of Non-Executive Director roles
2. Review of Board of Directors Terms of Reference
3. Standing Financial Instructions
4. Single Oversight Framework
5. Well Led Governance Review

Main Body

Purpose:

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

Background/Overview:

Please see attached

The Issue:

1. Annual Review of Non-Executive Director roles
The Chairman has reviewed the additional roles undertaken by Non-Executive Directors. The Board is asked to NOTE that Jan WIlson will remain as the Deputy Chair of the Board of Directors and David Anderson will continue as the Senior Independent Non-Executive Director and the Board lead for Whistleblowing.

2. Review of Board of Directors Terms of Reference
The Company Secretary has reviewed the terms of reference. The only change was to remove reference to 'Monitor' and replace with NHS Improvement. The Board is asked to REVIEW and APPROVE the terms of reference attached at appendix 1.

3. Standing Financial Instructions (SFIs)
The Audit and Risk Committee considered changes to the tendering section of the SFIs and have recommended these for approval by the Board. The amendments reflect the electronic processes that are now in place for the issuing, opening, assessment and approval of tenders. A full copy of the SFIs is available in the reading room on Boardpad or on the Trust intranet. The Board is asked to APPROVE the amendments to the SFIs.

4. Single Oversight Framework
At its meeting in September, the Board received a report setting out the new Single Oversight Framework as the means by which NHS Improvement will oversee and monitor the performance of the Trust. The Trust has now received notification that we will placed in segment three. As set out in the previous paper, the assessment is made up of five key themes. Currently there is only clarity on the assessment criteria for the finance and use of resources theme where the Trust clearly scores a 3.

5. Well Led Governance Review
At its meeting in June, the Board received an update against the Well Led Governance Review action plan. At that point there remained only two areas for further action, both of which were awaiting the Executive Director of Workforce and OD to come into post. A copy of the updated action plan is attached at appendix 2.
- Multi-professional leadership - there remained a requirement to ensure that multi-professional leadership would be captured in the Workforce Strategy. The Executive Director of Workforce and OD has confirmed that this is the case. The first draft of the strategy was discussed by the Workforce Committee at its meeting

in October.
- Board development - the remaining action was for the Executive Director of Workforce and OD to support the development of a programme for both executives and non-executives. The executive programme is underway and the Board plan will come to the January meeting.
The Board is asked to APPROVE the closure of the Well Led Governance Review actions.

Next Steps:

There was a requirement from NHS Improvement to undertake another well led governance self assessment in 2017. As part of the new oversight arrangements, NHS Improvement are looking to align their well led governance assessment more closely with the Care Quality Commission well led assessment. The Company Secretary is due to attend a workshop on this in November and will provide further feedback to the Board at a future date.

Recommendations:

The Board is asked to receive the report and:-
1. Approve the Annual Review of Non-Executive Director roles
2. Approve the reviewed of Board of Directors Terms of Reference
3. Approve the Standing Financial Instructions
4. Note the impact to the Trust of the new Single Oversight Framework
5. Approve the final Well Led Governance Review update

Appendix

Attachment:

COMBINED GOVERNANCE REPORT.pdf

BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTIUTION

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, for the information of the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees. The practice and procedure of the meetings of the Board of Directors – and of its committees – are not set out here but are described in the Board's Standing Orders.

2. PURPOSE

The principle purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the Membership Council and some decisions of the Board of Directors require the approval of the Membership Council. The Board consists of executive directors, one of whom is the Chief Executive, and non-executive directors, one of whom is the Chair.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, local health organisations, local government authorities and others to provide safe,

accessible, effective and well governed services for patients, [service users, and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:
- Ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

4.3. Quality

The Board:
- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:
- Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Monitors and reviews management performance to ensure the Trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

4.5. Culture

The Board:
- Is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation Trust business;

- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:

- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS Improvement from time to time) and appropriate codes of conduct, accountability and openness applicable to foundation Trusts;
- Ensures that all elements of the Trust's licence relating to the Trust's governance arrangements are complied with;
- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures that all required returns and disclosures are made to the regulators;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation Trust business.
- Agrees the schedule of matters reserved for decision by the Board of directors;
- Ensures that the statutory duties of the Trust are effectively discharged;
- Acts as a corporate trustee for the Trust's charitable funds.

4.7. Risk management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.
- Ensures there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining committees of the Board of Directors with delegated powers as prescribed by the Trust's standing orders and/or by the Board of Directors from time to time:

4.9. Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its membership councillors, members, staff and the local community.
- Meets its engagement obligations in respect of the Membership Council and members and ensures that membership councillors are equipped with the skills and knowledge they need to undertake their role;

- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website.
- Publishes an annual report and annual accounts.

4.10. Finance

The Board:

- Ensures that the Trust operates effectively, efficiently, economically
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and membership council and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Membership Council.

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chairman and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and membership council.

7. ACCOUNTABILITY TO THE MEMBERSHIP COUNCIL

The non-executive directors are accountable to the Membership Council for the performance of the Board of Directors. To execute this accountability effectively, the non-executive directors will need the support of their executive director colleagues. A well-functioning accountability relationship will require the non-executive directors to provide membership councillors with a range of information on how the Board has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the Trust. The non-executive directors will need to

encourage questioning and be open to challenge as part of this relationship. The non-executives also should ensure that the Board as a whole allows membership councillors time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS

The Board of Directors will meet at least 9 times a calendar year.

9. QUORUM

Six directors including not less than three executives, and not less than three Non-Executive Directors shall form a quorum.

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the Trust secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the membership council and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the chair and chief executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

In order that the Board can be assured that it is operating at maximum effectiveness in discharging its responsibilities at set out in these terms of reference it shall self assess its performance following each Board meeting. Once a year a full review of effectiveness will be undertaken including attendance, decision making, assessment against responsibilities and completion of the business cycle.

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

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

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

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

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

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

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

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: REVIEW OF PROGRESS AGAINST THE STRATEGY - The Board is asked to receive and approve the review of progress against the strategy	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and approve the review of progress against the strategy

Main Body

Purpose:

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan for 2016/17.

Background/Overview:

In June 2016, the Board of Directors agreed the updated 1 year plan and quality priorities for 2016/17.
The plan describes the objectives to be achieved against the four goals of the Trust:
- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

The Issue:

This report describes the progress made against each of the 16 objectives and identifies where the Board should expect to receive more detailed assurance of how the work is progressing.

Next Steps:

A further update will be brought to the Board in February.

Recommendations:

The Board is asked to receive and approve the review of progress against the strategy

Appendix

Attachment:

Progress against strategy Board report November 2016.pdf

Calderdale and Huddersfield NHS Foundation Trust
1 Year Plan - Progress Report November 2016

Introduction

The Trust's vision is:
Together we will deliver outstanding compassionate care to the communities we serve.

In May 2016, the Board of Directors agreed the refreshed 1 year plan and quality priorities for 2016/17. The plan describes the four goals of the Trust:

- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

These goals are underpinned by the four behaviours:

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

The plan sets out the key areas of delivery to support the achievement of each of the goals described in the table below. The risks of not delivering our goals have been assessed and are included in the Board Assurance Framework. The risks associated with each area of delivery have also been assessed and are included in the corporate risk register. The identified risks are reviewed and escalated as appropriate in line with the Trust's risk management arrangements.

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

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan 2016/17.

Structure of Report

The report is structured to provide an overview assessment of progress against key deliverables responses and this is rated using the following categories:

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

For each area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 16 deliverables:

- None are rated red i.e. off track with no plan in place.
- 11 are rated amber / red i.e. off track with a plan in place.
- 5 are rated amber / green i.e. on track but not yet delivered.
- None have been fully delivered or rated green.

Recommendation

Trust Board Members are requested to:

- Note the assessment of progress against the 2016/17 goals.
- Discuss and agree the future action and assurance that may be required

Goal: Transforming and improving patient care			
Deliverable	Progress rating	Progress summary	Assurance route
Subject to consultation, develop DoH approved implementation plans for the 5 Year Strategic Plan. Deliver on YE2017 including strengthening community services for 2017.	**On track - not yet delivered (amber / green)**	Formal public consultation on the proposals concluded on 21st June. The findings from the consultation were published on 25th August 2016. Clinical Commissioners made a decision to progress to full business case on 20 October 2016. Currently working with CCGs, NHS England and NHS Improvement to identify what is required and the timelines for development.	**Lead: AB** Hospital Services Programme Board Weekly Executive Board
Refocus the Care of the Acutely Ill Patient action plan and implement the SAFER (patient flow) and hospital@night programmes to improve quality of care.	**On track but not yet delivered (amber/green)**	SAFER programme in place and seeing some impact on key indicators. Hospital@night has rolled out. Still require further grip around implementation of care bundles. Progress continues to be made with the management of sepsis and a lead nurse has commenced in post.	**Lead: DB / HB** Reported to Weekly Executive Board and Quality Committee.
To work as an early adopter towards the implementation of selected 7 day NHS England standards (2,5,6 and 8)	**Off track with plan in place (amber/red)**	Currently assessed as green however timeline for delivery as an early implementer is March 2017 and there will be some standards that cannot be met with current two-site configuration. Compliance with 7-day services now included as an indicator in the Single Oversight Framework for Trusts.	**Lead: DB** Quality Committee Weekly Executive Board
Together with our partners deliver and implement a robust EPR system	**Off track with plan in place (amber/red)**	Decision made to delay go-live until results of trial load 3 are known. Go-live date likely to be between March and May 2017 and will be before BTHT. Staff engagement is a key priority.	**Lead: MG** Monthly to Board and Finance and Performance Committee Sponsoring Group Executive Board

Goal: Keeping the base safe			
Deliverable	Progress rating	Progress summary	Assurance route
Undertake a Well Led Governance Peer Review and implement any actions to support the findings and ensure ongoing compliance with NHS Improvement and CQC	**On track but not yet delivered (amber/green)**	Agreed with NHS I that Well Led Governance Peer Review will take place in early 2017. NHS I currently working with CQC to revise the well-led framework and align. Currently fully compliant with all NHS I requirements.	**Lead: VP** Progress Review Meeting feedback to Board Audit and Risk Committee

Implement the actions resulting from the findings from the CQC inspection	**On track but not yet delivered (amber/green)**	Following publication of CQC report on 15 August an action plan was approved at September Board meeting. This is being closely monitored through fortnightly Response Group	**Lead: BB** Monitored through Quality Committee.
Implement year 2 of the health and safety action plan and, via the estates strategy, deliver against level B quality standards	**On track but not yet delivered (amber/green)**	Progress has been made on delivery of the year 2 health and safety action plan. There are a small number of indicators where plans to deliver require further work and these are being closely monitored through the Health and Safety Committee. As part of the development of the Full Business Case for service reconfiguration, an assessment will be made as to the required ongoing maintenance for HRI to keep it to a safe standard for the delivery of patient care.	**Lead: LH** Monitored through Health and Safety Committee to Quality Committee and reported six-monthly to the Board.
Implement the local quality priorities	**On track but not yet delivered (amber/green)**	Progress is on track with the key Quality Priorities which includes the reduction of falls through the implementation of safety huddles; Hospital Out of Hours Programme; and improving patient experience in the Community. Outcome measures will be monitored following the implementation of the safety huddles on inpatient wards, and the hospital at night nerve centre task management system. A pilot patient questionnaire has been tested in community prior to further roll out in the division.	**Lead: BB** Quality Committee

Goal: A workforce fit for the future			
Deliverable	Progress rating	Progress summary	Assurance route
Develop and implement a 5 year workforce and organisational development plan	**On track but not yet delivered (amber/green)**	First draft presented to the Workforce Committee in October. Will be developed further during November with a final draft for discussion at Workforce Committee in December prior to Board approval in January.	**Lead: IW** To be signed off by the Board and then monitored through Workforce Committee
Implement the colleague produced action plan in response to Investor in People accreditation; the staff survey; Friends and Family Test and Workforce Race Equality Scheme.	**On track but not yet delivered (amber/green)**	Significant progress made against all actions described in the plan. Areas of delivery shared with all staff in advance of the 2016 Staff Survey launch including launch of thank you cards; implementation of mindfulness and other wellbeing opportunities; star awards; hello my name is campaign. Next update due to Board in December.	**Lead: OW** Weekly reporting to the Weekly Executive Board Report to Board in September.

Design and deliver a leadership and succession planning development programme.	**Off track with plan in place (amber/red)**	Meeting held to discuss the organisational development plan for the Trust. Will be linked to and described in the Workforce Strategy and supporting action plan.	**Lead: IW** To be monitored through Workforce Committee
Delivery of the integration of finance and workforce information systems ensuring the consistency of provision and integrity of data.	**Off track with plan in place (amber/red)**	Dir of WOD and Dir of Finance are currently establishing the link between ESR payroll and the finance information systems utilising THIS knowledge portal and will be presented to Workforce Committee in January.	**Lead: IW** To be monitored through Workforce Committee

Goal: Financial sustainability			
Deliverable	Progress rating	Progress summary	Assurance route
Deliver a robust financial plan including CIP for YE 2017	**On track but not yet delivered (amber/green)**	Trust is on track to meet forecast financial position showing a small positive variance against plan at Month 6.	**Lead: KG** Weekly progress monitored through Turnaround Executive. Reported to Finance & Performance Committee
Working with partners including across WY, develop and implement a sustainability and transformation plan including Carter compliance.	**On track but not yet delivered (amber/green)**	The Trust is an active member of the West Yorkshire Association of Acute Providers and is proactively participating in the development of plans that will inform and contribute to the West Yorkshire STP. The West Yorkshire STP was finalised and submitted in October. Within the Trust all Divisions are undertaking work to explore and where possible realise the Carter efficiency recommendations and opportunities.	**Lead: AB** Updates on this work are regularly provided to the Trust's Finance and Performance Committee. STP presented to Board.
Develop a full CIP programme for YE 2021.	**On track - not yet delivered (amber / green)**	Work is being undertaken (led by senior Finance and PMO teams) to develop a full CIP programme for YE 2021. This work is in progress and on track. It is scheduled that a report will be submitted to the October meeting of the Finance and Performance Committee.	**Lead: AB** Finance & Performance Committee
Develop the 5 year commercial plan for THIS and consolidate the existing PMU strategy.	**Off track with plan in place (amber/red)**	Consideration of future commercial opportunities built into the business planning days held 20/21 October.	**Lead: KG** Board approval of Business Plan.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Senior Nurse Clinical Governance
Date: Thursday, 3rd November 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient Programme Report - This is a progress report against the six themes identified within the CAIP programme	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Reports are provided monthly to the Clinical Outcomes Group (COG)	
Governance Requirements: Transforming and improving patient care	
Sustainability Implications: None	

Executive Summary

Summary:

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

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

Each of the themes are updated within the attached report

Main Body

Purpose:

This progress report in intended to keep the BOD informed of the progress of the 6 themes within the CAIP programme

Background/Overview:

As per the executive summary

The Issue:

Although mortality remains a concern there has been improvement work and progress in all themes with a noted reduction in HMSR

Next Steps:

Monthly monitoring of all the themes continues with reporting to COG

Recommendations:

To note the content

Appendix

Attachment:

CAIP programme summary for BoD_Oct 2016.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Care of the Acutely Ill Patient programme

Progress Report for October 2016

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

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

This is a working document and is reviewed with updates monthly to the Clinical Outcomes Group (COG). Performance is measured in the CAIP dashboard and a brief progress against themes noted below. Both the CAIP plan and CAIP Dashboard are currently being reviewed to assure the focus on improvement and appropriate measures are captured.

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	**SHMI** The latest release for SHMI is for Jan 15 - Dec 15 is 113. **HSMR** The latest HSMR release is for July 15 to June 16, and has shown a fall to 108.67 **Mortality Reviews** The completion rate for Level 1 reviews has fallen to 32.5% of cases reviewed in July. In the last 12 months, there have been a 1,582 deaths, of these, 797 (50.4%) have been reviewed by the team of 1st level reviewers. The overall preventability rate over the last 12 months is 1.25%. The top learning themes since July 2015 remain the	The next SHMI is expected to remain at a similar level, as it reflects a delayed period of time when the HSMR was also stablised. HSMR performance is expected to continue to reduce of the coming months. The process for consultants to perform mortality reviews is being developed and the review compliance is expected to rise once this is established. This process is expected to commence from November 1st level review forms are being reviewed and work is ongoing with

	same; delay in senior medical review, delay in medications including antibiotics and hospital acquired pneumonia including aspiration pneumonia. A mortality Surveillance Group meets monthly and is chaired by the Medical Director **30 day death investigations** The Assistant Medical Director and a GP have reviewed a small cohort of patients who died within 30 days of discharge. The review didn't highlight any preventability issues but did test the process which could be used for a targeted approach with selected deaths.	Health Informatics to accommodate the changes within the Mortality Knowledge Portal. The launch of the National mortality programme is expected in November and we are due to receive training with Bradford in early January.
2) Reliability in clinical care	There are five conditions where evidence-based care bundles have been developed to improve patient outcomes. These are; • Asthma • Acute Kidney Injury (AKI) • Sepsis • Chronic Obstructive Pulmonary Disease (COPD) • Community Acquired Pneumonia (CAP) The completion of the bundles continues to be variable with better compliance at starting the bundles but further work is required to fully complete the bundles. Clinical leads have been identified to lead the improvement work for each of the bundles. The care bundles have now been incorporated in the medical and surgical clerking documentation to	Continue support with clinical leads for each of the bundles to gain a better understanding of why there is better compliance with some elements of each bundle and why we fail to comply or document other elements of the bundles. Ensure progress is feedback to the Clinical Outcomes Board on a regular basis

	prompt the commencement of the appropriate bundle. This has probably contributed the improvement noted in some of the bundles and has allowed retrospective audit to take place. The bundles are being included in the first phase of the EPR (Electronic Patient Record).	
3) Early recognition and treatment of deteriorating patients.	The Deteriorating Patient Group meets monthly and attended by senior nurses and clinicians. An action plan is being developed. Hospital out of hours Programme (HOOP) has been set up at CRH with an electronic referral to the team between 5pm and 8am and weekend. The team is able to assist with deteriorating patients.	An audit of patient with NEWS 7 or more is being planned with the support of junior doctors. HOOP team due to go live at HRI on 16th November.
4) End of life care	Draft End of Life Strategy has been written taking into account the recent audit findings, current work streams and the CQC report findings. All deaths in the trust are being looked at in regards to whether they were on the Individualised Care of the Dying Document (ICODD) compared to how many should have been on the ICODD. DNACPR discussions were observed to be at 93.5% compliance in July	A steering group has been set up to implement the policy and action plan Breakthrough event to be organised to engage external stakeholders and Commissioners in end of life across the health economy. An Electronic Palliative Care System (EPACS) is being implemented at HRI and CRH
5) Caring for frail patients	Work is being is part of the SAFER programme and co-ordinated the by community ADN supported by colleagues in medicine and surgery. Focus on admission avoidance work in community and will feed into the action plan for elderly. A clinical manager and virtual ward team are	Further work required to increase knowledge and understanding of services available to avoid admissions.

	scoping patients on the wards that are suitable for community interventions.	
6) Clinical coding	Co-morbidity Form audit results in September fallen to 42% (following a period of being at 60%+) Specialist Palliative Care (SPC) capture during August was highest to date but still a very time consuming process Deterioration in September from August in both depth of coding and average Charlson Co-morbidity. Variation at specialty level although a lot more now in the IQ range than in previous months	Plans to roll out 3M Encoder ahead of EPR go live. Work is progressing to implement by the end of November Currently advertising for 2.5 wte coders that will continue to be advertised as a rolling advert with the plan that if no suitable applicants by January 2017 additional trainees will be recruited

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Lindsay Rudge, Deputy Director of Nursing
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Nursing and Midwifery Safe Staffing Report - This paper follows on from the detailed safe staffing report provided to the Board of Directors in May 2016, and provides assurance that Nursing and Midwifery staffing capacity and capability are monitored, reviewed and established in line with the recommendations of the Hard Truths (2014) document; Updated National Quality Board guidance (2016) and NICE Guidance for safe staffing of Adult Inpatient Wards (2014) and Maternity (2015).	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper follows on from the detailed safe staffing report provided to the Trust Board in May 2016, and provides assurance to the Board of Directors that Nursing and Midwifery staffing capacity and capability are monitored, reviewed and established in line with the recommendations of the Hard Truths (2014) document; Updated National Quality Board guidance (2016) and NICE Guidance for safe staffing of Adult Inpatient Wards (2014) and Maternity (2015).

Main Body

Purpose:

To confirm to the Board of Directors that the nursing and midwifery workforce has been reviewed in line with national recommendations and local needs.

Background/Overview:

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

The Issue:

N/A

Next Steps:

The non based ward reviews will be detailed in the next 6 monthly report alongside further review of inpatient and community nursing and midwifery services in line with national recommendations.

Recommendations:

The Board of Directors is asked to approve the report

Appendix

Attachment:

NURSING AND MIDWIFERY SAFE STAFFING BOARD REPORT FINAL OCTOBER 2016.pdf

NURSING AND MIDWIFERY STAFFING

REPORT

BOARD OF DIRECTORS – NOVEMBER 2016

CONTENTS		
1.0	Introduction	
2.0	Investment Update	
3.0	The Nursing and Midwifery Workforce	
4.0	Recruitment	
5.0	NQB Guidance & Care Hours Per Patient Day (CHPPD)	
6.0	Nursing model reviews	
7.0	Conclusion	

1.0 Introduction

This paper follows on from the detailed safe staffing report provided to Board in May 2016, and will provides assurance to the Trust Board that nursing and midwifery staffing capacity and capability are monitored, reviewed and established in line with the recommendations of the Hard Truths (2014) document; Updated National Quality Board guidance (2016) and NICE Guidance for safe staffing of Adult Inpatient Wards (2014) and Maternity (2015).

This paper provides an overview of the size and shape of the nursing and midwifery workforce. Current and potential workforce risks are highlighted including an update on investment recommendations from the 2015 nursing workforce reviews.

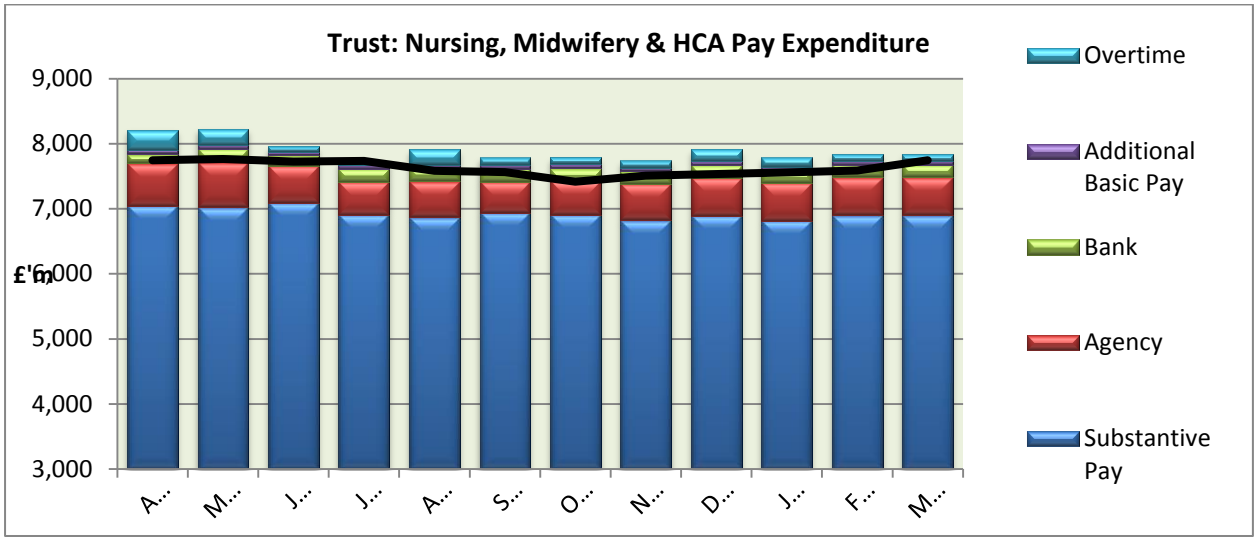
2.0 Investment Update October 2016

Projected year end nursing forecast is still higher than planned (see table's 1&2).

Nursing Expenditure April 2016 to March 2017 Table 1

Nursing, Midwifery & HCA Pay Expenditure	2016/17 Actual Expenditure						2016/17 Forecast Expenditure						
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Forecast Year End
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Substantive Pay	7,044	7,027	7,094	6,916	6,872	6,938	6,908	6,825	6,897	6,814	6,904	6,904	83,144
Agency	657	691	572	503	553	482	527	562	586	586	586	587	6,893
Bank	140	209	162	204	205	197	192	192	192	192	192	192	2,267
Additional Basic Pay	69	60	45	53	52	59	59	59	59	59	59	59	691
Overtime	300	240	88	54	232	107	103	103	178	140	103	103	1,752
Total Nursing Expenditure	8,209	8,227	7,961	7,729	7,915	7,784	7,789	7,740	7,912	7,791	7,844	7,846	94,746
Planned Nursing Expenditure	7,744	7,767	7,728	7,736	7,586	7,565	7,417	7,509	7,537	7,558	7,590	7,746	91,483
Variance	465	460	233	-7	329	219	372	231	375	232	255	100	3,263

Table 2



Nursing Agency Spend: Percentage of Substantive Spend (Qualified Nurses only)

Table 3

	2016/17 Actual Expenditure						2016/17 Forecast Expenditure						
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Forecast Year End
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Total Expenditure: Qualified Nursing	6,462	6,383	6,294	5,992	6,153	6,103	6,107	6,123	6,215	6,137	6,175	6,176	74,321
Agency Expenditure: Qualified Nursing	583	574	541	350	477	425	452	475	500	500	500	501	5,877
% of Total Expenditure	9.0%	9.0%	8.6%	5.8%	7.7%	7.0%	7.4%	7.8%	8.0%	8.1%	8.1%	8.1%	7.9%

2.1 Progress on Investment's from November 2015 review.

2.1.1 Families and Specialist Services

Recruitment to Band 2 posts in GAU and Ward 4C has been completed, with start dates for successful candidates identified for October 2016.

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

A flexible establishment model has been implemented across paediatrics to meet fluctuations in activity during different periods of the year to meet the needs of children. The first phase of implementing this plan has been completed over the summer months. The division are now focusing on the winter planning element, with a planned increase in qualified nursing hours over all shifts throughout this period All vacancies are now fully recruited into to enable the plan to be progressed.

2.1.2 Surgical Division

2.58 WTE additional HCA have been recruited to ward 15 and are now in post.

Funding for a Deputy Associate Director of nursing post supported in November 2015 had been used to support an uplift of a band 7 into a matron post to support development and manage a short term absence in this team. The post is now being reviewed to progress as planned.

2.0 WTE clinical educators' posts were identified for a fixed term to support the nursing workforce funded through a temporary reduction in supervisory time. There is 1.0 WTE clinical educator in post for twice the length of time.

2.1.3 Medical Division

Following a recommendation in November 2015 to increase nursing support for Non-Invasive Ventilation provision to meet the British Thoracic Society guidance a £100K investment was allocated to the division and is currently been utilised to provide specialist nurse cover in the areas when required and provide support and education required. This will be evaluated in quarter 4 of this financial year.

6.72 WTE Engagement support and care workers have been recruited to support multidisciplinary ward staff to deliver a multi-component prevention of delirium (POD) and patients who have a suspected diagnosis or diagnosis of dementia using activity as a therapeutic medium to support recovery and will commence on wards 5, 5AD and 8.

Investment for an additional 12.6 WTE RN's in the Emergency Department was supported to meet part of the recommendations aligned to a phased recruitment. Recruitment to these posts has not been fully realised and this continues to be risk assessed and closely monitored.

3.0 The Nursing and Midwifery Workforce

3.1 Vacancies

Vacancies for Registered Nurses / Midwives have increased each month from May 2016; rising to 223 Whole Time Equivalent (WTE) ,data reported via ESR in September 2016 .

The vacancy level on individual areas is managed divisionally with substantive staff deployed flexibly for periods of time to ensure stability in all areas to meet patient's needs.

Vacancies for non-registered staff are reported from ESR (September 2016) as 45 WTE.

Significant recruitment to non-registered roles has been completed and further work to confirm the vacancy data from ESR is underway with a task and finish group.

Table 4: Turnover Nursing and Midwifery Workforce

Month	May 2016	June 2016	July 2016	August 2016	September 2016
Turnover % RN / RM	1.19	0.77	1.35	1.04	0.88
Turnover % Non Registered	0.84	0.55	0.76	0.64	1.01

3.2 Absence

Absence rates have continued to reduce through focused attendance management.

Table 5: Absence Rates Nursing and Midwifery Workforce

Month	April 2016	May 2016	June 2016	July 2016	August 2016	September
Sickness % RN / RM	5.79%	5.39%	5.74%	5.30%	4.43%	2.9%
Sickness % Non Registered	8.99%	8.32%	8.0%	7.23%	5.99%	4.22%

3.4 Average Fill Rates

A continued focus and analysis of the nursing workforce continues to take place at a national level, with particular attention continued on safe staffing levels and the use of temporary and agency staffing. Calderdale & Huddersfield Foundation Trust (CHFT) continues to deliver within this agenda, and manage the complexity of nurse staffing issues with a pro-active and considered approach. Average fill rates are monitored by the Nursing Workforce Strategy Group and by the Associate Directors of Nursing for each division monthly. Average fill rates have decreased over the last 3 months. (See appendix 1 for a summary of fill rates per area). Staffing levels are reviewed at regular periods daily to ensure safe staffing levels are maintained. Ward and service based reviews will be conducted with each area throughout November and December to review establishments and fill rates.

4.0 Recruitment

Recruitment to the Nursing and Midwifery Workforce in 2016 is detailed in table 6 below.

The Nursing Workforce Strategy Group has developed their safe staffing data within the last 9 months to provide an electronic real time solution allowing staffing levels across both sites to be visible. Areas are RAG rated and visible to the flexible

workforce team to ensure priority areas are allocated nurses first. The tool also provides a record of escalated risks and mitigating actions taken

Table 6: Starters and Leavers Nursing and Midwifery Workforce
2015 Nursing Workforce

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

2016 Nursing Workforce

Month	Qualified Hires	Qualified Leavers	Unqualified Hires	Unqualified Leavers
January	22	21	22	5
February	27	19	15	6
March	15	36	4	12
April	28	26	0	3
May	11	23	5	6
June	15	12	6	3
July	13	26	12	7
August	19	20	8	6
September	30	18	17	7
Grand Total	**180**	**201**	**89**	**55**

Recruiting and retaining high calibre nurses has remained a key objective for the Nursing Workforce Strategy Group, but this has remained a challenge at CHFT mirroring the challenges experienced across the UK.

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

Currently the Nursing Workforce Strategy Group is in the process of working to procure recruitment of 75 overseas nurses.

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

Within the last 6 months significant recruitment of non-registered nurses to both permanent posts and the flexible workforce has been completed. All new starters both registered and non-registered are now invited to a nursing workforce induction to optimise their start at CHFT.

4.1 Retention

The nursing workforce has increasingly focused on retention noting that we have experienced an increasing number of leavers in 2015 (Table 6).

Face to face leaver's surveys primarily to qualified nurses within the last 12months have been offered to learn more about the reasons for leaving.

In response to the leaver's surveys:

- the rostering team have reviewed and reported variances from roster guidelines
- Introduced development support sister role to support new starters
- Provided week long induction for new starters
- Developed a new preceptorship and action learning programme for 12 months in line with national frameworks
- Introduced electronic site staffing tool to review staffing levels in real time across both sites
- Commenced preceptorship database
- Offered/advertised more flexible working patterns

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

5.0 Updates NQB guidance and Care hours per patient day (CHPPD)

The 2013 NQB guidance set out 10 expectations & a framework within which organisations & staff should make decisions about safer staffing. The Updated NQB guidance has been brought together with the Carter report finding, to set out the key

principles & tools that provider Boards should use to measure & improve their use of staffing recourse to ensure safe, sustainable and productive services.

In line with updated NQB guidance, CHFT report monthly on CHPPD data and commenced this in June 2016 in line with national framework.
Benchmarking data is not yet available via the efficiency portal. The data will allow the Trust to:

- Review the deployment of staff within specialty and by comparable wards, allowing the Organisation to see unwarranted variation in staffing levels.
- Enable the Trust to identify how it can change/flex staffing establishment – improving patient care & allowing for better financial control.
- Improve productivity of the workforce
- CHPPD data is not reviewed in isolation, but alongside local quality dashboards that include patient outcomes measured alongside workforce & financial indicators

A summary of CHPPD actual & planned for areas in scope at CHFT is detailed in Appendix 1. Further review of this will be completed in the ward based reviews detailed in 3.4 in report.

6.0 Nursing Workforce Review Panels

In April 2016 all nursing workforce models were reviewed using the nursing workforce model review panel which was introduced in October 2015. This ensured a consistent approach was utilised across each division to complete the reviews using standardised guidance and templates. This process is planned to be repeated in January/February 2017 and will be reported on in the following Board report

Specialist nursing reviews and non-ward based areas were predominantly out of scope as these areas will be covered through the annual non-ward based nursing reviews planned for October/November 2016. These will be reported on in the following 2017 Board report

7.0 Conclusion:

This 6 monthly review provides assurances to the Board that the Trust has a growing nursing & midwifery workforce. There remains significant risk to the workforce due to the national shortage of qualified staff & recent level of vacancies, therefore sustainable recruitment & retention to the nursing workforce is a priority.

Appendix 1

	Total CHPPD (Qualified)						Fill Rates Day (Qualified)			Fill Rates Day (Qualified)			No. of Beds	Funded Establishment (Qualified)	Current Vacancies (Oct-16)
	Jul-16		Aug-16		Sep-16		Jul-16	Aug-16	Sep-16	Jul-16	Aug-16	Sep-16			
	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL									
CRH MAU	7.1	5.7	7.6	5.9	7.9	5.8	79.7%	76.8%	70.9%	81.6%	76.7%	78.5%	24	32	8
HRI MAU	6.2	5.5	6.4	5.4	6.6	5.6	84.9%	79.5%	82.6%	93.4%	92.1%	90.4%	24	31	10
WARD 2AB	4.0	3.5	5.4	4.7	7.7	6.5	80.4%	78.4%	76.4%	97.6%	98.7%	99.2%	31	26	6
HRI Ward 5 (previously ward 4)	3.7	3.0	3.8	3.3	4.0	3.3	70.6%	77.2%	73.8%	97.8%	101.1%	96.7%	26	22	4
HRI Ward 11 (previously Ward 5)	4.6	4.0	4.7	4.1	4.9	4.2	78.0%	83.1%	81.5%	98.4%	96.0%	93.8%	24	26	2
WARD 5AD	3.9	2.9	4.1	2.9	4.0	2.9	60.4%	58.5%	61.1%	95.2%	94.4%	96.7%	31	28	11
WARD 5C	3.7	3.5	3.7	3.5	3.7	3.7	92.6%	89.1%	101.4%	99.6%	100.0%	100.0%	16	14	2
WARD 6	4.6	3.9	4.8	4.3	4.7	4.2	76.2%	86.7%	84.1%	98.9%	98.9%	100.0%	23	24	5
WARD 6BC	3.7	3.0	3.9	3.4	3.7	3.3	74.6%	80.5%	78.0%	96.8%	97.6%	100.9%	32	27	10
WARD 5B	3.9	2.8	4.0	3.1	4.0	3.2	57.8%	65.9%	67.1%	100.0%	100.0%	103.3%	16	15	9
WARD 6A	3.6	3.2	3.7	3.2	3.6	3.3	83.3%	79.5%	85.2%	98.4%	97.8%	102.0%	15	15	4
WARD 8C	3.5	3.1	3.8	3.2	3.7	3.1	79.5%	78.8%	76.9%	97.5%	95.8%	98.1%	16	14	8
WARD CCU	15.1	11.2	14.1	9.6	12.0	8.9	77.8%	70.7%	79.6%	68.5%	64.9%	67.9%	13	23	3
WARD 6D	7.1	6.1	7.5	6.4	7.4	6.4	81.2%	79.9%	81.6%	92.5%	93.5%	94.4%	15	21	6
WARD 7AD	3.8	3.5	3.9	3.3	3.8	3.2	91.1%	88.9%	88.3%	92.7%	79.8%	79.2%	26	23	2
WARD 7BC	3.9	3.7	3.9	3.5	3.8	3.2	96.1%	93.4%	89.7%	95.2%	82.3%	76.7%	26	23	5
WARD 8	3.9	3.0	4.1	3.0	3.9	2.9	75.4%	78.0%	78.2%	78.5%	68.8%	69.0%	21	19	7
WARD 12	4.7	3.8	4.7	3.9	4.6	3.3	81.6%	85.8%	73.3%	79.6%	74.2%	70.0%	20	21	2
WARD 17	3.7	3.0	3.9	2.9	3.7	3.0	84.9%	79.8%	84.4%	71.6%	67.2%	73.3%	24	21	7
WARD 21	3.4	2.9	3.5	3.1	3.4	3.0	75.6%	83.6%	79.3%	100.0%	100.0%	100.0%	18	15	4
ICU	26.8	24.2	33.7	28.1	29.5	25.2	89.6%	85.1%	84.8%	90.9%	81.8%	86.1%	13	59	3
WARD 3	3.9	3.6	4.1	3.6	4.1	3.8	85.6%	82.0%	86.4%	100.0%	100.0%	100.0%	15	14	0
WARD 8AB	5.3	3.9	5.5	3.9	5.8	3.6	69.0%	69.6%	58.2%	83.1%	70.6%	70.7%	26	19	6
WARD 8D	5.4	4.9	5.4	5.0	5.2	4.9	97.7%	97.6%	99.9%	83.9%	85.5%	86.5%	14	12	1
WARD 10	3.4	3.1	3.5	3.3	3.4	3.2	87.2%	88.2%	90.4%	100.0%	101.0%	100.0%	20	18	3
WARD 15	3.3	2.7	3.4	2.7	3.3	2.7	88.3%	87.5%	89.3%	72.0%	68.8%	69.5%	27	20	1
WARD 19	4.2	3.4	4.4	3.5	4.2	3.8	71.0%	70.1%	86.7%	96.6%	96.8%	96.7%	22	22	7
WARD 20	3.5	2.9	3.5	2.9	3.5	3.0	75.0%	77.7%	76.1%	94.6%	95.7%	97.8%	30	24	8
WARD 22	2.8	2.6	2.9	2.6	2.8	2.8	86.6%	83.2%	96.9%	100.0%	100.0%	100.0%	23	15	0
SAU HRI	6.6	5.8	7.5	6.6	7.2	6.2	82.4%	83.9%	81.2%	92.8%	94.4%	92.5%	20	25	1
WARD LDRP	25.2	20.0	25.8	20.7	25.2	20.7	79.3%	80.0%	84.4%	79.7%	80.5%	79.9%	16	64	0
WARD NICU	9.5	8.6	9.1	8.1	8.5	8.3	94.4%	88.5%	97.8%	86.0%	88.2%	97.2%	24	33	0
WARD 1D	5.7	5.5	6.6	6.0	6.8	6.3	92.5%	85.9%	92.3%	100.0%	98.9%	94.3%	14	15	0
WARD 3ABCD	12.2	10.4	18.1	14.6	11.5	9.6	82.7%	76.9%	79.5%	87.8%	84.8%	89.5%	35	41	0
WARD 4C	5.2	4.5	5.4	4.7	5.5	4.5	79.2%	79.0%	71.9%	100.0%	100.0%	100.0%	16	15	0
WARD 9	5.1	4.4	5.8	4.9	6.1	5.0	79.1%	73.1%	71.8%	100.0%	100.0%	96.7%	13	14	0
WARD 18	18.3	15.5	11.9	11.5	26.5	21.4	80.7%	94.8%	75.7%	88.7%	99.4%	86.2%	6	12	0
Trust	**5.4**	**4.6**	**5.7**	**4.7**	**5.6**	**4.7**	**80.9%**	**80.4%**	**81.1%**	**89.9%**	**87.6%**	**88.4%**			

Appendix 2

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

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

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

Best Practice	Current CHFT Practice	Proposed Action	Date to be Completed By
Development of clear career structure from Band 5 upwards, including advanced roles, with development opportunities to support.	Competency programme developed & Embedded Project group developing Band 6 and Band 7 programme	Continue to monitor Update (Sep 2016) – development programme running for Band 7's – facilitated by Director of Nursing	Completed Completed
Provision of robust preceptorship for new registrants to support their transition to practice.	Preceptorship programme & policy development Preceptorship database commenced Dec 15 Web based preceptorship training available (minimal uptake) Preceptorship documentation under review	Now in place at CHFT Develop reports from database to utilise data and present updates at Nursing and midwifery committee Promotion of role of preceptor and training Complete review and recommend format	Completed Dec 2016 Ongoing Completed

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

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

Dependency Audit Results - May 2016

	SURGERY										
Ward	Beds	AUKUH Nov 13	AUKUH Jan 14	SNCT Nov 14	SNCT June 15	SNCT Nov 15	SNCT May 16	Current N:B	Direct Patient Care % June 2015	Indirect Patient Care % June 2015	Comments
3	15	1.10	1.20	1.65	1.61	1.14	**1.18**	1.37	71.2 Q 85.8 Un Q	28.8 Q 14.2 Un Q	
10	20	1.10	1.50	1.30	1.41	1.39	**1.55**	1.25	59.9 Q 71.8 Un Q	40.1 Q 28.2 Un Q	
15	27	1.20	1.50	1.32	1.22	1.47	**1.33**	1.02	55.2 Q 78.6 Un Q	44.8 Q 21.4 Un Q	
19	22	1.30	1.60	1.42	1.62	1.53	**1.41**	1.75	54.7 Q 73.6 Un Q	45.3 Q 26.4 Un Q	
20	30	1.30	1.50	1.15	1.26	1.28	**1.44**	1.37	52.2 Q 69.4 Un Q	47.8 Q 30.6 Un Q	
22	23	1.10	1.20	1.18	1.18	1.19	**1.05**	1.23	60.2 Q 66.1 Un Q	39.8 Q 33.9 Un Q	
SAU	25	1.00	0.92	1.30	1.15	1.22	**1.17**	1.31	64.7 Q 49 un Q	35.3 Q 51.0 Un Q	
SAU AMB			-	-	-	0.83	**0.75**				
ICU HRI	8	-	-	3.03	2.30	3.02	**3.39**	4.95	40.7 Q 58.2 Un Q	59.3 Q 41.8 Un Q	
8AB	26	0.80	-	0.68	0.97	0.84	**0.71**	1.22	50.7 Q 66.1 Un Q	49.3 Q 33.9 UnQ	
8D	14	-	-	-	0.91	0.89	**0.92**	1.29	59.9 Q 71.2 Un Q	40.1 Q 28.2 Un Q	
ICU CRH	5	-	-	-	2.45	1.68	**1.60**		61.6	38.4	

	MEDICINE										
Ward	**Beds**	**AUKUH Nov 13**	**AUKUH Jan 14**	**SNCT Nov 14**	**SNCT June 15**	**SNCT Nov 15**	**SNCT May 16**	**Current N:B**	**Direct Patient Care % June 2015**	**Indirect Patient Care % June 2015**	**Comments**
6D	15	1.38	1.13	1.33	-	1.18	**1.30**	2.10	70.3 Q 62.1 Un Q	29.7 Q 37.9 Un Q	
7AD	26	1.59	-	1.54	1.55	1.60	**1.64**	1.50	59.7 Q 67.2 Un Q	40.3 Q 32.8 Un Q	
7BC	26	1.54	1.22	1.48	1.55	7B – 1.62 7C – 1.62	**7B – 1.63** **7C – 1.58**	1.50	73.1 Q 71.1 Un Q	26.9 Q 28.9 Un Q	
21	18	1.43	1.29	1.25	1.44	1.06	**1.28**	1.34	54.7 Q 71.9 Un Q	45.3 Q 28.1 Un Q	
HRI MAU	24	-	1.18	1.12	1.23	1.41	**1.23**	1.91	43.8 Q XXXX	56.2 Q XXXX	
HRI MAU AMB		-	-	-	-	0.30	**0.58**				
CRH MAU	24	1.24	1.15	1.22	1.46	1.47	**1.52**	1.91	60.5 Q 81.3 Un Q	39.5 Q 18.7 Un Q	
CRH MAU AMB		-	-	-	-	0.40	**0.53**				
6	23	-	1.35	1.26	0.98	1.37	**1.34**	1.46	43.5 Q 57.0 un Q	56.5 Q 43.0 Un Q	
2AB	31	1.28	1.24	1.24	1.14	1.26	**1.24**	1.31	54.7 Q 65.2 Un Q	45.3 Q 34.8 Un Q	
8	21	-	1.43	1.66	1.75	1.65	**1.36**	1.31	46.9 Q 61.7 Un Q	53.1 Q 38.3 Un Q	
4	15	1.70	1.54	1.31	1.36	1.44	-	1.7	71.2 Q 67.7 Un Q	28.8 Q 32.3 Un Q	
5AD	31	1.44	-	1.50	1.66	1.69	-	1.53	64.4 Q XXXX	35.6 Q XXXX	
17	24	1.21	-	-	1.21	2.43	-	1.32	62.5 Q 80.9 Un Q	37.5 Q 19.1 Un Q	
5C	16	1.42	1.42	1.59	1.59	1.57	**1.58**	1.42	62.8 Q 85.0 Un Q	38.7 Q 15.0 Un Q	

6BC / CCU		1.13	1.32	1.48	1.80	6BC 1.29 CCU 1.10	**6BC 1.12** **CCU 1.23**	1.49	6B– 54.8% Q 6C – 51.5% 6B–66.7 Un Q 6C–81.1 Un Q	6B – 45.2% Q 6C – 48.5% 6B–33.3 Un Q 6C–18.9 Un Q	
12	20	1.23	1.45	1.31	1.43	1.28	**1.36**	1.38	55.1 Q 65.9 Un Q	44.9 Q 34.1 Un Q	
5	19	0.82	1.38	1.26	1.46	1.20	**1.44**	1.36	55.2 Q 66.0 Un Q	44.8 Q 34.0 Un Q	
CRH CDU		-	-	-	-	1.13	**-**				
HRI CDU		-	-	-	-	-	**1.33**				

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jean Robinson, Lead Infection Prevention and Control Nurse
Date: Thursday, 3rd November 2016	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Quarterly DIPC report - The Board is asked to receive the report on the position of healthcare associated infections	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

none

Background/Overview:

none

The Issue:

none

Next Steps:

none

Recommendations:

none

Appendix

Attachment:

Quarterly DIPC Report October 2016.pdf

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

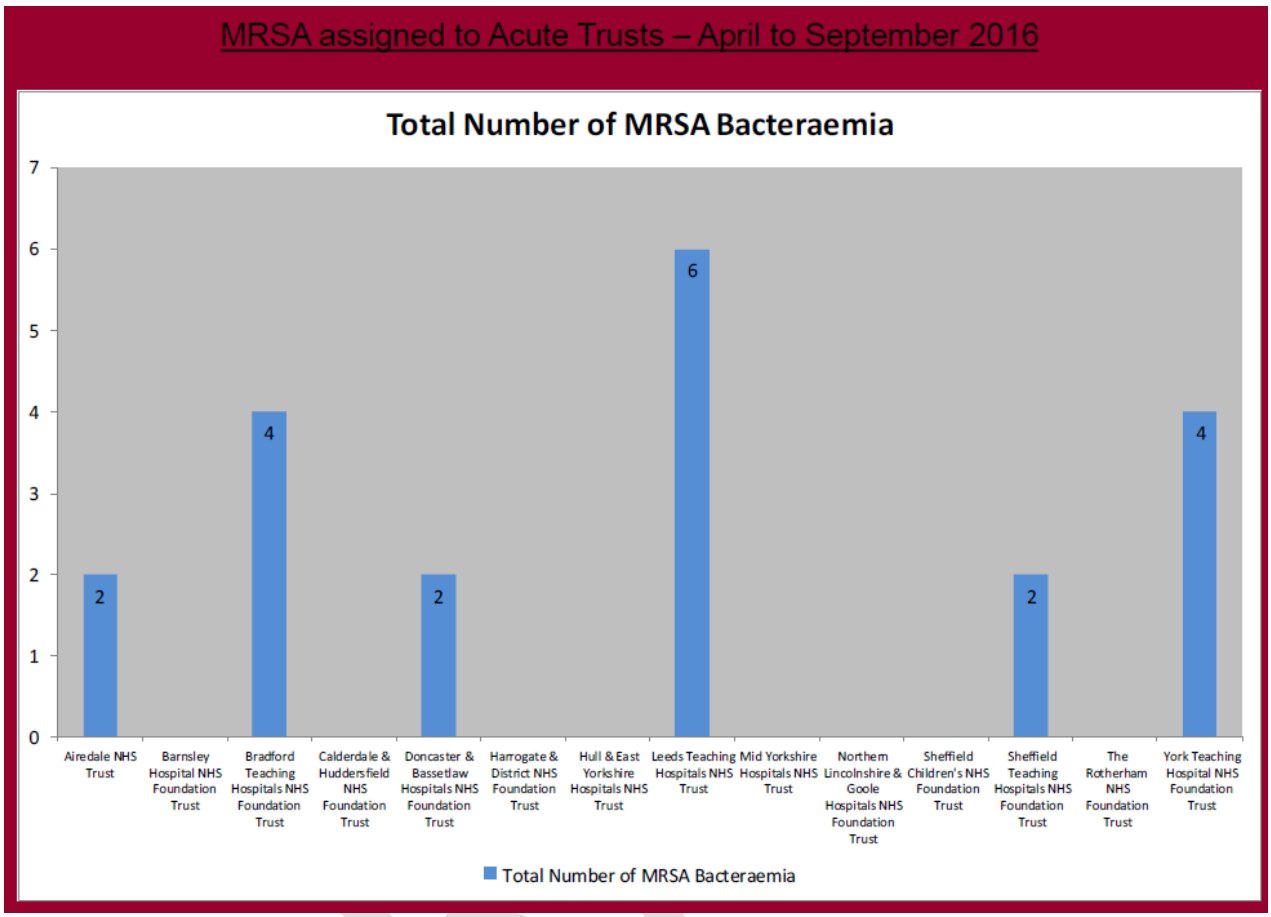
Performance targets

Indicator	End of year ceiling	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	383 days since the last infection
C.difficile (trust assigned)	21	**17**	4 avoidable and 13 unavoidable cases
MSSA bacteraemia (post admission)	9	**6**	Local ceiling – 15/16 outturn
E.coli bacteraemia (post admission)	25	**22**	Local ceiling – 15/16 outturn
MRSA screening (electives)	95%	95.14%	April validated
Central line associated blood stream infections (Rate per 1000 cvc days)	1	**0.5**	Rolling 12 months, August validated data.
ANTT Competency assessments (doctors)	95%	73.4%	5% increase in last 3 months
ANTT Competency assessments (nursing and AHP)	95%	81.7%	See below
Hand hygiene	95%	99.14%	

Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	**95%**	**90.63%**	Data cleansing of MRSA emergency screening to commence as some admissions may fall into the exclusion criteria for screening.
Isolation breaches	**Non set**	104	Compared to 152 for same time period last year
Cleanliness	**Non set**	97.2%	

MRSA bacteraemia:
To the end of September 2016 it has been 383 days since our last MRSA bacteraemia.



MSSA bacteraemias: there have been 6 post-admission MSSA bacteraemia cases during quarter one, against the internal objective of 9.

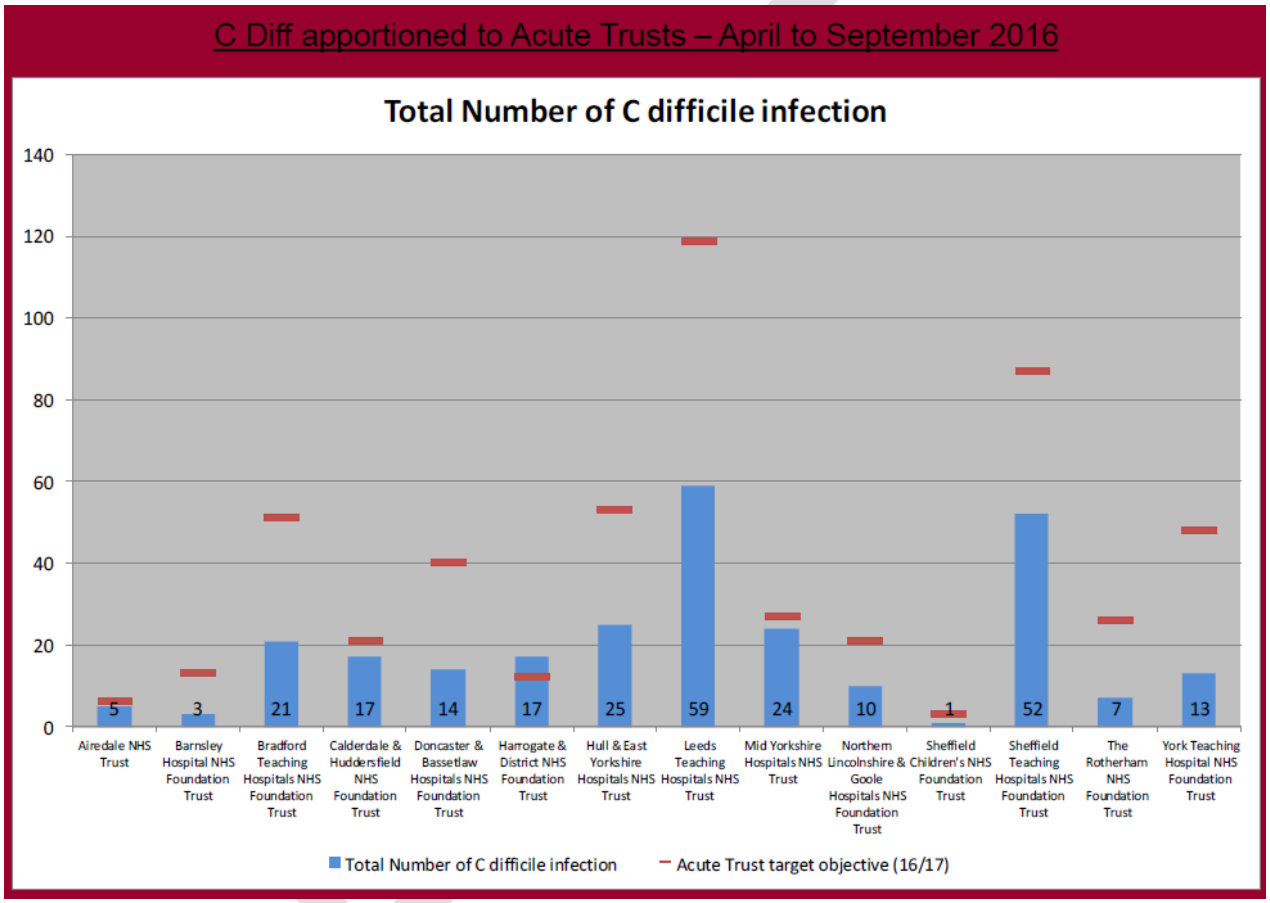
MRSA - Hospital-Acquired Infections (HAIs):
There have been 17 acquisitions this year compared to 10 for the same time period last year.
Wards are informed of any HAIs that occur within their area and are asked to carry out a ward-led investigation; these are presented to the PSQBs. These will be monitored throughout the year.

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

Key themes from the C-diff cases are:

- Delay in obtaining stool specimen
- Completion of the Bristol Stool Chart and assessing patient bowel habits.
- Delay in isolation.
- Antibiotic prescribing
- All cases a sporadic in nature with no dominant strain being identified.

Work is ongoing to improve compliance with the above issues.



Escherichia-coli (E-coli) bacteraemia:

There have been 22 post-admission E-coli bacteraemia cases against the internal objective of 25; a case review was completed in August with no common themes identified.

Outbreaks & Incidents:-

- 3 cases of MRSA acquisition identified on a medical ward in September. This is being investigated as an SI.
- A scabies outbreak on ward 5 HRI which required the closure of the ward and treatment of patients and staff. The ward was closed on the 7th September after a clinical diagnosis was confirmed in one patient who had 'Norwegian Scabies'. Contract tracing was carried out, patients and staff treated and the ward was reopened on the 17th September. Upwards of 180 people staff members and all patients on the ward received prophylaxis.
- There was a period of increased incidence of C-difficile gene detected and toxin positive on the Labour, Delivery, Recovery and Postnatal ward (LDRP) at CRH. The cases were not identical strains but it is unusual to have c-diff in this patient group. The ward was HPV'd and staff training and education on IPC has been provided and is ongoing. Some issues were identified regarding cleaning of the environment and these have been addressed. The provision of 24 hour cleaning in this area is under discussion.

Central Vascular Access Device related bacteraemias

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

Isolation Breaches

There have been 104 isolation breaches since 1st April 2016 compared to 152 breaches for the previous year. The majority of breaches are patients with a previous history of MRSA acquisition on the medical admission units.

The IPCT will continue to monitor isolation breaches; actions to reduce breaches have been included in the HCAI annual action plan, this includes ongoing work with the medical division where the majority of breaches occur.

Audits:

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

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

- 15 of the areas achieved a green rating.
- 16 of the areas achieved an amber rating; actions plans are produced by the ward/department following the audit in order to address any issues or concerns identified.
- One area's received a red rating in September this will be re-audited in October.
- One of the areas the report is pending.

Commode audits: these are carried out by the IPCT on a monthly basis. Commodes on all ward areas are inspected to ascertain whether they have been cleaned according to CHFT policy and are ready for use. The average commode compliance rate is 84.2%.
Compliance issues include urine splashes to the commodes, including some dried urine and faeces.
Results are discussed with ward staff at the time that the audit is carried out and are included on the IPC monthly reports.

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

Link Infection Prevention & Control Practitioners (LIPCPs):
The IPCT continue to provide 4 workshops per year for the LIPCPs for each ward area and department, plus one aimed specifically at community staff, in order to address specific IPC issues and provide relevant information and support.

Training: The IPCT continue to deliver 'right from the Start' and 'Beyond the Basics' training session. Bespoke sessions have been provided to areas identified either during incidents or at the Ward Srs/Matrons requests; 2667 staff has attended training in the last 2 years.

ANTT (Aseptic Non-Touch Technique) training for Assessors:
There are 98 new assessors have been trained since October 2015.
An e-learning package has been purchased and will be rolled out in the next few weeks; this will be initially for all junior doctors and ANTT assessors. All FY1 will be assessed prior to commencing on the wards in August. FY2 will have to provide evidence of previous ANTT assessment or they will have to be assessed within one month of starting in the Trust.

Competency rate is now at 81.69% for nursing staff (previously 80.25%) and 73.35% (previously 68.3%) for Doctors; Trust overall 78.72%. Plans to improve performance includes:- ANTT competency matrix on all divisional PSQBs; additional support provided to ANTT assessors by the IPCNs; new assessors identified and trained on ward/departments are being supplied with their individual clinical area matrix so that they can target those staff who are not ANTT assess, this is proving to have a positive effect.

IPCNs:
The on-call cover has restarted as of 1st October.
The annual Hand Hygiene Roadshow will be held during October.
IPCNs continue to work both proactively and reactively, dealing with potential and actual outbreaks and situations as they arise; informing ward staff of results which require further action such as isolating the patient and maintaining enhanced precautions; carrying out planned training sessions and ad hoc sessions upon request; audit and surveillance; reviewing and updating IPC policies.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Alison Wilson, Head of Compliance & Support Services
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Mid-year health & safety update - Mid year health and safety action plan update.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Health & Safety Committee	
Governance Requirements: Health & Safety legislation places a legal required on the Trust to provide suitable and sufficient health and safety arrangements. This requirement sits alongside CHFT's 1 year and 6 year objectives related to health and safety	
Sustainability Implications: None	

Executive Summary

Summary:

The mid-year report provides an overview of progress made in 2016 towards the annual health and safety action plan. All actions are progressing with a number of target dates extended.

Main Body

Purpose:

The mid-year report provides an overview of progress made in 2016 including changes to a number of target dates.

Background/Overview:

Progress has been made on a number of actions however, further work is required to deliver the remaining actions.

The Issue:

Trust Board are requested to accept the progress report and actions.

Next Steps:

Trust Board are requested to accept the progress report and action plan for 2016/17.

Recommendations:

Trust Board are requested to accept the progress report and action plan for 2016/17.

Appendix

Attachment:

HEALTH SAFETY ACTION PLAN MID YEAR UPDATE Oct 2016 FINAL.pdf

Board Meeting Cover Sheet

Meeting: Board of Directors	**Report Author:** A Wilson, Estates & Facilities
Date: 3rd November 2016	**Sponsoring Director:** Lesley Hill, Exec Director, Estates & Facilities
Title and brief summary: Mid-year Health and Safety Update – Six monthly progress review; health & safety action plan.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Health and safety is monitored and reported to the Health & Safety Committee.	
Governance Requirements: Health and Safety legislation places a legal requirement on the Trust to provide suitable and sufficient health and safety arrangements. This requirement sits alongside the Trusts 1 year and 5 year objectives to improve health and safety in general.	
Sustainability Implications: None	

Executive Summary

Summary:

The mid-year report provides an overview of progress made in 2016 towards the annual health and safety action plan. All actions are progressing with a number of target dates extended.

Main Body

Purpose:

The mid-year report provides an overview of progress made in 2016 including changes to a number of target dates.

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Next Steps:

Trust Board are requested to accept the progress report and action plan for 2016/17.

Recommendations:

Trust Board are requested to accept the progress and action plan for 2016/17

HEALTH & SAFETY UPDATE
OCTOBER 2016

At the request of Trust Board the following provides an interim report relating to progress made to date against CHFT's 2016/17 Health and Safety action plan. The following areas were identified as requiring improvement and this report provides a progress update. The detailed action plan is attached at appendix 1 complete with a mid-year analysis of staff related incidents attached at appendix 2.

Action	**Progress**	**Target Date**
Action No 1 – HEALTH & SAFETY POLICY	The Trust Health and Safety policy is due for review and update by 31st December 2016. A sub-group from the Health and Safety Committee are currently reviewing the policy with a view to the policy being completed by the end of December 2016. The policy will reflect current health and safety practice and take into account the risk management methodology endorsed for CHFT purposes.	The target date of 31st December 2016 will be achieved.
Action No 2 – CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSHH)	COSHH is the law that requires employers to control substances that are hazardous to health with the expectation that employers can prevent or reduce workers exposure to hazardous substances. Training across CHFT is now complete and the Trust holds a complete database of safety data sheets for all hazardous substances used. A sub-group from the Health and Safety Committee, including Divisional representation, will agree an engagement plan to embed COSHH within CHFT's daily activities.	The target date of 31st March 2017 will be achieved.
Action No 3 – RISK ASSESSMENT	The Management of Health and Safety at Work Regulations 1999 place a requirement on organisations to undertake suitable and sufficient risk assessments to identify significant risks to the health, safety and welfare of employees and anyone that may be affected by their activities. Whilst some specific risk assessments are completed for a number of tasks eg: fire safety, moving and handling, substances that may be hazardous to health there are tasks which still require being risk assessed. Risk Assessment training features in the 2 day health and safety training and there are further training dates planned. A helpful health and safety website which includes statistics, shared learning from incidents and risk assessment tools / methodology is being created. Training will also be incorporated as part of the health and safety committee for wider sharing within the organisation.	The target date of 31st March 2017 will be achieved.

Action No 4 – RIDDOR	RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents which include injuries, illnesses and dangerous occurrences. An explanation of RIDDOR incidents is included within the health and safety training and as part of November's Health and Safety Committee Meeting. RIDDOR Training is planned for the Risk Management Team who manage CHFT's incident reporting system (Datix). Simple RIDDOR guidance will also be provided on the health and safety website.	The target date of 31st December 2016 will be achieved.
Action No. 5 - MOVING & HANDLING	Moving and handling training remains a risk to CHFT due to insufficient resources to provide suitable training. Moving and handling staff related injuries contribute to a significant proportion of employee claims and, with suitable training, this could be improved significantly. A paper has been submitted to The Executive Board for support in resolving this issue. The target date of 31st December 2016 will not be achieved given the number of staff to receive training. However, progress will be monitored at monthly health and safety committee meetings to ensure improvements are being made.	Proposal to Weekly Executive Board 27th October 2016. New target date to be added following meeting.
Action No 6 – INSPECTION PROGRAMME NON-CLINICAL AREAS	Health and safety inspections take place in all areas on a monthly basis as part of the PFI arrangement for Calderdale Royal Hospital. A similar programme is in place for Acre Mill and being implemented for HRI Site commencing in the Estates and Facilities division.	The target date of 30th June 2016 was not achieved due to resourcing issues however, a plan is in place to deliver this by 30th November 2016 commencing in Estates and Facilities Division.
Action No 7 – NEEDLE-STICK / SPLASH RELATED INCIDENTS	The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 came into force on 11th May 2013. These regulations are intended to control the risks posed by needles and other 'sharps' in healthcare. Following a focussed HSE campaign in healthcare organisations (excluding CHFT) the Health and Safety Committee have tasked divisions to utilise the HSE audit tools to review their current practice. This action is supported by the sub-group who will work with Divisions when auditing their practice. Support is also being explored with CHFT's	The target date was not achieved due to the change in the original action and the time necessary to implement the audit. The target date is changed to 31st March 2017.

	supplier of sharps disposal units who carry out an annual audit on the safe use of sharps bins.	
Action 8 – SAFE MANAGEMENT OF MEDICAL DEVICES	The Medical Devices Regulations 2002(11) require all medical devices to carry the CE marking which is captured within the Medical Devices Management Policy. The Medical Engineering department provide an important service to the Trust and follow the MHRA document "Managing Medical Devices Guidance for healthcare & social services organisations". A significant risk relating to the maintenance of, and inventory of, medical devices was identified in 2015 and some elements had previously been identified during an audit by West Yorkshire Audit Consortium in 2014. Significant effort and additional resources have been provided to the Medical Engineering Team who are now managing the risk accordingly and, due to the controls implemented, have seen the risk reduce from a 15 to a 12). A robust planned preventative maintenance programme is in place with over 90% of high risk devices maintained and a target of 98% by 31st March 2017. Monthly reports provided to the Health and Safety Committee and demonstrate an increasing level of compliance. Areas of concern are escalated to the Quality Committee.	A target date of 31st March 2017 is in place.
Action No 9 – HEALTHCARE SPECIFIC HEALTH & SAFETY TRAINING	A programme of health and safety training has been provided to Supervisors and Managers throughout CHFT however, a significant number of staff (approx. 200 staff) still require the training. The training has been refreshed to include a CHFT flavour and includes learning from CHFT incidents, staff related injury statistics, CHFT risk methodology and regulatory specific information. During the last phase of training attendance varied due to significant work pressures. However, with more support from the Divisions and advanced notice of training staff should be in a position to attend training.	The target date of 30th June 2016 was not achieved due to poor CHFT attendance. A refreshed training plan will recommence in Q3 and roll out during Q4. This could continue into Q1 2017/18 depending on other training demands.
Action No 10 – APPROPRIATE	Improved attendance from staff side is apparent at monthly health and safety committees with staff side reps rotating attendance and bringing along items for	Target date of 30th June 2016

STAFF SIDE REPRESENTATION AT HEALTH & SAFETY COMMITTEE	discussion and sharing. Further work is required to ensure all Staff Side Reps can access health and safety information / minutes on a regular basis which will be supported by the development of the health and safety website.	achieved.

APPENDIX 1 – Health and safety action plan

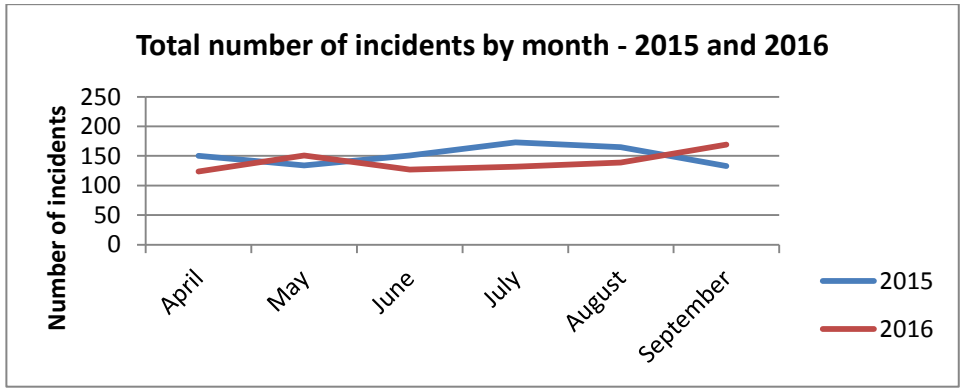
	WHAT	WHO	WHEN
1.	Review and update CHFT's Health and Safety Policy	Exec Director / H&S Committee	31.12.16
2.	Fully implement COSHH management and awareness training for Divisions and all staff	Health & Safety Advisor	31.3.17
3.	Embed risk assessment knowledge and understanding into the organisation.	Health & Safety Advisor / Risk Management	31.3.17
4.	Improve understanding of RIDDOR Injuries, illnesses and dangerous occurrences to ensure accurate reporting and learning.	Health & Safety Advisor / Risk Management	31.12.16
5.	Review moving and handling arrangements within the Trust to ensure a robust training and recording.	Medical Division / Health & Safety Advisor	31.3.17
6.	Introduce inspection programme for non-clinical areas.	Health & Safety Advisor / H&S Committee	30.11.16
7.	Introduce a Needle-stick Injury working group to investigate needle-stick & splash related incidents to embed learning within the Trust.	H&S Committee / Occupational Health / Infection Control	31.3.17
8.	Ensure robust arrangements are in place for the safe management of medical devices and provide monthly updates to the Health & Safety Committee.	Head of Medical Engineering / H&S Committee	30.6.16
9.	Provide a two day health and safety training programme for Managers / Supervisors.	Health & Safety Advisor.	31.3.17
10.	Ensure appropriate staff side representation at Health & Safety Committee	Exec Director / Ass. Director of Workforce Organisational Development	30.6.16

APPENDIX 2

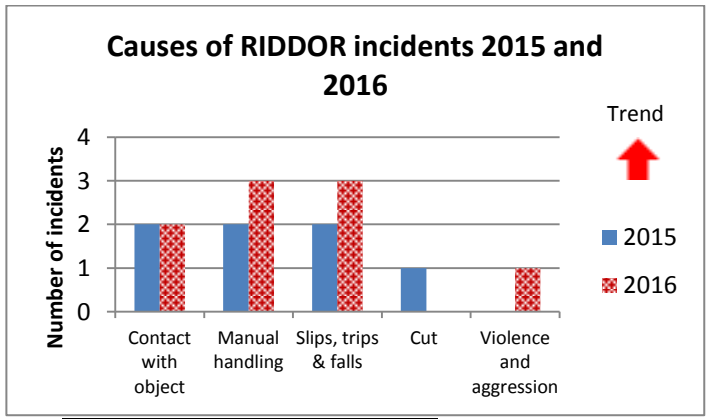
Health and safety six month incident review report

This report is a review of the numbers and types of incidents that have occurred within the Trust over the last 6 months (April to September 2016), in comparison to the same period in 2015.

1. Total number of incidents



2. RIDDOR incidents

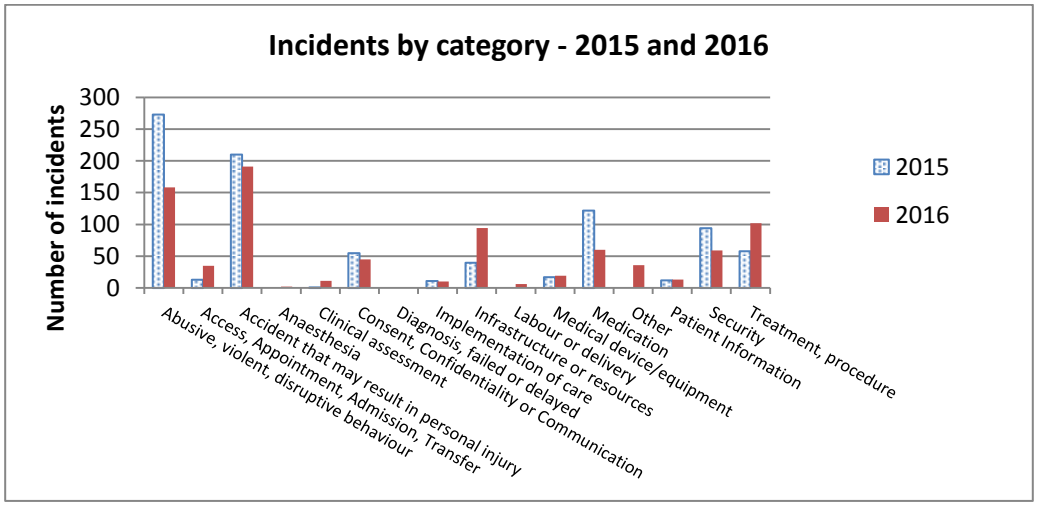


RIDDOR reason	2015	2016
Over 7 days absence	6	7
Specified injury	1	2
TOTAL	7	9

*Total RIDDOR incidents 2015 – **7** 2016 - **9***

All specified injuries were fractures due to slips, trips or falls

3. Incidents by category



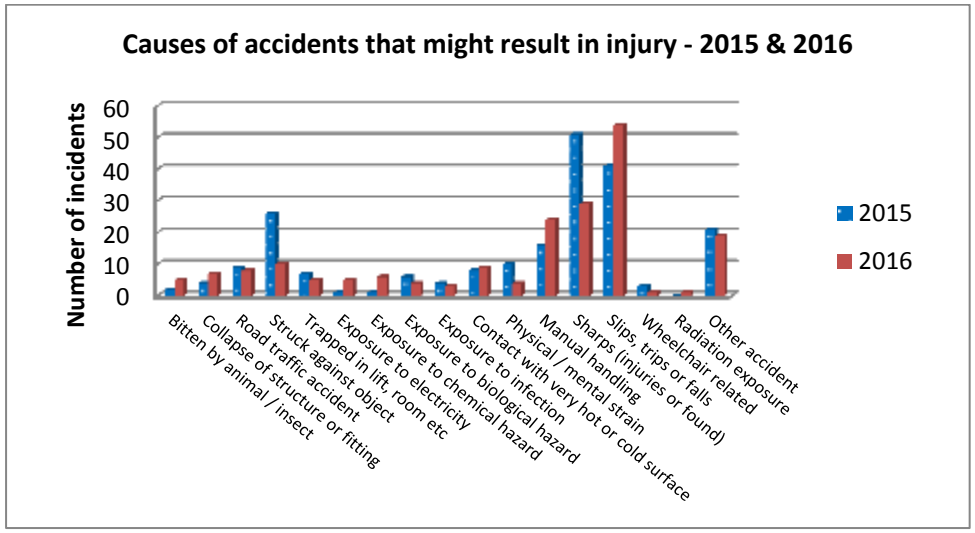
- *Violence & aggression*
- *Medication issues*
- *Security*

- *Access, appointment, admission, transfer*
- *Infrastructure or resources*

4. Incidents by Division

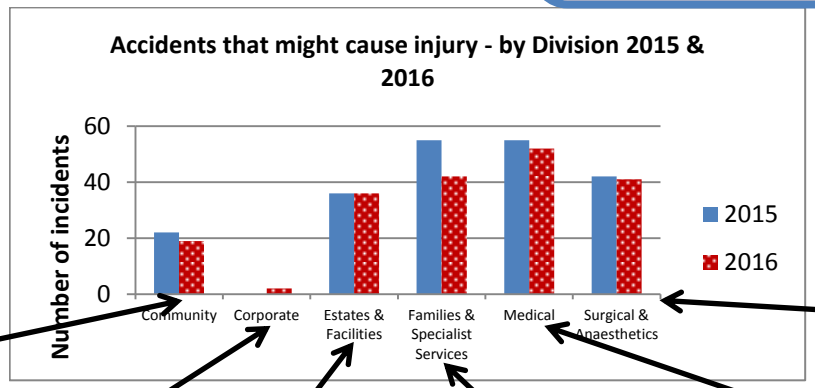
Division	Apr – Sept 2015 Number of incidents	Apr – Sept 2016 Number of incidents	Incident trend
Community	68	73	↑
Corporate	9	11	↑
Estates & Facilities	76	81	↑
Families and Specialist Services	270	177	↓
Medical	340	308	↓
Surgical & Anaesthetics	143	192	↑
TOTAL	906	842	↓

5. Accidents that may result in injury



- *Slips, trips, falls & collisions*
- *Manual handling (loads)*
- *Exposure to chemical hazard*
- *Exposure to electricity*

- *Contact with sharps*
- *Struck against object*



COMMUNITY
Main accident causes in 2016 are slips, trips & falls (4) and animal bites (4)

CORPORATE
- 2 incidents in 2016, 0 in 2015
- 1 RIDDOR in 2016 due to slips, trips or falls

ESTATES & FACILITIES
- Main types of incidents: Slips & trips(10) and vehicle accidents(6).
– 2016 increase in electricity and manual handling incidents

FAMILIES & SPECIALIST SERVICES
- 2016 main accident types: Slips & trips (11) and sharps (9)
- Marginal fall in sharps incidents

SURGICAL & ANAESTHETICS
- Slips & trips (13) and sharps were main incidents in 2016

MEDICAL
- 2016: Sharps (18) and manual handling main incident types
- 200% increase in sharps incidents

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: INTEGRATED BOARD REPORT - The Board is asked to receive and approve the Integrated Board Report for September 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board 27/10/16	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

September's Performance Score has improved to 68% for the Trust. The Trust has now seen an improvement of 14 percentage points since April. Within the Safe domain % Harm Free Care has gone below target hence domain has edged to an AMBER rating. 3 of the 6 domains improved in month with Safe, Caring and Responsive just short of Green ratings.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

Board Report Sept 16.pdf

Board Report

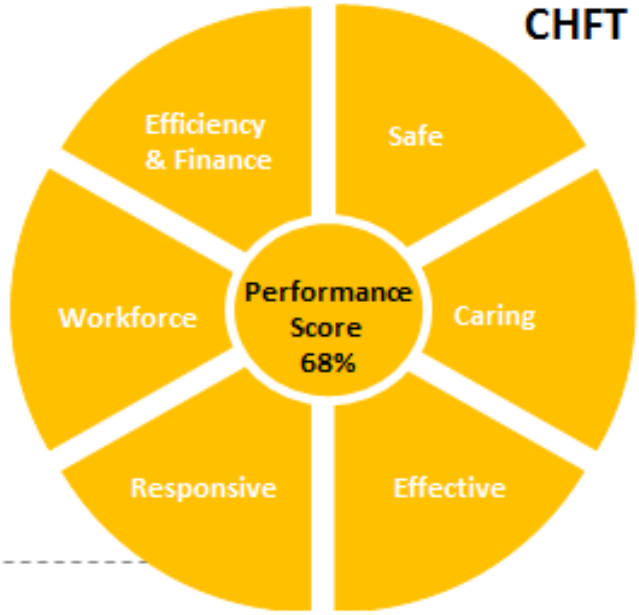
September 2016

Performance Summary

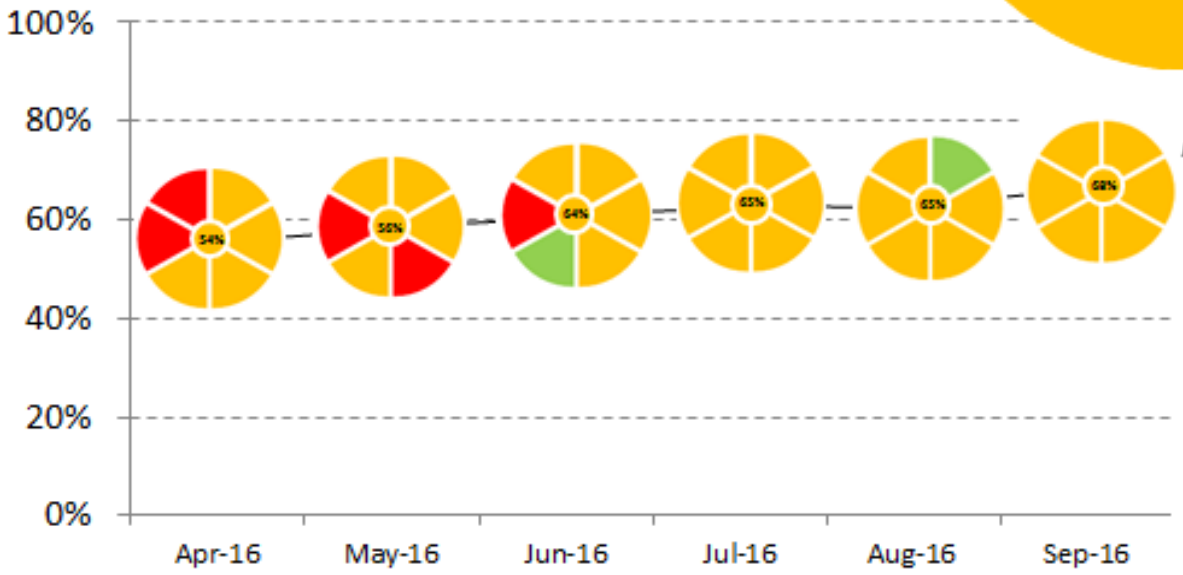
Most recent month's performance

RAG Movement

September's Performance Score has improved to 68% for the Trust. The Trust has now seen an improvement of 14 percentage points since April. Within the **Safe** domain % Harm Free Care has gone below target hence domain has edged to an AMBER rating. 3 of the 6 domains improved in month with **Safe, Caring** and **Responsive** just short of Green ratings.



Total performance score by month



September Score by Domain

Safe	73%	↓
Caring	70%	↑
Effective	67%	↑
Responsive	72%	↓
Workforce	63%	↑
Efficiency & Finance	63%	↓
Performance Score	68%	↑

Regulatory Targets

CDiff Cases 3 (0)	Cancer 62 day Referral to Treatment
Avoidable Cdiff	Cancer 62 day Screening to Treatment
ECS 4 hours 94.38% (95%)	Cancer 31 day targets x3
RTT Incomplete Pathways	Cancer 2 Week Referral to Date first seen
Data Completeness Community Care x3	Cancer 2 week Breast Symptoms

Other Key Targets

VTE Assessments	FFT targets x6
Never events	FFT A&E x2 FFT OP 91.5% (95%)
MRSA	FFT Community 87% (96%)
SHMI 113.8 (100)	Stroke % admitted 4 hours 69.09% (90%)
HSMR 106 (100)	Diagnostics 6 weeks
Emergency Readmissions GHCCG 7.4% (7.05%)	Net surplus/ (deficit) £80k
% Complaints closed 42% (100%)	Sickness 4.43% (4%)

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.4%	98.2%	↓	96%
	Inpatient Complaints per 1000 bed days	2.1	2.5	↑	TBC
EFFECTIVE	Average Length of Stay - Overall	5.0	5.4	↑	5.17
	Delayed Transfers of Care	2.21%	2.49%	↑	5%
	Green Cross Patients (Snapshot at month end)	109	104	↓	40
	Hospital Standardised Mortality Rate (12 months Rolling Data)	106.12	108.67	↑	100
	Theatre Utilisation (TT) - Trust	83.43%	84.13%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.65%	0.54%	↓	0.6%
	Emergency Care Standard 4 hours	94.38%	94.66%	↓	95%
	% Incomplete Pathways <18 Weeks	96.10%	95.49%	↑	92%
	62 Day GP Referral to Treatment	89.9%	89.6%	↑	85%
SAFE	% Harm Free Care	93.71%	95.14%	↓	95.0%
	Number of Outliers (Bed Days)	838	997	↑	495
	Number of Serious Incidents	7	4	↓	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: There has been a significant improvement in month in % of patients with #NoF operated on in 36 hours. The month's performance is significantly above the national average.

Improved: Continued improvement in the RTT position meaning that the Trust is now performing better than all other benchmarked Trusts. Further work continues in validating patient pathways and improving the timeliness of patient treatment.

Improved: Still Birth Rate has reduced in month to 0.20%. Stillbirth Rate (excluding known abnormalities) is now 0.30% for the year.

MOST DETERIORATED

Deteriorated: % Harm Free Care - There has been a reduction in the % Harm Free Care, especially noticable in the Medicine division.

Deteriorated: 38 Day Referral to Tertiary. At 27.3% lowest position since August 2015.

Deteriorated: % Stroke patients scanned within 1 hour of hospital arrival. At 29.1% lowest position since March.

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

ACTIONS

Action: ADN for Medicine has commissioned a deep dive into the Harm Free Care measure to look into ongoing trends and improvement plans.

Action: Action plans requested from all specialties to secure required improvement from October. A deep dive in Urology has highlighted potential areas to reduce the pathway, this speciality is a high contributor to breaches. No agreement on IPT has yet been reached across West Yorkshire.

Action: Pilot initially took delivery significantly beyond national guidance. Agreement has been reached that delivers compliance with national guidance and should show improvement in forthcoming months.

Arrow direction count ↔ 1 ↑ 10 ↓ 8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	42,614	42,583	↓	
Sickness Absence Rate	4.1%	4.4%	↑	4.0%
Turnover rate (%) (Rolling 12m)	12.3%	13.7%	↑	12.3%
Vacancy	376.4	459.0	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4	80.00%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4	61.00%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	£2.25	£1.94	
Expenditure vs Plan var (£m)	-£2.68	-£2.28	
Liquidity (Days)			
I&E: Surplus/(Deficit) var (£m)	£0.08	£0.12	
CIP var (£m)	£2.08	£1.41	
FSRR	2	2	
Temporary Staffing as a % of Trust Pay Bill			

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care/All Falls -** There has been a reduction in the % Harm Free Care, especially noticable in the Medicine division. ADN for Medicine has commissioned a deep dive into the Harm Free Care measure to look into ongoing trends and improvement plans. The Lead Nurse for Falls is embedding the improvement work around Safety Huddles and education in relation to fall prevention equipment and this will continue over the next 6 months and is linked to the safety huddle CQUIN. The roll out of the falls five bundle has commenced across all medical wards focusing on 5 quality interventions to reduce the risk of falls . The Top ten wards with falls have been identified and there is a plan to roll out sleep hygiene (an initiative noted from a 'Go See' visit). • **Maternity - % PPH ≥ 1500ml/Major PPH - Greater than 1000mls** - In-month performance is stable and continues to be marginally above Trust target. • **Number of Category 4 Pressure Ulcers Acquired at CHFT -** There have been 3 Category 4s in the period to the end of August. A new weekly PU panel has been implemented to mirror the orange incident panel. This will result in PUs accurately validated weekly and learning captured and actioned.
Caring	• **Complaints closed within timeframe** - 71 complaints were closed in September, which is a 20% increase from August. Of the 71 complaints that were closed in September 42% were closed within target timeframe which is an 18 point decrease from August. • **Friends and Family Test Outpatients Survey** - % would recommend has improved in month to its highest position since December 2015 although at 91.5% is still below the target of 95%. Further work to continue as part of directorate action plan to achieve Q3 improvement trajectory (December 16). • **Friends and Family Test Community Survey** - FFT continues to report 2% of people would not recommend services. To provide alternative methods of responding to the FFT the Community division has included paper forms in Outpatient areas and has ensured that the webform is available to all staff using laptops. An options paper for FFT recording will be presented at October Board and will be shared at PRM with a recommendation.
Effective	• **Total Number of Clostridium Difficile Cases -** There have been three clostridium Difficille cases reported in month however all cases have shown as unavoidable following RCAs that have been undertaken. YTD 17 against an annual plan of 21. • **Number of E.Coli - Post 48 Hours** - There were 4 post 48 hours E-Coli Bacteraemias reported in September, 2 of these occurred on surgical wards (ward 15 and ICU). An analysis of both incidents was undertaken and there were no common themes or links between the 2 cases. • **Local SHMI - Relative Risk** (12 months Rolling Data April 15 - March 16) - Latest figures are still at 113. There is only one diagnostic group alerting in this release which is Acute Cerebrovascular Disease. • **Hospital Standardised Mortality Rate** (12 months Rolling Data August 15 - July 16) - has shown a further fall to 106. The weekday/weekend split shows a 7 point difference. 111.87 weekend against 104.34 weekday. • **Mortality Reviews** - The completion rate for Level 1 reviews stands at 23% of August deaths having had a corporate level one review. This reduction was anticipated as internal processes are adapted to capture more robust data from Q3 onwards. • **Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG** - Further improvement in month. Community division has agreed, with Locala, to undertake an audit of readmissions.

Background Context

New compliance regime

Following the introduction of the Single Oversight Framework (SOF) additional indicators are now included in this report:
Emergency C-Section Rate
Executive Turnover (%)
Proportion of temporary Staff
Hospital Bed Days per 1000 population - Adults
Emergency Hospital Admissions per 1000 population - Adults

The Trust held a 2 day Planning Workshop in October to jointly develop Divisional plans for 17/18 with a view to 18/19 looking at the management of interdependencies within the revised planning timeline as set nationally.

Activity has seen growth in month 6 across all points of delivery, with the exception of planned daycase and elective where activity is below planned levels.

A&E has seen activity continue to over-perform in month 6 and has seen an increase from month 5. Activity is 6% above the month 6 plan and cumulatively 3.7% above plan.
Non-elective activity overall is 0.1% above the month 6 plan which is an increase from month 5 when activity was 2.2% below plan. The in-month over-performance is within non-elective long and paediatric short stay admissions. Cumulatively activity is 0.6% below planned levels due to emergency long stay activity. The impact is that the Trust has continued to rely on additional capacity in September with 14 beds open above plan and associated staffing challenges

CCGs are currently working on demand management strategies which will need to be considered alongside new capacity plans internally. Through recent planning workshops options to support Commisioners with demand reduction strategies have been explored; this is also being discussed across West Yorkshire providers where the picture locally is reflected with the aim of maximising consistency.

Planned day case and elective activity deteriorated against plan in month 6. This is driven by continued under-performance within inpatient elective activity. Some related to Q1 issues and some reflecting a transformation from inpatient to day case not yet reflected in plans.

The Safer programme continues with progress in ambulatory and Frailty via the collaboratives and our own internal teams enabling effective management of some of the increased demand and retaining a positive conversion rate from AED.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours -** September's position was the 95% target at 94.38% with 94.4% performance for Q2. An ED escalation SOP is in place and is being followed to ensure that any ED delays are addressed in a timely manner. • **A&E Ambulance 60+ mins** - 1 Patient with a YAS turnaround of over 60 minutes. An RCA is being completed. The Trust is exploring whether the ED can create a receiving area for YAS patients. • **Stroke -** Patients admitted to a stroke ward within 4 hours and scanned within 1 hour not being achieved. The division of Medicine will submit a business case to continue the pilot with Radiology as a permanent service. To ensure beds are available the Medical Division is running a pilot on 7B to look at reducing LOS. This involves all members of the MDT and will make beds available so that all patients have access to the unit. • **RTT pathways over 26weeks** - numbers are improving as divisions continue further validation. • **38 Day Referral to Tertiary** is now at its lowest position since August 2015 with a number of late referrals in September. A deep dive in Urology has highlighted potential areas to reduce the pathway. • **Appointment Slot Issues on Choose & Book** - The Trust's position stands at 16.6% which compares favourable with its peers. There has been a reduction of 656 referrals for patients awaiting appointment from the July position of 1824. The top 4 specialties for E-referral ASIs backlog are: Ophthalmology, Respiratory, General Surgery and Colorectal. Specialty action plans are in place to continue to reduce the ASIs over the forthcoming weeks and access meetings have restarted within the Surgical Divison.
Workforce	• **Sickness Absence rate** has improved in month and is now achieving its short term sickness target. • **Return to work Interviews have** improved again in month to 66% but are still some way short of 100% target. • **Mandatory Training and appraisal -** Information Governance, Fire Safety, Infection Control and Manual Handling. Currently just Manual Handling is off plan. Appraisal activity is now measured against planned activity. A more rigorous approach is being adopted at Divisional Performance Review Meetings to emphasise the need for improved appraisal coverage and quality.
Efficiency/ Finance	• **Finance:** Year to date: The financial position stands at a deficit of £9.67m, a favourable variance of £0.08m from the planned £9.74m. The in month, clinical contract activity position is above plan albeit at a slightly lower level that that seen last month. This drives an overall income position at Month 6 which is £2.25m above planned levels in the year to date. The in-month overperformance is seen across non electives, outpatients and A&E attendances. The non elective increase is due to success in discharging long stay patients. It continues to be the case that, in order to deliver activity and access standards across the Trust, there is a reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.87m, compared with £2.17m last month. This improvement brings the agency expenditure close to a revised trajectory submitted to NHS Improvement. This trend will need to be continued in the remainder of the year to stay in line with the expectations of the regulator and secure the overall financial forecast. • **Theatre Utilisation** has stabilised around 84%. Having discussed the appropriateness of the 92.5% target it was agreed at Surgical Performance Review meeting to adopt more suitable targets for each theatre which will allow sufficient turnaround to clean theatres and prevent overrunning.
CQUIN	• **Staff Well Being Flu Vaccination** - The campaign is underway, the first two weeks have seen over 2,000 colleagues vaccinated. The Trust is projected to perform above the partial payment threshold. It is too early to state whether the full CQUIN will be achievable.
Activity	• **Activity** has seen growth in month 6 across all points of delivery, with the exception of planned daycase and elective where activity is below planned levels.

Background Context

The Trust has developed an improvement plan for agency spend 'Safer Staffing Workforce Utilisation and Efficiency Programme 2016/17'. The purpose of this plan is to define the overall improvements and a consistent model for medical, nursing, midwifery and AHP workforce utilisation, and efficiency. The plan links to the broader Workforce & Organisational Development work to improve recruitment, retention and staff engagement.

The Surgical Division has been struggling with Medical capacity where there has been difficulty in recruitment. In addition there has been limited capacity within the management team and a shortfall of key staff in critical areas such as theatres restricting the Division's ability to improve performance.

Within the Community Services division there has been a significant piece of work undertaken through September to support a collective understanding between CHFT and commissioning colleagues of the services that are within the block contract. This supports the contract agreement for the next two years. All services within the block contract arrangements have completed templates describing in detail the service that is delivered, the demand profile and the activity undertaken within the service. This information has been shared with commissioners and the division is awaiting feedback.
The scope of a service review within MSK has been agreed and is commencing in October.

Direct access and unbundled outpatient imaging has continued to see a large over-performance within MRI and Ultrasound with in-month performance 6.4% above plan. Diagnostic testing has seen a significant further increase in month 6 and is 4.4% above plan. This continues to be mainly driven by a large increase within Biochemistry and Haematology. Adult Critical Care is below plan in month 6 by 5.2% which is a decrease from the over-performance seen in month 5 which was driven by the discharge of 2 long-stay patients. NICU has seen an increase in activity in month 6 and is 22% above the month 6 plan. Rehabilitation is in line with planned levels for month 6. This is a small reduction in the over-performance seen in month 5 of 4.2%. Cumulatively activity is 6.7% above plan and continues to be driven by Calderdale activity.

Outpatient activity overall has continued to see an increase and is 1.8% above the month 6 plan. This is a reduction in the level of over-performance seen in month 5 when activity was 4.7% above plan. The over-performance in-month is across both first and follow-up attendances including procedures. The specialties with the more significant over-performance within first attendances are ENT, T&O, Paediatrics, Rheumatology, Dermatology and Gynaecology. General Surgery has continued to under-perform. Cumulatively outpatient activity is now 2.5% above plan however with demand continuing at high levels this is not resulting in a reduced waiting list size.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: FINANCIAL NARRATIVE - MONTH 6 - NHS IMPROVEMENT SUBMISSION - The Board is asked to approve the Month 6 Financial Narrative	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee - 1.11.16	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve Month 6 Financial Narrative

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve Month 6 Financial Narrative

Appendix

Attachment:

NHSI Financial Commentary Month 6 1617 final for submission.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 6 SEPTEMBER 2016, NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

The notes below provide a management commentary on the financial position of Calderdale & Huddersfield NHS Foundation Trust at the end of September 2016.

The report is structured into three sections to describe:

- Key messages;
- Detailed commentary for the period with variance analysis against the annual plan as submitted to NHSI;
- Financial Sustainability Risk Rating (FSRR) and forecast.

1. Key Messages

The year to date financial position stands at a deficit of £9.67m, a favourable variance of £0.08m from the planned £9.74m. The in-month, clinical contract activity position is above plan albeit at a slightly lower level than that seen last month. This drives an overall income position at Month 6 which is £2.25m above planned levels in the year to date. The in-month over-performance is seen across non electives, outpatients and A&E attendances. The non elective increase is due to success in discharging a number of long stay patients.

It continues to be the case that, in order to deliver activity and access standards across the Trust, there is a reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.87m, compared with £2.17m last month. This improvement brings the agency expenditure in line with a revised trajectory that has been discussed with NHS Improvement.

Month 6, September Position (Year to Date)

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	185.11	187.35	2.25
Expenditure	(182.09)	(184.63)	(2.54)
EBITDA	**3.02**	**2.73**	**(0.29)**
Non operating items	(12.77)	(12.25)	0.51
Deficit excluding restructuring costs	**(9.74)**	**(9.53)**	**0.22**
Restructuring costs	0.00	(0.14)	(0.14)
Deficit including restructuring costs	**(9.74)**	**(9.67)**	**0.08**

- EBITDA of £2.59m, an adverse variance of £0.43m from the plan.
- A bottom line deficit of £9.67m, a £0.08m favourable variance from plan.
- Delivery of CIP of £6.73m against the planned level of £4.65m.
- Contingency reserves of £1.0m have been released against pressures.
- Capital expenditure of £7.98m, this is below the planned level of £11.82m.
- A cash balance of £2.95m, this is above the planned level of £1.94m, supported by borrowing.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

The year to date activity over performance sits alongside strong CIP delivery, achieving £2.08m in advance of the planned timescale. The combined benefit has not flowed through in full to the bottom line but has rather absorbed the activity related expenditure pressures and one off issues such as the Junior Doctors' strike action. However, of the £2m contingency reserves planned for in the year to date, £1m has not been released but rather has been held back to mitigate against pressures in the latter part of the year. This lesser reliance on contingency reserves in the year to date continues to be supported by the income over performance and CIP delivery.

In summary the main variances behind the year to date position, against the reforecast plan are:

Operating income	£2.25m favourable variance
Operating expenditure	(£2.54m) adverse variance
EBITDA	**£0.29m adverse variance**
Non-Operating items	£0.51m favourable variance
Restructuring costs	(£0.14m) adverse variance
Total	**£0.08m favourable variance**

Operating Income

There is a £2.25m favourable variance from the year to date plan within operating income. In last month's report it was explained that £1.88m of the then £3.82m favourable income variance was driven by a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. This discrepancy does not exist at month 6 due to this being a quarter end, the timing difference is caught up.

The £2.25m positive variance therefore represents the favourable trading position. Full achievement of financial and operational metrics in the year to date against the STF criteria means that the related funding of £5.65m is in line with plan. Whilst there has been a slight under-performance against the A&E trajectory in the most recent months, this is overridden by the cumulative year to date performance which is above the agreed year to date trajectory. This will remain a challenging target for the Trust due to activity levels described below. The Trust is however seizing this challenge having been selected as an 'Accelerator' site for A&E performance.

NHS Clinical Income

Within the £3.82m favourable income variance, NHS Clinical income shows a favourable variance of £3.06m. As described above, overall activity has had a strong performance in month which augments the position seen in the year to date. The breakdown by point of delivery is as follows:

- Elective inpatient performance is 1.1% (72 spells) below the month 6 plan whilst day case activity is in line with planned level. Cumulatively, the day case over performance offsets the shortfall on elective activity.

- Non-elective activity overall is 0.1% (42 spells) above the month 6 plan and cumulatively is 0.6% (163 spells) below planned levels. Increased discharges of long-stay patients have been seen in-month.

- A&E has seen activity has continued to over-perform and has seen an increase from month 5. The month 6 activity is 6% (727 attendances) above plan and cumulatively is 3.7% (2,721 attendances) above plan.

- Outpatient activity overall has continued to see an increase above the month 6 plan by 1.8% (518 attendances). The over-performance in month is across both first and follow-up

attendances, including procedures. Cumulatively activity is 2.5% (4,327 attendances) above plan.

- Adult critical care bed day activity is above plan by 219 bed days in the year to date which is driven by the discharge of 2 long-stay patients in month 5, coupled with the previously reported discharge of a 5-organ supported very long stay patient in quarter 1. NICU performance is also above planned levels.

The clinical contract PbR income position is driven by these areas of activity over performance as well as Rehabilitation and Diagnostic testing & imaging. The non elective activity under-performance is compensated in income terms by case mix changes.

This position continues to reflect an over-performance against the Trust's year to date plan and a greater over-performance against contracts with the Trust's Commissioners. The 2016-17 contracts with the Trust's commissioners incorporated a lower level of activity and income to the Trust plan in the main due to the CCG QIPP plans, Trust CIP plans and a differing view of baseline activity levels. The Trust remains in close contact with commissioners to highlight this position both from a point of view of securing cash relating to the overtrades in a timely manner and also to guard against unexpected challenges. Whilst the Trust is mindful of the affordability pressures to the health economy as a whole, no provision against PbR contractual challenges is reflected within the position.

The 2016-17 plan was inclusive of £1.97m of System Resilience Group (SRG) funding which in previous months had been reflected in line with planned levels. Whilst the Trust is continuing to pursue this full value, commissioners are looking to hold back this funding on the grounds of affordability. The projects that are supported within the Trust with this funding are committed and embedded recurrently to aid improved patient flow and capacity in the context of pressures in the social care sector. A £0.43m level of reduction has now been reflected within the month 6 and year-to-date position, £0.86m reduction in the full year forecast, which contributes to the need for recovery plans and additional CIP schemes. The residual £1.1m funding full year is assumed within the current forecast but at high risk based on the latest commissioner position.

Other income

Overall other income is below plan by £0.81m in the year to date. This is mainly due the transfer of the West Yorkshire Audit Consortium to another host provider, which has reduced income by £0.47m cumulatively. The Trust also planned for Bowel Scope income as part of non-NHS Council funding which changed contractually to be funded through NHS England, showing below plan within non-NHS Clinical income, off-set by over-performance within NHS Clinical income at a cumulative value of £0.33m.

Operating expenditure

There was a cumulative £2.54m adverse variance from plan within operating expenditure across the following areas:

Pay costs	(£0.91m) adverse variance
Drugs costs	£0.30m favourable variance
Clinical supply and other costs	(£1.93m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £0.91m higher than the planned level in the year to date. £19.94m was spent on pay in-month, which has stabilised from a high of £20.32m last month to come in line with the underlying run rate seen in June and July.

For 2016/17 the Trust was originally given a £14.95m ceiling level for agency expenditure by NHSI. In-month, the Trust was given the opportunity to restate the agency trajectory for the year with the clear expectation that this would form a commitment by the Trust to reducing the agency costs. The

revised full year position is to reduce the run rate in the second half of the year and contain spend within a £24.31m total. The Trust understands that it will now be held to this commitment.

In overall terms at the end of Month 6 the Trust was carrying 390 vacancies, a rate of 7% of the total establishment. This number is a decrease for the third month in succession (down from 460, 8% in July), however, the highest vacancy rates continue to be in directly patient facing staff groups, medical and nursing staffing at 14% and 10% respectively. In order to control the use of agency staff, recruitment to these posts or finding ways to work differently in areas where national shortages exist remains a priority. Total agency spend in month was £1.87m, compared with £2.17m last month as a result of some success in reducing vacancies alongside other operational actions such as work to drive down the contractual rates paid to Medical agencies and develop a tiered approach to bookings which is now beginning to impact. The Trust is mindful of the need to deliver in line with the restated agency ceiling described above. This will require close management by all Divisions and staff groups on a week by week basis.

It should be noted that £2.0m of contingency reserves are planned against pay across the first six months of the financial year. This contingency has been released against the pay position; meaning that the underlying divisional year to date pay overspend was nearly £3m. In overall terms, there has been a year to date benefit from releasing reserves of £1m to the bottom line, a provision has been made against the £1m balance of the available contingency for potential future risks. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan.

Drug costs

Year to date expenditure on drugs was £0.30m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £0.63m below plan. Underlying drug budgets are therefore overspent by £0.33m, congruent with the activity over performance.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £1.93m above the plan. This overspend reflects activity related factors such as outpatient test costs and a considerable increase in MRI usage driving hire costs and outsourced reporting charges, with growth in internal diagnostics demand outstripping the overall activity increase. This has been subject to a deep dive analysis by the FSS division to ensure that the best balance is being maintained between access times and value for money in delivery of the service. Another factor is high cost devices which are 'pass through' costs are £0.26m above the planned level, compensated directly by income.

As was the case last month, an element of the overspend in this area is driven by purely technical reasons. The annual plan includes £2.0m of contingency reserves all of which was planned as pay spend. There has been a release of £1.0m contingency reserves to the bottom line in the year to date position; a provision has been made against the £1m balance for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan. The accounts for £1m of the total £2.07m overspend against clinical supply and other costs.

<u>Non-operating Items and Restructuring Costs</u>

Non-operating items and restructuring costs are £0.51m below the planned level. This is driven by a combination of lower than planned depreciation charges and Public Dividend Capital payable. The adoption of a different valuation method for the PFI site and a review of equipment asset lives have reduced the asset value upon which both depreciation and PDC are chargeable. This benefit is supplemented by the £0.06m gain on disposal against the sale of the old Occupational Health building which was surplus to Trust requirements. Other elements of non-operating expenditure are in line with plan.

These benefits are offset in part by higher than planned interest payable due to both the timing of drawing down borrowing and higher than planned interest rates. The greater impact of this interest pressure is included in the full year forecast where a continuing to bear the current interest rate of 3.5% for a Working Capital Loan as opposed to the planned switch to a Revenue Support Loan at 1.5% will cost £0.5m more than plan.

Restructuring costs of £0.14m have been incurred in the year to date to fund redundancy costs which will deliver savings in the future periods.

Cost Improvement Programme (CIP) delivery

In the year to date, £6.73m of CIP has been delivered against a plan of £4.65m, an over performance of £2.08m. The over delivery comes in a number of areas, most materially being as follows:

£0.6m Estate related commercial opportunities including securing rates and utilities rebates, a gain on disposal of Trust property and reduced depreciation charges as a result of adopting a new asset valuation method;
£0.3m reduction in consultant costs secured against recharges from other NHS organisations;
£0.1m increase in delivery against the Nursing portfolio through the use of the apprenticeships;
£0.3m over performance on the Surgical Pathways portfolio with increased productivity in specific specialties;
£0.5m rebate successfully pursued from supplier on Pharmacy charges.

As was highlighted in previous months, whilst the level of over performance is positive news it should be noted year to date over performance is counterbalanced forecast delivery in the latter half of the year being lower than the planned level. The £2.08m over performance against CIP plans in the year to date has not translated to an equivalent benefit to the Trust's bottom line financial performance but has rather offset other pressures. The issue that this raises is that this will lead to a budgetary pressure in the second half of the year which will have to be mitigated and will need to form part of the divisional recovery plans.

The year end forecast CIP delivery has increased from £14.05m last month to £14.78m this month, whilst this is positive news it must be tempered with the fact that the majority of this improvement is in the year to date position. As described above, this is offsetting other pressures and therefore the increase in the CIP forecast does not offer an improvement to the overall year end forecast, or any respite against future risks.

Work is ongoing to ensure that CIP delivery in the latter part of the year can be secured, this is where the highest risk schemes are due to commence in earnest, for example the complex portfolio focussing on operational productivity through improved patient flow. Additional savings opportunities also need to be progressed in support of the divisional recovery plans that are required to deliver the overall financial control total of £16.1m deficit. An Executive Director time-out was held in early September to generate ideas; these are being expedited through the gateway process to delivery stage alongside the balance of the divisional recovery plans.

Statement of Financial Position and Cash Flow

At the end of September 2016 the Trust had a cash balance of £2.95m against a planned position of £1.94m, a favourable variance of £1.01m. This is due to receiving some VAT reclaims in advance of forecast timescales and also a level of contract income in September which was not due until October, in both cases this was beyond the control of the Trust but purely a timing issue. All invoices approved for payment and due were paid in September.

The key cash flow variances against plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	0.08
	Non cash flows in operating deficit	(0.46)
	Other working capital movements	(6.27)
	Sub Total	**(6.64)**
Investing activities	Capital expenditure	3.90
	Movement in capital creditors	(3.89)
	Sub Total	**0.02**
Financing activities	Drawdown of external DoH cash support	7.97
	Other financing activities	(0.34)
	Sub Total	**7.63**
	Grand Total	**1.01**

Operating activities

Operating activities show an adverse £6.64m variance against the plan. The adverse cash impact of the I&E position of £0.38m (£0.08m favourable I&E variance offset by £0.46m non-cash flows in operating deficit) is in addition to a £6.27m adverse working capital variance from plan. The working capital variance reflects the catch up of payments to suppliers.

Total aged debt based on invoices raised is £4.98m. The performance against the Better Payment Practice Code has seen a worsening in month with 69% of invoices paid within 30 days against the 95% target. This is driven by the impact of the catch-up in payment of invoices due for payment in month and the payment of some older invoices which have now been approved to be paid.

Investing activities (Capital)

Capital expenditure in the year to date is £7.98m which is £3.84m below the planned level of £11.82m.

Against the Estates element of the total, year to date expenditure is £2.16m against a planned £4.00m. The main area of spend in month was on the continuation of the Theatre refurbishment programme with a year to date spend of £1.4m, this is coupled with spend on backlog maintenance including the continuation of fire compartmentation, fire detection and roofing work.

IM&T investments total £4.02m against a plan of £3.93m. The main areas of spend in month were the continuation of the Electronic Patient Record (EPR), and EDMS projects and replacement of PCs and laptops. The primary reasons for the £0.11m overspend versus plan is due to EPR related spend; £0.03m due to pressures on overtime, £0.15m on EDMS to bring scanning work forwards in readiness for the EPR go live date. These cost are offset in part by an underspend on wired network which has not commenced in line with planned timescales.

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

The favourable cash impact of the £3.90m (£3.84m capital expenditure variance plus £0.06m funded by donated assets) under spend is offset by a £3.89m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way.

Financing activities

Financing activities show a £7.63m favourable variance from the original plan, of which £7.97m is due to additional cash support through borrowing. This position includes borrowing brought forward in earlier months to settle supplier invoices, a position which is being maintained versus the planned position which was to extend creditor payments. Extending creditor terms was not sustainable in operational terms in order to maintain key lines of supply.

The Trust remains keen to pursue with NHSI any opportunity to convert our loan from a Working Capital Facility (at 3.5% interest) to a Revenue Support loan (at 1.5% interest) in order to reduce interest charges. The Trust is also exploring with NHSI the possibility of switching some of our current debt, by drawing down of the £8m balance of our pre-approved capital loan (at 2.35%). Continuing to borrow at the current planned levels at an interest rate of 3.5% for the remainder of the year will bring a pressure of £0.5m against the original plan which assumed a switch to the lower interest rate in-year. This pressure is included in the current forecast and forms part of the need to implement recovery plans and generate additional savings.

3. Financial Sustainability Risk Rating (FSRR) and forecast

FSRR

Against the FSRR the Trust stands at level 2 in both the year to date and forecast position, in line with plan. The shadow monitoring of the Use of Resources Rating under the new Single Oversight Framework shows the Trust at level 3, equivalent to the existing rating on the new inverted rating scale.

Forecast – Income and Expenditure

The year end forecast position continues to be delivery of the planned £16.1m deficit and control total, prior to consideration of costs associated with EPR implementation. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to and contingent upon delivery of the planned deficit.

It has been acknowledged in discussion with NHSI, both at the time of setting the plan and subsequently, that the £16.1m control total excluded any I&E or cash pressures for EPR 'go live'. It is now becoming clear at the mid-way point of 2016/17 that the likely costs that will be incurred in-year will be £3m. The revised timescale for implementation, now being at the latter end of 2016/17 and into 2017/18 means that the implementation costs will cross the financial years, bringing an additional £2m non-recurrent cost in 2017/18 in addition to the issues considered in the allocated indicative control total. The Trust looks to NHSI to support this position and recognise the associated cash backing requirement.

There are inevitably other areas of underlying pressure and risk emerging in year, including areas that have impacted in the year to date which are beyond the organisation's direct control, such as the Junior Doctor's strike action and the higher than planned rate of interest being borne on current borrowing. This pressure is heightened in the remainder of the financial year as the Trust plans to deal with the combination of EPR implementation; delivery of complex CIP schemes with greater returns; response to the outcome of the CQC inspection and commencement of the Junior Doctor's contract; managing winter pressures alongside quelling agency staff usage; and potential affordability related challenge from commissioners.

Operational plans are in place and being constantly refined against the above. At the same time, the Trust's Divisions are required to financial deliver recovery plans to mitigate against issues in their respective areas of service. In addition there will need to be Trust wide action to address these risks and balance the need for innovative solutions with the maintenance of rigorous budgetary control.

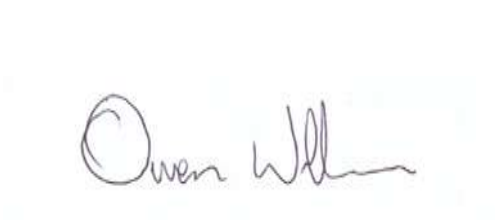
It is with these actions in mind that the Trust continues to plan and drive to deliver a deficit in line with the control total at £16.1m, prior to EPR implementation costs. The total year end forecast position including these exceptional costs would be £19.1m.

Forecast – Capital and cash

In overall terms the capital expenditure is currently expected to be £27.63m, £0.58m below the planned full year value of £28.22m. Due to the delay in go live of EPR which as a result will incur is forecast to increase spend against this element of the original plan by £7.5m, there has been some

further reprioritisation of capital plan, resulting in reduced spend on the Estate and Equipment to offset the additional EPR cost. This follows the completion of a full risk and quality impact assessment.

Total borrowing forecast to be drawn down in year remains in line with plan, with the cash benefit on reduced forecast capital investment being offset by the non-cash I&E benefit of lower than planned depreciation.



Owen Williams
Chief Executive

Keith Griffiths
Executive Director of Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd November 2016	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from each of the sub-committees.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from each of the sub-committees:
- Quality Committee - minutes of 27.9.16 and verbal update from meeting 31.10.16
- Finance and Performance Committee - minutes of 26.9.16 and verbal update from meeting 1.11.16
- Audit and Risk Committee - minutes of 18.10.16
- Workforce Well Led Committee - minutes of 19.10.16
- BOD/MC Joint AGM Draft Minutes - 15.9.16

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the updates and minutes from each of the sub-committees:
- Quality Committee - minutes of 27.9.16 and verbal update from meeting 31.10.16
- Finance and Performance Committee - minutes of 26.9.16 and verbal update from meeting 1.11.16
- Audit and Risk Committee - minutes of 18.10.16
- Workforce Well Led Committee - minutes of 19.10.16
- BOD/MC Joint AGM Draft Minutes - 15.9.16

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Quality Committee held on Tuesday, 27th September 2016 in Discussion Room 2, Learning Centre, Huddersfield Royal Infirmary

PRESENT

Linda Patterson	Non-Executive Director **(Chair)**
Karen Barnett	Assistant Divisional Director, Community Division
Brendan Brown	Executive Director of Nursing
Juliette Cosgrove	Assistant Director of Quality
Martin DeBono	Divisional Director, FSS Division
Tracy Fennell	Associate Nurse Director, Medical Division
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Andrea McCourt	Head of Governance and Risk
Amanda McKie	Matron Complex Needs Care Coordinator
Maggie Metcalfe	Matron for Operating Services
Jackie Murphy	Deputy Director of Nursing, Modernisation
Julie O'Riordan	Divisional Director, Surgery and Anaesthetic Services
Vicky Pickles	Company Secretary
Ian Warren	Executive Director of Workforce and Organisational Development
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Dr Tim Jackson	Consultant Anaesthetist and Clinical Lead for CVAD, Vascular Access, Organ Donation and Sepsis
Michelle Augustine	Clinical Governance Secretary **(Minutes)**

ITEM NO	
170/16	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
171/16	**APOLOGIES** Rob Aitchison – Director of Operations, FSS Division Asif Ameen – Director of Operations, Medical Division David Anderson – Non-Executive Director / Committee Chair Kirsty Archer – Deputy Director of Finance Helen Barker – Chief Operating Officer Stuart Baron – Deputy Director of Finance David Birkenhead – Medical Director Elaine Brotherton – Patient Safety & Quality Lead - FSS Division Diane Catlow – Associate Nurse Director, Community Division Jason Eddleston – Deputy Director of Workforce and Organisational Development Keith Griffiths – Executive Director of Finance Carole Hallam – Senior Nurse Clinical Governance Anne-Marie Henshaw – Associate Nurse Director/Head of Midwifery, FSS Division Joanne Middleton – Associate Nurse Director, Surgery and Anaesthetic Services Lynn Moore – Membership Council Representative Lindsay Rudge – Associate Director of Nursing Kristina Rutherford – Director of Operations, Surgical Division Nicola Sheehan – Head of Therapies, Community Division Sal Uka – Divisional Director, 7 Day Service/Hospital at Night
172/16	**DECLARATIONS OF INTEREST** There were no declarations of interest to note
173/16	**MINUTES OF THE LAST MEETING**

	The minutes of the last meeting held on Tuesday, 23rd August 2016 were approved as a correct record.
174/16	**ACTION LOG AND MATTERS ARISING** ▪ Mock Paediatric Cardiac Arrest Mr DeBono (Divisional Director for FSS Division) gave an update on paediatric defibrillators in the organisation. A paper will be submitted from the FSS division to the Resuscitation Committee regarding assurance that paediatric patients in an emergency situation get rapid access to appropriate defibrillation equipment. The paper outlines three options: – Continue with adapting adult defibrillators for paediatric use – Equip resuscitation trolleys in areas where acutely ill children and young people are cared for – Equip all 15 paediatric resuscitation trollies with a paediatric defibrillator instead of adapting the adult defibrillator **OUTCOME**: The Quality Committee were assured that the Resuscitation Committee will take responsibility on the best action to take, and keep the Quality Committee updated. ▪ Calderdale Vanguard Programme See item 176/16 ▪ Stroke Services Report See item 185/16 ▪ Incident 121228 Action Plan See item 178/16 ▪ Status of scans for stroke and thrombolysis patients See item 185/16 ▪ Invited Service Reviews See 186/16 ▪ CQC Report See 175/16
175/16	**CQC REPORT** Brendan Brown (Executive Director of Nursing) reported on the circulated report (Appendix C1) and the CQC post inspection action plan (Appendix C2). In relation to the plan, once an action is ready to be delivered and sustained, the Quality Committee will review the evidence regarding the delivery of the action and make a recommendation to the Board of Directors. The action plan is predominantly amber (on track to deliver) and will be reported to the Board of Directors this week (Thursday, 29th September 2016) A provisional date of Monday, 17th October 2016 has been scheduled for the Quality Summit, but this is yet to be confirmed by the CQC. **OUTCOME**: The Quality Committee received and noted the content of the report.
176/16	**CALDERDALE VANGUARD PROGRAMME** Karen Barnett (Assistant Divisional Director for Community Division) reported on the circulated report (Appendix D) gave an update on the progress of the Vanguard programme, which focusses on two specific areas: ▪ Locality integrated teams – Five localities have been agreed and identified a GP board

	member to lead for the locality. Community nursing teams are currently being realigned into localities. A new role known as a Care Navigator is being created and will support people who have low level needs to access the most appropriate care provider. ▪ Supported self-management and prevention – This work is being led by the Public Health team with significant input from the Trust to develop mechanisms to support people to manage their own condition and maintain wellness. The Committee expressed an interest in how the supported self-management will link into the wider Trust, and it was stated that this will be captured through the Community division's Patient Safety and Quality Board (PSQB) reports on a quarterly basis as well as the Vanguard programme. It was also stated that a presentation on supported self-management will be given to this Committee in November. The Committee were asked to note that further discussion regarding the implications of the Multispecialty Community Provider (MCP) contract framework will emerge in the next few months. This predominantly will be Weekly Executive Board (WEB) conversations and the Quality Committee will be kept informed through these regular updates. **OUTCOME**: The Quality Committee received and noted the content of the report and will expect a presentation on supported self-management in November.
177/16	**INTEGRATED PERFORMANCE REPORT** The circulated Integrated Performance Report for August 2016 was noted. **OUTCOME**: The Quality Committee received and noted the content of the report
178/16	**BRIEFING ON INCIDENT 121228 AND ACTION PLAN** Amanda McKie (Matron Complex Needs Care Coordinator) was in attendance to give an update on the circulated action plan (Appendix F) involving an incident where a patient with a brain injury became aggressive and violent with staff. A safeguarding alert had been raised due to concerns regarding the care provided by the Trust. The action plan sets out what has already been achieved and what is still to take place in regard to the incident. All actions are on target to be finished by December 2016. **OUTCOME**: The Quality Committee received and noted the content of the action plan.
179/16	**PATIENT SAFETY GROUP** Andrea McCourt (Head of Governance and Risk) gave an update on the last Patient Safety Group meeting which took place on Tuesday, 6th September 2016, and a copy of the draft minutes from the meeting was circulated (Appendix G). The main item of the report was that an update on falls will be brought to the October Patient Safety Group meeting. It was also reported that the Patient Safety Group is one of the sub-groups of the Quality committee which has struggled with attendance; however, work is ongoing to resolve this. The Quality Committee was assured that there were no issues with patient safety, but there is a considerable gap with learning and trying to learn from incidents. The Quality Committee was assured that the next report from the Patient Safety Group will include more detail on what is taking place in the group. **OUTCOME**: The Quality Committee received and noted the content of the report.
180/16	**BOARD ASSURANCE FRAMEWORK** Vicky Pickles (Company Secretary) gave an update on the circulated Board Assurance Framework (Appendix H), which was updated following the recent publication of the Trust Care Quality Commission report. No new quality risks were closed or opened on the Board Assurance Framework; however, there are more references to risks identified on the corporate risk register.

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

181/16	**SERIOUS INCIDENT REPORT** Andrea McCourt (Head of Governance and Risk) gave an update on the circulated report (Appendix I) highlighting serious incidents reported in July and August 2016, including: ▪ six new serious incidents (one delayed diagnosis of cancer; one patient identified from mortality review – deteriorating patient; one intra uterine death; one ante natal screening incident; one sickle cell disease incident and one Emergency Department performance breach) ▪ three falls with harm that have been investigated and reviewed ▪ six serious incident reports submitted to commissioners, the learning from which will be circulated via divisional Patient Safety and Quality Board meetings It was reported that a survey to understand how people can learn better will be undertaken, as well as focus groups and consultation from organisations that have reputations for good learning. The results from these will be fed back to this Committee at a later date. It was agreed that a small group would be convened to discuss learning processes in the organisation. Input from members of the Committee was requested, and Dr Julie O'Riordan (Divisional Director, Surgery and Anaesthetic Services) agreed to join the group. **OUTCOME**: The Quality Committee received and noted the content of the report.
182/16	**CORPORATE RISK REGISTER** Andrea McCourt (Head of Governance and Risk) gave an update on the circulated corporate risk register (Appendix J1) highlighting: ▪ Top six risks: – Progression of service reconfiguration impact on quality and safety – Over-reliance on middle grade doctors in the emergency department – Staffing risk - nursing and medical – Delivery of Electronic Patient Record Programme – Non-delivery of 2016/17 financial plan – Cash flow risk ▪ Risks with reduced score: – Outlier on mortality levels, reduced from score of 20 due to progress with understanding the cause of mortality. – Patient flow risk reduced from score of 20 due to progress with discharge planning. – Cost improvement delivery risk score reduced from 20 and now managed within divisional risk register. ▪ New risk – One new risk added in September 2016 - on Electronic Patient Record operational readiness risk. A copy of the full risk register was also circulated (Appendix J2). **OUTCOME**: The Quality Committee received and noted the content of the report.
183/16	**HEALTH AND SAFETY COMMITTEE REPORT** Lesley Hill (Executive Director of Planning, Performance, Estates and Facilities) gave an update on the circulated Health and Safety Committee Report (Appendix K), which gave a summary of the meeting held on 17th August 2016. Lesley also gave an update from the last meeting held on 21st September, which included:

	▪ Fire safety training – Trust is currently at 25% and feedback from this training is good ▪ Slips, trips and falls – this is a common type of incident, the majority of which are preventable. ▪ Medical devices training – less than 50% of staff have attended this training. It was reiterated that staff should not be using equipment if they are not trained. ▪ Staff side health and safety risks – there are currently no health and safety issues reported, however, members are working to promote their roles to all staff in the organisation to ensure that colleagues know what they do. **OUTCOME**: The Quality Committee received and noted the content of the report.
184/16	**ORGAN DONATION** Dr Tim Jackson (Clinical Lead for Organ Donation) was in attendance to give a presentation on the overview of the work of the organ donation team in the Trust, including the challenges of organ donation in the UK, the number of donors, transplants and waiting list patients in the UK, the principles applied to patients and families regarding organ donation, and what has been done in the Trust since the national organ donation taskforce in 2008: ▪ Specialist Nurse for Organ Donation (SNOD) embedded ▪ New guidance for medical staff in ICU and emergency department ▪ National Institute for Health and Clinical Excellence (NICE) guidelines and General Medical Council (GMC) guidance to ensure organ donation is a standard element of end of life care ▪ Target to increase donor numbers by 50% in five years (this was met in 2013) Information on the total amount of donations and transplants taken place in the last six months was presented, which generated £16,000 into the organisation in reimbursement from the National Health Service Blood and Transplant (NHSBT). Discussion ensued on the use of tissue and corneas, and where the Trust would get support with this. It was stated that a strategy is now in place and the Tissue team at Leeds are in talks with Trust to try to increase these. It was asked whether any comparative data was available in order to benchmark the Trust against other comparable Trusts, and it was stated that this will be included in the annual report from the NHSBT (due in the New Year), which will be presented to this Committee. A report from the Organ Donation Committee will also be presented on a quarterly basis. Dr Jackson was thanked for his presentation and left the meeting at this point. **OUTCOME**: The Quality Committee received and noted the content of the report.
185/16	**STROKE SERVICES REPORT** Tracy Fennell (Associate Nurse Director, Medical Division) gave an update on the circulated Stroke Services report (Appendix L) which included highlights on: ▪ Thrombolysis – the stroke team have completed 'go see' visits to Scunthorpe and planning on visiting Aintree hospital which is performing above this Trust on the Sentinel Stroke National Audit Programme (SSNAP). ▪ Therapy triage – a huge improvement has been made by changing practice and completing a triage of patients on admission. ▪ Real-time data collection – documentation has improved through a new care pathway and different ways of working by real time data capture with the Stroke Audit and Data Officer (SADO) being more visible on ward areas ▪ Leadership – there is a daily presence of matrons, Band 6 staff and general managers on wards to implement changes ▪ Working with palliative care team – weekly input from palliative care consultants to help

	identify patients that need end of life care. ▪ CT trial – working with radiology to improve percentage of patients that receive a scan within one hour, and shown improvement on SSNAP from C to B. Discussion ensued on the CT trial and it was stated that all patients presenting with a stroke – clinical onset - within four hours, will be scanned within one hour. 50% of all patients with a stroke will be scanned within one hour and all other patients will be scanned within 12 hours – this complies with the NICE and SSNAP standards. This is monitored within the Families and Specialist Services (FSS) division management board meetings. It was stated that really good progress has been made in the service, however there is still a huge crude mortality for stroke and some concerns are still present. This report will be updated to the Quality Committee on a quarterly basis. **OUTCOME**: The Quality Committee received and noted the content of the report.
186/16	**INVITED SERVICE REVIEWS** Tracy Fennell (Associate Nurse Director, Medical Division) gave a verbal update on the invited service review reports for respiratory and elderly, which are being reviewed in the medical division and will be circulated to the Committee once finalised.
187/16	**CLINICAL OUTCOMES GROUP REPORT** The Clinical Outcomes Group Report was circulated (Appendix N) which included key issues from the last three meetings held in June, July and August: ▪ Clinical Effectiveness and Audit Group (CEAG) – significant progress has being made with NICE national guidance. A standard has been set whereby clinical areas that have non-compliance with a guideline will justify reasons why they are non-compliant, such as: – Services are not commissioned – work is ongoing with the Clinical Commissioning Groups (CCGs) where the Trust believes non-compliance to be non-commissionable – There is a strong body of opinion that it is not a service that the Trust ought to be complying with – some regional and local standards may exceed NICE recommendations – There is prioritisation based on financial pressures. ▪ Mortality Review Process – There is now a two stage process for mortality reviews – level one reviews will be shifted to a consultant led process and be part of consultant job planning, and level two reviews are expected to be replaced by the new national mortality review process **OUTCOME**: The Quality Committee received and noted the content of the report.
188/16	**MORTALITY SURVEILLANCE GROUP REPORT** The Mortality Surveillance Group Report was circulated (Appendix O) highlighting key issues from the last meetings held in July and August. **OUTCOME**: The Quality Committee received and noted the content of the report.
189/16	**PATIENT EXPERIENCE AND CARING GROUP REPORT** Juliette Cosgrove (Assistant Director for Quality) gave an update on the circulated report (Appendix P) from the Patient Experience and Caring Group meeting held in August 2016. The well-attended meeting focussed on the published CQC report which the group regarded as positive for the Trust. The matters for escalation to this Committee were: ▪ Facility to capture compliments on DATIX, and guidance to be cascaded to divisions ▪ Extended October 2016 Patient Experience meeting to allow time to plan the next phase

	of patient experience improvement work **OUTCOME**: The Quality Committee received and noted the content of the report.

190/16	**SERIOUS INCIDENT REVIEW GROUP** Andrea McCourt (Head of Governance and Risk) gave an update on the circulated minutes (Appendix Q) from the Serious Incident Review Group meeting held in August 2016, highlighting learning from serious incidents and that a survey on learning will be undertaken this month and further work to strengthen the delivery and audit of actions and learning from the serious incident process; and feedback provided from a meeting with the Coroner in July. One matter for escalation to this Committee was the need for a support package for staff and patients in relation to serious incidents/adverse events. **OUTCOME**: The Quality Committee received and noted the content of the report.
191/16	**INFECTION CONTROL COMMITTEE** The minutes from the last Infection Control Committee meeting held in July 2016 were circulated (Appendix R). **OUTCOME**: The Quality Committee received and noted the content of the report.
192/16	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** ▪ Presentation from the Organ Donation Committee ▪ Medical devices training and use of equipment
193/16	**QUALITY COMMITTEE WORK PLAN** The work plan for 2016-2017 was noted and it was stated that the Calderdale Vanguard update on supported self-management should be added in November.
194/16	**ANY OTHER BUSINESS** Discussion ensued on the change of future meeting dates due to Quality Committee meetings to fall during the same week as Board of Director's meetings. Future meetings to now be:

Original date	New date	
Tuesday, 25th October 2016	Monday, 31st October 2016	12:30 – 3:30 pm
Tuesday, 22nd November 2016	Tuesday, 29th November 2016	2:00 – 5:00 pm
Tuesday, 13th December 2016	Tuesday, 3rd January 2016	2:00 – 5:00 pm

DATE AND TIME OF NEXT MEETING

Monday, 31st October 2016
12:30 – 3:30 pm
Boardroom
Sub-Basement, Huddersfield Royal Infirmary

Minutes of the Finance & Performance Committee held on Monday 26 September 2016 at 1.00pm in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnerships
David Birkenhead	Medical Director
Keith Griffiths	Director of Finance
Lesley Hill	Director of Planning, Performance and Esates & Facilities
Richard Hopkin	Non-Executive Director – (Acting Chair)
Ian Warren	Director of Workforce & Organisational Development
Owen Williams	Chief Executive

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Gary Boothby	Deputy Director of Finance
Andrew Haigh	Chair of CHFT
Mandy Griffin	Interim Director of Health Informatics
Brian Moore	Membership Councillor
Victoria Pickles	Company Secretary
Betty Sewell	PA (Minutes)

ITEM

136/16 WELCOME AND INTRODUCTIONS

Richard Hopkin, Acting Chair, welcomed attendees to the meeting.

137/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Brendan Brown – Director of Nursing
Phil Oldfield – Non-Executive Director, (Chair of the F&P Committee)
Jan Wilson – Non-Executive Director

138/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

139/16 MINUTES OF THE MEETINGS HELD 23 AUGUST 2016

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

140/16 MATTERS ARISING AND ACTION LOG

113/16: It was confirmed that an email had been circulated to clarify the VAT and capital element – **action closed**.

Working Capital Facility – The Director of Finance confirmed that we had been treated equally with regard to our loan arrangements even though it will cost us a minimum of £0.5m in extra interest. However, we will still continue to raise this issue with NHS Improvement.

127/16: Financial Forecast - To be covered as an agenda item, however, it was noted that the Chair of the Committee and Richard Hopkin, Non- Executive Director had met with The Director of Finance and Deputy Director of Finance.

FINANCE AND PERFORMANCE

141/16 MONTH 5 FINANCE REPORT

The Director of Finance reported the main headlines:

- Activity in Month 5 continued on trend, ahead of plan.
- I&E position is £100k above forecast.
- Year-end forecast is to deliver a £16.1m deficit but it has been acknowledged that there is a residual risk of £2.2m, work is ongoing with PMO and Divisions to close the gap. This could grow by a further £1.1m due to SRG funding being removed.
- Capital is currently being reviewed due to the EPR position, this will continue to be revalidated and tested.

The Chief Operating Officer took the opportunity to advise that yesterday 524 patients had visited A&E which was one of the busiest days ever. Helen Baker went on to explain that there had been discussions taking place over the last month with regard to the formation of 'Accelerator Zones' and West Yorkshire has been chosen and accepted as an accelerator area. There is still a lack of clarity regarding the funding which will be available and the penalties if targets are not achieved. Further discussions will take place at Partnership Board with Commissioners and decisions will be made with regard to how to take this forward.

With regard to the Finance Report, the Acting Chair pointed out that visibility of the one-off items should continue to be highlighted and monitored. The adverse movement of working capital in month, partly due to payment of creditors, and the aged debt increase in month was noted. The Assistant Director of Finance, Kirsty Archer, agreed to include key points with regard to the movement in future reporting.

142/16 FINANCIAL FORECAST & RECOVERY PLANS

The Deputy Director of Finance talked the paper and in summary the Month 5 financial forecast prior to Divisional recovery plans is for an £18.9m deficit. However, within this forecast there remain a number of risks and challenges. An assessment has been made of those risks and of the likely impact of the divisional recovery plans and a £2m challenge remains in order for the Trust to meet its planned deficit of £16.1m.

Opportunities to close this gap have been identified and are progressing through the agreed gateway challenge process. The Trust continues to forecast a £16.1m deficit based on recovery plans being delivered.

The Chief Executive took the opportunity to update the Committee with regard to conversations which had taken place at Turnaround Executive with regard to the possible imposition of the junior doctor's pay reforms that may leave us with a fiscal challenge and should be factored into the assumptions.

The Chair of the Trust reported back from the NHS Providers meeting he attended recently with the message that the NHS has to deliver on finances this year, if not this may lead to a more aggressive regulatory regime.

The Acting Chair acknowledged that following the session between Keith Griffiths, Gary Boothby, Phil Oldfield and himself they have a greater understanding of the

process which was helpful.

ACTION: To share Reserves on a monthly profile model with the Committee for the rest of the financial year - **GB**

Post-meeting note: the Reserves Schedule up to Month 5 has been circulated.

The Director of Finance highlighted the over-performance on income from Commissioners and the affordability issues this raises for CCGs as we run towards year end. There were no indications of CCGs making a decision to stop referrals, though income projections must present a risk. Also, the SRG funding referred to earlier is a real risk, as is the impact removal of this funding would have on urgent care performance.

STRATEGIC ITEMS

143/16 EPR HIGHLIGHT REPORT & EPR UPDATE

The Director of Health Informatics informed the Committee that the financial forecast does not take into account the change in go-live. The key project risks for CHFT were received by the Committee and it was noted that the Business as Usual (BAU) team structure has since been signed off at the Programme Board.

The Director of Health Informatics presented the EPR Update paper which described the 3 options of deployment of EPR. The individual options and their relevant risks were discussed in detail and it was confirmed that Option A or B would be the recommended options. The paper would be presented to Board of Directors for approval on the 29 September 2016 then presented to the EPR Transformational Board on the 30 September for ratification. A detailed plan and proposal would then be developed around the approved option to include a more detailed clinical risk assessment including mitigation and a more detailed non-clinical risk assessment including mitigation.

The Medical Director expressed his concerns that without the clinical risk assessment for the March go-live he still could not make a decision. It was suggested that he should think how this should be done and drive the process. Helen Barker confirmed that a piece of work has been started with the Divisions and following their input round-table discussions will take place at the beginning of November which should include David Birkenhead and Brendan Brown.

The Chief Executive stated that it was important to note that there is a more realistic view and both Trusts accept they are at different stages and do not necessarily need to go-live together.

In summary it was agreed that by the end of November a better picture will emerge with regard to Trial Load 3 along with a clinical risk assessment. With regard to the communication to the wider forum, nothing will be confirmed until absolutely certain. The next detailed updated to this forum will be at the end of November.

ACTION: Conversations with NHS I will take place with regard to EPR and Capital at Month 6 – **OW**

The Committee were advised that Cerner had written to the Trust with regard to delayed notices and they have been asked to substantiate their costs. There is a follow up meeting during the week to discuss the issue and feedback would be given to this Committee at the next meeting.

The Director of Finance took the opportunity to inform the Committee that EPR costs can be capitalised up to 31 March 2017 but that there would need to be another conversation with regulators. It was acknowledged that any CIP for 2017/18 would be deferred if the project was delayed beyond Spring.

There were new implications on 17/18 control totals and capital plans due to the delay.

GOVERNANCE

144/16 INTEGRATED PERFORMANCE REPORT – DEEP DIVE

The Chief Operating Officer reported on the August performance which has remained at 65%, however, within the Safe domain, with an improved performance, the standard has edged into the 'Green' rating. It was noted that there are still three of the regulatory targets still in 'Red', two of which are linked, namely CDiff and the Emergency Care Standard. It was highlighted that outside Harrogate we are looking positive against both the local and national picture.

In terms of the Carter dashboard the following two areas were highlighted:-

- Complaints, which has deteriorated for the second month in a row. It was confirmed that at Divisional PRMs there is particular focus to provide a sustainable position with regard to the close-down of complaints within a timely manner.
- Vacancy Control, which has improved for the second month in a row

In terms of the most improved matrix the data shows that stroke patients are spending 90% of their stay on a stroke unit, however, the time in getting patients onto the stroke ward within 4 hours has deteriorated. The Medicine division have been asked for a deep-dive with regard to Stroke at the next IPR Executive Board.

With regard to Theatres, the overall theatre utilisation is deteriorating, a detailed conversation has taken place with the Surgical division at their PRM and it has been agreed that a more detailed discussion will take place within the next few weeks.

The following specific domains with regard to Community, relevant to the F&P Committee, were called out:-

- Avoidable admissions have deteriorated over the last few months and there appears to be a correlation with regard to community staffing. They are also linking with Locala to carry out a patient to patient review with a view to using a single community dashboard between organisations by the end of November.
- MSK Service – there has been a 7.5% increase in demand for this service in the last year due to the change in pathway and recruitment challenges. Work is taking place with the Division on an improvement plan and a proactive narrative for the CCG is being worked on.

Safe
Duty of candour – This is now included in weekly reporting and there are 6 breaches at the moment which have a potential financial penalty, a robust process is being looked at with all divisions.

PHH/C-section – Internal stretch targets have been set by the Trust, however, it was agreed that stretch targets should not just be driven by executives but should have non-executive involvement.

Effectiveness
Cdiff – is a cause for concern and the Infection Control Performance Board is being reinstated.
#NoF – still a concern, there is a challenge to the Division around how they manage the surge planning of #NoF.

Responsiveness
The Trust has joined the Frailty Collaborative with a specific piece of work around the intervention with frail patients at home.

It was noted that work is taking place with regard to patients who have waited between 8/10 hours in A&E with a new escalation process and early Director involvement. Work is also taking place with Social Care with regard to the transfer of care.

It was agreed that Diagnostics would be included in the IPR going forward, Helen Barker reported that LTHT are having major problems with their pathology service, we have be doing an additional 500 tests a day for them. Lessons learned to be formulated to ensure we have a robust process in place should we encounter the same technical issues. Discussions then took place with regard to the resilience of our business continuity process which underpins key technology such as EPR.

Workforce
The Director of Workforce and Organisational Development called out the following:-

- Long Term Sickness – hitting targets
- Short Term Sickness – failing - focussed activity with Divisions
- Vacancies – highlights a major problem with retention and this is a PRM focus
- Agency/Locum Usage Plan – to be signed off at Executive Board and then will go to the Workforce & Well Led Committee in detail.
- Appraisal/Mandatory Training – seeing improvements, a trajectory has been requested from now until year end from each division and HR support will be given. Escalation pathway needs to be clearer and will be in place within the month.

CQUINS

- There is a challenge around Sepsis for Qtr. 2, information will be split by Divisions to hold them individually to account.
- Antimicrobial Resistance – real challenge and active conversations are taking place.

ACTIONS: The following actions were agreed:-

Duty of candour – To agree a robust process with Divisions – **HB**
PHH & C-Section – To establish what the issues are and to implement internal stretch targets, it was thought that this should not just be driven by executives and should have non-executive involvement – **HB**
#NoF - still a challenge for the Division regarding the management of this service, Ian Warren to liaise with Helen Barker with regard to providing a contact for a 'go-see' – **IW/HB**

Discussions took place with regard to the level of reporting of the Integrated Performance Report, and it was thought it may be more relevant to summarise the Divisional PRMs once a quarter for the purpose of this Committee. It was thought that this should be discussed at a Board Timeout.

ACTION: To arrange to discuss the level of IPR reporting at a Board Timeout – **HB/VP**

145/16 SINGLE OVERSIGHT FRAMEWORK

The Company Secretary reported that with effect from 1 October 2016, NHS Improvement will be using the SOF to monitor and oversee all providers (both Foundation Trusts and NHS Trusts). The framework is also intended to identify where providers may benefit from or require improvement support across a range of areas.

A presentation on the requirements of the framework and an assessment of the Trust's position was provided to the Committee.

The Committee noted the requirements and introduction of the framework.

146/16 MONTH 5 COMMENTARY TO NHS IMPROVEMENT

The Committee received the paper which provides the Management Commentary on the financial position of the Trust at the end of May 2016 for submission to NHS Improvement. It was pointed out that we are reporting a different position internally than externally purely for the timing of the Strategic Transformation Funding (STF), NHS Improvement now ask for this monthly and we accounted for it quarterly in our original plans, as agreed with NHS Improvement.

The Committee noted the contents.

147/16 WORK PLAN

The Work Plan was received and noted by the Committee.

148/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES

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

- Accelerator Zone
- Forecast Reconfirmation
- EPR Discussions

149/16 ANY OTHER BUSINESS

Planning Guidance – The Director of Finance announced that the Planning Guidance for 17/18 & 18/19 has been received and the submission date will be the 23 December 2016. It was acknowledged that to meet this deadline there is a lot of hard work ahead. It was also confirmed that the NHS Providers Guidance had been circulated to attendees of this Committee who were encouraged to read the document.

Month 5 – The Assistant Director of Finance, Kirsty Archer, updated the forum with regard to the issues for the increased aged debt raised under Item 141/16 of the agenda:-

- High Cost Drugs
    - Hepatitis C – we invoice approx. £180k per month and NHS England has raised some validation checks for about £29k – issue is ongoing.
    - Cancer Drugs Fund – the overtrade is approx. £180k per month June and July were outstanding but both have now been approved and July has been received.
- SRG Funding is the largest increase in month, quarterly invoices have been raised and these invoices are not being paid with the first quarter invoice just tipping into aged debt.

DATE AND TIME OF NEXT MEETING

Tuesday 1st November 2016, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Audit and Risk Committee Meeting held on Tuesday 18 October 2016 in Acre Mill, 3rd Floor commencing at 10:45am

MEMBERS

Prof Peter Roberts	Chair, Non-Executive
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director (Teleconference)

IN ATTENDANCE

Gary Boothby	Deputy Director of Finance
Kathy Bray	Board Secretary (minutes
Michael George	Internal Audit Manager
Keith Griffiths	Executive Director of Finance
Andrew Haigh	CHFT Chairman
Adele Jowett	Local Counter Fraud Specialist
Andrea McCourt	Head of Governance and Risk
Peter Middleton	Membership Councillor
Alistair Newall	Senior Manager, KPMG
Victoria Pickles	Company Secretary
Ian Warren	Executive Director of Workforce and OD
Sarah Parkin	Payroll and Pensions Manager (for part of meeting)

Item

57/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Brendan Brown, Non-Executive Director
Helen Kemp-Taylor, Head of Internal Audit
Clare Partridge, External Auditor

58/16 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

59/16 MINUTES OF THE MEETING HELD ON 21 JULY 2016

The minutes of the meeting held on 21 July 2016 were agreed as a correct record subject to:-

57/16(3) 5 – LCFS – removal of the second bullet point related to the live investigation update (second bullet point).

46/16 - Internal Audit – As discussed at the last meeting, Peter Middleton suggested that it was good practice for Internal Audit to identify opportunities for cost reductions. It was agreed by all present that this should have been reflected in the minutes.

OUTCOME: The Committee **APPROVED** the minutes as a correct record subject to the above amendments.

60/16 ACTION LOG AND MATTERS ARISING

a. 49/16 - Clinical Negligence Claims – It was agreed that the Q2 collation of clinical negligence costs would be circulated to the ARC as part of the Quality Report after Quality Committee on the 31.10.16

ACTION: AM

b. 46/16 - Payroll Internal Audit – As agreed at the last meeting Ian Warren, Executive Director of Workforce and OD, together with Sarah Parkin, Payroll and Pensions Manager attended the meeting to give the Committee an update on the progress made to address

the issues identified in the Audit. To date 90% of the action plan had been completed. The actions included:-

- A Policy has been introduced for double checking of payroll actions.
- Reports have been developed to ensure that terminations and new starters are captured in the system.
- Variance in pay reports identified to divisions significant changes in staff remuneration.
- A Business Case is being developed to look at skill levels within the team and identify gaps.
- Backlog of filing due to be completed by the end of October 2017. It was noted that the e-filing system had been delayed until the new financial year to enable work to continue on the EPR implementation.

It was acknowledged that maintaining two systems was a potential risk but overall it was felt that the Payroll Team were achieving the plan.

One area of concern identified was the challenge with regard tocapacity during periods of annual leave, doctor change over periods, as well as the implementation of the new junior doctor contract which would have an impact on both the payroll and HR teams. It was noted that benchmarking work had identified that the service was being undertaken at relatively low cost and this would be taken into account when the business case was developed.

The Committee thanked Ian and Sarah for the assurances received and it was agreed that a further update would be brought to the Audit and Risk Committee on 18 January 2017.

ACTION: ARC AGENDA 18.1.17

OUTCOME: The Committee noted the work undertaken to date and agreed to receive a further update at the meeting on 18 January 2017**.**

61/16 RISK

a. APPROVAL OF RISK APPETITE

The Head of Governance and Risk presented the paper which summarised the work undertaken by the Board to develop a risk appetite using the matrix for NHS organisations developed by the Good Governance Institute.

The draft risk appetite framework had been included for review and comment prior to presentation at the public Board meeting on 3 November 2016.

The process of developing the risk appetite involved first identifying the categories of risk the organisation was dealing with. The following categories of risk were agreed at the Board workshop:

- Strategic / Organisational
- Reputation
- Financial and assets
- Regulation
- Innovation and technology and commercial
- Quality
- Harm and safety
- Workforce
- Innovation and technology (separate from commercial)
- Quality was further defined to be quality innovation and improvement, distinguishing it from harm and safety.

The categories and levels agreed were noted. Phil Oldfield asked how this work fitted with the risk management matrix and how this would be communicated in the organisation. It was noted that this document had been shared with the Risk and

Compliance Group and it was expected to be cascaded to staff at all levels. It was noted that this work would also be encompassed within the Risk Management Strategy and would support the Board in its decision-making.

It was noted that although this would be presented to the Board on an annual basis it was agreed that this would be reviewed by ARC on a 6 monthly basis.

ACTION: KB – ANNUAL PLAN APRIL & OCTOBER 2017

b. RISK MANAGEMENT ARRANGEMENTS

The Head of Governance and Risk reported that the Risk Management Strategy had been developed and shared with the Risk and Compliance Group. This would be forwarded to ARC Members for approval outside the meeting. Responses would be required from ARC Members by the 14 November 2016.

ACTION: AM

OUTCOME: The Committee RECEIVED and noted the Risk Appetite paper and **AGREED** that it would be reviewed by the ARC on a 6 monthly basis. The Committee noted that the Risk Management Strategy would be circulated outside the meeting.

COMPANY SECRETARY'S BUSINESS

62/16 The Company Secretary presented a number of reports relating to governance within the Trust.

1. REPORT ON CURRENT REGULATORY COMPLIANCE ISSUES

The Audit and Risk Committee were asked to receive the updated Regulatory Compliance Register and note that no breaches have arisen in meeting the deadlines. Concern had been raised about the number of requests for information being received by different personnel in the organisation. It was noted that the Company Secretary was undertaking a piece of work collating where requests from NHS Improvement are being received and how these are being responded to.

OUTCOME: The Audit and Risk Committee **RECEIVED** the regulatory compliance register and **NOTED** that all appropriate submissions had been made within the deadlines. Further work was on-going to identify requests for information being made outside the usual route.

2. REVIEW OF BOARD ASSURANCE FRAMEWORK

The Company Secretary presented the most up to date version of the Board Assurance Framework.

It was noted that following discussion at the Board meeting in September, the HSMR risk (001) had been reviewed however the score will not be reduced until further improvement in the HSMR has been seen. The 7-day services risk (004) had been increased from 12 to 15. This increase in score reflected the fact that we are unlikely to achieve the required standards by end of March. The single oversight framework also uses compliance with 7-day services as one of its metrics.

Following the discussions at the Annual General Meeting, Peter Middleton asked for assurances that the ARC was undertaking sufficient scrutiny of the mortality issues. The Committee heard about a number of pieces of work which had significantly impacted on the figures and that further work was being undertaken particularly on crude mortality to ensure that this is benchmarked to give exact numbers of deaths, rather than the calculations used for HSMR and SHIMI. It was noted that the assurance route for this work was through the Quality Committee.

OUTCOME: The Committee **RECEIVED** and **NOTED** the updated Board Assurance Framework

3. REVIEW OF TERMS OF REFERENCE
The Terms of Reference for the Audit and Risk Committee have been reviewed. Minor amendments have been made and are tracked.
OUTCOME: The Committee **RECEIVED** and **AGREED** the Terms of Reference

4. REVIEW OF STANDING FINANCIAL INSTRUCTIONS
The Company Secretary presented the amendments requested at the July meeting. Further work had been undertaken to incorporate changed procurement processes. It was agreed that the Scheme of Delegation would be presented to the ARC in January 2017

ACTION: COMPANY SECRETARY

OUTCOME: The Committee **RECEIVED and APPROVED** the revisions to the Standing Financial Instructions and it was agreed that the Scheme of Delegation would be presented to the ARC in January 2017

5. REVIEW OF COMMITTEE ANNUAL WORKPLAN
The Committee received and approve the updated annual work plan
OUTCOME: The Committee **RECEIVED and APPROVED** the updated annual work plan.

6. REVIEW OF ARC MEETING DATES 2017
The meeting dates for 2017 were approved
OUTCOME: The Committee **APPROVED** the meeting dates for 2017.

7. DECLARATION OF INTERESTS AND STANDARDS OF BUSINESS REGISTERS AND CONSULTATION PAPER
The Company Secretary presented the updated Registers of Interests for the Board of Directors, Membership Council and wider staff group, as well as the Trust register of gifts and hospitality.

Discussion took place regarding the recently published Managing Conflicts of Interest in the NHS: A consultation by NHS England. The document proposed a single approach to managing conflicts. It was agreed that the Company Secretary and Director of Workforce and OD would meet to look at interim arrangements on how the Trust might meet the recommended practices as it did not currently have an electronic system available to capture declarations. The work undertaken at Leeds Teaching Hospital in receiving a positive response from each Band 7 and above each year was noted.

ACTION: IW/VP

It was agreed that the feedback to the Consultation would be circulated to ARC Members for review prior to submission on 31.10.16. Concern was expressed regarding the low number of declarations received within the Trust and the Chair requested that the Communications Team remind staff of the need to declare interests, in order both to safeguard their individual position and that of the Trust.

ACTION: VP

63/16 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review Waiving of Standing Orders
The Deputy Director of Finance presented a report detailing the waving of Standing Orders for the second financial quarter of 2016/2017. During this quarter, 4 orders were placed as a result of standing orders being waived, at a total cost of £407,022.50. No amendments to earlier single sources were made this quarter.

Discussion took place relating to the waiver of the fire alarm upgrade and the fact that no other provider could undertake this due to the nature of the procurement. It was noted

that when tendering processes are undertaken in the future the issue of maintenance was to be taken into account.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the report.

2. Review of Losses and Special Payments

In accordance with the Standing Financial Instructions, the Deputy Director of Finance presented the losses and special payments for the quarter ending 30 September 2016.

The Committee discussed the item relating to overseas visitors and the Deputy Director of Finance assured the Committee that the Trust was doing everything possible to comply with the government directives. He confirmed that as following notification to Customs of an unpaid debt there had been a refusal of entry to this country.

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

64/16 INTERNAL AUDIT

1. Review of Internal Audit Follow-up Report

The Internal Audit Manager presented the report and noted the progress made around the majority of recommendations.

He highlighted two areas of ongoing concern.

- The first related to E-Expenses although action is being taken, the original recommendation was dated October 2014 and it is now proposed that the action will be implemented by March 2017; and
- The second was that no response had yet been received about the action being taken to implement the Safeguarding audit despite a number of contacts.

The Committee agreed that in terms of the BAF and Risk Register this was a risk and it was agreed that the Company Secretary would invite the safeguarding management team to attend the next ARC Meeting in order to indicate the progress made and the reasons for any delays

ACTION: VP

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

2. Review of Internal Audit Progress Report

The Internal Audit Manager reported that since the last report to the Committee in July 2016 the following reports had been issued to and discussed with management:

Report No	Report	Opinion
CH/01/2016	General Office Cash Handling	Limited
CH/02/2016	Fit and Proper Persons	Significant
CH/03/2016	External Reporting Governance	Significant
CH/04/2016	Cash Sales in Community Division	Significant
CH/05/2016	Patient Appliances	Limited
CH/06/2016	Payroll, Progress Report	Significant

The Committee discussed the two limited assurance reports in more detail:

CH/01/2016 General Office Cash Handling

In a typical week around £36,000 in cash passes through the General Offices at CRH and HRI. This is predominantly income for car parking from each site. Both sites had poor security arrangements with access being permitted from a wide range of people and cash not being secured during these times.

Since the audit it was noted that a loss of cash had occurred and been investigated by the Police. Arrangements had been strengthened and spot checks were being put in place.

CH305/2016 Patient Appliances

The Community Division had outsourced the provision of orthotics to an external supplier. The same external supplier supplies the orthotic products (patient appliances) to the specification of the orthotics. The budget for patient appliances was £756,000 and there was a risk that the lack of segregation in the ordering and the provision of the appliances could present a risk of inappropriate payments being made and of poor value for money for the Trust. The Committee were assured that this issue was being dealt with through the Procurement Team.

OUTCOME: The Committee **RECEIVED** the report and **NOTED** the good work and improvements demonstrated by some of the audits, as well as the need to strengthen some processes and practice.

Richard Hopkin asked if additional work would impact on the plan. Michael George advised at the present time there was no additional work which would impact significantly on the costs of the plan and this was left flexible to allow for movement in work areas.

65/16 LOCAL COUNTER FRAUD

1. Local Counter Fraud Specialist Progress Report

The Local Counter Fraud Specialist (LCFS) presented the progress report, based on the 2016/2017 Key Framework of Duties and which was approved by the Audit and Risk Committee in April 2016.

Progress had been made towards the delivery of the work plan, notably:-

- Regular talk at Nurse Induction mandatory training
- Liaison with the Trust Local Security Management Specialist (LSMS)
- Lunch and learn training event with the finance team
- Closer working with WOD including the introduction of a new protocol
- On-going presentations to the PMU

In addition she updated the Committee on the live investigations being undertaken. This included detailed investigations in the Estates and Facilities department. It was noted that this work continued and it was agreed that the Executive Director of Planning, Performance, Estates and Facilities would be approached regarding this matter.

ACTION: AJ

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

2. LCFS and LSMS Protocol

The LCFS presented the LCFS and LSMS Protocol. It was noted that it was intended that the LSMS manager would attend the meeting but unfortunately had been unable due to sick leave. It was noted that the protocol had been prepared in accordance with national guidance.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the protocol.

66/16 EXTERNAL AUDIT

Technical Update

The External Auditor explained that the Technical Update was for information and highlighted areas of particular interest:

- Thought Leadership – KPMG and Locala – local devolution and moving forward
- Apprenticeship Levy – progress 6 months on
- Survey of Fraudster Profiles – exploiting internal control weaknesses
- Discussion took place regarding BREXIT guidance and it was noted that KPMG

was collating impact effects and events and would feedback in due course.

It was noted that this document would be circulated to the remaining Board Members for information.

ACTION: KB – CIRCULATE TO BOD

Discussion took place regarding the information received within the technical update and it was agreed that where possible reference would be made to how the issues might impact on CHFT. The Executive Director of Finance pointed out the challenges in the Trust and suggested that the information within the update did not always reflect reality.

ACTION: AN

OUTCOME: The Committee **NOTED** the report

67/16 INFORMATION TO RECEIVE

The Committee **RECEIVED** the following minutes:

1. Quality Committee Minutes – 28.6.16, 26.7.16 and 23.9.16
2. Risk & Compliance Group Minutes – 16.6.16 and 12.7.16
3. THIS Executive Meeting Summary Notes – 14.9.16
4. Information Governance & Records Strategy Committee Minutes – 12.9.16
5. Nomination and Remuneration Committee (MC) Minutes – 21.7.16

68/16 REPORT ON WHISTLEBLOWING AND OTHER EXPRESSIONS OF CONCERN

The Company Secretary advised that the Executive Medical Director was involved in this and would conclude his investigation by the end of the following week.

69/16 ANY OTHER BUSINESS

1. Audit Yorkshire Board Nomination

It was noted that the Chair had been nominated to sit on the newly formed Audit Yorkshire Board. Phil Oldfield, Non-Executive Director agreed to act as deputy on this Board.

ACTION: KB – Notify Audit Yorkshire

2. Keith Griffiths, Executive Director of Finance - Leaving

The Committee formally thanked Keith Griffiths for the work undertaken in the Trust over the past 5 years. Keith had been successful in securing the post of Director of Sustainability at East Lancashire Teaching Hospitals and would be leaving at the end of October 2017.

3. Annual General Meeting – Consultation Testimonials

Peter Middleton asked for feedback on whether the questions raised at the AGM had been addressed. The Company Secretary assured him that the enquirer had been advised that the proper processes had been followed and a formal response had been sent.

70/16 MATTERS TO ESCALATE TO BOARD

The Committee noted the following items to be brought to the attention of the Board at its meeting on 3 November 2016:

- Payroll Progress Report – on-going
- Risk Appetite – update annually to BOD – bi-annually to ARC
- Company Secretary Business
  - Approval of ARC Terms of Reference
  - Declarations of Interest – Consultation and low levels of declarations
- Waiving and Losses
- Internal Audit Report
  - General Office Cash Handling
  - Patient Appliances
- LCFS Update report
  - Estates Department

- External Audit – Technical Update

71/16 DATE AND TIME OF NEXT MEETING

Wednesday 18 January 2016 at 10.45 am – 3rd Floor Acre Mills Outpatient Building.

72/16 REVIEW OF MEETING

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

KB/VP/ARC-28.10.16

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Wednesday 19 October 2016, 3.00 pm – 5.00 pm in Discussion Room 3, Learning and Development Centre, Huddersfield Royal Infirmary.

PRESENT:	
David Birkenhead	Medical Director
Gary Boothby	Deputy Director of Finance
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Karen Heaton	Non-Executive Director (Chair)
Rosemary Hedges	Membership Councillor
Vicky Pickles	Company Secretary
Phil Oldfield	Non-Executive Director, (Deputy Chair)
Ian Warren	Director of Workforce and Organisational Development
Jan Wilson	Non-Executive Director
IN ATTENDANCE:	
Chris Burton	Staff Side Chair
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development

69/16	**WELCOME AND INTRODUCTIONS:** The Chair welcomed members to the meeting.
70/16	**APOLOGIES FOR ABSENCE:** Asif Ameen, Director of Operations, Medical Helen Barker, Chief Operating Officer Brendan Brown, Executive Director of Nursing Anne-Marie Henshaw, Associate Director of Nursing, Families and Specialist Services Andy Lockey, Director of Medical Education Kristina Rutherford, Director of Operations, Surgery and Anaesthetics Ashwin Verma, Divisional Director, Medical
71/16	**DECLARATION OF INTERESTS:** No declarations of interest were received.
72/16	**MINUTES OF MEETING HELD ON 14 JUNE 2016:** The minutes of the meeting held on 14 June 2016 were approved as a true record.

73/16	**ACTION LOG (items due this month)** Terms of Reference See item 75.16 **ACTION:** IW/VP Sub-group structure See item 75.16 **ACTION:** VP Board Assurance Framework/Corporate Risk Register Test the role of the Committee in ensuring the Board Assurance Framework / Corporate Risk Register is appropriately maintained. **ACTION:** PO/JW/JE/VP Visible Leadership: Process and Outcome of First Visits To identify reports to be received by the Committee. **ACTION:** VP Human Resources Management Group To consider as part of Terms of Reference review. **ACTION:** IW/VP CQC Inspection Update LR to provide the Committee with an update once the final CQC report is received. **ACTION**: LR Care of the Acutely Ill Patient To remove from the Committee agenda. **ACTION: TR**
	MAIN AGENDA ITEMS
	FOR DECISION
74/16	**WORKFORCE STRATEGY** The draft Workforce Strategy prepared by Jackie Green was shared with the Committee. IW presented to the Committee the key elements of the workforce strategy which link into the Trust's 5 Year Strategy goal - A workforce for the future. A 'Keep it Simple' theme identified the seven key areas of focus with supporting metrics required to deliver the strategy: • Recruitment • Retention • Attendance

	• Engagement • Workforce Planning • Productivity/efficiency (Carter) • Future workforce/talent management A 12 month workforce plan is to be developed for each metric to monitor progress. The committee welcomed the focus and it was agreed that the Strategy will be presented formally in December 2016 for sign off. The Strategy will then be presented to the Board for approval. **ACTION:** IW to develop workforce plans and refresh draft Workforce Strategy. TR to add workforce plan to the December 2016 agenda. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the presentation.
75/16	**WORKFORCE (WELL LED) COMMITTEE AND SUB-GROUPS TERMS OF REFERENCE AND STRUCTURE** The Terms of Reference had been approved by the Board of Directors, however it was agreed by the Committee that the focus of the Committee should be reassessed to determine its membership and sub-structures. The Terms of Reference would be refreshed and shared with the Committee before being re-submitted to Board for sign off. A picture of the sub-group structure will also be shared at the next Committee meeting. **ACTION:** VP/IW to review the Terms of Reference. VP to share the Governance reporting structure with the Committee.
76/16	**WORKFORCE (WELL LED) COMMITTEE WORKPLAN 2016/2017** The Committee agreed the workplan should be reshaped to align to the workforce strategy. **ACTION: IW/JE** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.
	FOR ASSURANCE
77/16	**NHS IMPROVEMENT SMART PLAN** IW reported the Trust's SMART plan in relation to agency spend had been submitted to NHS Improvement (NHSI). IW advised that performance against the plan will be monitored (RAG rated) by the weekly Safer Staffing Utilisation and Efficiency Programme Board which is attended by Directors and the Programme Manager. IW confirmed he is in conversation with NHSI and a Trust performance meeting with NHSI is due to take place in November 2016. It was noted the NHSI are to publish a list of Trusts with the highest agency spend.

	ACTION: IW to report progress to next Committee meeting. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
78/16	**BOARD ASSURANCE FRAMEWORK** VP confirmed the BAF had been submitted to the Executive Board. The workforce elements of the framework were shared with the Committee and in particular noted the risk 'Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites'. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
79/16	**CORPORATE RISK REGISTER** The position of the 4 risks were noted by the Committee. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	PERFORMANCE
80/16	**WORKFORCE MONTHLY TRUST REPORT (OCTOBER 2016)** IW informed the Committee this is a first draft of a refreshed monthly report on key workforce metrics. The Committee agreed it wanted to see a more pictorial report. The content should include a 13 month cycle, a 3 month trend and for comparison, 3 years of data. Data validation is to be built into the workplan along with KPI links to the strategic elements of the workforce plan. IW reported that the Stepchange recommendations are being implemented in the recruitment process. Plan to Committee 8 December. **ACTION:** IW to progress amendments to the workforce report**.** IW to update the workplan in terms of data validation and KPI links JE to invite Rachael Pierce, Resourcing Manager to present to the December Committee meeting. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	INFORMATION
81/16	**2015 WORKFORCE RACE EQUALITY SCHEME (WRES)/STAFF SURVEY ACTION PLAN** JE updated the Committee on the progress and implementation of the 25 actions. 9 actions have been delivered with 5 more on track. 11 actions are off track and zero actions off track with no plan. JE confirmed the Committee will be kept updated on progress and advised the action plan is retained live on the Trust's intranet.

	The Committee questioned how realistic the deadlines were but agreed the action plan is a good piece of work and links well into the Workforce Strategy. The Committee suggested responsibility for the action plan should sit with one individual. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the action plan.
	ITEMS TO RECEIVE AND NOTE
82/16	**ANY OTHER BUSINESS:** JW requested an update on the progress on the implementation of the Junior doctor contract. JE confirmed that good progress is being made and a cost of £750k had been advised to the Board. The Trust is adhering to the timeline for implementation given by NHS employers. A progress review meeting is to take place in November with regard to cost. KH made some suggestions to the format of Committee papers - a front sheet to accompany each paper – highlighting executive summary, recommendations and decision(s) required. The possibility of uploading committee papers onto the BoardPad system is to be explored. **Action:** TR to create front sheet replicating Trust standard format and follow up BoardPad use.
83/16	**MATTERS FOR ESCALATION:** There were no matters identified for escalation to the Board of Directors
DATE AND TIME OF NEXT MEETING: Thursday, 8 December 2016, 1.00pm – 3.00pm, Syndicate Room 1, Learning and Development Centre, Calderdale Royal Hospital.	

Calderdale and Huddersfield NHS

NHS Foundation Trust

Minutes of the Calderdale & Huddersfield NHS Trust Board of Directors and Membership Council Members Annual General Meeting held on Thursday 15 September 2016 at 6.00 pm in the Lecture Theatre, Learning Centre, Calderdale Royal Hospital

PRESENT

Speakers
Mr Andrew Haigh, Chairman
Mr Wayne Clarke, Publicly Elected Member-Deputy Chair/Lead MC
Mr Keith Griffiths, Director of Finance
Mrs Clare Partridge, Engagement Lead – KPMG External Auditors
Mrs Lindsay Rudge, Deputy Director of Nursing
Mr Owen Williams, Chief Executive

Others present:
Board of Directors
Dr David Anderson, Non-Executive Director
Mrs Helen Barker, Chief Operating Officer
Dr David Birkenhead, Executive Medical Director
Mr Richard Hopkin, Non-Executive Director (part)
Dr Linda Patterson, Non-Executive Director
Mr Ian Warren, Executive Director of Workforce and OD
Mrs Jan Wilson, Non-Executive Director
Mrs Victoria Pickles, Company Secretary

Membership Council
Mr Stephen Baines
Mrs Nasim Banu Esmail
Mrs Rosemary Hedges
Mrs Dianne Hughes
Mrs Katy Reiter
Mrs Veronica Maher
Mr Peter Middleton
Mr Brian Moore
Mrs Lynn Moore
Mrs Jennifer Beaumont
Mr Brian Richardson
Mr George Richardson (part)
Mrs Di Wharmby
Mr Bob Metcalfe

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chairman opened the meeting by welcoming people to Calderdale Royal Hospital. He introduced the speakers and noted that other members of the Board of

Directors and Membership Councillors were also present in the audience. The Chairman highlighted the Information Technology Developments showcase given by the Health Informatics team both and, on behalf of the Board and Members thanked staff for their support.

2. APOLOGIES

Apologies were received from:

Board of Directors

Mr Brendan Brown, Executive Director of Nursing
Mrs Karen Heaton, Non-Executive Director
Mrs Lesley Hill, Director of Planning, Performance, Estates & Facilities
Mr Philip Oldfield, Non-Executive Director
Prof. Peter Roberts, Non-Executive Director

Membership Council Members

Mrs Annette Bell
Mrs Charlie Crabtree
Mr Grenville Horsfall
Mrs Michelle Rich
Ms Kate Wileman
Mr David Longstaff
Mrs Sharon Lowrie
Dr Cath O'Halloran
Mrs Dawn Stephenson
Mrs Chris Bentley
Mrs Eileen Hamer
Dr Mary Kiely
Mrs Linda Salmons

3. ANNUAL REPORT 2015/16

The Chairman reported that 2015/16 was a challenging year for the Trust. The national deficit was £2.45 billion and the Trust deficit stood at £20 million. He explained that the Trust had worked hard, in liaison with the regulators, to deliver high quality services both in hospital and the community with targets being maintained in the majority of areas.

The Chairman reported some of the key things that had happened during the year including the launch of a monthly Star Award to recognise and celebrate the achievement of Trust staff. He also highlighted the Care Quality Commission inspection in March which had shown some good care across both acute and community settings yet also highlighted areas for improvements and this work has been underway since their visit in March.

The Chairman commented that the NHS financial position is challenging and will continue to be in the future. NHS organisations will face difficult choices and that locally this has been seen in the Right Care, Right Time, Right Place (RCTP) consultation. Colleagues from the Trust had spent a lot of time with CCG colleagues talking to the public, patients and service users about the proposed changes and that the CQC inspection report findings supported the case for change.

The Chairman reported that this was the ninth year when the Board of Directors and Membership Council had come together at a joint Annual General Meeting, alternating sites between Huddersfield and Halifax each year to present the Annual Report and Accounts, to report on the work of the Membership Council and to present the results of the recent Membership Council elections.

4. ANNUAL ACCOUNTS – APRIL 2015 TO MARCH 2016

Keith Griffiths, Executive Director of Finance presented the Annual Accounts, full details of which were available in the Annual Report. It was noted that the details of these had been discussed at the Board of Directors Meeting and these were approved as a correct record.

The key areas were noted:

Financial Context

The Executive Director of Finance explained that over the year the Trust had seen:

- 122,000 inpatients – elective, non-elective and day cases
- 441,000 outpatients
- 147,000 A&E attendances

In addition the Trust has a turnover of £350m, the majority of which is spent on staffing with 5,909 colleagues employed by the Trust. There is property and equipment over two hospital sites with a combined value of £218m. The Trust is required to make efficiency savings, driven by tariff against a challenging financial and operational landscape.

The Trust's Performance in 2015/16 compared to 2014/15:

- 5% more non elective inpatients were treated
- 3.5% more activity was seen in A&E
- This put pressure on the Trust's capacity to deliver planned elective activity
- Savings/efficiency gains worth £18m were delivered.

2015/16 Financial Performance

	Plan	**Actual**
Income and Expenditure (excl. exceptional items)	(23.0)	(21.0)
Capital Expenditure	20.7	20.2
Cash Balance	1.9	1.9
Continuity of Service Risk Rating	2	2
Unqualified Audit Opinion	√	√

Key Financial Pressures

- Bed capacity linked to system resilience issues and the closure of capacity in community
- High levels of clinical staffing vacancies and national recruitment pressures driving high levels of agency staffing costs

Efficiency Savings Achieved

Procurement	£1.4m
Administrative and management	£2.2m

Clinical productivity	£2.5m
Clinical workforce	£3.2m
Non clinical and clinical income	£5.6m
Estates & facilities systems	£1.2m
Divisional budgetary control	£1.9m
Total savings achieved	£18m

The Future
The Executive Director of Finance explained that the NHS faces unprecedented financial challenges both locally and nationally. Locally the Trust has an increased demand for services which will require closer joint working with other organisations across West Yorkshire and modernisation of both technology and the estate. He concluded that there were no short term solutions to CHFT's financial deficit.

5. QUALITY REPORT
Lindsay Rudge, Deputy Director of Nursing presented the Quality Report. The presentation highlighted the quality priorities for 2015/16 and their progress:-

- Improving Sepsis – partially achieved
- Ensuring intravenous antibiotics are given on time – partially achieved
- Improving the discharge process - complete
- Better food – complete

She reported that work which had been undertaken throughout the year included:-

- Safety Huddles - a multi-disciplinary programme aimed at reducing falls.
- Technology supporting care – 'Nervecentre' roll-out to detect when a patient's condition is deteriorating
- Hospital Out of Hours Programme
- Visit by CQC Inspectors – overall rating "Requires Improvement"
- Development of a new Community Division

Joint work with the Membership Council to address patient experience feedback included:-

- Reduce Noise at Night – introduction of soft closing bin lids. Research study commenced on Ward 1, HRI
- Community – Time arranged to meet the midwife – increased number of community drop in clinics
- Not many menu choices – updated menus reviewed every 4 weeks. Additional options and special diet menus available
- Care and residential homes required more information around falls prevention and mental health guidance – The QUEST multi-disciplinary team have developed advice sheets for homes.

The Trust had also been successful in receiving a patient safety award for the Dementia team's work and this was being further developed within the Trust. It was noted that the CQC had commented on this work and acknowledged it as an example of good practice.

Finally, she highlighted that 'Compassionate Care' was a key motivator for all Trust colleagues and that the legacy of the late Dr Kate Granger who introduced "Hello my name is …" would be continued throughout all departments.

6. EXTERNAL AUDIT OPINION ON ANNUAL REPORT/QUALITY ACCOUNTS

Clare Partridge, Engagement Lead from KPMG gave a presentation outlining the work undertaken by the external auditors on the Annual Report and Accounts and the Quality Accounts. She explained the three areas focussed on within the Audit were:-

- Use of resources
- Financial Statements Audit
- Quality Accounts

Use of Resources

The Engagement Lead explained that the audit had concluded that the Trust had adequate arrangements to secure economy, efficiency and effectiveness in its use of resources with the following exceptions:-

- The Trust provided evidence that progress has been made against the enforcement undertakings issued in January 2015, and therefore arrangements were in place to secure value for money through responding to the enforcement undertakings. However the undertakings and modifications of the licence remained in place at the date of the report.
- Additionally, the Trust's strategic and turnaround plan still forecasts the Trust to be in deficit and reliant on Secretary of State external financial assistance beyond 2016/17.

Financial Statements and Annual Report

It was noted that within the financial accounts there had been one unadjusted audit difference and a number of minor presentational changes had been made but no recommendations were raised. There were no adjusted audit differences.

No inconsistencies had been found between the content of the Annual Report and Accounts. The Annual Governance Statement was found to be consistent with the financial statements and complied with relevant guidance.

Quality Accounts

A clean limited assurance opinion had been issued on the content of the Quality Report which could be referenced to supporting information and evidence provided. This represented an unmodified audit opinion on the Quality Report. It was noted that feedback from Calderdale Council Overview and Scrutiny Committee had been requested but not received.

Two mandated indicators had been tested:

- % of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the report period; and
- % of patients with a total time in A/E for 4 hours or less from arrival to admission, transfer or discharge.

A clean limited assurance opinion was given on the presentation and recording of the A&E Indicator data. It had not been possible to provide a limited assurance

opinion on the incomplete pathways indicator due to issues with accuracy of data, specifically in relation to the validation checks undertaken.

No issues were identified in the testing of the local indicator 'complaints closed within target time', as selected by the Membership Council.

Two recommendations were made in relation to improvement of processes in place.

7. FORWARD PLAN

Owen Williams welcomed everyone and thanked staff, volunteers and Membership Councillors for their work and commitment in caring for patients. He also wished to thank the Board of Directors for their commitment and challenge over the past year throughout the reconfiguration of services consultation.

Looking ahead the Chief Executive reported that the Trust would continue to use the 4 pillars of behaviour to achieve compassionate care:

- we put the patient first
- we work together to get results
- we do the must do's
- we go see

The Chief Executive set out the key areas of work for the Trust over the next year:

- Reconfiguration – he explained that commissioners would be make a decision on whether or not to progress to the next stage with proposals around the future configuration of hospital services in October.
- West Yorkshire – the Trust is a key participant in the work across West Yorkshire to develop a Sustainability and Transformation Plan. These were also being impacted upon by national discussions around the financial challenges in the NHS.
- Electronic Patient Record (EPR) – the Trust would implement a whole new EPR which would be key to ensuring better patient care and help to provide efficient services in the future.
- Care Quality Commission – The Trust's ambition was to keep improving services and to deliver the actions which had been developed following the inspection.

The Chief Executive shared a patient story which highlighted the care of a suicidal patient visiting the area who had been inappropriately admitted to the Trust. He highlighted the need to ensure that patients are treated in the right place, at the right time, by the right person to ensure complete compassionate care.

The Chairman thanked everyone for their contributions and reinforced that it was clear that this current year was going to be just as challenging as 2015/16.

8. ELECTION RESULTS AND APPOINTMENTS

The Chair reported that the second half of the meeting would concentrate on the Membership Council AGM.

a. Council Members

The Chairman reported the results of the elections run by the Electoral Reform Services on behalf of the Trust over the period 7 June to 22 August 2016. This had resulted in six public membership council appointments (Veronica Maher, Katy Reiter, Dianne Hughes, Nasim Esmail, Stephen Baines and Michelle Rich) and three staff membership council appointments (Nicola Sheehan, Linda Salmons, Charlie Crabtree).

It was noted that Peter Middleton had been appointed as Deputy Chair/Lead Governor to take over from Rev Wayne Clarke. The Chair thanked Wayne for his support as Membership Councillor for the past three years and latterly as Deputy Chair/Lead Governor for the Membership Council since 2015.

The Chairman extended a welcome to the newly elected and re-elected members along with Grenville Horsfall who had agreed to stay on for another year on the Reserve Register.

All these appointments could be seen on the Register of Members which was available within the packs. The ballot turnout rates this year was around 15% which was comparable to other trusts.

The Chairman wished to thank the other retiring members who included:- Mrs Jennifer Beaumont, Avril Henson, Julie Hoole, Kenneth Batten in addition to Chris Bentley who had been on the Reserve List. Two Stakeholder representatives had also ended their tenures – Prof John Playle and Cllr Naheed Mather.

b. Board of Directors – Non Executive Directors

The Chairman reported that the Nomination and Remuneration Sub Committee (Membership Council) had met on the 21 July 2016 to consider the two Non-Executive Directors whose tenures were due to expire this year. The Committee had agreed that the tenures of Dr Linda Patterson and Mr Phil Oldfield should be extended for a further three year period.

Those present formally ratified the aforesaid appointments and the Chairman introduced and welcomed the new members of the Membership Council.

9. MEMBERSHIP COUNCIL UPDATE – OVERVIEW OF THE MEMBERSHIP COUNCIL CONTRIBUTION DURING 2015/16

Rev Wayne Clarke, Deputy Chair gave an overview of the work of the Membership Council during 2015/16. This included:-

- Development of plans for the Trust, particularly through the Divisional Reference Groups
- Participation in training and development opportunities including Induction, individual training and development days.
- Oversight and holding to account of the Board of Directors through:
  - Chairman's One to One Meetings
  - Attendance at full Membership Council meetings and AGM
  - Attendance at Board of Directors Meetings.
  - Attendance of Council members on a wide range of sub committees such as Nomination and Remuneration, Organ Donation, Quality, Finance and Audit, Workforce, EPR and Charitable Funds.

- Joint workshops with the Membership Council and Board of Directors
- Involvement in interview panels
- Development of Patient Information Leaflets
- Awards panels for the Trust's Celebrating Success.
- Selection of indicators and oversight of the Quality Accounts.

Additional work undertaken by the Membership Council in 2015/16 included:-

- Participation in Theatre Action Week to improve theatre use and increase efficiency
- Involvement in the Integrated Transport Review to assess the efficiency of hospital and community resources
- Views on designing the best possible signage and way-finding techniques for patients through our hospitals
- Participation in the Trust's sustainability strategy
- Participation in familiarisation tours around specific areas of the Trust
- Work with Clinical Commissioning Groups to help design the Right Care, Right Time, Right Place public consultations
- Being a focus group for the Care Quality Commission inspection to the Trust
- Attending sessions on the Future State Validation on how EPR would affect the patient experience.

In conclusion Rev Wayne Clarke wished to thank the Membership Office for their help and support throughout the year.

10. QUESTIONS AND ANSWERS

The Chairman gave opportunity for those present to raise any general questions of the Board or Membership Council.

Question 1

Could the Trust be described as having a "good" year when HSMR and complaints rates were up?

The Chairman responded that the Trust's mortality rates were considered at each Board meeting as it remains a concern. He highlighted that a lot of work had been done to understand the reason behind the figures and that this would continue. This had included an independent review of mortality. In relation to complaints he commented that it was important people that people felt able to raise issues about services and make a complaint so that the Trust could learn from any case where a patient and their family had not been totally happy with their care. He said expectations are very high and that all complaints were investigated and responded to.

Question 2

Whether one of the testimonials in the consultation document was valid and that it had been submitted by the Trust to the CCG without consent.

The Chairman responded that this issue would be investigated as a complaint and formal response provided.

Question 3
What is the impact of the Government's decision to cease nurses' training grants?

The Deputy Director of Nursing Lindsay Rudge said that the Trust works closely with the University and that there would be plans in place for when the new system comes in in 2017/18. She said there are strong recruitment and retention policies in place and we would be trying to ensure the change was not detrimental to how we operate.

Question 4
Is the Trust affected by expensive drug costs?

The Executive Director of Finance and Chief Executive said that like all other Trusts, CHFT is affected by expensive drug costs but the more we use the cheaper they become.

Question 5
What is the impact of rising clinical negligence costs?

The Executive Director of Finance said that the pay outs often relate to historical cases and that he expected pay outs to rise again. The Chief Executive said it was important we try to support families so they do not feel as though litigation is their only route of action.

Question 6
If the CCG plans to reduce A&E attendances will that mean a reduction in income for the Trust?

The Chief Executive responded that as the Trust is also a community provider, there would be an opportunity to increase community income as more care is provided outside of hospital. The Trust is also working closely with GP Federations to provide joined up care in community. He said nationally there is the desire to reduce the number of patients.

Membership councillor Peter Middleton commented that over the last 20 years, life expectancy has increased by up to four years and that is due to excellent NHS care. He wanted to thank everyone working in the Trust.

11. DATE AND TIME OF NEXT MEETING
It was noted that a provisional date had been set for the next Annual General Meeting - Thursday 14 September 2017. The time and venue would be confirmed nearer the date.

The Chairman closed the formal meeting at approximately 7.15 pm.

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