Board of Directors Public Meeting - 5.4.18

Schedule	Friday 05 April 2019, 09:00 AM — 11:15 AM BST
Venue	Boardroom, Huddersfield Royal Infirmary
Organiser	Kathy Bray

Agenda

9:00 AM	1.	Welcome and introductions: Dianne Hughes, Public Elected Governor Kate Wileman, Public Elected Governor Brian Moore, Lead Governor To Note - Presented by Philip Lewer
9:01 AM	2.	Apologies for absence: To Note - Presented by Philip Lewer
9:02 AM	3.	Declaration of interests To Note - Presented by Philip Lewer
9:03 AM	4.	Minutes of the previous meeting held on 1 March 2018 To Approve - Presented by Philip Lewer APP A1 - PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 1.3.18.pdf 1 APP A2 - PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 1.3.18 - Appendix - DRAFT - PUBLIC BOD MINS - 1.3.18 (2).pdf 3
9:08 AM	5.	Action log and matters arising For Review - Presented by Philip Lewer APP B1 - ACTION LOG - PUBLIC BOARD OF DIRECTORS.pdf 13 APP B2 - ACTION LOG - PUBLIC BOARD OF DIRECTORS - Appendix - DRAFT ACTION LOG - BOD - PUBLIC - As at 1 APRIL 2017.pdf 15
9:13 AM	6.	Chairman's Report a.Council of Governors' Meeting – 4.4.18

	To Note - Presented by Philip Lewer	
9:18 AM	7. Chief Executive's Report: To Note - Presented by Owen Williams	
9:23 AM	8. Patient/Staff Story & Quality Report deep-dive: "Digital Award" presented by Anne-Marie Henshaw, Associate Director of Nursing/Head of Midwifery To Note	
9:43 AM	9. High Level Risk Register To Approve - Presented by Victoria Pickles	
	APP C1 - HIgh Level Risk Register.pdf	21
	APP C2 - HIgh Level Risk Register - Appendix - Risk Register paper 23.03.18.pdf	24
9:48 AM	10. Governance Report a.BOD Attendance Register b.Declaration of Interests Register – Board of Directors c.Compliance with Licence To Approve - Presented by Victoria Pickles	
	APP D1 - GOVERNANCE REPORT - APRIL 2018.pdf	54
	APP D2 - ATTENDANCE REGISTER - 1.4.17 - 31.3.18.pdf	57
	APP D3 - DECLARATION OF INTERESTS REGISTER - BOD ONLY - 1.4.18 - COMPLETE.pdf	59
9:53 AM	11. Fit and Proper Person Self Declaration Register To Approve - Presented by Victoria Pickles	
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9:58 AM	12. Travel and Transport Review To Note - Presented by Victoria Pickles	
	APP F1 - TRAVEL AND TRANSPORT REVIEW.pdf	71
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10:03 AM	13. Annual Plan	

To Approve - Presented by Gary Boothby

10:13 AM	14.	Data Quality Update To Note - Presented by Helen Barker	
		APP H1 - Data Quality Update.pdf	120
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10:23 AM	15.	Integrated Performance Report To Note - Presented by Helen Barker	
		APP I1 - Integrated Performance Report.pdf	130
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10:33 AM	16.	Month 11 – 2017-2018 – Financial Narrative To Approve - Presented by Gary Boothby	
		APP J1 - Financial Commentary for NHS Improvement - Month 11.pdf	144
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10:48 AM	17.	Guardian of Safe Working Quarterly Report To Approve	
		APP L1 - Guardian of safe working hours (GOSWH) Q1 Report 2018.pdf	152
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	18.	UPDATE FROM SUB COMMITTEES AND RECEIPT OF MINUTES AND PAPERS Presented by Philip Lewer	
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DRAFT - Appendix - Minutes 21 Feb 2018.pdf

- Quality Committee - minutes of 26.2.18

- Finance and Performance Committee - minutes of 23.2.18, 19.3.18 and verbal update from meeting held 3.4.18

- Workforce Well-Led Committee - minutes of 16.3.18

- Charitable Funds Committee - minutes 21.2.18

19. Date and time of next meeting - Thursday 3 May 2018 at 9.00 am in the Large Training Room, LC, CRH

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th April 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 1.3.18 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 1 March 2018	
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 1 March 2018

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 1 March 2018

Appendix

Attachment:

DRAFT - PUBLIC BOD MINS - 1.3.18 (2).pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 1 March 2018 at 9am in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Andrew Haigh	Chairman
Owen Williams	Chief Executive
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Dr David Birkenhead	Medical Director
Gary Boothby	Executive Director of Finance and Procurement
Karen Heaton	Non-Executive Director (tele-conference)
Lesley Hill	Executive Director of Planning, Estates and Facilities (tele-conference)
Phil Oldfield	Non-Executive Director (tele-conference)
Andy Nelson	Non-Executive Director (tele-conference)
Dr Linda Patterson	Non-Executive Director (tele-conference)
Richard Hopkin	Non-Executive Director (tele-conference)
Suzanne Dunkley	Executive Director of Workforce and Organisational Development

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships (tele-conference)
Kathy Bray	Board Secretary (minute taker)
Juliette Cosgrove	Assistant Director of Quality and Safety (for items 9 and 10)
Victoria Pickles	Company Secretary
Lindsay Rudge	Deputy Director of Nursing
Dr Sal Uka	Associate Medical Director (for item 14)
Dan Wood	Unison staff-representative (tele-conference)

OBSERVERS

Philip Lewer
15 members of staff from Estates & Facilities

33/18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, particularly the members of staff and staff-side representatives who had been invited to give their views on item 8 "Wholly Owned Subsidiary". The Chair also welcomed Philip Lewer who would take over as CHFT Chair with effect from the 1 April 2018. Due to weather conditions it was noted that a number of attendees had been unable to attend in person and tele-conference arrangements had been set-up. It was therefore agreed that item 8 would be taken first on the agenda.

34/18 APOLOGIES FOR ABSENCE

Apologies were received from:
Brendan Brown, Executive Director of Nursing
Alastair Graham, Non-Executive Director
Mandy Griffin, Managing Director Digital Health
Dr Peter Bamber, Staff Elected Governor
Veronica Maher, Publicly Elected, Governor
Brian Moore, Publicly Elected Governor – Lead Governor
Linzi Smith, Staff Elected Governor

35/18 WHOLLY OWNED SUBSIDIARY (WOS)

As mentioned at the beginning of the meeting the Chair advised that staff-side representatives had been invited to attend the meeting to air their views with the Board on this item. A request had been received from the three staff-side representatives that this item should be deferred and a delay in the decision making process. Due to the fact that 15 members of staff had attended and the Board was quorate it was agreed that discussions should continue. It was noted that a letter received from Pat Pepper, Unite Union had been circulated to the Board prior to the meeting.

The Chief Executive gave a presentation which outlined the case for change and the history of the work which had been undertaken both within the Trust and across the West Yorkshire Acute Association of Trusts (WYAAT). Following a thorough appraisal against financial and non-financial benefits, the preferred option to develop a CHFT Wholly Owned Subsidiary had been discussed and agreed by the Board in December 2017 and January 2018. He highlighted the engagement and consultation that had been undertaken to date with both staff and staffside representatives.

The presentation provided the details of the case for change, business case development and consultation overview. The key principles included:

- a movement towards the Living Wage
- commitment to the protection of Agenda for Change terms and conditions for those staff that transfer into the WOS for the duration of the contract between the WOS and the Trust
- a minimum contract duration of 15 years
- a guarantee that the totality of services would not be sold on outside of NHS ownership
- ensure staff who TUPE into the WOS and subsequently get promoted will stay on the same Agenda for Change terms and conditions
- ensure that these principles will remain in place regardless of any decision of the Secretary of State regarding reconfiguration and any potential future methods of financing.

The next steps, subject to Board approval would be:-

– Agree to the establishment of a Wholly Owned Subsidiary Company for CHFT
– Nomination of the Executive Director of Workforce & OD and a designated Non-Executive Director to be a part of any future governance
– Determine the Executive Director of Estates & Facilities Management to be nominated as the interim lead director for the WOS
– Establishment of an Estates, Facilities and Procurement Joint Consultative Committee to facilitate local, meaningful consultation on the WOS following the Board Meeting
– Work towards a target date for the WOS to be fully operational as of 31st August 2018
– Commence formal TUPE consultation

The Chairman gave opportunity for the Board, Dan Wood, Unison and staff members present to give their views. The concerns of the unions related to the consultation period and timescale, together with the impact of this model which was felt to be against the NHS Constitution were noted. The unions appreciated the challenges in the NHS but felt that other models such as using secondment of staff from the Trust rather than TUPE should be investigated and greater involvement with staff. It was noted that continuation of the proposals would compel UNISON to proceed to a formal industrial action ballot of its membership over this issue.

The Board agreed that it had undertaken lengthy debate on the proposals and felt that as developments within the NHS unfolded the principles of this entity would afford greater security to the workforce and help improve patient care in the long term. The Board committed to ensuring that these principles would be upheld in the future as other Board members took up post. It was recognised that significant consultation and engagement had been undertaken and the Executive Director of Workforce pointed out that the process of consultation with staff was an ongoing issue.

The Board noted that the timescale had been extended from June to August and that this would enable further work to be undertaken to investigate other models which had been suggested by the Unions.

The Chair asked for the Board to indicate their support for the proposal to continue to establish a CHFT Wholly Owned Subsidiary. Dr Linda Patterson confirmed that she wished to have placed on record that she did not agree with this proposal. All other members of the Board present approved the recommendation.
OUTCOME: The Board of Directors AGREED to support the development of a CHFT Wholly Owned Subsidiary but that other models to TUPE would be investigated and the outcome shared with staff.

36/18 DECLARATIONS OF INTEREST
There were no declarations of interest to note.

37/18 MINUTES OF THE MEETING HELD 1 FEBRUARY 2018
The minutes of the previous meeting were approved as a correct record subject to the following amendments:

8/18 HIGH LEVEL RISK REGISTER – Richard Hopkin advised that this should read "23 February" meeting rather than "30 January 2018".

29/18 INTEGRATED PERFORMANCE REPORT – Andy Nelson asked that an action be recorded for the item "weighting of mandatory training set against other targets should be reviewed". The Board agreed that this should be actioned by the Chief Operating Officer as this could affect the scorecard going forward.

ACTION: Chief Operating Officer

OUTCOME: The minutes of the meeting were APPROVED as a correct record subject to the above amendments.

38/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG

11/17 IPR ACTION CARDS – It was confirmed that this had not yet been actioned. The Chief Operating Officer was asked to circulate a briefing to the Non-Executive Directors to explain the process around the use of these cards.

ACTION: Chief Operating Officer

STATUS: OPEN ON ACTION LOG

39/18 CHAIR'S REPORT

a. Chair's Recruitment Process Update

As reported earlier in the meeting the Chair announced that Philip Lewer had been appointed Chair for the Trust with effect from 1 April 2018.

b. Feedback from Workshop with NHS Improvement on Quality Improvement Held 12.2.18

The Chair reported on the feedback received following the quality improvement workshop with NHS Improvement held on the 12 February 2018. All present agreed that this had been a useful workshop and reinforced all the good work which had been achieved and was on going in the Trust. It was noted that quality improvement was happening in a range of services across the Trust but weren't always recognised as such. Congratulations were given to all staff for the various strands of quality improvement, appreciating that this was being achieved through various programmes/initiatives.

OUTCOME: The Board NOTED the Chairman's report

40/18 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the extraordinary weather conditions and thanked all staff, both those who had managed to get into work and those working from home, for their continued hard work .

The Chief Operating Officer confirmed that actions had been undertaken to ensure patient safety through adequate staffing in the Trust and contact with Kirklees Council for additional gritting services to enable access between the two hospitals.

OUTCOME: The Board NOTED the Chief Executive's report

41/18 QUARTERLY QUALITY REPORT AND QUALITY IMPROVEMENT STRATEGY

a. Quarterly Quality Report

The Assistant Director of Quality and Safety presented the quarterly quality report which provided data regarding progress with quality improvement priorities and the 2017/18 quality account priorities.

The contents of the report were noted and Dr Linda Patterson reported that the quarterly quality report had been discussed in detail at the last Quality Committee and commended this report to the Board.

b. Quality Improvement Strategy

The Assistant Director of Quality and Safety presented the Quality Improvement Strategy. It was noted that the strategy had four identified project drivers:

• **Leadership and culture** – In order for the strategy to be successful in improving outcomes for our patients the implementation and monitoring of the strategy will require leadership from every level of the organisation. Senior leaders, and boards in particular, play a vital role in creating a supportive culture and environment for quality improvement.

• **Building quality improvement capability** – Enabling staff to identify their own areas for improvement and giving them the right tools and training to carry out tests of change, measure their impact and act on the results.

• **Quality improvement measurement** – Using good quality, deep dive data to define how we track interventions, measure our success, recognise and understand variation and therefore provide assurance to the Board.

• **Learning culture and systems** - Change is more likely to happen when staff are given opportunity to reflect on how things are done now and think about how they could be done better in the future, with feedback to staff wherever possible. There needs to be shared learning from investigations and promoting of best practice and excellence.

Discussion took place regarding the wider view and how other quality improvement initiatives (non-clinical) are recorded within the Trust. It was agreed that the Chief Operating Officer and Executive Director of Workforce and OD would discuss this outside the meeting and report back to the Board in May 2018.
It was noted that the five year plan would shortly be revised and this would be included.

ACTION: Chief Operating Officer and Executive Director of Workforce and OD to report to BOD. Agenda item - May 2018

OUTCOME: The Board APPROVED the Quality Improvement Strategy

42/18 HIGH LEVEL RISK REGISTER

The Assistant Director of Quality and Safety reported the risks scoring 15 or above within the organisation. These had been discussed in detail at the Executive Board, Finance and Performance Committee, Quality Committee and Risk and Compliance Group.

These were:-
6967 (25): Non-delivery of 2017/18 financial plan
7169 (25): Trust Financial Control 2018/19
7147 (20): EPR financial risk medical division 7049 (20): EPR financial risk
7062 (20): Capital programme
7078 (20): Medical staffing risk
6903 (20): Estates/ ICU risk, HRI
6658 (20): Patient flow
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
6441 (20): Divisional income Surgery and Anaesthetics

Risks with increased score
There were no risks with an increased score.

Risks with reduced scores
6971 – Endoscopy
This risk regarding business continuity for endoscopy and hysteroscopy has been reduced to a score of 12, following discussion within the Surgical and Anaesthetics Patient Safety Quality Board and discussion between the Chair of the Risk and Compliance Group and the Director of Operations for the division. The rationale for the reduction in score was noted.

New risks
7169 – 2018/2019 Income and Expenditure Risk
The risk for income and expenditure for 2018/19 has been reviewed at Finance and Performance Committee on 23 February 2018 and agreed that this should be added with a score of 25.

Once the 2017/2018 financial position is confirmed, risk 6967 on income and expenditure will be removed.

Closed risks
There were no closed risks during the month.

It was noted that the governance of the divisional digital boards was being tested to ensure there were robust systems to identify and manage electronic patient record (EPR) risks. Once this assurance is in place, the EPR risks would be transferred to the divisional digital boards and the standard escalation process put in place.

It was noted that the Board Workshop on Risk Appetite had been deferred but this would be picked up by the new Chair when he came into post.

ACTION: Action Plan item

The Chair identified that slow patient flow had been on the register for some time. It was noted that a number of improvements had been made and it was suggested that a 'planned improvement trajectory' column be included to identify the work undertaken. The Company Secretary advised that work was on going to review the whole of the risk register narrative and this suggestion would be taken on board which would assist the Board when looking at long standing risks.

OUTCOME: The Board APPROVED the High Level Risk Register

43/18 CARE OF THE ACUTELY ILL PATIENT REPORT (CAIP)

The Executive Medical Director updated the Board on the Care of the Acutely Ill Patient report which aimed to reduce mortality in the Trust. The report highlighted the progress in the following areas:

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

It was noted that the CAIP improvement plan is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee.

There were no outlying areas of concern and work continued on sepsis and acute kidney injury. Compliance with DNACPR had been achieved. Data and metrics were now available through the introduction of the EPR were beginning to show benefits in all the above areas.

The Board discussed the need to receive this report in the future given the progress made and that the work was embedded through different work streams including end of life and learning from death. The Medical Director agreed to consider this further.

The Chief Executive commended the Medical Director and Associate Medical Directors for their leadership and ability to identify where improvements are required and communicate this to staff, recognising the good achievements and how this is translated to the workforce. The Chief Executive agreed that he, along with the newly appointed Chair would ensure that lines of communication with staff continued and wider communications put in place.

ACTION: Chief Executive

OUTCOME: The Board **APPROVED** the Care of the Acutely ill Patient Report

44/18 GOVERNANCE REPORT

The Company Secretary advised that the Governance report brought together a number of governance items for review and approval by the Board:

a. Board Skills and Competencies

As agreed at the December Board of Directors meeting, the composite information regarding the Board Skills and Competencies had been collated and attached to the papers. The Company Secretary advised that this will be used to help identify any required development and also the assessment of what skills are required when consideration is given to future board vacancies.

It was noted that arrangements were being made for the Chief Executive/Chair/Executive Director of Workforce and Company Secretary to prepare a Board Development Programme and utilise some of the intelligence from this exercise, along with strategic issues in its development and would be brought back to the Board in the near future.

Andy Nelson felt that he had misinterpreted the report and would resubmit.

OUTCOME: The Board APPROVED the report.

ACTION: BOD Workplan
ACTION: OW/PL/SD/VP

b. Board Workplan

It was noted that the Board Work Plan has been updated and was presented to the Board for review. The Board were asked to consider whether there are any other items they would like to add for the forthcoming year and notify these to the Company Secretary.

Karen Heaton questioned whether the Workforce Strategy going to the Board in February 2019 was too late and should be brought forward. It was agreed that she would discuss this outside the meeting with the Executive Director of Workforce and go back to the Company Secretary to amend if required.

ACTION: KH/SD

OUTCOME: The Board APPROVED the work plan.

c. BOD Terms of Reference

It was noted that the Terms of Reference had been circulated with the papers and there were no significant changes required. The Terms of Reference and Annual Reports from the Sub Committees were expected to be presented to the BOD in May 2018.

OUTCOME: Subject to amendments to the reference to CoG instead of MC, the Board APPROVED the Terms of Reference and noted that the information from all the sub-committees would be presented to the BOD in May.

ACTION: BOD AGENDA ITEM – MAY 2018

d. Use of Trust Seal

It was noted that there had been no sealing of documents since the last report to the Board in October 2017.

OUTCOME: The Board NOTED report.

45/18 LEARNING FROM DEATHS REPORT

Dr Sal Uka, Associate Medical Director presented the Quarter 3, Learning from Deaths Report. It was noted that in the last 12 months, there have been 1,682 deaths. Of these, 436 (26%) have been reviewed using the initial screening process that assesses the quality of care. The quality of care was assessed as either excellent or good in 71.3% (311) of cases reviewed. Poor or very poor care had triggered further investigation using the structured judgement review (SJR) from July 2017 and prior to this using a similar approach.

It was noted that the ambition remained to screen all 100% of deaths except those directed to a SJR. A total of 29 deaths have been escalated for SJR in Q3.

From December 2017, initial screening reviews (ISR) have been allocated to consultants and Senior Associate Specialist doctors across the Trust. Despite the initial problems with access to the online tool and requests for training, a total of 75 ISRs have been completed. A number of training sessions were being provided together with guidance for the clinical staff. The challenges associated with driving this process were acknowledged.

The reason for the escalations were noted and the Board were assured that learning identified was being actioned and themes were now beginning to emerge.

Dr Uka reported that a programme of improving communication was being re-established to involve patient relatives/carers, clinical and non-clinical staff and a pilot was currently underway utilising bereavement surveys and bereavement cafes.

Richard Hopkin questioned whether achieving 100% reviews was realistic. Dr Uka confirmed that he was not confident but did not want to move away from this at the present time until more work is undertaken regionally with the toolkit.

OUTCOME: The Board RECEIVED and NOTED the Learning from Deaths report.

46/18 QUALITY PERFORMANCE REPORT

The Chief Operating Officer highlighted the key points of operational performance. It was noted that this report had been discussed in detail at the Executive Board, Quality Committee and Finance and Performance Committee.
The key highlights from the report were noted:-

- January's performance score had improved by 5 percentage points to 60%.
- All domains have improved scores with the exception of EFFICIENCY & FINANCE.
- The CARING domain has improved significantly due to FFT performance.
- The EFFECTIVE domain has returned to GREEN. Although fractured neck of femur performance was below target, over 90% of admitted patients had been to theatre within 36 hours in January which means that the February performance should see an improvement.
- The RESPONSIVE domain has improved slightly with 3 out of 4 stroke targets now achieving target plus cancer has maintained good performance for the third month running across all metrics. For emergency care standard the score reflects failure to deliver the 95% standard however the Trust did achieve the NHS Improvement agreed trajectory of 90% for January.
- EFFICIENCY & FINANCE had deteriorated with day case and A&E activity both missing target in-month.
- WORKFORCE had improved slightly with better sickness absence rates. It was noted that although all performance against all five mandatory training focus areas remained behind target there had been significant improvement during February.

The Chief Operating Officer reported that the Trust was looking to increase elective activity in March following the stoppage to support patient flow during January and February. Assurance was given that activity profiles were being looked at to provide adequate staffing cover during the Easter holiday period.

The Executive Medical Director confirmed that work was on going to review Infection Control practices and both external and independent input had been sought.

OUTCOME: The Board **RECEIVED** the Integrated Board Report and **NOTED** January's position

47/18 MONTH 10 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance presented the Month 10 Financial Narrative.

The Month 10 position is a year to date deficit of £30.81m. On a control total basis this is an adverse variance from plan of £8.70m; excluding the impact of the loss of Sustainability and Transformation funding (STF) of £5.04m based on Q1 and 2 A&E performance and financial performance in Months 7-10. When loss of STF funding is included, the total adverse variance is £13.74m against the control total of £17.00m.

Since appealing the 17/18 £15.9m control total deficit in January 2017, the Trust's Board has continued to express concerns regarding the scale of this challenge. For 2017/18, the impact associated with the abnormal risk of EPR implementation was estimated at £5m, whilst only £17m of the required £20m CIP was believed to be achievable, leaving the Trust with a total risk which was assessed at the start of the year to be £8m plus any subsequent loss of STF funding.

As discussed with NHSI in recent meetings, it is now clear that these concerns were well founded. Indeed, the underlying operational performance would drive a greater adverse financial variance due to a number of a number non-recurrent income and expenditure benefits supporting the forecast position. This includes a £4.2m negotiated settlement with

the facilities management provider in support of CIP delivery; non-recurrent income and release of prior year accruals; and £1.9m associated with the setup of the estates wholly owned subsidiary. This is in addition to the release in the year to date of the full £2m contingency reserve available for this financial year.

Since Month 7 the Trust has been unable to deliver the financial plan reporting a year to date adverse variance of £8.70m of which £3.15m related to Month 10. The implementation of EPR continues to have a significant impact on both productivity and the capture of activity data and is significantly contributing to a material clinical contract income variance of £9.5m year to date.

As reported in Month 9 and previously discussed with colleagues in NHS Improvement, the Trust does not expect to achieve the 17/18 control total due to a combination of: slower than expected recovery of clinical activity levels and therefore income following EPR implementation; reduced operational capacity whilst resolving implementation issues and associated cost pressures; income values being lower than planned for the actual activity delivered and assumed within the HRG4+ test grouper; cost pressures linked to the requirement to open additional beds, winter and remaining unidentified CIP of £2.0m. The Trust has undertaken a detailed forecast review of both activity and income which indicates that activity levels are unlikely to recover to planned levels during this financial year. Whilst every effort continues to be made to improve the financial out turn, including pursuing innovative technical accounting benefits, the current forecast indicates that the Trust will end the year with a gap to control total of £8m, (excluding loss of STF funding). Delivery of the financial plan remains the highest risk on the Trust risk register scoring the maximum of 25.

OUTCOME: The Board NOTED the contents of the report

48/18 UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES

The Board received an update from each of the sub-committees who had met prior to the Board meeting.

a. Quality Committee

Dr Linda Patterson, Chair of the Quality Committee reported on the key items discussed at the meeting held on 26 February 2018 which had not been previously covered on the Board's agenda:

- Serious incidents report actions monitored – regular agenda item
- Infection Control issues – being monitored

OUTCOME: The Board RECEIVED the minutes from the meeting held on 29 January 2018 and the verbal update of the meeting held on 26 February 2018.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 23 February 2018 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- Focus on year-end outturn
- Understand establishment budgets for next year and challenges faced
- Formal submission of budgets due 8 March 2018.
- Sustainability and transformation fund update
- Risk Register

OUTCOME: The Board RECEIVED the minutes from the meeting held on 30 January 2018 and verbal update from 23 February 2018 meeting.

c. Workforce Well Led Committee

Karen Heaton, Chair of the Workforce Well-Led Committee presented the minutes from the meeting held on the 14 February 2018 and the contents were noted.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 14 February 2018.

d. Audit and Risk Committee

Richard Heaton, Chair of Audit and Risk Committee presented the minutes from the meeting held on the 24 January 2018. The key items had been discussed at the Board of Directors Meeting on the 1 February 2018.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 24 January 2018.

e. Council of Governors

The Chair presented the minutes from the meeting held on the 23 January 2018.

OUTCOME: The Board RECEIVED the minutes from the meeting held on the 23 January 2018

DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 1 April 2018 commencing at 9.00 am in the Boardroom, Huddersfield Royal Infirmary.

The Chair thanked everyone for their contribution and closed the public meeting at 11:55 am.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th April 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 April 2018	
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 April 2018

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 April 2018

Appendix

Attachment:

DRAFT ACTION LOG - BOD - PUBLIC - As at 1 APRIL 2017.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
7.12.17 183/17	**PATIENT STORY** It was agreed to discuss how EPR can support the serious incident investigation and information capture.	OW / JC	**1.2.18** **Agreed that EPR/Serious Incident Investigation would be presented at a future meeting.** **WINTER PRESSURES** **The COO advised that at the end of the quarter she would bring a paper to Board updating on winter planning arrangements and conversations with partners**	TBC		
7.12.17 187/17	**CHIEF EXECUTIVE'S REPORT** The Quality Committee will undertake a review of the impact of the recent interim medical services reconfiguration and report back to the Board	Chair of Quality Committee / HB		April 2018		
7.12.17 188/17	**QUARTERLY QUALITY REPORT** The Quality Committee will undertake a deep dive on sepsis and will report back to the Board	Chair of Quality Committee / DB		April 2018		
7.12.17 191/17	**GOVERNANCE REPORT – SKILLS & COMPETENCIES** All Board members to complete their self-assessment and return to the Board Secretary	ALL	**1.2.18** **All Board members were reminded to return their self-assessment submissions to the Board Secretary before 21.2.18 in order that a composite report can be prepared for the March 2018 BoD meeting.**	March 2018		1.3.18
7.12.17 197/17	**UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES** The Chief Executive advised that a piece of work was underway looking at staff experience of appraisals would be brought to a future BOD	JE		TBC		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	meeting					
4.1.18 9/18	**PREPARATION FOR THE GENERAL DATA PROTECTION REGULATIONS (GDPR)** Presentation received. It was agreed that progress against plan would be monitored by the Executive Board and Audit and Risk Committee. It was agreed that clear governance arrangements would be provided through this route and an update brought to the Board in May 2018.	MG		May 2018		
1.1.18 13/18	**GUARDIAN OF SAFE WORKING** Update received. Concern was expressed regarding the lack of administrative support for the Guardian. It was agreed that the Executive Medical Director would speak to colleagues in the Trust to ascertain whether there was any dedicated support which could be provided from within the organisation to assist the Guardian of Safe Working.	DB	**1.2.18** **Requirements were clarified with Guardian, the Trust are in support and will hopefully be resolved very shortly. It was agreed that this would remain on the Action Log until the matter had been fully resolved.**	TBC		
4.1.18 11/17	**IPR – ACTION CARDS** Discussion took place regarding Action Cards and it was agreed that the COO would be asked to circulate a briefing to the NEDs to explain the process around the use of these cards.	HB	1.2.18 The COO agreed to circulate a briefing to the NEDs to explain the process around the use of these cards. **1.3.18** **It was confirmed that this had not yet been actioned. The Chief Operating Officer was asked to circulate a briefing to the Non-**	April 2018		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			Executive Directors to explain the process around the use of these cards.			
1.2.18 25/18	**GOVERNANCE REPORT – COUNCIL OF GOVERNORS ELECTION TIMETABLE** The Chief Executive suggested further work was needed to encourage a more inclusive membership and potential governors. The Executive Director of Workforce and OD explained Kirklees have a Young Employee's Network that could be explored.	SD/VP	**Company Secretary and Executive Director of Workforce to discuss outside the BOD meeting.**			March 2018
1.2.18 26/18	**FREEDOM TO SPEAK-UP/WHISTLEBLOWING ANNUAL REPORT** Karen Heaton asked if other Trusts had used alternative routes and Dr Anderson agreed that he would investigate this further.	DA		TBC		
1.2.18 28/18	**EQUALITY AND INCLUSION ANNUAL REPORT** Karen Heaton recommended that the Trust set itself targets in relation to diversity of the workforce. The Chief Executive recommended that this could be discussed as part of a Board workshop.	VP SD/KH		May BOD Workshop		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 2018/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	Action A: It was agreed that the Company Secretary would include on the agenda for a future Board workshop. **Action B: Suzanne Dunkley / Karen Heaton to explore the workforce element timeline.**					
1.3.18 37/18	**INTEGRATED PERFORMANCE REPORT – WEIGHTINGS REVIEW** Andy Nelson asked that an action be recorded for the item "weighting of mandatory training set against other targets should be reviewed". The Board agreed that this should be actioned by the Chief Operating Officer as this could affect the scorecard going forward.	HB		TBC		
1.3.18 41/18	**QUALITY IMPROVEMENT STRATEGY** Discussion took place regarding the wider view and how other quality improvement initiatives (non-clinical) are recorded within the Trust. It was agreed that the Chief Operating Officer and Executive Director of Workforce and OD would discuss this outside the meeting and report back to the Board in May 2018. It was noted that the five year plan would shortly be revised and this would be included.	HB/SD		3.5.18		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 2018/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
1.3.18 42/18	**HIGH LEVEL RISK REGISTER – BOARD RISK APPETITE** It was noted that the Board Workshop on Risk Appetite had been deferred but this would be picked up by the new Chair when he came into post.	PL/SD/VP		TBC		
1.3.18 43/18	**CARE OF THE ACUTE ILL PATIENT REPORT** The Chief Executive commended the Medical Director and Associate Medical Directors for their leadership and ability to identify where improvements are required and communicate this to staff, recognising the good achievements and how this is translated to the workforce. The Chief Executive agreed that he, along with the newly appointed Chair would ensure that lines of communication with staff continued and wider communications put in place.	OW/PL		TBC		
1.3.18 44/19	**BOARD SKILLS AND COMPETENCIES** Arrangements were being made to prepare a Board Development Programme and utilise some of the intelligence from this exercise, along with strategic issues in its development and would be brought back to the Board in the near future.	OW/PL/SD/ VP		TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 2018/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
1.3.18 44/19	**GOVERNANCE REPORT – BOARD TOR** Subject to amendments to the reference to CoG instead of MC, the Board APPROVED the Terms of Reference and noted that the information from all the sub-committees would be presented to the BOD in May.	VP		3.5.18		
1.3.18	**BOARD WORKPLAN** Karen Heaton questioned whether the Workforce Strategy going to the Board in February 2019 was too late and should be brought forward. It was agreed that she would discuss this outside the meeting with the Executive Director of Workforce and go back to the Company Secretary to amend if required.	KH/SD		TBC		

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, 5th April 2018	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: HIgh Level Risk Register - To present the high level risks on the Trust Risk Register as at 19 March 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The draft high level risk register has been reviewed by members of the Risk and Compliance Group at it's meeting on 12 March 2018.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The high level risk register is presented on a monthly basis to ensure that the Board of Directors are aware of key risks facing the organisation 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 high level risk register.

Background/Overview:

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

The Risk and Compliance Group consider and review all risks that may be deemed a high level risk with a risk score of 15 or more on a monthly basis, prior to these being presented to the Board of Directors.

Divisional risk registers are also discussed within divisional patient safety quality boards, with divisions identifying risks for consideration for escalation to the high level risk register for review at the Risk and Compliance Group.

The Issue:

The attached paper includes:

i. Identification of the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks. This paper refers to a summary of the Trust risk profile as at 19 March 2018.

ii. The high level risk register which identifies risks and the associated controls and actions to manage these.

iii. Three new risks which have been added to the high level risk register during March 2018. These are:

- Risk 7194 regarding laboratory systems from the Family and Specialist Services division scored at 15, regarding the re-use of lab numbers. It is anticipated that a solution will be in place by May 2018, meaning that the risk will then be removed from the high level risk register.

- Risk 7132 regarding calculation of deteriorating patient scores (NEWS and PAWS) in the Emergency Department on the electronic patient record (EPR)., a Medical division risk scored at 16. This is a risk that has been identified at he divisional digital board following work identifying risks from the divisional EPR issue log.

- Risk 7223 THIS, Corporate Division, digital IT risk regarding inability to access clinical and corporate digital systems due to infrastructure failure, including cyber failure, risk score of 16.

It has been confirmed that risk 7147; an EPR financial risk for the Medical Division, remains on the high level risk register, with a reduced risk score from 20 to 16. .

Next Steps:

The EPR risk panel on 2 March 2018 was cancelled due to operational issues and is now meeting on 6 April 2018 to seek assurance about divisional identification of risks relating to EPR from the issue log as discussed within their digital board.

Divisions are raising risks relating to EPR scoring 15+ in the usual was via the Risk and Compliance Group,

following discussion within divisional digital board meetings, ensuring that these are managed within the usual risk management framework.

Any trustwide EPR risks (which do not sit within the remit of a divisional digital board)s scoring 15+ have been raised at the EPR Operational Group for further review.

Recommendations:

Board members are requested to:

I. Consider, challenge and confirm that potential significant risks within the high level 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:

Risk Register paper 23.03.18.pdf

HIGH LEVEL RISK REGISTER SUMMARY OF CHANGES

Risks as at 19 March 2018

TOP RISKS

The following risks scored at 25 or 20 on the high level risk register are:

6967 (25): Non-delivery of 2017/18 financial plan
7169 (25): Trust Financial Control 2018/19
7049 (20): EPR financial risk
7062 (20): Capital programme
7078 (20): Medical staffing risk
6903 (20): Estates/ ICU risk, HRI
6658 (20): Patient flow
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
6441 (20): Divisional income Surgery and Anaesthetics

The Trust risk appetite is included below.

RISKS WITH INCREASED SCORE

None

RISKS WITH REDUCED SCORE

Risk 7147, EPR financial risk within the medical division has reduced from a score of 20 to 16.

NEW RISKS

New risks agreed at the Risk and Compliance Group on 12 March were:

- 7194 Family and Specialist Services: Laboratory systems and re-use of numbers which could lead to results being reported back on the wrong patient, scored at 15. A solution is expected to be in place by May 2018.

- 7132 Medical division: Risk of not identifying deteriorating patient scores (NEWS / PAWS) within the Emergency Department due to these not being calculated accurately within EPR, risk score of 15.

New risk agreed via Chair's action:

- 7223 THIS, Corporate Division, digital IT risk regarding inability to access clinical and corporate digital systems due to infrastructure failure, including cyber failure, risk score of 16.

CLOSED RISKS

None

19 MARCH 2018 – BOARD - SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 19.3.18

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	March 18
012	2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
007	6990	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/18	Medical Director (DB)	=16	=16	=16	=16	=16	=16
007	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	↑16	=16	=16	=16	=16	=16
007	6829	Keeping the Base Safe	Aseptic Pharmacy Unit production	Director of Nursing	=15	=15	=15	=15	=15	=15
011	5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	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	=16
014	6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD (SD)	=16	=16	=16	=16	=16	=16
014	6977	Keeping the base safe	Mandatory training 2017/18	Director of Workforce and OD (SD)	=16	=16	=16	=16	=16	=16
011	6903	Keeping the base safe	ICU/Estates joint risk	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	6924	Keeping the base safe	Misplaced naso gastric tube for feeding	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
007	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
020	7046	Keeping the base safe	EPR Quality and safety risks	Exec Medical Director (DB)	=16	=16	=16	=16	=16	=16
007	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
007	6011	Keeping the base safe	Blood transfusion process	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
007	6949	Keeping the base safe	Blood transfusion service	Divisional Director of FSS (JO'R)				!15	=15	=15
007	**7132**	**Keeping the base safe**	**Miscalculation of deteriorating patient scores in Emergency Department**	**Divisional Director of Medical Division (AV)**						**!15**

007	**7194**	**Keeping the base safe**	**Laboratory system – risk of results being reported on wrong patient**	**Divisional Director of FSS (J O'R)**						**!15**
	7233	**Keeping the base safe**	**Digital IT systems risk**	**Managing Director – Digital Health**						**!16**

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	March 18
	7169	2018/19 income	Income and expenditure	Director of Finance (GB)					**!25**	**=25**
021	6967	Financial sustainability	Non delivery of 2017/18 financial plan	Director of Finance (GB)	=25	=25	=25	=25	=25	=25
021 & 022	7049	Financial sustainability	EPR financial risk due to increased costs and decreased income	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
022	7062	Financial sustainability	Capital programme 2018/19	Director of Finance (GB)	**=**20	=20	=20	=20	=20	=20
021	6441	2017/18 income	Divisional income surgery and anaesthetics	Associate Director of Nursing, Surgery and Anaesthetics (JM)	↑20	=20	=20	=20	=20	=20
021	7147	2018/ 18 income	EPR financial risk medical division	Associate Director of Nursing, Medical Division (AM)				!20	=20	=20
Performance and Regulation Risks										
007	6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (BB)	=20	=20	=20	=20	=20	=20
007	6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
009	7047	Keeping the base safe	EPR Performance – failed regulatory standards, contractual KPIs, patient / staff performance	Chief Operating Officer (HB)	=16	=16	=16	=16	=16	=16
012	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce	=20	=20	=20	=20	=20	=20
012	7078	Keeping the base safe	Medical Staffing - ability to deliver safe	Medical Director (DB) ,Director of	=20	=20	=20	=20	=20	=20

			and effective high quality care and experience service	Nursing (BB), Director of Workforce						

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

TRUST RISK PROFILE AS AT 19/3/2018

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation = 6829 Pharmacy Aseptic Unit ! 7194 Laboratory systems	= 6345 Nurse Staffing = 7049 Financial risk arising from EPR = 6658 Inefficient patient flow = 7078 Medical Staffing	= 6967 Not delivering 2017/18 financial plan ! 7169 Not delivering 2018/19 financial plan
Likely (4)				= 6300 CQC improvement actions = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 5862 Falls risk = 6990 CQUIN sepsis = 6977 mandatory training = 7046 EPR quality and safety risks = 7047 EPR Performance /regulatory/KPI risk arisisng from EPR = 7147 EPR financial risk medical division ! 7223 IT Digital systems	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6903 ICU/ resus estates risk = 7062 Capital programme 2018/19 = 6441 Divisional income 2017/18 surgery and anaesthetics
Possible (3)					= 6924 Misplaced naso gastric tube = 6011 Blood transfusion process = 5747 Vascular /interventional radiology service = 6949 Blood transfusion service ! 7194 Labs system number recycling ! 7132 Miscalculation of deterioration scores in ED
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE NOVEMBER 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**

Risks 15 or more

Board meeting 5 April 2018

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
6967 (BAF ref 021)	Trustwide	Apr-2017	Financial sustainability	The Trust is planning to deliver a £15.9m deficit in 2017/18. There is a high risk that the Trust fails to achieve its financial plans for 2017/18 due to: - £20m (5.3% efficiency) Cost Improvement Plan challenge is not fully delivered - loss of productivity during EPR implementation phase and unplanned revenue costs - inability to reduce costs should commissioner QIPP plans deliver as per their 17/18 plans - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level - Risk overlaps that referred to in Ref. 6441 (Surgical Division).	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 Financial recovery actions were agreed by Turnaround Executive on 13th June. Controls around use of agency staffing have been strengthened. For 2017/18 the Trust has been given a £16.86m ceiling level for agency expenditure by NHS Improvement. Agency spend is planned to reduce considerably from the level of expenditure seen in 16/17 if the Trust is to deliver the financial plan, and not exceed the ceiling. Year to date this planned reduction in expenditure has been achieved.	Lack of direct consequence to budget holders for poor budgetary management. Difficulty in identifying EPR benefits to offset additional committed resource. Nursing Agency spend above planned level. Not all Agency shifts booked through flexible workforce team.	20 5 x 4	25 5 x 5	15 5 x 3	Whilst the Trust agreed the 17/18 Control Total of £15.9m, serious concerns about the achievability of this target have been raised with the regulator. It left the Trust with a planning gap of £3m that was added to the £17m CIP target. The organisation currently has plans for £17.95m of the £20m CIP target, but £2.1m of this forecast saving is currently considered at a high risk. In addition opperational pressures have resulted in a deteriorating financial position, with activity and income well below the planned level. EPR implementation has had a significant impact on productivity and the capture and coding of activity which continues to impact on clinical income. The corresponding underlying expenditure is above plan and in Month 10 the Trust reported a position that is £8.70m away from Control Total. In the first six months of the year achievement of the Control Total relied on the release of our entire Contingency Reserve and a number of non recurrent benefits that were one off in nature and cannot be repeated. As discussed with regulators the Trust is no longer forecasting to achieve the full year 17/18 Control Total and is reporting a forecast deficit of £45.25m, an adverse variance to plan of £15.41m. This variance incorporates a gap to control total of £8.00m which in turn drives the loss of Sustainability and Transformation funding (STF) of £7.40m. The scale of the financial impact is such that the risk score is likely to remain unchanged for the remainder of the financial year.	Mar-2018	Mar-2018	FPC	Gary Boothby	Philippa Russell

7169 (BAF ref 021)	Trustwide	Jan-2013	Financial sustainability	The Trust financial control total for 2018/19 has now been confirmed by NHS Improvement as an £8.4m deficit. There is a extremely high risk that the Trust fails to achieve this control total for 2018/19 due to: - large planning gap carried forward from 17/18 due to: non-recurrent / unidentified Cost Improvement Plans (CIP), loss of productivity and recurrent cost pressures. - CIP challenge likely to be in excess of 17/18 values - inability to reduce costs should commissioner QIPP plans deliver - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - non receipt of £14.2m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels	Financial recovery plan shared with Board in February 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 Controls around use of agency staffing have been strengthened.	Lack of direct consequence to budget holders for poor budgetary management. Capacity planning challenges Difficulty in identifying EPR benefits to offset additional committed resource. Nursing Agency spend above planned level. Volume of agency breaches remain comparatively high and a higher value for each breach.	25	5 x 5	25	5 x 5	15	5 x 3	Early indications are that there is a significant planning gap to control total for 18/19. Draft plans are to be submitted to NHS Improvement by 8th March 2018, at which point a decision will have to be made regarding acceptance (or not) of the 18/19 Control Total.	Mar-2018	Mar-2019	FPC	Gary Bo[illegible]nby	Philippa Russell
6903 (BAF ref 011)	Estates & Facilities	Dec-2016	Keeping the base safe	Collective ICU & Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to inadequate access granted to estates maintenance and capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.This incluides: ICU - Air Handling Unit (AHU) RESUS - Ventilation RESUS – Electrical Resilience ICU & RESUS - Flooring ICU & RESUS - Electrical Infrastructure RESUS - Plumbing infrastructure ICU & RESUS - Life Support Beams/Pendant ICU - Building Fabric ICU - Nurse Call System RESUS - Medical Engineering Risk - 4 Dameca Anaesthetic Machines RESUS - Operational Safety f RESUS – Compliance / Statute Law All of the above does not meet the minimum requirement as stipulated in the Health Technical Memorandums (HTM) and Health Building Notes (HBN)and principal statue law whicdh could result in prosecution	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU & RESUS, currently this is not achievable due to inadequate access and budget constraints.	20	5 x 4	20	5 x 4	0	0 x 0	December 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. The Authorising Engineer (AE (V)) has concluded his annual report for the Trust on Ventilation and has strongly advised on installing mechanical ventilation for the HRI Resus area as the current method of ventilation does not meet regulatory standards. January 18 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Estates are looking at all options to mitigate any future risk of closure, this includes partial and full refurbishment of Resus. February 18 Update - Estates are continuing to look at all options to mitigate any future risk of closure, this includes partial and full refurbishment of Resus. **March 18 Update** Estates are continuing to look at all options to mitigate any future risk of closure, this includes partial and full refurbishment of Resus.	Apr-2018	Dec-2018	RC	Lesley Hill / David McGarrigan	Chris Davies

7049 (BAF ref 021 and 022)	Trustwide	Aug-2017	Finance sustainability	EPR Financial risk with increased costs and decreased income. Due to: Reduction in activity arising from increased time per patient in outpatients leading to reduced templates, errors with booking process related to migration and build leading to DNAs etc, pre-assessment build impacting on elective activity & mapping issues impacting on overall income capture. Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff Increased costs to ensure timely and appropriate response to clinical & operational risks.	Developing financial recovery plans. Weekly activity and income meeting chaired by Director of Transformation and partnership, weekly Theatre scheduling now attended by an Executive. systems to capture activity. Weekly performance monitoring. Targeted improvement for those in greatest need. Activity coding issues being addressed. Continuing to shadow monitor activity using existing systems. Cymbio dashboard deployed from Day 1 of EPR, weekly Data Quality Board, validation expertise deployed and extended, retaining senior analytical support until post Bradford Go-live, increased Booking staff to maximise appointment booking. Stabilisation plan developed.	Adequate system build BAU Team capacity. Staff training.	20	4 x 5	20	4 x 5	0	0 x 0	Identification of staff training needs. Specialty delivery of recovery plans. System build changes identified and prioritised, BAU team capacity review. Education and training for clinical staff. Placing Coders in clinical areas February Update Data quality meeting reviews data capture and system issues with Divisional, Finance and THIS representation. Divisional financial recovery plans to address activity maximisation. Additional costs incurred being monitored with approvals to be taken through Commercial Investment Strategy Group and monthly financial monitoring. Discussions have taken place with regulators, NHSI with regards to the exceptional financial pressure incurred as a result of EPR implementation in-year and the impact on achievement of control total. Negotiations with commissioners have settled a position for 2017/18 which is inclusive of an agreed estimate for income impacted by data capture issues, thus mitigating further risk. **March 2018** 2018/19 challenge to Divisions to regain productivity shortfalls.	Apr-18	Mar-19	FC	Gary Bi[illegible]nby	Kirsty A[illegible]ner

7062 (BAF ref 022)	Trustwide	Sep-2017	Finance and sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2018/19 due to having insufficient cash to meet ongoing commitments resulting in a failure to maintain infrastructure for the organisation. Based on the two year plan submitted to NHS Improvement in March 2017, the Trust will only have access to internally generated capital funds of £7.1m in 2018/19 to cover all capital requirements Whilst the capital risk for 2017/18 has been reduced to a current assessment of 9, the risk in 2018/19 is likely to be much higher as internal generated funds will only support Capital expenditure of £7.1m, less than half the amount committed for 2017/18. This value is constrained by the fact that the remainder (£8m) of the Trust's pre-approved capital loan of £30m is to be spent in 2017/18. Therefore, the Trust can only call on internally generated capital funding to the level of annual depreciation charges, against which PFI charges and capital loan repayments are pre-committed, leaving the £7.1m balance. In the context of the Trust's ageing and ailing HRI estate; medical equipment requirements including MRI investment; and with a number of schemes being pushed back from 2017/18, the risk in 2018/19 is heightened.	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances.	Limited Contingency available. Potential for slippage of 17/18 schemes in next financial year. Uncertainty regarding long term capital planning while FBC is awaiting approval.	20	5 x 4	20	5 x 4	12	4 x 3	18/19 Capital Plan has been developed but is currently in excess of internally generated capital funds by £1.3m. Reviewed by Commercial Investment Strategy Committee on the 25th of January 2018. Trust is exploring alternative methods of increasing Capital Delegated Limits	Apr-18	Jun-2018	FPC	Gary Bo[illegible]by	Philippa Russell

7078 (BAF ref 012)	Corpo	Oct-20	Keepi	Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing) Risk of not being able to deliver safe effective and high quality care with a positive experience for patients due to: - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record) "	Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	March 2018 New Specialty Doctor in Emergency Medicine who has been appointed with support from the Royal College of Emergency Medicine, that commenced in post in February. This doctor will support the middle grade rota and reduce some of the reliance on Agency workers in A&E. Through the CESR Opportunities one of our existing trust doctors in A&E has confirmed that they wish to join the CESR cohort to progress through to consultant level. Medical HR are also working with some recruitment agencies who are looking for overseas doctors who may interested in these opportunities. By appointing to NHS posts we will be able to reduce over reliance on hourly paid Agency doctors. Medical HR is expecting information to start arriving from health Education England regarding the trainees that we can expect to commence in post with us in August 2018. this will enable forward planning and vacancies can be identified and recruitment can commence for any gaps. The Medical HR Manager has been working closely with the Deputy Medical Director to develop a rollout plan for electronic job planning within the Trust.	Apr-18	Sep-18	WF	David E enhead	Pauline rth

6658 (BAF ref 007)	Corpo	Mar-20	Keepin	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 [illegible] This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20	4 x 5	20	4 x 5	9	3 x 3	January 2018 Winter Plan remains in place.Tactical Command will be in place until the end of January 2018. Winter initiatives being reviewed. February 2018 Tactical Command in place for all of q4 2017/18. Health and social care system tactical command with partners now in place for full q4 2017/18. Interventions outside of winter plan implemented during January due to pressures, learning from these and continuing some initiatives during q4 due to continued pressures. Learning event for March 2018 planned. **March 2018** Risk reached target date. New risk being developed regarding patient flow for review at Risk and Compliance Group on 16 April 2018, therefore proposing to close this risk and agree at April meeting.	Mar-18	Mar-18	BOD	COO H n Barker	Bev We r

2827 (BAF ref 012)	Medic	Apr-20	Devel ng our workforce	The inability to recruit sufficient middle grade and consultant emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used 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 4 weeks worth of rota's requested in advance from flexible workforce department Development of CESR programme ACP development Continued recruitment drive for Consultant and Middle Grade doctors Weekly meeting attended by flexible workforce department, finance, CD for ED and GM	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level CESR training will extended time to reach Consultant level with no guarantee of retention	20 4 x 5	20 5 x 4	12 4 x 3	Jan 2018 No significant change from last month Feb 2018 MTI doctor in post. Currently working in a supernumerary capacity getting used to NHS systems. Plan to get onto Junior rota in the next 2 weeks with a view to Middle Grade level by the end of April **March 2018** MTI not likely to be suitable for MG rota for some time. Programme of support being developed	Apr-2018	Aug-2018	WEB	David E enhead	Dr Mark avies/Mrs Caroline Smith
5806 (BAF ref 011)	Estates & Facilities	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. Details of specific risks listed in full on risk register.	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.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. 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	January 18 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. The Capital Plan for 18/19 is now at the final stages of planning, due to funding this will not include any major refurbishment but will cover statutory compliance action plans for HRI. February 18 Update - The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The Capital Plan for 18/19 is now at the final stages of planning, due to funding this will not include any major refurbishment but will cover statutory compliance action plans for HRI. **March 2018 Update** The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The Capital Plan for 18/19 is now at the final stages of planning.	Apr-2018	Feb-2019	RC	Lesley Hill / David McGarrigan	Paul Gilling / Chris Davies

6345 (BAF ref 012)	Corpo g	Jul-20	Keepi the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) 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 resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment		16 4 x 4	20 4 x 5	9 3 x 3	**March 2018 Update** Applicants from International recruitment trip to the Philippines are progressing (119 offers were made in country, since March 2017, with ongoing training and tests underway). Currently advertising for 20 Nurse Associate roles, a new training role which will support divisions with their nurse staffing supply in the future, advert closes mid 15 March with interest shown. The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has continued and is progressing with interviews during March 2018. Also recruiting to band 5 student nurse posts, advertised to encourage final year university students to apply and provides additional information around the support offered to newly qualified nurses at CHFT (interviews in March 2018). Options are being reviewed for the Physician Associates (PAs) vacancy within Medicine for 2 additional Pas, following withdrawals by two candidates.	Apr-2018	Dec-2018	WF	Brenda rown, Jason Eddleston	Rachaeierce

6441 (DMF ref 021)	Surgery & Anaesthetics	May-27	Finance sustainability	Risk of income being below planned levels for Division due to failure to delivery contract activity / income plan, inability to recover lost activity during EPR go live or planned level of activity in an appropriate case mix and inability to remove the equivalent total cost base to recognise this non delivery Resulting in non achievement of the Divisional planned contribution impacting on the Trusts ability to deliver its 17/18 I & E plan and remain a viable sustainable organisation	* Division Weekly activity / scheduling meeting attended by Executive lead " "Weekly Operational Performance meeting with Director of Operations * Monthly Business Meeting incorporating performance management' 'Revised activity forecast as at month 5 clinically owned and monitored weekly" 'Ongoing review of recovery plans with a need to consider cost out equivalent to income loss' 'Data Quality Group meeting weekly to ensure data quality in place and all activity captured and income generated appropriately'	Not all specialties job plans linked to activity volumes * individual surgeon performance management to activity plans	12	4 x 3	20	5 x 4	12	4 x 3	January 2018 update Risk score remains at 20. The underlying forecast has deteriorated by £2m as a consequence of the National Agenda to managing the winter capacity. Ie cancellation of non urgent daycase, elective and outpatient activity. At a trust level it is recognised that there will be a level of increase income within non elective predominately within the Medicine financial position to compensate in part for this deterioration. Also at trust level the overall Control Total is being reviewed with NHSI around the level of non recurrent winter monies that will be allocated. Anna Basford has been appointed as the lead Director for planning for 18/19 with the Division. One key task will be the review of the core capacity available within the existing medical workforce. February 2018 update Risk score remains at 20. January actual is circa £750k better than first estimate in relation to the management of winter pressures. Positive impact on LIVE forecast to be reported at month 10. **March 2018 update** Risk score remains at 20. February actual circa £133k better than first estimate in relation to the management of winter pressures. However, March will still be subject to maintaining capacity inline with cancer and urgent hence impacting on the Division income performance against plan. A detailed capacity model has been built for 2018/19 per speciality which should provide a level of assurance regarding the delivery of income plans for 18/19.	Mar-2018	Mar-2018	DB	Will Ain[illegible]	Joanne[illegible]rdcastle

7147 (DRF ref 021)	Medic	Dec-2 7	Financ sustainability	EPR Financial risk with increased costs and decreased income. Due to: Reduction in activity arising from increased time per patient in outpatients leading to reduced templates, errors with booking process related to migration and build leading to DNAs etc, pre-assessment build impacting on elective activity & mapping issues impacting on overall income capture. Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff Increased costs to ensure timely and appropriate response to clinical & operational risks. See High level risk 7049	Developing financial recovery plans. Weekly activity and income meeting chaired by Director of Transformation and partnership. Weekly performance monitoring. Targeted improvement for those in greatest need. Activity coding issues being addressed. Continuing to shadow monitor activity using existing systems. Cymbio dashboard deployed from Day 1 of EPR, weekly Data Quality Board, validation expertise deployed and extended, retaining senior analytical support until post Bradford Go-live, increased Booking staff to maximise appointment booking. Stabilisation plan developed.	Adequate system build BAU Team capacity. Staff training.	20 4 x 5	16 4 x 4	0 0 x 0	Identification of staff training needs. Specialty delivery of recovery plans. System build changes identified and prioritised, BAU team capacity review. Education and training for clinical staff. Dec 2017 update - Financial recovery plans being developed, with a fortnightly medical divisional 'Access' meeting running which covers the issues / risks highlighted in risk 7147 below.. The Divisional Access meeting provides a forum whereby divisional colleagues can discuss, raise any concerns, highlight and action any pressures which may impact on the Medical division's ability to safely deliver a challenging 'Access' agenda; this includes EPR data capture issues, outpatients, procedure codes, elective activity, build issues etc. Ultimately though it is about how unsatisfactory performance will impact on patient care and safety, particularly if there are data quality / validation issues. The meeting provides a forum for discussion of complex issues highlighted by either the Divisional Information Team or SMT, providing advice and guidance where required on a series of KPIs in order to facilitate safe delivery of these standards. Contract income is impacted upon as a by-product of these actions **February 2018 Update** Contract income has been manually adjusted where recording is an issue, clinic outcome data well recorded and templates not reduced resulting in some overruning of clinics. Some financial impact remains but not material to the Medicine position. Significant score reduction will be confirmed at next Risk & Complaince Group **March 2018** Risk score reduced from 20 to 16 (see February update)	Apr-2018	Apr-2018	DB	Ashwin rma	Andrew se

7223	Corpo	Mar-2(	Keepi	Inability to access all clinical and corporate digital systems: lack of access to clinical patient systems (EPR, Athena, Bluespier), clinical diagnostic and [illegible] as well as corporate systems (email etc). Due to failure of CHFT's digital infrastructure, failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure resulting in the inability to effectively treat patients and deliver compassionate care, not achieving regulatory targets and loss of income.	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data and Cyber Security	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16	16	8	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete).	Apr-2018	Sep-2018		RC	Mandy [illegible]ffin	Rob Bi[illegible]t

6596 (DATIX ref 007)	Corpo	Jan-20	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 - Scheduling of SI reports into orange divisional incident panels to ensure timely divisional review of actions. - 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. - Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Risk Team support to 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, particularly doctors.	16	16	8	January 2018 Development of investigators pack to support investigators. Revised serious incident report template to improve level of analysis within serious incident reports. Effective investigations course being held 10 January 2018, with 20 staff booked to attend. February 2018 Investigators pack being finalised by end of February 2018. Positive feedback from commissioners on reports using new style template. improving position on number of extensions requested. **March 2018** Learning page (Sharing Learning - Improving Care) transferred to new intranet and promoted via screen saver. Learning newsletter issues - Focus in Infection Prevention including learning from serious incident (safe storage of food) and post infection reviews. Investigation pack awaiting sign off. Winter pressures impacting on timeliness of investigation reports.	Apr-2018	May-2018	QC	Director Nursing, Brendan Brown	Juliette Isgrove

6598 (DF ref 014)	Corpo	Jan-20	Keepi	the base safe	There is a risk of reporting low compliance against many of the agreed essential skills, therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely and competently. Some is this is due to the fact that many of the essential skills have only recently had a target audience set to enable compliance reporting. This means that completion of these newly added essential skills is still in the early stages resulting in low compliance. A RAG rating across compliance rates for all essential skills identified none in green, most in amber but some in red. There are frequent requests for new subjects to be added to the list with no formal review process in place to determine the suitability. Currently, requests for new essential skills are referred to Brendan Brown and Lindsay Rudge for a decision.	1/ A communications strategy has now been agreed and implement to inform colleagues of any newly added essential skills to ensure the highest possible level of early uptake. 2/ The lead for essential skills is working closely with the Subject Matter Experts (SMEs) to identify ways to drive up compliance for each particular essential skill, including exploring options around alternate delivery. Compliance reports are produced monthly and deviation compared to the previous month to track improvement and build on successes. 3/ A review of the maternity essential skills is underway to determine if all subjects currently on the essential skills require compliance reporting. For those on externally hosted sites, the review will explore whether the data can be extracted and added to ESR. If not, the compliance requirement will be reviewed and reporting delivered outside of ESR. 4/ In the absence of a formal review process, the Lead for Essential Skills has designed a proforma to capture the details of requests for new essential skills to ensure a clear audit trail is in place.	1/ Essential skills training data held has historically been inconsistent and patchy. 2/ Target audiences setting to allow compliance monitoring across all but 1 essential skill was completed in December. This means that some skills are newly added to colleagues requirements and as such compliance rates are low. 3/ Heavy focus on EPR training and implementation had an impact on staff being able to complete essential skills training due to time and resource implications. 4/ Small number of clinical staff with bank contract have some discrepancies with competencies assigned to bank position but not their substantive post. 5/ recent focus on mandatory training and appraisal has had an impact on staff completing essential skills training. 6/ A small number of maternity essential skills are set in ESR but the actual learning takes place on an externally hosted e-learning platform. There are issues with extracting this data to be added to ESR meaning a false low compliance rate is currently	16 4 x 4	16 4 x 4	12 4 x 3	. **March 2018 Update** Compliance rates are increasing as a direct result of planned actions. We are on track to achieve 95% compliance for 20 of the 39 essential skills as planned by 31.03.18. Presently, 3 essential skills have achieved this with a further 6 now showing compliance of 90-94%. In addition, 14 more essential skills have compliance rates at over 80%. Efforts will be focussed on these essential skills over the coming weeks to ensure best possible compliance is achieved. We now have reporting access to e-learning for health so a strategy is being developed to determine how best to get the data into ESR in the most efficient manner possible. A new 'Essential Skills Tracking Tool' has been developed and can be accessed by anyone who has manager self-service on ESR. This shows compliance at Trust, divisional, directorate and department level for all 39 essential skills. This goes live on 1 April 2018.	Apr-18	Apr-18	WF	Jason F leston	Ruth M on

5862 (DATIX ref 007)	Medic	Aug-2 3	Keepin the base safe	We have a in-patient falls risk due to a number of care planning issues that could be enhanced; patient risk assessments not being completed to support clinical judgements made, failure to use preventative equipment appropriately, low levels of staff training, failure to implement preventative care, limited amount of falls prevention equipment, ward environmental factors, on occasion staffing levels below workforce model exacerbated by increased acuity and dependency of patients. These issues are resulting in a high number of falls incidents, falls with harm, poor patient experience and increased length of hospital stay.	Safety Huddles 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. Focussed work in the acute medical directorate as the area with the highest number of falls. Butterfly scheme. Delirium assessment	Insufficient uptake of education and training of nursing staff, particularly in equipment. On occasion staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency 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	January 2018 update. Decembers number of falls have increased in number 172 with 2 harm falls. Extra capacity wards on each acute site has impacted on the number in month ,Community place(n-5) and CHFT community beds(n-4) have both had increased incidents in month. Slips and falls reported in the hospital grounds due to adverse weather have totalled 4 in month. ESR trajectory set to improve Falls prevention training. Reported compliance in Dec -57%. Falls policy revised in line with EPR introduction and includes the post falls management flow chart. Post falls safety huddle tool (FISH)now available on datix documents for capture immediate information and patient experience. Ward assurance tool to be used consistently to audit falls assessment and interventions for centralised compliance and actions for individual ward February 2018. Improvement work continues as above . Challenges as additional wards open to manage demand on both sites.147 falls in total in month,1 harm fall a reduction on previous 2 months. EPR compliance with falls prevention training now 69.97% for Trust **March 2018** Risk description and controls reviewed and updated to more accurately reflect the risk and mitigations being undertaken	Apr-2018	Apr-2018	PSQB	Brenda rown	Janette ckroft

6977 (BAF ref 014)	Corpo e	May-2 7	Devel ng our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period. It was agreed at WED (June 2017) that the target compliance would be set at 95%. This risk is exacerbated by the requirement to complete EPR training in the same timeframe and there was a temporary issue concerning the National IG e-learning package which was withdrawn over the months of March - April 2017. This has now been resolved and is available under the refreshed title of Data Control. Impact: - Colleagues practice without the necessary understanding of how their role contributes to the achievement of strategic direction/objectives and without the knowledge/competence to deliver compassionate care. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised.	All electronic mandatory training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	Computer settings across the Trust have proved inconsistent. This can inhibit access to mandatory training and cause delays in compliance. This issue has been prioritised and a solution has been sourced. October 2017 - update: technical issues now resolved. Computer settings now consistent across the Trust.	16 4 x 4	16 4 x 4	4 4 x 1	January 18 Weekly compliance reports are produced for the Weekly Executive Board with actions to improve compliance before end of March 2018. A mandatory training summit is being held with key stakeholders from WOD on 22 January. February 18 Letters have been issued to individuals who are non-compliant or are due to expire before 31.3.18, signed by the divisional operations manager with a deadline to complete their learning by 28.2.18. A letter has also been issued by a non-executive director inviting specific areas to come to the workforce well-led committee and discuss plans to drive compliance. Weekly driving compliance meetings are taking place with the senior WOD team and the mandatory training lead to explore all options to improve compliance. **March 2018 Update** Individual compliance detail has been uploaded on the Trust intranet. This details individual compliance for our 5 key subjects and indicates whether a colleague is compliant, due to expire or non-compliant. Acceptance of mandatory training attained at previous NHS Trusts' is now being awarded to new starters and doctors in training.	Apr-18	Apr-18	WF	Jason F leston	Ruth M on
6990 (BAF ref 007)	Corporate	Jun-2017	Transforming and improving patient care	CQUIN target at risk of not being met for 2017/19 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non - compliance with NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also financial penalties.	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 2016/17 -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign was launched introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards -sepsis prompt in EPR	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of communication and joined up working between nursing and medical colleagues Information on patients not receiving the sepsis bundle in a timely manner. Clarity on use of EPR prompts required	16 4 x 4	16 4 x 4	4 4 x 1	December update Continuing analysis of sepsis prompts with plan to develop Standard Operating Procedure to guide staff Policy review continues No significant change in trigger compliance January 2018 update In depth review of screening completed and will show increased compliance with screening following the implementation of EPR **March 2018 Update** Sepsis policy reviewed Improvement in compliance with screening Training being delivered in key areas.	Apr-2018	Sep-2018	SC	David Birkenhead	Juliette Cosgrove

7046 (DAF ref 020)	Trustwide	Aug-2017	Keeping the base safe	EPR Clinical risk of patients receiving delayed access to care due to migration issues which placed incorrect location codes to activity; access issues for several members of staff resulting in delays. RTT build issue which does not place patients correctly onto the pathway. Electronic Discharge summary process not adhered to resulting in delayed information to GP. Lack of understanding on use of 'Encounters' leading to activity being connected with the incorrect episode. A 45 day purge of all activity within the Message Centre including correspondence unknown to users resulting in delayed distribution of correspondence. Reductions in outpatient activity & issues with appointment correspondence delaying access to review. Lack of familiarity with the system leading to an increased potential for clinical risk	Remedy on Demand for escalation of all system related issues for resolution. Stabilisation plan. Issues log populated by specialties, clinical and non-clinical staff to ensure all issues, risk, concerns were known and prioritised. All Divisions have own risk register and included in PSQB & Digital Modernisation Boards; high risks and risk changes reviewed at PRMs. Two weekly Operations Board with clear process for escalation. Datix reporting encouraged and all Red Datix received by Medical Director, Chief Nurse & Chief Operating Officer. Clinical Risk Panel established and Stabilisation plan in place SWAT team deployed to undertake Deep Dives/RCAs. DT meeting undertaken as required Visible leadership and feedback. Manual workarounds. Targeted support and training. On going training requirements identified and developed. Additional expert support deployed for Junior Doctor Change. Training & Access process for new and agency staff agreed. Access rights provided for all staff to undertake role as delivered pre-EPR	Response of external partner slow leading to delayed resolution. BAU team capacity & focus on stabilisation and build necessary to satisfy organisational priorities such as CQUIN Thematic review of incidents complaints, PALs etc. Adequate system build Training Review of access right. Robust audit of end to end pathways and documentation.	16 4 x 4	16 4 x 4	0 0 x 0	January Update SOP process has been revised There is no longer a resource to undertake the access/roles, discussion being had CEO regarding the risk associated with this Project team contracts will end this month The action plan agreed with Cerner is being worked through February Update The correspondence backlog continues to be actioned, the key challenge currently is the validation of clinic letters. Weekly meetings chaired by the CEO continue to monitor progress 40 medical secretaries have undertaken further training to ensure there is an improved understanding of templates and encounters Further drop in sessions are planned The lesson plan for correspondence has been updated and will be utilised for training; it will also be circulated to be utilised for reference No further work undertaken regarding access rights The BAU team have undertaken further training to enable them to maintain and develop the system **March 2018 Update** Further issues with correspondence discovered with work on-going to mitigate the issues BAU team are receiving further training The stabilisation and optimisation prioritisation is taking place The ECDS for ED will be prioritised for build over the stabilisation and optimisation	Apr-18	Mar-2018	QC	David Greenhead	Alistair Harris

7047 (BAF ref 009)	Medic	Aug-2 7	Keepi the base safe	EPR Performance risk of failed regulatory standards, contractual key performance indicators or other patient/staff focussed performance due to: Issues with data migration impacting on RTT pathways. Build/Configuration impacting on reporting data and pathway tracking. Delayed access for patient as a result of migration, build and staff familiarity. Patient satisfaction and reputational issues due to the perceived impact of the system as staff familiarise themselves. Staff satisfaction as they learn the new system or there are delays in resolving issues pertaining to patient care, flow and efficiency. Data Quality issues, duplications, incorrect pathways, coding all impacting on ability to report. Management capacity & capability to resolve issues with the new system and maintain sufficient focus on all KPIs. Management reports inaccurate and requiring additional validation before deployed delaying responsiveness. Management reports timeliness to comply with local and national reporting deadlines	Weekly Performance meetings, Weekly Data Quality Board, Additional Data Quality expertise and capacity, weekly activity review. Modelling of data to identify potential performance risks. Recruitment of additional staff into AED & Booking office. Shadow monitoring of activity using existing systems. Task and finish groups to address activity dips. Investigating areas of most concern. Manual recovery where poor recording is identified. Micromanagement of pathways. Working with IT to design appropriate reports. Use of Cymbio reports. Manual recording and collection of data. Stabilisation plan developed. Management capacity increases prioritised. All regulatory bodies kept informed proactively	Adequate system build. Availability of additional management capacity with correct skill set. Vacancies remain across all staff groups BAU capacity to support resolution of outstanding issues. Partner responsiveness & ability to find solutions. Several very large scale priorities to be managed. Communication and engagement	16 4 x 4	16 4 x 4	0 0 x 0	**March 2018 Update** Cystoscopy validation now progressing well and draft positions been provided last 4 weeks. Minimal validation now required and fully expect external return to be issued for March position to be issued mid-April. RTT reporting – now realised that the numbers of incomplete RTT pathways that have a decision to admit is not being reported. Work to start investigating this will not be progressed until April 2018. In addition a new Cymbio dashboard indicator of inpatient / day case unplanned waiting list patients without an open RTT pathway has been implemented to help support this work.	Apr-2018	Apr-2018	QC		Ashwin rma	Asif Arm n
7132 (BAF ref 007)	Medical	Nov-2017	Keeping the base safe	The Trust EPR system whilst having the facility to record NEWS and PAWS assessments, it does not have the facility to calculate the score. This has therefore become a manual process and is prone to human error and can be missed. The previous IT system automatically calculated and recorded the score. There is a risk to patient safety due to EPR system not automatically calculating and recording the score. This provides the potential for non recording, miscalculation and non detection of deterioration of patients.	PAWS and NEWS assessments are able to be recorded in EPR, however, it is not easily identifiable where on the EPR front screen and calculation is manual. All staff have been made aware of the change and a SOP and training has been provided to mitigate/reduce the risk	Clinical staff not routinely looking at PAWS and NEWS and relying on individual judgement of vital signs recorded.	16 4 x 4	16 4 x 4	2 1 x 2	Immediate mitigation: All staff informed to document PAWS and NEWS as a clinical note with PAWS and NEWS in the title and laminated charts put up in the cubicles in the department. Regular documentation spot checks by lead nurses. Medical staff to evidence use of early warning scores in their clinical decision making. Issue escalated to A Morris and J Murphy to establish if PAWS and NEWS can be on the front page of the ED clinical summary. **March 2018 Update** Still awaiting update from digital board. Mitigations still in place as above	May-2018	Jul-2018	PSQB		Divisional Director Medical Division Ashwin Verma	Louise Croxall

6300 (BAF ref 007)	Corpo a	May-2 5	Keepi 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 the inspection we will be judged as inadequate in some services. Additionally the CQC has announced a programme of Well Led Inspections which the Trust will be subjected to prior to Autumn 2018 ,there is a risk that we may not meet the required standard resulting in a judgement of "requires improvement".	Follow Up Inspection 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 Action plans progressed for all must and should do actions Separate action plans in place for each core service Reports to the Trust Board on those core services requiring improvement CQC compliance reported in Divisional Board reports to the Quality Committee Mock inspections for core services System for regular assessment of Divisional and Corporate compliance Routine policies and procedures Quality Governance Assurance structure The Risk and Compliance Group has oversight of areas outstanding actions not completed Well Led Inspection A mock PIR for the Well Led domain is taking place to identify further areas for improvement Each division is restarting CQC groups to oversee pre inspection activity A Trust wide CQC Group started meeting in September 2017	The March 16 inspection report placed us in the has shown us to be in the "requires improvement" category. We do not know the date of the next inspection We do not know when core service inspections will take place as these are unannounced visits	16 4 x 4	16 4 x 4	8 4 x 2	January 2018: continued development of plans to address any issues noted as part of the PIR submission and core service self-assessments (overall self-assessment of good for the Trust); Trust Board workshop held Dec 17; now receiving CQC monthly 'insight' reports which replace the intelligence monitoring reports – key messages shared at risk and compliance meetings; CQC relationship / engagement meetings continue to be held with our local Inspection team - from Jan 18 these will include attendance at meetings such as matrons, ward managers in addition to scheduled walk-throughs in clinical areas February 2018 CQC senior steering group now meeting weekly focused on sharing intelligence, monitoring the well-led plan including key risk areas, receiving updates from core services, briefing on communication and engagement activity and sharing good news and emerging issues; Workshop for Divisions and core service leads delivered by Capsticks; Board good governance leadership event scheduled with NHSI; Providing supporting information for colleagues including –learning from the CQC (review of actions from March 16 inspection), updated staff handbook. The Trust has received formal notification of the Use of resources assessment which is scheduled for 28th March 2018 - working with NHSI to provide information required ahead of the assessment. **March 2018 Update** Unannounced inspections in Maternity, Paediatrics, Critical Care and Emergency Department during March as expected ahead of the planned well led inspection 3rd – 5th April. Further unannounced inspections may take place ahead of this.	Apr-18	Apr-2018	WEB	Brenda rown	Juliette sgrove
7194 (BAF ref 007)	Family & Specialist Services	Feb-2018	Keeping the base safe	Risk of multiple (distinct/separate patient) orders being assigned the same lab number in the lab system, due to necessity for lab number recycling in the lab system resulting in samples being assigned to the wrong patient order (in lab system) and ultimately results being reported back on the wrong patient.	1) Laboratory aware of risk and requirement to identify incidents. 2) Laboratory to check details on sample tube match details on Apex system at point of booking in. 3) Pathology users/requesting staff expecting results to be returned on patient sample collected from. May therefore identify reporting to incorrect patient.	1) Laboratory staff fail to identify incidents 2) Laboratory staff fail to check samples match with LIMMS system- due to pace of workload. 3) Many results are not viewed immediately after reporting.	15 3 x 5	15 3 x 5	0 3 x 0	Lab system supplier can develop a solution to identify and allow users to select the correct version of the order in the lab sytem. This solutions would cost approximately £5k. PO being raised. Will chase with supplier once PO sent through	Apr-18	May-2018	PSQB	Rob Aitchison	Jonathan Bray

6924 (DATIX ref 007)	Trustwide	Feb-2017	Keeping the base safe	Risk of mis-placed nasogastric tube for feeding due to lack of of knowledge and training in insertion and ongoing care and management of NG feeding tubes from nursing and medical staff resulting in patients fed into the respiratory tract or pleura and possible death or severe harm	Risk overseen by Nutritional Steering Group Task and finish group established by director of nursing to address elements of NPSA alert 22.7.16 on nasogastric tube misplacement Training package available Nursing staff have been encouraged to undertake self assessment and declaration of competency Check X rays are performed where aspirate is not obtained, or greater than pH5.5 Radiology team flag when sighted if tube is in the lung following xray Training and competency package in place for nursing staff identified from high use areas	Initial X Rays are reviewed by medical staff - currently have no record of training or competency assessment for medical staff working at CHFT Daily process for checking is dependent on individuals competency to be performed accurately Training data base is only available through medical device data base and is not monitored for compliance No assurance that all medical and nursing staff who are inserting and managing NG tubes have the competency required to do this No policy in place at CHFT to support guidelines	15	5 x 3	15	5 x 3	8	4 x 2	. July Update All areas identified now at 75% or above training compliance with some areas scoring 90% or over. Training and reassessment in these areas will be delivered after 3 years. Further training is ongoing for new staff at induction and sessions have been planned for existing staff. Plan in place to identify 3 key trainers on all other ward areas who will be able to support areas where use is less frequent. Reassessment for this group will be delivered after 12 months. Teaching for medical staff has been timetabled in for early next year – CNS approaching training to ask if this can be expedited. Comms team have been approached to support trust wide communication regarding NG tubes, training and access. CNS plan to launch nutrition event and recruit link nurses across all areas – event planned for September with quarterly link meetings planned. No progress on medical staff training – package is ready to deliver need to agree medical staff sign up. Dr Uka is attending July task and finish group to progress. August 2017 update:	Apr-2018	May-2018	QC	Brenda rown,	Jo Midgon

6949 (DAF ref 007)	Family Specialist Services	Mar-2(7	Keeping the base safe	The inability to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain sufficient numbers of HCPC Biomedical Scientists to maintain two 24/7 rotas, resulting in a potential inability to provide a full Blood Transfusion / Haematology service on both sites	1. Substantive Biomedical Scientists are working additional shifts to cover gaps in the rotas. 2. Staff rotas changed to a block pattern for night shifts. 3. All substantive vacancies are being advertised and gaps backfilled with locum staffing. 4. Staff development plan in place for training Biomedical Scientists 5. Existing business continuity plan in place	1 & 2. Substantive Biomedical Scientists are working additional shifts on a voluntary basis with no obligation to provide cover and over a sustained period of time with no imminent resolution. 3. Delay in recruiting locums due to impact of Flexible workforce procedures. 4. Staff development plan for trainees is compromised and time scale lengthened, due to reduced levels of trainers present during core hours as a result of additional shift commitments. 5. Business continuity plan has not had a recent test with relevant stakeholders. 6. Failure to understand the reason why CHFT are not an employer of choice for Blood Transfusion/Haematology Biomedical Scientists.	10	5 x 2	15	5 x 3	5	5 x 1	3. Understand blockers to the recruitment process and determine options to expedite the process. 5. Organise a test for Business continuity plan with relevant stakeholders. Update 12/1/2018- BCP test planning meeting arranged for 15th Jan. Planning actual test for last week Feb 2018 6. Full root cause investigation to determine all contributory factors in the current failures to recruit and retain HCPC Biomedical Scientists and develop long term achievable solutions. 12/1/2018 Gavin Boyd investigating option for an independent person in trust to facilitate a root cause investigation. HB still trying to provide suitable time out date/vtime. Update-February 2018: Department organising dates for root cause into contributory factors. Test of BCP - dates last week of february being investigated. Planning meeting took place Jan 2015 **March 2018 Update** BCP exercise booked for the end of March Root cause session held 9/March/2018. Action plan being developed	Apr-2018	Jul-2018	DB	Rob Aitkinson	Hayley Parker

6715 (DATIX ref 007)	Corpo	Apr-20	Keepin 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 when deterioration occurs, poor communication and multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs.	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy / Alistair Morris, via back office team, December 2018 Establish a joint CHFT / BTHFT clinical documentation group.- lead Jackie Murphy and Alistair Morris timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group.	20 4 x 5	15 3 x 5	6 3 x 2	January 2018 Ward assurance including the audit of documentation is not well embedded and requires some further support, JM to meet with the Deputy Chief Nurse to discuss how assurance can be achieved. The optimisation booklet has been circulated to wards. JM to discuss details of reports that can support ward assurance. Lights on to be rolled out to managers so that they can understand where support is needed. February 2018 JM writing to all representatives on the previous clinical records group with draft terms of reference in order to re-commence the meetings. JM followed through the actions from January update and has met with Deputy Chief Nurse and THIS colleagues to review the reporting of documentation from EPR. First reports to be available March 2018. **March 2018** The clinical documentation group will re-commence following feedback from TOR. The work to establish high quality data from EPR continues, a meeting took place to understand progress, the aim is to complete this data set this month.	Aug-2018	Aug-2018	WEB	Brenda rown	Jackie phy

6829 (DAF ref 007)	Family Specialist Services	Aug-2[illegible]5	Keeping the base safe	The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately [illegible] 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(SPS) on behalf of NHSE. The latest audit undertaken on 5 April 2017 rated the overall risk assessment to patient safety as high with two major deficiencies. It was strongly recommended that the workload is not increased in the HRI facility and consideration must be given to close the facility if a business case for replacement is not approved.Capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards to enable the closure of the HRI facility.	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 HRI unit will be undertaken by the Quality Control Service on behalf of NHSE every 6 months. Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance. The capacity plan of the HRI unit will not be exceeded. A strategy of buying in ready to administer injectable medicines will be implemented but there are concerns about the sustainability of the current pharmaceutical supply chain.	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	3 3 x 1	January 2018 - still discussing options for the business case - preferred option still to locate at CRH and extend the current facilities February 2018 - awaiting outcome of discussions - will be confirmed by end March 18 **March 18 - Update** final approval to go ahead with the development of the ADU at CRH. Meeting 7th March for initial scoping and planning project implementation. Once detailed plans and dates in place this risk will be reviewed.	Apr-18	Mar-2018	DB	Brenda rown	Fiona S[illegible]h

6011 (BAF ref 007)	Family & Specialist Services	May-2014	Keeping the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBH) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust).	Lack of electronic systems Lack of duplicate sampling Training compliance not at 100%	15	5 x 3	15	5 x 3	3	3 x 1	January 2018 We have installed some of the Haemonetics equipment in December 2017, however no progress will be made with this risk until implementation of stage 2 (HLB) Apex upgrade has been delayed until next spring as this isn't required until stage 3 (HLB) February 2018 Work continues towards implementation of the Haemonetics equipment, however no progress will be made with this risk until implementation of stage 2 (HLB) Apex upgrade has been delayed until next spring as this isn't required until stage 3 (HLB) **March 2018 Update** Work continues towards implementation of the Haemonetics equipment, however no progress will be made with this risk until implementation of stage 2 (HLB)	Apr-2018	Mar-2019	PSQB	Julie O'Jordan	Sarah Fensden
5747 (BAF ref 007)	Family & Specialist Services	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of failing to provide an interventional vascular service due to challenges recruiting substantively to vacant posts at consultant interventional radiologist level resulting in our inability to meet the 6 week referral to treatment target; inability to deliver an appropriate service at CHFT and our inability to provide hot week cover on alternate in collaboration with Bradford Teaching Hospitals FT.	1wte substantive consultant Part-time short term Locums supporting the service	Failure to appoint to vacant post substantively due to limited availability. Failure to secure long term locum support.	16	4 x 4	15	5 x 3	6	2 x 3	December 2017 update: Advert currently out for joint post (regional initiative in collaboration with Leeds and Bradford). Service still being supported by part time locum cover - continuing to seek long term locum cover. January 2018 update: Advert for joint post with Bradford closed on Friday 12 January 2018, with no applicants. **February & March 2018 update:** Full time locum in place for next 6 weeks; in discussion with neighbouring Trusts to consider long term solution.	Apr-2018	Apr-2018	DB	Rob Aitchison	Sarah Clenton

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th April 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - APRIL 2018 - 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: -	
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:
Board of Director attendance register - to note
Declaration of Interests register - BoD - to receive and confirm that declarations are accurate
Compliance with Licence Conditions - to note

Main Body

Purpose:

The Trust has a cycle of governance and this report sets out those areas that are due for review by the Board this month.

Background/Overview:

-

The Issue:

1. Board of Directors attendance register
The Trust's Standing Orders state that 'the names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors.' The attendance register from April 2017 to March 2018 is attached at appendix 1.

The Board is asked to NOTE the attendance register.

2. Declaration of Interests Register - Board of Directors
The Declaration of Interests Register for the Board of Directors is attached at appendix 2.

The Board is asked to APPROVE the register and advise the Board Secretary of any amendments.

3. Compliance with Licence Conditions
The NHS Provider licence requires the Board to make three declarations:
1 - Condition G6(3) - Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - Deadline 31.5.18
2 - Condition FT4(8) - Providers must certify compliance with required governance standards and objectives. Deadline 30.6.18
3 - Condition CoS7(3) - Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service.

The Trust position is:
In January 2015 Monitor (the Regulator of Foundation Trusts at that time) declared the Trust to be in breach of licence as a result of an unplanned year-end deficit position of £4.3m which Monitor believed to be a breach of financial and board governance. Monitor wrote to the Trust setting out the undertakings it expected the Trust to deliver.
The certificate of compliance with two of the three undertakings relating to Board governance and effectiveness and general actions was presented to the Board last year.
The remaining undertaking requires the Trust to 'ensure the Licensee's clinical and financial stability is maintained from the end of the financial year 2016/2017'. Clearly due to the Trust's deficit position, this undertaking is still in place. It is recognised that while the Trust has financial controls, governance and actions in place to manage its deficit position, the long term plan for getting back to a sustainable financial position across the local health economy includes the proposals for the reconfiguration of hospital services. The Full Business Case for the reconfiguration is currently going through NHS Improvement's process of review and approval. In the meantime the Trust remains in a deficit position and therefore NHS Improvement has not certified compliance with this final undertaking.

The Board is asked to RECEIVE the certificate of compliance. (To follow)

Next Steps:

-

Recommendations:

The Board is asked to:
- NOTE the attendance register
- APPROVE the Declarations of Interest register
- RECEIVE the certificate of compliance

Appendix

Attachment:

There is no PDF document attached to the paper.

Attendance	✓	Apologies	×	Not Exec BOD members	-

ATTENDANCE REGISTER – BOARD OF DIRECTORS
1 APRIL 2017 – 31 MARCH 2018

DIRECTOR	6.4.17	4.5.17	1.6.17	6.7.17	20.7.17 AGM	3.8.17	7.9.17	5.10.17	2.11.17	7.12.17	4.1.18	1.2.18	1.3.17	TOTAL
A Haigh (Chair)	√	No meeting held	√	√	√	√	√	√	√	√	√	√	√	12/12
D Anderson	√	-	√	√	√	√	√	√	√	√	√	√	√	12/12
Helen Barker	√	-	√	√	√	x	√	√	√	√	x	√	√	10/12
D Birkenhead	√	-	x	√	√	√	√	√	√	x	√	√	√	10/12
G Boothby	√	-	√	√	√	√	√	√	√	x	√	√	√	11/12
B Brown	√	-	√	√	√	√	√	x	√	√	x	√	x	09/12
J Eddleston (Acting Dir WOD from 10.7.17 – 10.1.18)	-	-	-	√	√	√	x	√	√	√	x	-	-	06/08
A Graham (from 1.12.17)	-	-	-	-	-	-	-	-	-	√	√	√	x	03/04
K Heaton	√	-	√	√	√	√	x	√	√	√	√	√	√	11/12
L Hill	√	-	√	√	√	√	√	x	√	√	√	√	√	11/12
R Hopkin	√	-	√	√	√	√	x	x	√	√	x	√	√	09/12
P Oldfield	√	-	√	x	x	√	√	√	√	x	√	√	√	09/12
A Nelson (from 1.10.17)								√	x	√	√	√	√	05/06
L Patterson	√	-	√	√	√	√	√	√	√	√	√	√	√	12/12
P Roberts (tenure ended 22.9.17)	√	-	√	√	x	√	√	-	-	-	-	-	-	05/06
I Warren (from 1.8.16 – 9.7.17)	√	-	√	x	-	-	-	-	-	-	-	-	-	02/04
O Williams	√	-	√	√	√	√	√	√	√	√	√	√	√	12/12
J Wilson (tenure ended 30.11.17)	x	-	√	√	√	√	√	√	√	-	-	-	-	07/08
Vicky Pickles	x	-	√	√	√	√	√	√	√	√	√	√	√	11/12
Suzanne Dunkley (appointed 1.2.18)								-	-	-	-	√	√	02/02
A Basford	√	-	√	√	√	√	x	√	√	√	√	√	√	11/12
Mandy Griffin	x	-	√	√	√	√	√	√	√	√	√	√	x	10/12
Cornelle Parker (for DB)	-	-	√	-	-	-	-	-	-	√				2
Lindsay Rudge (for								√						1

BB)														
David McGarrigan (for LH)								√						**1**

BOD-ATTENDANCE REGISTER
2017-2018

Calderdale and Huddersfield NHS Foundation Trust

DECLARATION OF INTERESTS – BOARD OF DIRECTORS
AS AT 1 APRIL 2018

DATE OF DECLAR-ATION	NAME	DESIGNATION	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES
1.4.18	Philip Lewer	Chair	-	-	-	-	-
2.10.14	David Anderson	Non Executive Director	Director of Prime Health Huddersfield Limited and Grange Prime Health Limited Director of Synergy P, Partner in Grange Group Practice –Member practice of Greater Huddersfield CCG	As 'Directorship'	-	-	-
18.9.14	Lesley Hill	Director of Service Development	Pennine Property Partnership	-	-	-	-
1.7.14 16.12.15	Owen Williams	Chief Executive	-	-	-	-	• Trustee – NHS Confederation • Director – York Health Economics Consortium – fee paid to CHFT • Chair of the Local School Committee for Beckfoot Thornton School, Leaventhorpe Lane, Bradford, BD13 3BH. Circa

							12 hours a year.
17.2.13	Dr David Birkenhead	Consultant Microbiologist Executive Medical Director	-	-	-	• Trustee Childrens' Forget Me Not Hospice	• Provide Infection Control advice to the BMI, Hudds. • Wife – GP and member of Huddersfield Federation
1.9.13	Linda Patterson	Non Executive Director		Sole Trader Dr Linda Patterson Ltd Health Service Consultancy	-	Trustee Health Quality Improvement Partnership	Consultancy Health care Improvement in NHS, Deloitte
19.8.13	Philip Oldfield	Non Executive Director	Director and Owner of Tanzuk Consulting Livability at home in the community Finance Director – Young Epilepsy	-	-	-	-
9.3.16	Helen Barker	Chief Operating Officer	-	Husband owns a lighting company which sells to NHS. I am Company Secretary.	-	-	Company Secretary of husband's business.
17.3.16	Richard Hopkin	Non Executive Director	Capri Finance Ltd – own consultancy company. All part of 'Derwent' Group:- • Derwent Housing Association Ltd • Derwent FM Ltd • Centro Place Investments Ltd	-	-	Finance Director (part-time) of Age UK Calderdale & Kirklees	Unpaid – Treasurer of Community Foundation for Calderdale
31.3.16	Karen Heaton	Non Executive Director	One Manchester	-	-	-	• University of Manchester – Director of Human Resources
19.9.16	Brendan Brown	Executive Director of Nursing	-	-	-	-	-
10.10.17	Andy Nelson	Non-Executive	• Director of Alphagrange	-	-	-	-

		Director	Consulting Ltd (own company) • NED – Disclosure & Barring Service • NED & Strategic IT Advisor to the Management Board of The Law Society				
1.10.17	Gary Boothby	Executive Director of Finance	Director of Pennine Property Partnerships	-	-	-	-
28.1.18	Alastair Graham	Non-Executive Director	Director of Golden Lane Housing (a charity, a company limited by guarantee and a registered housing provider)	-	-	-	-
12.2.18	Suzanna Dunkley	Executive Director of Workforce & OD	-	-	-	-	-
ATTENDEES AT BOARD OF DIRECTORS							
28.11.16	Anna Basford	Director of Transformation & Partnerships	-	-	-	-	-
28.11.16	Mandy Griffin	Director of THIS	-	-	-	-	-
28.11.16	Victoria Pickles	Company Secretary	-	-	-	-	-

All the above Board Directors have confirmed that they continue to comply with the Fit and Proper Person Requirement

STATUS: Complete

P:Declaration of Interest-bod - kb

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th April 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: FIT AND PROPER PERSON TEST REGISTER - The Board is asked to receive and approve the Fit and Proper Person compliance register	
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 Care Quality Commission (CQC) introduced new requirements regarding the 'Fit and Proper Person Tests' (FPP) for Directors in November 2014, which became law from 1 April 2015. This approach is to ensure that providers meet Government regulations about the quality and safety of care, to ensure an open, honest and transparent culture within the NHS to ensure accountability of Directors to NHS Bodies.

The Trust put in place procedures to ensure that all Directors met the FPP test. We have recently reviewed this process to learn from good practice, implement an annual declaration and broaden the scope of those required to make a declaration to senior staff who may have a deputising role.

Main Body

Purpose:

Calderdale and Huddersfield NHS Foundation Trust has extended the definition of the requirement to include; all members of the Board (Directors) and senior staff in attendance at the Board and/or those with significant influence in reporting information to the Board for decision making.

The Board Secretary maintains the Trust's register to support compliance of the 'Fit and Proper Person Test' (copy attached)

It is the responsibility of the Chair of the NHS body to discharge the requirements placed on the provider, to ensure that all Directors meet the FPP test and do not meet any of the 'unfit' criteria.

Background/Overview:

The Fit and Proper Person Test is a regulation to ensure that providers meet their obligations to only employ individuals who are fit for their role and to ensure that appropriate steps have been taken to ensure they are of good character, are physically and mentally fit, have the necessary qualifications, skills and experience for this role and can supply certain information (including a Disclosure and Barring Service (DBS) check and full employment history, if required. The regulations also extend to individuals who are prevented from holding the office (for example, under a Director's disqualification order) and significantly, excluding people who:

'Have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity'.

As part of the recruitment process (and compliance for the Fit and Proper Person Test) for the defined staff group appointed by CHFT, a number of checks have taken place;
- Checks on the individuals
- Qualifications
- Competence, skills required, relevant experience and ability
- Good character
- Consideration to the physical and mental health in line with the role and good occupational health practice
- Ensure, as far as possible the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful of not) in the course of carrying on a regulated service; this includes any allegations of such - including a search of the Register of Disqualifications
- A Disclosure and Barring Service (DBS) check where appropriate to the role in line with Trust policy.

For those Directors who were already in post when the FPP came into place, a historical review was undertaken. Through appraisal each year individuals are asked to confirm that they meet the requirements to hold office of their appointment. Where they do not, action will be taken by the Chief Executive and / or

Trust Chair or respective Director / defined senior staff (and where appropriate consultation with the Nomination and Remuneration Committee (BOD).

As part of their inspection process, the CQC stated they would use the 'well-led' key question to ensure that the provider has undertaken appropriate checks and is satisfied that, on appointment and subsequently, all new and existing Directors are of good character and are not unfit

The Issue:

To strengthen the arrangements already in place, the Fit and Proper Persons Self-declaration Register has been established and will be updated on an annual basis. This requires all Directors and senior staff who have attendance at Board or a deputising role to make a self certification declaration as follows:

Self-Certification
I declare that I am a Fit and Proper Person to carry out my role, I am of good character, I have the qualifications, competence, skills and experience which are necessary for me to carry out my duties, I am capable by reason of health of properly performing tasks which are intrinsic to the position, I am not prohibited from holding office (e.g. directors disqualification order), within the last 5 years I have not been convicted of a criminal offence and sentenced to imprisonment of 3 months or more, been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged it, nor is on any 'barred' list.
The legislation states, for those required to hold a registration with a relevant professional body to carry out their role, they must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where the person no longer meets the requirement to hold the registration, and if they are a health care professional, social worker or other professional registered with a health care or social care regulator, they must inform the regulator in question.
Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the Chair of Calderdale and Huddersfield NHS FT.

In addition to this process, a check of all Board members has been carried out from the Insolvency Register and Disqualification as a Director held on the register at Companies House and can confirmed that all Board Members held on the CHFT Fit and Proper Persons Register are still valid against these external checks.

Next Steps:

Directors are asked to confirm their self-declaration of compliance against the regulations for the Fit and Proper Persons Test and any amendments should be notified to the Company Secretary. The Register will be updated on an annual basis and reported to the Board and included in the Annual Report.

Recommendations:

The Board is asked to RECEIVE the register for 2018.

Appendix

Attachment:

FIT AND PROPER PERSON REGISTER-27.3.18.pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

FIT AND PROPER PERSON SELF-DECLARATION REGISTER

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
12.2.18	**ADDY**	Melanie	Director of Ops for Surgery & Anaesthetics	RGN – no longer registered to practice (NMC aware)	2007	August 2017	Kristina Rutherford	04.01.82
27.2.18	**AITCHISON**	Rob	Director of Operations (FSS)	-	July 2009	23.08.17	Helen Barker	July 2009
26.3.18	**AMEEN**	Asif	Director of Operations	-	11.03.16	15.09.17	Helen Barker	18.07.16
13.2.18	**ANDERSON (Dr)**	David	Non-Executive Director	MBBS MRCGP 1.4.17 – voluntary erasure from medical register GMC 2497365	06.01.05	15.02.17	Andrew Haigh	22.09.11
28.2.18	**ARCHER**	Kirsty	Deputy Director of Finance	Chartered Management Accountant,	March 2018	July 2017	Gary Boothby	August 2008

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
				ACMA (CIMA)				
28.2.18	**BARKER**	Helen	Chief Operating Officer	-	December 2015	27.07.17	Owen Williams	01.01.16
13.2.18	**BARNETT**	Karen	Director of Operations (Community)	-	Feb 2016	15.06.17	Helen Barker	01.03.16
7.3.18	**BASFORD**	Anna	Director of Transformation & Partnerships	-	28.06.16	July 2013	Owen Williams	July 2013
13.2.18	**BATES**	Julian	Assistant Director of Informatics	Member of Institute of Health Management	02.03.16 (expires 2.3.19 – Cricket Coach DBS)	11.08.17	Mandy Griffin	13.02.95
14.2.18	**BIRKENHEAD (Dr)**	David	Executive Medical Director	MB.ChB, MD, FRCPath	30.11.15 & 29.1.18 001511499967	03.01.18	Owen Williams	01.12.99
13.2.18	**BOOTHBY**	Gary	Executive Director of Finance	Assoc CMA 8659790 CIPFA 41612-	30.11.17	15.09.17	Owen Williams	07.03.16

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
				CIP				
19.2.18	**BROWN**	Brendan	Chief Nurse	NMC 881O160E	13.06.16	12.10.17	Owen Williams	13.06.16
6.3.18	**BURTON**	Sue	Assistant Divisional Director – Planning, E&F	Fellow of Association of Certified Accountants (FCCA)	-	October 2017	Anna Basford	Jan 2009
27.2.18	**COSGROVE**	Juliette	Assistant Director of Quality and Safety	RGN	To be confirmed	01.11.17	Brendan Brown	16.09.13
7.3.18	**CRAGG**	Lorna	General Manager – Facilities	-	24.08.07	02.08.17	David McGarrigan	7.10.13
12.2.18	**DUNKLEY**	Suzanne	Executive Director of Workforce & OD	FCIP 31049644	December 2017	N/A	N/A	01.02.18
20.3.18	**EDDLESTON**	Jason	Deputy Director of Workforce and	CIPD 10327459	March 2018 to be progressed	23.10.17	Owen Williams	08.02.99

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
			OD					
12.2.18	**GRAHAM**	Alastair	NED	N/A	December 2017	4.01.18	Andrew Haigh	01.12.17
6.3.18	**GRIFFIN**	Mandy	Managing Director – Digital Health	-	Awaited	22.09.17	Owen Williams	18.01.09
13.2.18	**HAIGH**	Andrew	Chairman	FCA	08.07.16	01.03.18	David Anderson, SINED/CoG	01.12.10
13.2.18	**HEATON**	Karen	Non-Executive Director	Member of CIPD	May 2016	01.02.18	Andrew Haigh	01.03.16
15.2.18	**HENSHAW**	Anne-Marie	Associate Director of Nursing and Head of Midwifery	NMC 85A3198E – Registered Midwife and Teacher	February 2013	30.10.17	Brendan Brown	01.03.13
7.3.18	**HILL**	Lesley	Director of Planning, Estates & Facilities	HRPham S	December 2016	18.09.17	Owen Williams	01.05.06

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
14.2.18	**HOPKIN**	Richard	Non-Executive Director	-	14.12.17	14.01.18	Andrew Haigh	01.03.16
13.3.18	**LEWER**	Philip	Chair	-	26.2.16	N/A	N/A	1.4.18
1.3.18	**MURPHY**	Jackie	Deputy Director of Nursing – Modernisation	NMC 8312713E	-	17.8.17	Mandy Griffin and Brendan Brown	July 2007
27.2.18	**NELSON**	Andy	Non-Executive Director	-	09.10.17	N/A	N/A	01.10.17
7.3.18	**OLDFIELD**	Phil	Non-Executive Director	ACA 7569142	12.12.17 Enhanced CRB	23.02.18	Andrew Haigh	Sept 2013
16.2.18	**PARKER**	Cornelle	Deputy Medical Director	GMC 3286582	May 2017	19.01.18 – management and 15.2.18 – clinical	David Birkenhead Dr N Scriven	08.05.17
14.2.18	**PATTERSON (DR)**	Linda	Non-Executive Director	GMC 2232692	01.12.16	02.03.17	Andrew Haigh	01.10.13
27.2.18	**PICKLES**	Victoria	Company Secretary	-	March 2016	06.09.17	Owen Williams	06.02.14

DATE OF DECLARATION	SURNAME	FIRST NAME	JOB TITLE/ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/RE-CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMENCED IN CHFT
6.3.18	**RUDGE**	Lindsay	Deputy Chief Nurse	RGN 90E0076E	Awaited	18.10.17	Brendan Brown	1993
28.2.18	**WILLIAMS**	Owen	Chief Executive	-	08.07.18	12.03.18	Andrew Haigh	14.05.12
1.3.18	**WILLIAMS**	Lisa	Assistant Director of Transformation and Partnerships	NMC 90J012EE – lapsed 2017	November 2007	31.10.17	Anna Basford	July 2003
7.3.18	**WILSON**	Alison	General Manager – Estates	Chartered Member of IOSH – 024422 MBA Facilities Management	September 2008	28.07.17	David McGarrigan	September 2008

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th April 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: TRAVEL AND TRANSPORT REVIEW - The Board is asked to RECEIVE the Independent Travel and Transport Report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Estates Sustainability Committee; Partnership Transformation Board	
Governance Requirements: Transforming and Improving Care	
Sustainability Implications: None	

Executive Summary

Summary:

Following the public consultation on the proposed reconfiguration of hospital services, the two local Clinical Commissioning Groups agreed to set up an independent working to consider and develop plans to address the implications in relation to access, travel, parking and public transport.

This report has been considered by the Partnership Transformation Board (which has members from the Trust) and by the Estates Sustainability Committee.

The Report is attached and the appendices can be found at https://www.calderdaleccg.nhs.uk/download/tandt_appendices/

Main Body

Purpose:

This report presents the Report of the Independent Travel and Transport Working Group to the Board to note.

Background/Overview:

Following the public consultation on the proposed reconfiguration of hospital services, as part of the recommendations to proceed to explore implementation in the Full Business Case the two local Clinical Commissioning Groups agreed to set up an independent working group to consider and develop plans to address the implications in relation to access, travel, parking and public transport as a parallel work stream. The Working Group included executive membership from the Trust. The Working Group published their report in February 2018.

The Issue:

The Working Group had an independent chair and included a wide ranging membership, with representatives from commissioners, providers - including CHFT - local authorities, patient representatives groups and transport organisations.

The report also had a comprehensive equality section which described the impact of travel and transport on particular protected groups. This was further explored through a Travel and Transport reference group made up of patient and public representatives and who agreed the recommendations and proposed actions.

The Report highlights two recommendations in relation to the Trust:
- The first action relates to parking at Calderdale Royal Hospital and requires an action plan for short term and longer term action to address parking issues and the feasibility of additional multi-storey car parking at CRH evaluated. This is in line with the car parking action captured within the Full Business Case reflecting the feedback from the public consultation.
- The second is in relation to the shuttlebus service with an immediate action for the Trust on advertising the service, signage and timetables, adequate weatherproof shelters and enhanced patient and public experience. There is also a longer term action relating to a review of the service to meet the needs of the population and the consideration of a more frequent service with greater capacity and exploration of links between both Hospitals and local transport hubs to contribute to a more integrated transport system. This will require work with commissioners.

Next Steps:

The Trust will continue to work with Commissioners and patient groups to ensure the identified actions are appropriately implemented.

The Board is asked to RECEIVE the Travel and Transport report and note the recommendations for the Trust.

Appendix

Attachment:

18.01.30 Travel and Transport Final Report v1.1 without Appendices.pdf

RIGHT CARE | RIGHT TIME | RIGHT PLACE

Calderdale and Greater Huddersfield Travel and Transport Review

REPORT OF INDEPENDENT CHAIR
TRAVEL AND TRANSPORT GROUP

30 January 2018

SECTION 1
FOREWORD

The Travel and Transport Group was established in May 2017 with an independent Chairperson and wide ranging membership including representatives from Greater Huddersfield and Calderdale Clinical Commissioning Groups (CCGs), Calderdale Huddersfield Foundation Trust (CHFT), South West Yorkshire Partnership NHS Foundation Trust (SWYFT), Calderdale Council, Kirklees Council, Healthwatch, Upper Calder Valley Renaissance Sustainable Transport Group (UCVR-STG), West Yorkshire Combined Authority (WYCA) and Communication experts.

The Travel and Transport Working Group met for the first time in May and has had eleven meetings to date. In addition to agreeing its Terms of Reference and work plan, the Working Group has considered information in relation to: the WYCA Transport Strategy; the A629 upgrade (both Halifax and Huddersfield); Primary Care in both Calderdale and Greater Huddersfield; Patient Transport Services, Shuttle Bus Service and existing CHFT transport methods; Care Closer to Home for Calderdale; and Greater Huddersfield an update from Yorkshire Ambulance Service (YAS) and from providers (Locala, CHFT and SWYPFT) and; Public and Private Travel times by postal district.

The Working Group also established a Reference Group, independently managed and supported by a Coordinator from Sector Support Calderdale. The Coordinator became a member of the Travel and Transport Working Group to enhance the interface between the Reference Group and Working Group.

The Reference Group provides the Working Group with access to a range of input and feedback that is representative of geographical locations and protected groups in line with CCGs' Equality duties. A facilitated Working Group Session identified key elements to be addressed in gathering evidence and framing recommendations. These issues were then shared with the Reference Group in order to ensure that there was correlation between the public views and the group work plan.

The issues identified include parking, access, travel between hospitals, public transport, reducing need to travel, hospital discharge, patient travel and greener transport. These categories were endorsed by the Reference Group.

Lead Officers were identified and detailed work grids developed, with analysis addressing what people have told us in consultation and previous engagement activity, to ensure public voices were prominent. The draft work grids were subsequently submitted for scrutiny and comment to the Reference Group before sign off by the Travel and Transport Working Group. The report is evidence based and the main report is referenced against the presentations and documentation received from the range of relevant organisations and individuals considered by the

Working Group. The detailed sections of this report reflect the outcome of the Travel and Transport Group evaluation of that evidence.

1.1 Terms Of Reference

The Terms of Reference agreed by the local Hospital Services Programme Board is set out below:

Travel and Transport Group – Terms of Reference v3.0

Purpose: To advise, inform and provide expert input on transport and access matters

The Travel and Transport Group will ensure that the programme considers and develops plans to address the implications of the proposed changes in relation to Access, Travel, Parking and Public Transport. The group will:

- Review suggestions for improvements to existing access and travel arrangements identified during public consultation and make recommendations.
- Identify the potential implications of the proposed changes in relation to Access, Travel, Parking, and Public Transport, taking account of the timing and potential impact of the sequencing of the movement of services into community and the proposed improvements to the A629.
- Review and take account of the relevant findings from the Equality and Health Inequality Impact Assessment as part of any recommendations.
- Review the existing and updated Patient travel analyses .

The group will only consider the additional implications of the option on which the CCGs consulted.

Responsibilities

The Group will

- Agree a consistent set of assumptions to support quantification of the likely impact and development of suggested improvements to travel and access.
- Review the current public transport provision and identify improvements and adjustments based on visiting times and appointment times
- Identify potential service changes that could reduce the need to travel and mitigate the expected impact
- Develop options for meeting the predicted transport demand which takes account of travel by Public Transport, Shuttle bus, other Patient Transport services and car. Illustrate options with quantification of: current and future journey times (including wait times for public transport or shuttle bus options), current and future cost and impact in relation to parking.
- Review the current Shuttle Bus operation, identify areas for immediate, and medium term improvement.
- The work to identify the impact on resource and travel times for the Yorkshire Ambulance Service will continue in parallel and an update provided to the group.
- Members are expected to act as supporters of the Working Group and engage others within their organisations and groups which represent the public's view.

Membership

Chair: Independent, tbc

The full group membership will include:

- Healthwatch
- Calderdale Council – Head of Highways , Engineering and Transport
- Kirklees Council - Group Leader Highway Transportation Improvement Scheme
- West Yorkshire Combined Authority – Head of Transport Operation
- Upper Calder Valley Sustainable Transport
- MYHT
- CHFT
- Calderdale CCG
- Greater Huddersfield CCG
- Kirklees CCG
- SWYPFT
- Calderdale Council - Councillor representative.
- Kirklees Council – Councillor representative
- Sector Support Interface

Format

Frequency

- Fortnightly

Decision-making

- None. Makes recommendations through Partners' Governance
- Reports to Programme Board

Quorum

- Chair + at least 1 member from Provider Organisation and one member from Commissioner organisation

Authority

- Accountable to PB

Reporting Strategy

- Full report to PB

Support from

- PMO

Decisions

- Make recommendation to PB with regard to approval of plans to address the priority areas in relation to transport and access matters.

1.2 ACKNOWLEDGEMENTS

I wish to thank the Members of the Travel and Transport Reference Group for their hard work, participation and input in developing the work plan and in drafting the final Report and recommendations.

SECTION 2
EXECUTIVE SUMMARY
Key Messages from The Travel And Transport Group

Right Care, Right Time, Right Place (RCRTRP), the Strategic Review of Hospital and Community Health Care in Greater Huddersfield and Calderdale, set out a clear direction for a shift to more localised services “Care Closer to Home” (CC2H) and a reconfiguration of acute services consistent with clinical evidence and National Health Service England policy.

Delivering such transformational change means reconsidering transport and travel issues, in particular road and public transport, parking, access, travel between the two hospitals, reducing the need to travel, health care discharge arrangements, patient transport and greener transport considerations. This agenda has been addressed by the Group and shared with a Reference Group that is representative of geographical locations and protected groups in line with Clinical Commissioning Group equalities duties.

The evidence considered is set out in Appendices to the main report for ease of access.

2.1 Reducing The Need To Travel: Care Closer To Home

The Review was provided with coherent and comprehensive evidence by a range of NHS Commissioners and NHS and Community Health Care Providers which demonstrated a shift to a more localised service with further plans to consolidate this shift in the coming years. Such a shift will impact and reduce the need for Patients and Carers to travel to Acute Hospital Centres to access the care they need. This will be beneficial to both Patients and their Carers.

2.2 Public Engagement

The Travel and Transport Group sought to build on the baseline understanding of the public from consultation and earlier engagement activity. A Reference Group was set up to offer advice and to consider any matters relating to travel and transport. The Reference Group was supported by an independent community organisation chosen in an open tendering exercise. The Transport and Travel Group work plans were shared with the Reference Group and active involvement fostered. Feedback from the Reference Group has been incorporated into key sections of our final report and recommendations.

Hands off HRI and Lets Save HRI campaign groups were invited to contribute.

2.3 Road And Public Transport

Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) can be accessed by public transport with high frequency private bus services from central Halifax and Huddersfield. There is only one direct bus route between the hospitals.

A major upgrade of road transport is already underway sponsored by Kirklees Council, Calderdale Metropolitan Council and West Yorkshire Combined Authority. Work on the A629 will see a multimodal corridor improvement scheme prioritised for delivery within 5 years which will drive economic growth by addressing transport and accessibility for private and public transport. The aim is to reduce congestion at key bottlenecks with decreased journey times for private and public users and increased reliability for planned journeys. This has important implications for travel and transport to and between hospitals at Halifax and Huddersfield.

2.4 Travel Analysis – Public And Private Transport

Two separate analyses have been completed. The initial analysis was completed by the North of England Commissioning Support Unit (NECS). Subsequently a separate analysis was undertaken by Kirklees Council (KC) and West Yorkshire Combined Authority (WYCA).

Both analyses:

- Utilise the industry standard TRACC accessibility mapping software.
- Produce findings in relation to travel by both public and private transport.
- Outline the implications for people travelling to one hospital or the other.

The NECS analysis uses 12 months of actual data for those people who attended A&E who did not arrive in an Ambulance. A&E data has been used because that is the only reliable actual data that is available to us. This data is not the additional journey time to A&E; people going to A&E would, in most instances travel by ambulance. The results show the average time for people who would normally travel to one location who would now travel to another. This could, for example, show the impact for those people visiting hospital or those who are given an appointment at a different hospital. Based on actual patient data the high level findings are:

Private Transport comparative Journey Times

80 % of respondents to the CCGs consultation indicated they travel to hospitals by car or taxi. The table sets out the maximum average journey times for travel by private car or taxi.

Travel by Car / Taxi from:	Maximum average journey times in minutes			
	Based on actual data		Based on modelled data assuming people travel to a different location	
Calderdale Post codes	To CRH	17.6 minutes	To HRI	24 minutes
Kirklees Post codes	To HRI	15.1 minutes	To CRH	20.5 Minutes

Public Transport comparative Journey Times

Based on the outcome of the CCGs consultation approximately 20% of Patients or Visitors travel to the hospitals by Public Transport. The table sets out maximum average journey times.

Travel by Public Transport from	Maximum average journey time in minutes			
	Based on actual data		Based on modelled data assuming people travel to a different location	
Calderdale Post codes	To CRH	52.7 minutes	To HRI	66.1 minutes
Kirklees Post codes	To HRI	46.3 minutes	To CRH	65.8 minutes

The KC and WYCA analysis uses whole population data. Based on population data, the average journey time along the A629 section between the two hospitals is approximately 13 minutes. There are instances, particularly in the afternoon peak, where the journey time is 40% greater than average.

It is important to understand the impact of the upgrade to the A629 to be completed by 2022. It is predicted that journey times in each direction between Halifax and Huddersfield will reduce by 4 to 4.5 minutes. The average journey time between the two hospitals is predicted to be ten minutes with much greater reliability of journey times through peak times allowing for greater certainty in planning journeys.

The population in the high maximum public transport time band who would normally take approximately 60 minutes currently represents about 4% of the total population of Calderdale and Kirklees.

2.5 Parking At Calderdale And Huddersfield Foundation Trust

The availability and management of car parking on the hospital sites is a longstanding concern. 2346 places are available but the spread is uneven with 1559 spaces at Huddersfield and 787 at Halifax.

Immediate action to address the problems includes a number of initiatives on staff parking; use of the Acre Mill site; off-site car parking and a staff car sharing scheme. These will be actioned in 2018 in an attempt to free up car parking space on the hospital site.

In the longer term, the feasibility of building a multi-storey car park at CRH is to be explored within a time frame consistent with the major road upgrade and the proposed reconfiguration of acute hospital service.
Action on signage, drop off bays, disabled parking bays and enforcement. Barriers and Greener Transport form part of a detailed plan to improve the current situation.

2.6 Shuttle Bus Service

There is a shuttle bus service which runs between Calderdale Royal and Huddersfield Royal Hospitals. It runs on a section 19 permit which means it can carry the public visitors, patients and staff free of charge.

The current contract expires in May 2018 with an option to extend on a 2 x 12 monthly basis.

Analysis of journey times using GPS data has been undertaken. Average travel time between the two hospitals is 22 minutes in term time and 21 minutes in school holidays. At peak periods times increase to a time of approximately 30 minutes or more on a small number of occasions. The upgrade to the A629 will reduce journey time by 4 to 4.5 minutes and increase reliability significantly.

The service is valued by the public and staff. However it is not fit for purpose in its current form.

The service requires more visible and widely advertising with better signage and adequate bus shelters on both sites.

More importantly the service should be more equitable providing for the needs of vulnerable older people, people with disabilities, especially wheelchair users as well as infants and young children and their parents.

Ideally, a more frequent service which links both hospitals and local transport hubs would contribute to a more integrated transport system for the travel corridor.

2.7 Patient Transport Services (PTS)

PTS is a major contributor with up to 190 vehicles operating each day to transport patients who meet the eligibility criteria being transported to and from hospitals across West Yorkshire.

Whilst most patients are happy with and appreciate the service, a number of improvements have been identified. These include:-

- Timings of journeys.
- Notice of collection times with pre-collection calls to patients.
- Revised hospital portering arrangements.
- Better lounges for waiting for transport.

A detailed action plan is set out in the full report.

2.8 Seamless Hospital From Home Service

Seamless Home from Hospital Service is run jointly by Calderdale Community Transport and Age UK Calderdale and Kirklees, funded by Calderdale and Greater Huddersfield CCGs. The service provides an accessible journey home from hospital for elderly and vulnerable patients with support provided as soon as the patient arrives home.

Analysis has been undertaken on journey times and no significant impact was identified.

2.9 Greener And Sustainable Transport

Sustainable development across health and social care services is a key driver for public sector services. Reducing carbon footprint, maximising use of resources, and improving individual and community health are challenging targets. Strategies and travel plans which facilitate active travel, minimise emissions and maximise the promotion of good health create the conditions within which people and communities take control of their own lives and health.

2.10 Communication

Calderdale and Greater Huddersfield CCGs have developed an action plan to ensure wide publication and dissemination of progress in implementing Care Closer to Home and the outcome and recommendations of the Travel and Transport Group.

2.11 Equality And Health Inequality Impact Assessment

A review of the Equality and Health Inequality Impact Assessment that was completed post consultation to identify any Equality and Health Inequality implications, has been undertaken on behalf of the Travel and Transport Group. The appointment of an independent Chair and a Travel and Transport Reference Group set the tone for the conduct of the review which has sought to be engaging

and inclusive in the management of business. The outcome of the impact assessment highlights actions taken to improve access and acknowledges public and patient concerns. Action on those has been incorporated into the text and recommendations of the final report.

2.12 Yorkshire Ambulance Service

Work to identify the impact on resources and travel times for the Yorkshire Ambulance Service continued in parallel to the review undertaken by the Travel and Transport Group. A summary of a presentation to the Group by the Yorkshire Ambulance Service has been incorporated into the final report.

2.13 RECOMMENDATIONS

1) **That the strategic direction set in Right Care, Right Time, Right Place, continues to be implemented with an emphasis on shifting the focus of health and social care services closer to home reducing reliance on Acute Health Service setting at local Hospitals.**

2) **Regular updates of the progress being made on implementation of Care Closer to Home, the A629 upgrade and a local Travel and Transport Plan should be highlighted in the local NHS Communication Strategy.**

3) **That the Calderdale and Greater Huddersfield CCGs continue to work through their existing engagement channels in line with each CCGs' 'Engagement and Experience Strategy for local people' to seek advice and feedback on Travel and Transport issues to influence the implementation of the report's recommendations.**

4) **The upgrade of the road network and the proposed reconfiguration of health services are challenging and complex parallel projects which require active management throughout the 5 year transition period. We recommend the local NHS consider identifying a Board Level Transport Champion to work in partnership with Calderdale and Kirklees Councils, WYCA and other key players to develop a coherent travel plan which sets out strategy, measures, action plans and targets to maximise alignment of both projects and to develop a sustainable and integrated Transport Strategy.**

5) **The West Yorkshire Combined Authority should bring to the attention of Commercial Bus Companies the opportunities created by the Road Transport Upgrade and the proposed reconfiguration of health services to secure more direct and frequent services between the hospitals and local transport hubs promoting a more integrated transport system.**

6) **The action plan outlined for short term and longer term action to address parking issues should be implemented and the feasibility of additional multi-storey car parking at CRH evaluated.**

7) **We recommend that the Shuttlebus service is upgraded with:**
   a) **Immediate action on advertising the service, signage and timetables, adequate weatherproof shelters and enhanced patient and public experience.**
   b) **A more equitable service is developed meeting the needs of vulnerable people, people with disability and wheelchair users as well as infants, children and their parents / carers.**
   c) **Consideration of a more frequent service with greater capacity and exploration of links between both Hospitals and local transport hubs to contribute to a more integrated transport system.**

8) **Improvements to the Patient Transport Service outlined in the Future Action section are implemented in a timely way consistent with Patient and Public feedback.**

Dr Mike Grady
Independent Chair, Travel and Transport Group.

SECTION 3
FUTURE ARRANGMENTS FOR HOSPITAL SERVICES, CARE CLOSER TO HOME AND PRIMARY CARE

3.1 Background And Introduction

The Calderdale and Greater Huddersfield Clinical Commissioning Groups together with Calderdale Hospital Foundation NHS Trust have determined that transformation of the current models of service delivery is required to ensure the delivery of consistently safe high quality care to all patients and to deliver care in the most appropriate and cost effective setting to meet patients' clinical needs. The proposed future arrangements for the delivery of hospital and community health services in Calderdale and Greater Huddersfield are based on the integration of service delivery across primary, community and acute care.

3.2 Outline Of Proposals

The future arrangements for primary and community health services are being delivered through each CCG's inter-related Care Closer to Home and Primary Care plans. The proposal for hospital services is that there would be a single Emergency Centre at Calderdale Royal Hospital and a single Planned Care Centre on the Acre Mills Site opposite the current Huddersfield Royal Infirmary. Both the CRH and the Acre Mills site would have an Urgent Care Centre. HRI would close. This model of service will impact directly by providing more services locally reducing the need to travel to the hospital sites. Progress in delivering this Care Closer to Home is set out in the following sections.

3.3 Calderdale Care Closer To Home[i] And Primary Care Developments [ii]

The CCG has for several years been pursuing a strategic approach to bring care closer to home across Calderdale. The main aim of the work is to ensure that community and third sector services are integrated across health and social care, wrapped around groups of GP practices, working together to provide care on a locality basis. Some services have already moved to a community setting. Examples include: Telehealth/Telecare in Care homes began in 2013; level 3 Diabetes services moved to community in December 2015, a community Respiratory service in 2017, and community Muscular Skeletal Service (MSK) in 2017. An approach for the delivery of access to GP services in and out of hours, which works to agreed local core standards and expectations, has been agreed across Calderdale. A pilot to provide locality access between 18:30 and 20:00, Monday to Friday started in September 2017 and will be rolled out across all localities by April, 2018.

Future plans include provision of extended weekday and some weekend access to General Practice on a Calderdale wide basis from April 2018 and the delivery of additional/improved services, such as work with CMBC to ensure increased homecare capacity that was delivered in 2017, recovery at home and in community settings over the next the next 12 months, and the development of

more service offers in the community in line with consultation undertaken as part of RCRTRP.

3.4 Greater Huddersfield Care Closer To Home[iii] And Primary Care Development[iv]

Greater Huddersfield Care Closer to Home is delivering services which provide a flexible pattern of delivery across health and social care through the wider partnerships and assets within local communities. Some services have already moved to a community setting, examples include: Musculoskeletal (MSK) Service was fully mobilised with a centralised Hub in October 2017; Respiratory during 2016 and community Dementia service were established within holistic community model in October 2015. Plans are in place to pilot/move additional services, as per the community model which was consulted on during 2015 including Rehabilitation Services and Complex Wound Management, over 2018/19. A model for delivery of Primary Care providing delivery at scale that is accessible to patients seven days per week has been agreed across Greater Huddersfield. Services such as the Anti-coagulation service which will ensure the most appropriate medication is prescribed and reduce the need for individuals to travel to hospital has been operating on a collaborative basis since April 2015.

Future plans include the collaborative provision of complex wound care, phlebotomy and the extended access to primary care on a Greater Huddersfield wide basis from 2018 and the delivery of additional/improved services such as Community Intermediate Care Services and Enhanced Care Home Support in community settings over 2018/19.

The three main providers of community and mental health services across Calderdale and Greater Huddersfield: Locala; CHFT; and SWYPFT also presented evidence to the group concerning the development of more local health care provision.

3.5 Locala Community Services[v]

Locala described the, predominantly home based, children's services it delivers across Calderdale and the locality based community services it delivers across Kirklees that are aligned with the Greater Huddersfield Care Closer to Home Programme. Future plans in relation to Risk management and admission avoidance to help keep people at home were also presented. Particular issues were raised in relation to future management of substance misuse recovery nursing services where transfer between sites is important.

3.6 CHFT Community Services[vi]

CHFT described the community services which it currently delivers and the alignment with the Calderdale Care Closer to Home Programme. Examples of future plans include continuing the integrated approach, such as partnership working to reduce falls and out of hospital rehabilitation were also presented.

3.7 SWYPFT Mental Health Services[vii]

South West Yorkshire Partnership NHS Foundation Trust provides a range of Mental Health Services for Children, Young People and Adults and specialist health support, advice, interventions and information for Adults with Learning Disability in Calderdale. The Trust works with other services including GPs, District Nursing Teams, Adult Social Care, Carers and Providers, benefits, housing and tenancy support and other health service providers to offer the best support to patients and their families.

No specific transport or travel issues arising from the proposed reconfiguration were highlighted in their evidence to the Travel and Transport Review group.

All individual presentations considered by the Travel and Transport Group can be found in the appendices.

In summary, significant progress has been made by NHS Commissioners in both Clinical Commissioning Groups and with local NHS, Community Sector Providers and Social Care in delivering the strategic vision set out in Right Care, Right Time, Right Place with increased local provision of service closer to people's homes.

RECOMMENDATIONS

1) **That the strategic direction set in Right Care, Right Time, Right Place, continues to be implemented with an emphasis on shifting the focus of health and social care services closer to home reducing reliance on Acute Health Service setting at local Hospitals.**

2) **Regular updates of the progress being made on implementation of Care Closer to Home, the A629 upgrade and a local Travel and Transport Plan should be highlighted in the local NHS Communication Strategy.**

3) **That the Calderdale and Greater Huddersfield CCGs continue to work through their existing engagement channels in line with each CCGs' 'Engagement and Experience Strategy for local people' to seek advice and feedback on Travel and Transport issues to influence the implementation of the report's recommendations.**

SECTION 4
SUMMARY OF PUBLIC ENGAGEMENT AND EQUALITY

Continued engagement was central to the work of the Travel and Transport Group throughout the review.

Following the consultation on hospital and community services work took place to identify the key themes for local people. A composite report was developed to include:

- All the findings relating to travel and transport from the consultation on hospital and community services.
- Any patient opinion postings on travel and transport.
- PALS or complaints intelligence on travel and transport.
- Any reference to travel and/or transport in other engagement activities.

This information once pulled together provided intelligence to support a baseline understanding of public views. The report also had a comprehensive equality section which described the impact of travel and transport on particular protected groups. The protected groups identified as being the most likely groups to be impacted by travel and transport are:

- Disabled people and carers.
- Older and younger people (including parents).
- People living in deprived areas/in poverty (including - people without access to private transport).
- Some BME groups – Asian/Asian British (including– Pakistani), Other White groups.

In order to understand further what recommendations should be made to ensure all travel and transport impacts are considered it was agreed that a 'Travel and Transport Reference Group' be set up. The reference group would be in place to advise on, and consider, any matters relating to travel and transport.

The launch of the reference group took place at a stakeholder meeting on 19th June 2017[viii]. The members invited to the initial event were;

- Engagement Champions in Calderdale.
- Community Voices in Greater Huddersfield.
- Patient Reference groups in Calderdale and Greater Huddersfield.
- Members of CHFT membership.
- Third sector organisations in Calderdale and Greater Huddersfield.

The invited members had already worked closely with the CCGs on the 'Right Care, Right Time, Right Place' programme by attending stakeholder events and supporting both engagement and consultation activity. The purpose of the meeting was to present what people had already told us about travel and transport, discuss the key

themes and help to identify any next steps, including how to get people involved going forward.

There were a number of key emerging themes[ix] from the composite report and stakeholder event. These themes were used as headings to support what people had already told us and to identify individual action plans. The themes were:

- Parking.
- Access.
- Travel between hospitals.
- Public transport.
- Reducing the need to travel.
- Discharge and patient transport.
- Greener travel.

An individual or joint action plan for each of the key emerging themes was developed which included what people told us, what the current position is, recommendations and actions. The Working Group worked with the reference group to agree the recommendations and identify actions.

Each of the recommendations from the action plans are set out below. It is worth noting that each of these recommendations are referenced under the relevant section to ensure that actions continue to be delivered. The recommendations for each of the action plans are set out below:

4.1 Car Parking[x]:

- To assess demand for cycle parking, and if warranted put further facilities in place.
- Identify any drop off bay improvements including ways to improve information and communication on this facility.
- Map the blue badge spaces available and any alternative access spaces. Identify any additional improvements including signage.
- Continue working on the proposal for weekly/ monthly public parking permits. Continue with the feasibility study including:
  - A potential multi-story car park at CRH.
  - Making Dry Clough Close a car park.
  - More park and ride spaces.
  - Tighten up on staff permits.
- Assess barrier accessibility and parking to ensure car parks can be used by people with a disability.
- Whilst there are no plans to create any designated parking spaces it is recommended that further conversations take place to identify any specific needs that are not being met by designated parking spaces.
- Identify any potential technology solutions to parking.

4.2 Public Transport[xi]:

- To advertise current bus service provision with a designated hospital leaflet.
- To work with West Yorkshire Combined Authority and commercial operators to divert some current services, where possible, to improve direct access to the hospitals Calderdale Royal Infirmary (CRH) and Huddersfield Royal Infirmary (HRI).
- Work with Bus 18 to engage further with service users through existing engagement channels in line with each CCG's engagement and experience strategies for local people.
- Re-configure the existing NHS shuttle service into a local bus service.
- Work towards providing a high frequency service linking Halifax bus and rail stations, the two hospitals, and Huddersfield bus and rail stations.
- All partners to work together to do a comprehensive review of transport links between Halifax and Huddersfield, taking into account:
  - Any new developments such as hospital, Elland Parkway rail station and the proposed bus/ rail interchange at Halifax station.
  - Reducing car traffic, supporting active lifestyles and improving air quality.

4.3 Discharge And Patient Transport (PTS)[xii]:

- Do an internal review of hospital porter arrangements.
- Publicise the discharge facility at HRI and work with the reference group to create a Calderdale facility.
- Identify the requirement to have a PTS service for those people who do not meet criteria.

4.4 Other[xiii]:

- Identify future discharge requirements and continue to evaluate the current discharge service.
- Continue the development of the patient portal to implementation and work on pre-collection calls.
- Continue the development of the revised operating model to implementation. Monitor performance through the contract process.
- Identify other solutions that may reduce travel to hospital.
- Look at improvements to communication and information of travel and transport including staff training in all departments, clear timetables and website improvements.
- Look at how public transport can further support the CHFT shuttle bus service. Identify main visiting times to increase the frequency of the service and provide indoor waiting with clear information on areas such as wards and the website.
- Identify how well the current service operates and any alternatives for transferring patients between sites.

Sector Support Calderdale at North Bank Forum, Calderdale's Voluntary and community sector infrastructure provider were contracted to support Reference Group Involvement. The recommendations set out are included in the action plans which identify opportunities for further involvement. In addition Sector Support Calderdale have gathered case studies and completed journeys as part of the work to support the Working Group.

RECOMMENDATION

3) **That the Calderdale and Greater Huddersfield CCGs continue to work through their existing engagement channels in line with each CCGs' 'Engagement and Experience Strategy for local people' to seek advice and feedback on Travel and Transport issues to influence the implementation of the report's recommendations.**

SECTION 5
PUBLIC TRANSPORT INFRASTRUCTURE

Both hospitals can be accessed by public transport with high frequency services from their town centres. There is only one direct service between the two hospitals (343), however this is not a suitable option due to the length of route. Passengers can currently use public transport between the two hospitals by changing in the town centres.

Bus operators have been made aware of the possible reconfiguration and will consider their commercial intentions. However it is unknown whether they will alter their current networks.

Calderdale Council, Kirklees Council and WYCA are sponsoring improvements to the A629 between Halifax and Huddersfield which will see a multi-modal corridor improvements scheme prioritised for delivery within five years to drive economic growth by addressing transport and accessibility issues.

The scheme aims to reduce congestion and decrease journey times particularly for public transport. These journey time savings may result in bus service frequency enhancements.

The scheme will primarily focus on Salterhebble, Halifax Town Centre and Ainley Top.

5.1 Travel Analysis Summary

Background

One of the elements in the Terms of Reference for the Travel and Transport Working Group is that it should review the existing and updated Patient travel analyses in order to support the delivery of its responsibilities.

The existing Patient Travel Analysis was produced by Jacobs Engineering and formed part of the Pre Consultation Business Case.

In response to feedback from the consultation, two revised travel analyses have been produced. One has been produced by North of England Commissioning Support Unit (NECS) and utilises (anonymised) actual A&E attendances where the patient did not arrive by ambulance. A second analysis has been produced jointly by Kirklees Council and West Yorkshire Combined Authority which provides an analysis using population data contained within census Lower Super Output Area.

The main additional information from the NECS analysis is the provision of average journey times by Postal District for both private car and public transport. The Kirklees Council/West Yorkshire Combined Authority analysis is focused on

public transport times and the differences in travel times for Peak (am and pm), interpeak and off peak. The completion of two separate analyses should provide greater confidence in the findings.

Both analyses use the industry standard TRACC accessibility mapping software. TRACC uses public transport and highways data to create journey times from origins and destinations. It uses timetable information showing both arrival times at stops from public transport services against a specific time/day period. Highways information from an underlying road network is used to fill the gaps between public transport services by creating a linear network that connects the origins, destinations and stops together to give a fully routable network of nodes and lines.

For a public transport journey, the journey time produced then includes the walk from the origin to the road, from the road to the public transport stops, any interchange of public transport using the road and then from the final stop to the destination via the road, and finally from the nearest point on the road network to the destination. The journey assumes arrival at the first stop 1 minute before the initial departure, with any subsequent interchange waiting times included as part of the final journey time.

5.2 NECS – Travel Analysis[xiv]

Context

The analysis that was commissioned assumed that Dewsbury District Hospital (DDH) would be closed to blue light ambulances. This is the same assumption as was made in the Pre-Consultation Business Case and CHFT's five year plan. Mid Yorkshire Hospital Trust (MYHT) have confirmed that this assumption is incorrect. The changed assumption in relation to Dewsbury results in the inclusion of a higher number of patients' data.

The reports have been produced using CHFT, MYHT and YAS data to model the same two scenarios:

- A single Emergency Centre at CRH without HRI and DDH.
- A single Emergency site at HRI without CRH and DDH.

5.3 Analysis

The methodology and high level results are included in the Analysis report. The breakdown by Postal Sector is included in the appendix to that report and shows:

- The Actual time taken.
- The average time for the journey by Public Transport.
- The average time taken by private car.

The following should be borne in mind when considering the analysis.

a) The results are rounded to the nearest five minutes (so 7:29 would become 5 minutes and 7:31 would become 10 minutes).
b) The analysis assumes that people go to their nearest hospital (even if they think they would be going to CRH/HRI/DDH) which also reduces the average.
c) Whilst the analysis provides an indication of the total volume of people affected. It overestimates through inclusion of data in relation to attendances at DDH.
d) The total volume of people affected is further overestimated in that it does not subtract 54% in line with the rationale that this would be the volume of patients who would attend an Urgent Care Centre at the site where they currently attend.
e) It does not provide the split in the percentage of people who would travel by public transport versus the percentage who would travel by private car.
f) We cannot provide meaningful data on the number of visitors to hospital or any reliable assumptions on the starting point for their journey.
g) The data used includes MYHT data which impacts on the volume of people affected and their average journey time.
h) The analysis cannot take account of the impact of the proposed improvements to the A629 or the proposed transport plan for public services.
i) Acknowledging the limitations described above, the spreadsheet produced as part of the analysis does provide average journey times by postal district and both the report and the spreadsheet were provided to the Travel and Transport Working Group to inform its work.

5.4 Summary Of Outcome And Comparative Journey Times in Minutes

The NECS analysis uses 12 months of actual data for those people who attended A&E who did not arrive in an Ambulance. A&E data has been used because that is the only reliable actual data that is available to us. This data is not the additional journey time to A&E; people going to A&E would, in most instances travel by ambulance. The results show the average time for people who would normally travel to one location who would now travel to another. This could, for example, show the impact for those people visiting hospital or those who are given an appointment at a different hospital. Based on actual patient data the high level findings are:

Private Transport comparative Journey Times

80 % of respondents in consultation indicated they travel to hospitals by car or taxi.

Travel by Car / Taxi from:	Maximum average journey times in minutes			
	Based on actual data		Based on modelled data assuming people travel to a different location	
Calderdale Post codes	To CRH	17.6 minutes	To HRI	24 minutes
Kirklees Post codes	To HRI	15.1 minutes	To CRH	20.5 Minutes

Public Transport comparative Journey Times

20 % of respondents in consultation indicated they travel to hospitals by public transport.

Travel by Public Transport from	Maximum average journey time in minutes			
	Based on actual data		Based on modelled data assuming people travel to a different location	
Calderdale Post codes	To CRH	52.7 minutes	To HRI	66.1 minutes
Kirklees Post codes	To HRI	46.3 minutes	To CRH	65.8 minutes

These journey times should improve following the upgrade of the A629 and reduce travel times by 4 to 4.5 minutes.

5.5 Kirklees Council and West Yorkshire Combined Authority Travel Analysis Methodology

This analysis focussed on the public transport journey time changes that would occur as a result of the reconfigurations.

Due to the complexities surrounding the provision of specific services in different hospitals, and the fact that many people wish to know how it will affect their public transport journey with the assumption that there already is a requirement for them to change hospitals, despite the fact that might not necessarily be the case, it was decided to run the following analyses:

- A base situation (i.e. people travel to the nearest hospital).
- All hospital services provided at HRI but keeping Dewsbury.
- All hospital services provided at Calderdale Royal Infirmary but keeping Dewsbury.

All three analyses were run in an am peak (0700-0900) an interpeak (100-1200), a pm peak (1600-1800) and an off-peak (1900-2100).

5.6 Headline Results

The independent population based travel analysis indicates that residents will be required to travel on average 10 minutes further by public transport.

The use of the average masks some substantial increases for sections of the population in the high travel time bands, particularly if a journey would normally take an hour to access either Calderdale or Huddersfield hospitals, which it might for approximately 4% of the combined population of Kirklees and Calderdale.

Additionally the average assumes

- All of the population travels by public transport rather than car when 80% of respondents to consultation indicate they travel by private car or taxi.
- The total volume of people affected does not subtract 54% of residents in line with the rationale that this would be the volume of patients who would attend an Urgent Care Centre at the site where they currently attend.
- The upgrade of the A629 will impact positively of the journey times with estimates suggesting 4 to 4.5 minute reduction.
- All these assumptions would be likely to significantly affect the average.

A visualisation of the change in journey times using the bands above is included in Appendix B of the travel analysis. It shows contour maps with the different journey time bands represented by different colours and can be used to highlight areas where there is a significant increase in journey times for certain geographic areas.

The methodology, data sources and results are included at Appendix C of the travel analysis.

5.7 Journey Time and Reliability between the two hospitals

Throughout the consultation process a lot of comments have been received about congestion and reliability issues along the main route that connects the two hospitals, the A629.

Improvements along the A629 corridor between Halifax and Huddersfield is one of the priority schemes programmed to be implemented as part of the Transport Fund programme. Corridor improvements under the Transport Fund will see a £120.6m transport package comprising multi-modal interventions which will improve journey time reliability, through a combination of road space reallocation and targeted junction improvements to address key congestion hot spots. The A629 interventions are being delivered jointly by Kirklees Council and Calderdale

Council and have been split into phases to manage on site delivery and traffic management during construction phases. This has important implications for travel and transport to and between the hospitals at Halifax and Huddersfield.

Whilst not all the scheme details are available at the moment, plans for phases 1a and 1b are. Further information is available on the "Calderdale Next Chapter website": http://www.calderdalenextchapter.co.uk/.

Information relating to phase 5 can be found on the Kirklees website: http://www.kirklees.gov.uk/beta/transport-roads-and-parking/major-transport-schemes.aspx.

A timeline for implementing phase 5 is also available with completion expected by August 2021.

It is important to understand the effect of transport schemes in terms of reducing the congestion along the A629 in both directions and more importantly, ensuring that there will be reliable journey times between the two hospitals.

In both cases the average journey time along the A629 section between the two hospitals is approximately 13 minutes, but the standard deviation (i.e. in this case a proxy measure of reliability) is 15% of the average journey time. In addition there are instances, particularly in the afternoon peak where the journey time between the two hospitals is 40% greater than the average and double the lowest journey time in the early morning.

It should also be noted that the analysis was undertaken in a month where there was no construction taking place. At the moment phase 1a of the West Yorkshire Transport Fund scheme is currently in construction and so there are significant delays along the A629 around Salterhebble Hill.

The schemes promoted through phases 1a/b and 4 and 5 of the West Yorkshire Transport Fund aim to reduce the journey time along this section of road in particular, but more importantly bring some journey time reliability to the route. This is particularly important for regular users of the route, such as commuters or patient transfer services between the two hospitals, for example.

Early indications from work carried out as part of phase 4 shows that globally with the full range of West Yorkshire Transport Fund implemented along the A629 journey time savings of 4 to 4.5 minutes in the peak in both directions could be expected along this route. The average journey time could potentially drop to around 10 mins, but more importantly the standard deviation, drops to 8% of average journey time, showing that the reliability of the journey becomes much greater, allowing for greater certainty in planning journeys.

RECOMMENDATION

4) **The upgrade of the road network and the proposed reconfiguration of health services are challenging and complex parallel projects which require active management throughout the 5 year transition period. We recommend the local NHS consider identifying a Board Level Transport Champion to work in partnership with Calderdale and Kirklees Councils, WYCA and other key players to develop a coherent travel plan which sets out strategy, measures, action plans and targets to maximise alignment of both projects and to develop a sustainable and integrated Transport Strategy.**

SECTION 6

BUS SERVICES ACT UPDATE

The Bus Services Act 2017 was enacted in May 2017; it expands the range of powers available to directly elected mayors and local transport authorities (LTAs) in areas in England outside of London to improve local bus services. The Act provides the following options for LTAs to adapt its approach to local circumstances:

- Franchising- where the LTA issues contracts with bus operators to provide services in the area. The Act provides mayoral LTAs with "London-style" powers to franchise local bus services, application for franchise powers by non-mayoral authorities will need to be made to the Secretary of State.
- Partnership- joint arrangements between LTAs and bus operators. The Act develops the existing Quality Partnerships powers extending their scope to include matters such as fares and frequencies. Two new forms of formal partnership are established "Advanced Quality Partnership Schemes" and "Enhanced Partnerships Schemes".

The Bus Services Act also enables data about routes, fares and times across the country available to be openly available to app developers and further facilitates smart multimodal ticketing schemes. On 27 November 2017, the Secretary of State issued guidance on the use of the powers contained in the Act. Currently these powers only apply to those cities with elected mayors.

WYCA adopted its Bus Strategy 2040 in August 2017 which sets out a vision for the bus system and a target to grow bus patronage by 25% over the next ten years.

RECOMMENDATION

5) The West Yorkshire Combined Authority should bring to the attention of Commercial Bus Companies the opportunities created by the Road Transport Upgrade and the proposed reconfiguration of health services to secure more direct and frequent services between the hospitals and local transport hubs promoting a more integrated transport system

SECTION 7

PARKING AT CALDERDALE AND HUDDERSFIELD FOUNDATION TRUST

As part of the consultation in 2016, concerning the proposed reconfiguration of health services in Calderdale and Kirklees, the availability and management of car parking facilities at Calderdale Royal Hospital was high on the list. These concerns were echoed in feedback from the Travel and Transport Reference Group who highlighted issues relating to car parking availability, cost to regular users, enforcement in designated bays and use of technology.

The issue is doubly important because approximately 80% of people attending the two local hospitals do so by car or taxi. However, the poorer you are the less likely you are to drive. In the lowest income quintile 44 % have no access to a car.

Currently there are 2346 available car parking spaces at the Calderdale and Huddersfield Foundation Trust but the spread is uneven. There are 1559 spaces at HRI where the focus will be planned activity and 787 at CRH.

An internal review of car parking has been undertaken and a number of actions are planned for action in both the immediate future and longer term.

Immediate action in 2018 includes:

- Providing an area for staff parking at the Acre Mill OPD HRI site and using the shuttle bus for travel to CRH freeing up spaces there.
- Reviewing off site car parking for staff using park and ride to free up spaces for patients and visitors.
- Development of a staff car sharing scheme.

Additional Action

- **Drop off Bays**: Drop off zones are available at both HRI and CRH located at the main entrance. The first 30 minutes car parking is free. Wider publicity about this service would be helpful.
- **Better and bespoke disabled bay design**: whilst there are a large number of blue badge holder car parking spaces design could be improved especially allowing for rear access to vehicles. Currently disabled patients can be allocated bays (subject to availability). Consideration is also being given to increasing the availability of parent / child parking.
  The current capacity precludes expansion of designated parking bays at this point.
- **Enforcement:** CHFT sites are patrolled on a regular basis identifying breaches of car parking rules and enforced.
- **Signage** within the car park will be subject to annual review and include car park and public transport information.

- **Barriers:** there are a small number of barrier remote controls available which can be issued to some patients who are regularly visiting the hospitals. The remotes are costly which impacts on availability.
- **Greener Transport:** Electric car charging is installed on the Acre Mills site and the issue is under review as part of the revised car parking policy.
- **Cycle** Lock up areas in secure, weather proof and well-lit areas would also encourage active travel.

Longer Term Plans

CHFT is planning to build a new multi-storey car park within the next 3 to 5 years subject to necessary approvals and public consultation.

- **Cost of Parking**: Car Parking Charges are consistent with other NHS Trusts. Free car parking is offered in line with the NHS England Healthcare Travel Cost scheme. Free Parking is offered to some parents visiting children, relatives visiting terminally ill patients and patients attending for cancer or life threatening treatments. Work is currently underway to develop concessionary charging for identified patient groups and cheaper parking per week will be made available in 2018.
- **Smart Payments**: New pay on foot machines are available now at HRI and Acre Mills sites and accept all methods of payment including cash, notes, and credit cards. On-line payments for car parking are under review.

RECOMMENDATION

6) The action plan outlined for short term and longer term action to address parking issues should be implemented and the feasibility of additional multi-storey car parking at CRH evaluated.

SECTION 8

SHUTTLE BUS SERVICES AND PATIENT TRANSPORT SERVICE AND SEAMLESS HOME FROM HOSPITAL

Shuttle Bus Services: Current Position

The shuttle bus service currently runs between Calderdale Royal and Huddersfield Royal Hospitals.

The service is operated by the Trust Transport department and is run on a section19 permit which enables the service to carry patients, visiting public and staff free of charge.

The service operates from 6.30am – 8.30pm, Monday – Friday and from 1.00pm – 8.30pm, Saturday – Sunday.

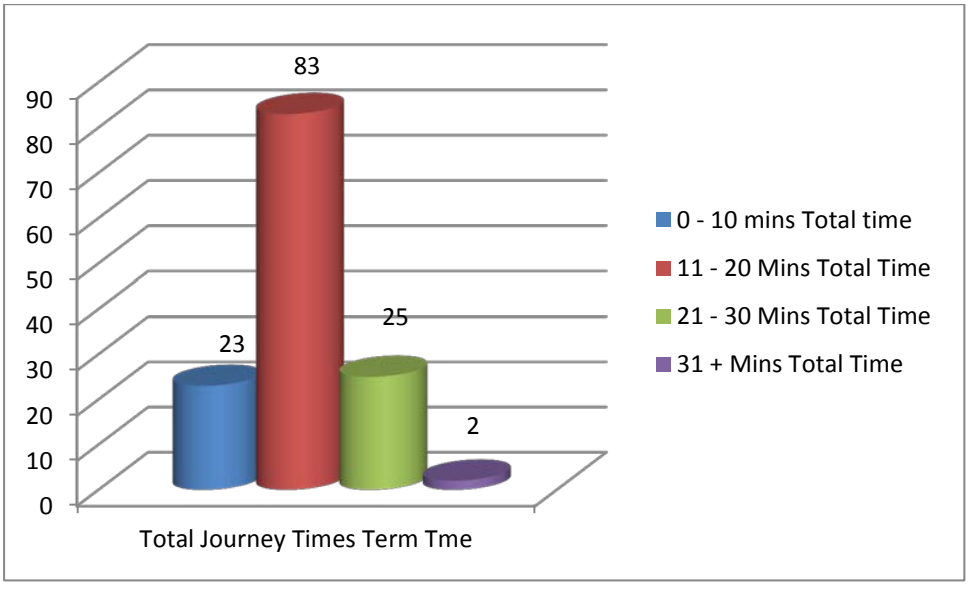
Service frequencies, dates and times are regularly reviewed and amended as necessary according to need.

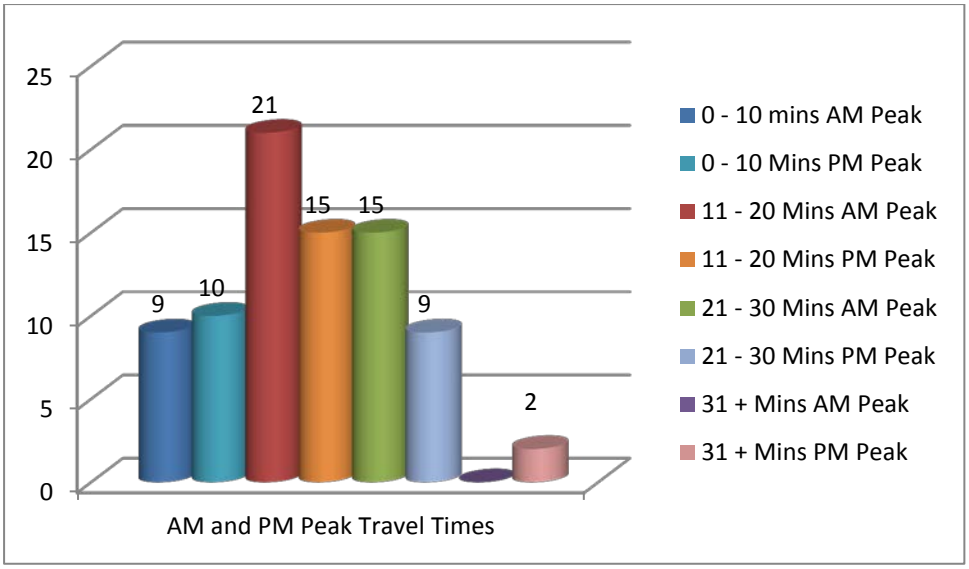
Buses run every 30 mins, with the exception of peak times (7.15am – 9.45am, & 2.45pm – 5.15pm) when they run every 15 mins.

The service is currently advertised via the Internet, through word of mouth, appointment letters, and posters on various wards and departments.

The current vehicle contract is due to expire in May 2018, with the option to extend on a 2 x 12 month basis.

An analysis of journey times has been undertaken using GPS data which is available from every shuttle bus journey as listed below.

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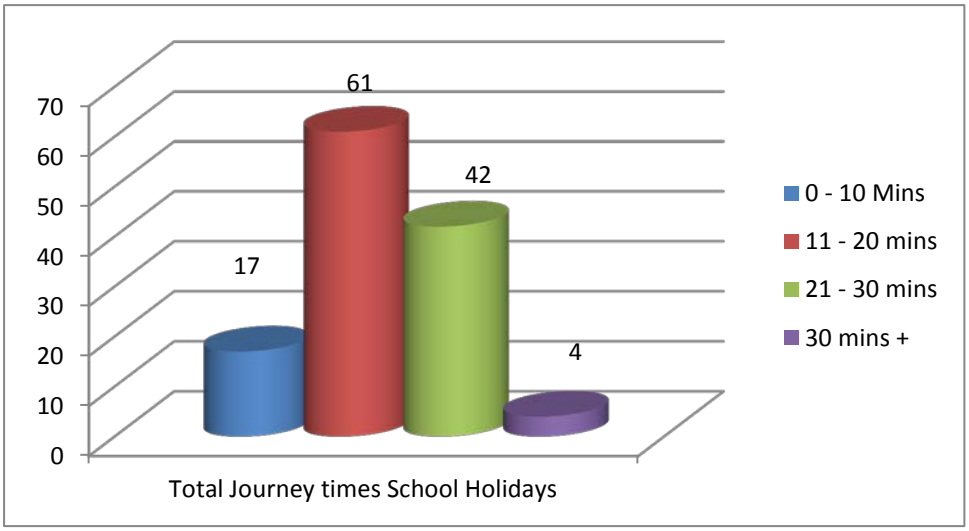
11 - 20 Mins AM Peak
11 - 20 Mins PM Peak
21 - 30 Mins AM Peak
21 - 30 Mins PM Peak
31 + Mins AM Peak
31 + Mins PM Peak
AM and PM Peak Travel Times


70
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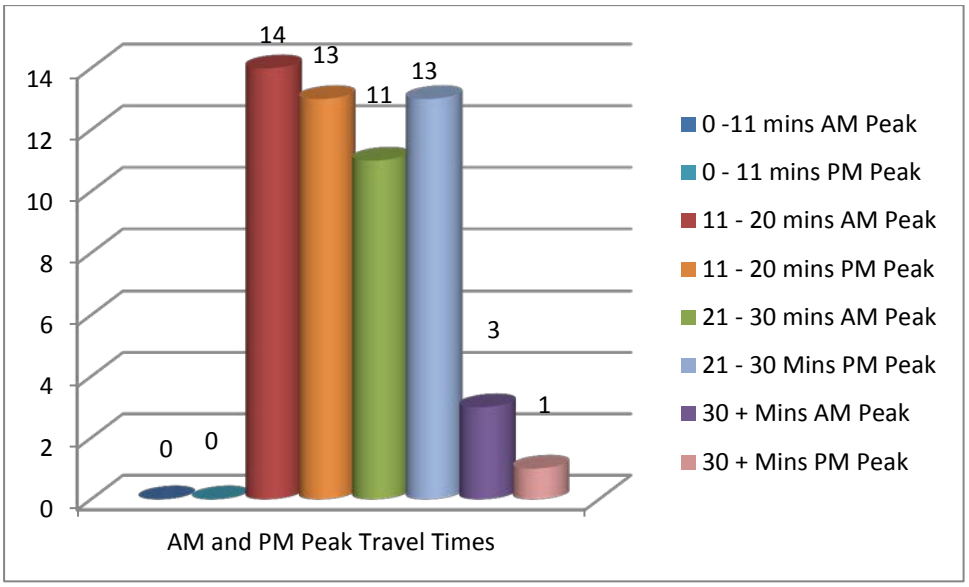
Total Journey times School Holidays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11 - 20 mins AM Peak
11 - 20 mins PM Peak
21 - 30 mins AM Peak
21 - 30 Mins PM Peak
30 + Mins AM Peak
30 + Mins PM Peak
AM and PM Peak Travel Times

The service is valued by the public, patients and staff. However feedback from the public, our reference group and the direct experience of a member of the Travel and Transport review Group suggest improvements to improve the service would support the proposed reconfiguration of services and enhance patient and public experience.

Summary feedback includes:-

- A more visible and widely advertised service to meet current and future demand.
- Better signage relating to shuttle pick up points and timetables.
- Adequate and safe bus shelters on both hospital sites with appropriate seating and weatherproof shelter.
- Patient sensitive welcome.
- More equitable service responsive to the needs of vulnerable elderly people, people with disability and young children and young people.
- Greater capacity to reduce waiting times and extended evening availability to cover visiting times.
- A wider more frequent service to include links to both hospital site and local transport hubs to contribute to a more integrated transport system for the area.

The Travel and Transport Review Group are conscious of the limitations created by the current Section 19 Permit for the service and a retendering exercise may need to be considered as the current contract expires. Examples of more enhanced services are available to be explored in partnership with the advice and expertise of colleagues in the West Yorkshire Combined Authority.

RECOMMENDATION

7) We recommend that the Shuttlebus service is upgraded with:

a) Immediate action on advertising the service, signage and timetables, adequate weatherproof shelters and enhanced patient and public experience.

b) A more equitable service is developed meeting the needs of vulnerable people, people with disability and wheelchair users as well as infants, children and their parents / carers.

c) Consideration of a more frequent service with greater capacity and exploration of links between both Hospitals and local transport hubs to contribute to a more integrated transport system.

SECTION 9
PATIENT TRANSPORT SERVICES (PTS)
Background
A number of key areas identified by the Travel and Transport Reference Group related to the provision of Patient Transport Services (PTS).

Introduction
This section provides:

a) Information in relation to the current service, including eligibility, access and service usage.
b) A summary of the feedback received from all our engagement and consultation, together with relevant areas from the Working Group's plan and the feedback from the Reference Group.
c) An outline of the commissioning intentions for the future service.
d) Conclusions, recommendations and the decisions required from the Working Group.

Current Service
Eligibility Criteria
Eligible patients are those:

- Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
- Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
- Recognised as a parent or guardian where children are being conveyed.

The following services are **not** covered within the transportation:

- Transport to primary care services such as a GP surgery or Dentist.
- Patients travelling for private treatment paid for by themselves.
- People who do not normally live in the United Kingdom are not automatically entitled to use the NHS free of charge. Asylum seekers are eligible for free NHS treatment for as long as their application is under consideration and they meet the required medical need criteria.

Access to the Service
Requests for transport are made via telephone on the day the transport is required or by telephone and online booking up to 2.00pm the day before the transport is required. Previously planned transport was also arranged via Patient Ambulance Service (PAS). All transport requests are accepted by Yorkshire Ambulance Service; however transport that is classified as an Extra Contractual Request (ECR),

e.g. transport out of hours or out of West Yorkshire, requires approval by the CCG where the cost of the journey is above £200.

Other types of Transport for Patients

There is no alternative transport for patients in Kirklees but in Calderdale some patients are transported to Podiatry and Chronic Obstructive Pulmonary Disease (COPD) appointments by Community Transport Calderdale. This service is reviewed in the following section of the report.

There is also a home from hospital scheme in Calderdale and Huddersfield. Transport from out of area hospitals, e.g. repatriations may be provided by transport providers which have contracts in that area, e.g. North West Ambulance.

PTS Service Usage

The 2015 Service Review identified that just over 60% of Greater Huddersfield and Calderdale CCG clients attend hospital in their Local Authority area. (This means Calderdale patients going to CRH and Greater Huddersfield patients going to HRI. Approximately 25% of patients in both CCG areas go to the Leeds hospitals.

The contract activity includes both planned and unplanned transport.

On average 173 PTS vehicles operate from West Yorkshire bases during the week each day. However, the number used fluctuates from day to day and can be as high as 190. This will depend on:

- the number of vehicles off the road for servicing or repair,
- Staff absence.
- Patient demand and profile. (The number of patients requiring 2 crew members varies significantly from day to day. A busy double crew day will mean fewer vehicles used across the area, a busy single crew day will mean more crews operating a vehicle on their own.).
- In addition, there is considerable cross use of vehicles. A vehicle from Harrogate may travel into Leeds and then take a Greater Huddersfield CCG patient from Leeds home to Huddersfield before taking a Brighouse patient in to Bradford and then discharging a patient from Bradford back to Harrogate. This is one of the advantages that having a single supplier covering the whole of the Leeds catchment area brings.

There are 5 bases used by PTS that YAS think could be classed as being in Calderdale and Huddersfield area. (Brighouse, Halifax, Honley, Huddersfield and Todmorden). On this basis an average of 39 vehicles operate each day from Calderdale and Huddersfield with as many as 44 on any single day.

The number of vehicles moving patients is more complex. On an average weekday 85 different vehicles will be used to move Greater Huddersfield and Calderdale patients. Across the whole of West Yorkshire, on an average weekday, 198 different vehicles will be used to move patients.

Future Service

What have people told the CCGs in previous engagement?

Targeted engagement has been undertaken with people who use 'Patient Transport' services to understand what user think about the service.

Responses were received from **406 patients** living in Calderdale and Greater Huddersfield. As part of this specific piece of engagement, people told us:

a) **The things that work well:**
   - Majority of patients are happy with the service and are very appreciative of the service.
   - Many patients have a high praise for the staff who they describe as friendly, polite, helpful, caring and pleasant. .
   - Most patients explained how they are extremely grateful of the support from the drivers.
   - Advance calls from drivers to inform patients they were on their way or if there would be a problem was valued highly.

b) **The things that could be improved:**
   - Timing of journeys – particularly for outpatients and renal either too late or too early, or long waiting times to go home without refreshment or assistance for toileting.
   - More staff and greater knowledge of local area.
   - Not knowing when vehicle is going to turn up to collect them for appointment.
   - Wrong type vehicles being ordered – GP and Hospital issues.
   - Renal patients have particular issues pertinent to their condition. Longer waiting times impacts adversely on their treatment.
   - Safety and comfort, vehicles being described as old, uncomfortable and seatbelts not feeling secure.
   - Accessibility – lack of access for wheelchairs if manual or not specified acceptable type.

What has the Travel and Transport Review Group identified?

- The PTS contract is clear that people should be taken right from the house door to the clinic – with some exceptions. Hospital discharge is the responsibility of the Clinic.
- The "Discharge" Lounge should and has been renamed as the Libby and Bertie lounge consistent with the patient feedback.

What has the Travel and Transport Reference group told us

Discharge and patient transport:

- After an appointment patients are not always taken to collection area for transport.
- There should be accessible transport for patients and visitors.
- The Age UK 'discharge from hospital scheme should be continued.
- Patient transport should give notice about collection times where possible (i.e. within the area: 10-15 minutes) so people can get the coat on, use the bathroom and not just sit and wait.
- Patient transport is not always on time/reliable.

Future Actions

- A 'patient portal' is being developed which will allow people to see where the transport is. A pilot will be rolled out fully during next year. Service user testing has taken place during the pilot.
- A new IT system for managing transport is being trialled to ensure better use of vehicles. It is being rolled out gradually over the next year. It represents a completely different way of working, e.g. vehicles will be used where they finish rather than going back to base.
- Hospital portering arrangements to be looked at again.
- Plans to establish discharge lounge at CRH will be taken forward.
- The requirement to have a PTS service for those people who do not meet the current criteria will be explored.
- Clearer communication will be provided to explain why carers and families have to travel separately.
- Further work to be done to incorporate pre-collection calls to patients using transport wherever possible.

RECOMMENDATION

8) Improvements to the Patient Transport Service outlined in the Future Action section are implemented in a timely way consistent with Patient and Public feedback.

SECTION 10
SEAMLESS HOME FROM HOSPITAL

The Seamless Home from Hospital service (SHFH) is run jointly by Calderdale Community Transport and Age UK Calderdale and Kirklees. The service provides an accessible journey home for elderly and vulnerable patients with support as soon as the patient arrives home, which may include turning on heating, making beds, making lunch or a hot drink, clearing out the fridge, doing some shopping, a Safe & Warm check etc. The aim is to ensure that patients are safe and comfortable at home.

SHFH is funded by the Calderdale and Greater Huddersfield CCGs and works across the Calderdale and Huddersfield NHS Trust area.

Assumptions

Seamless Home from Hospital patients are recorded as either “Avoiding Admission” or “Discharges”. Patients avoiding admission will have arrived at A&E by ambulance, in most cases, or in a neighbour, friend or relative’s car. Patients are typically aged over 80, frail with low mobility, and the most common reason for attending A&E is a fall. Patients are not usually collected directly from A&E: most have gone to a Clinical Decision Unit (CDU) or a Medical Assessment Unit (MAU) and may have been kept in for one or two nights for observation and further clinical tests.

Assuming that all patients avoiding admission would in future be collected mostly from CRH rather than HRI, discharges would be unaffected (see data table).

The Baseline data used is for the twelve months from November 2016 to October 2017. The most recent dataset has been used because there has been a significant increase in the number of patients avoiding admission, from 24% of total patients in 2016 to 39% in 2017, and a corresponding drop in the number of discharges. We expect this trend to continue and have awareness of the benefits of avoiding admission for older people.

Results

Reconfiguration would not result in significantly increased travel times for SHFH patients. Having a single emergency site at CRH would increase the overall average travel time by 1.6 minutes. There would be no increase in the cost of the SHFH service due to hospital services reconfiguration.

SECTION 11
GREEN TRANSPORT AND SUSTAINABILITY ISSUES

Sustainability is intrinsic to NHS principles and values as part of a sustainable health and social care system reducing carbon emissions, protecting natural resources, addressing extreme weather events, and improving health and lives.

Improving health and wellbeing and people's experiences of the NHS and giving people greater control over their lives and health care in the everyday things that make people's lives better is as important as improvements in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Transport and travel to, and between, the two hospitals and other sites within CC2H programme should therefore be managed through a local Transport Plan agreed with Partners which seeks to achieve the lowest possible levels of carbon usage, minimise harmful emissions, and maximise opportunities for promoting the health and wellbeing of individuals and communities.

There is a balance to strike. Many people – those with a range of disabilities, psychological or medical conditions, carers, younger children, and those with inadequate access to public transport services may have no realistic travel choice other than private car or taxi. The approach to sustainability must allow priority to such groups and should not penalise them for use of less sustainable travel modes.

Access to hospital by active travel (walking and cycling)

Local Health and Wellbeing Strategies which encourage active travel where appropriate have contributions to make. This means ensuring that those walking or cycling to hospital and CC2H sites – including those transferring from buses and private cars – can do so safely and without the nuisance of excessive traffic speeds or vehicle emissions within or close to the hospital estate. The pedestrian environment should be as step-free as possible with clear signage and tactile surfaces as appropriate. Road crossings should be well-lit and free of obstruction from parked cars. Routes through car parks to reception areas must be accessible to wheelchairs and mobility scooters.

Annual Renewal

An annual Sustainable Development and Travel Plan involving key partners considering carbon usage, emissions, air quality and impact on promoting improved health of individuals and communities and reducing local health inequalities would be beneficial in keeping the focus on continuous improvement. Outcomes should be published and fed back into strategies and policy plans.

SECTION 12
COMMUNICATION STRATEGY

The Travel and Transport Group was set up, in part, because of the high level of public interest in transport matters identified throughout the engagement and consultation process. It is therefore expected that there will continue to be ongoing interest in the group's final report and recommendations, and in the CCG's response. As a result, CCGs are committed to taking the following communications approach in relation to the next step of the process.

a) Continue to update the public on implementation of Care Closer to Home to demonstrate that the overall strategy for Health and Social Care Services is being delivered as part of a coherent plan for delivering safe and sustainable Services for Greater Huddersfield and Calderdale.
b) Promote publication of the report.
   The CCGs will use their own channels including social media, websites, bulletins and direct communications with key stakeholders as well as issuing a press release to promote publication of the group's final report of findings and key recommendations.
c) Promote CCGs response to the report and recommendations.
   The CCGs will use their own channels including social media, websites, bulletins and direct communications with key stakeholders as well as issuing a press release to promote their response to the report and recommendations and the next steps that will be taken.
d) Publish action plan and timeline.
   The CCGs will publish an action plan and key timeline on their websites. The action plan will be updated on a regular basis/as appropriate. Press releases and more targeted stakeholder communications will be used to promote key achievements.

The identification of key stakeholders and messages and the development of a media handling plan will support the steps outlined above.

The Travel and Transport group endorse this approach.

SECTION 13
EQUALITY AND HEALTH INEQUALITY IMPACT ASSESSMENT[xv]

Background

Prior to consultation, the CCGs commissioned an Equality Impact Assessment to inform the consultation plan regarding the protected groups likely to be affected by the proposals and to assure the CCGs of their readiness to consult. During consultation, reviews were undertaken to enable specific targeted action to be taken to ensure that the consultation was meeting a representative sample of local communities. Post consultation, the CCGs commissioned an Equalities and Health Inequalities Impact Assessment (EHIIA), in order to review the findings from consultation and provide an assessment of the potential impact of the proposals.

Introduction

Whilst the EHIIA concluded that no indication was found of the proposed changes being discriminatory, one of the key recommendations from the EHIIA was that the CCGs should **consider the issues raised in relation to travel, transport and improved access to local services.** The report recommended key actions for consideration to enhance the potential positive impacts identified and mitigate any potential negative impact. The Mitigating/Remedial actions in relation to Travel and Transport and Parking are set out below.

Role of the Travel and Transport Group

The Terms of reference for the Travel and Transport Working Group identify that the group will

Review and take account of the relevant findings from the Equality and Health Inequality Impact Assessment as part of any recommendations.

Action Taken by Travel & Transport Working Group

- Collaborative working across NHS/local council's patient groups and voluntary groups. Membership as set out on Terms of Reference.
- Reviewed outcomes of public consultation and incorporated into work plan model.
- Developed key messages format for each meeting setting out key elements of discussion/agendas.
- Conducted two travel analysis surveys.
- Established a representative Reference Group to review work of Travel & Transport Working Group.
- Independent community based support agency appointed to facilitate Reference Group work.
- Developed a range of participative activities to ensure a public voice including virtual networks and two inclusive workshops chaired by the independent Chair of Travel & Transport Working Group.
- Appointment of independent Chair of Travel & Transport Working Group.

- Clear communication strategy and dissemination pathway to promote outcomes of Travel & Transport Working Group report and recommendations.

The following paragraphs set out the specific action in relation to each of these recommendations.

EHIIA – Mitigating/remedial Actions
The provision of a specialist Paediatric Emergency Centre should ensure the speedy and appropriate treatment of children and young people.
This is a mitigating action that does not require action by the Travel and Transport Working Group.

Treatment at Urgent Care Centres in the existing locations should mean that only a very minimal number of people are travelling further to the Emergency Centre. Most will travel by ambulance, be treated on arrival of the ambulance team and in transit.
This is a mitigating action that does not require action by the Travel and Transport Working Group.

The provision of more care locally in the community should reduce the requirement to travel for clinic appointments.
The Travel and Transport Working Group has considered the plans to provide more care locally in the community.

The concerns raised about the Elland bypass may be ameliorated by works that are scheduled.
The Travel and Transport Working Group has considered the works that are scheduled in relation to the A629 (and A621).

Work with local stakeholders and representatives to develop and publicise travel information to reduce people's worries about additional travel.
The Travel and Transport working group established an independently managed Reference Group. The Demographic information from the membership, both in relation to themselves and the profile of the groups that they could reach through their networks has been collated and analysed. This has confirmed that there is adequate representation from geographical locations and protected groups in line with the CCGs' Equality duties.

Two travel analysis surveys have been undertaken. These will be analysed to understand the impact by location (postcode) and where any significant additional travel is established, consideration will be given to the profile of the population affected, by equality group, where data is available and by deprivation indices. So that the CCGs can identify if this has been mitigated by, and/or the impact from this on, the Travel and Transport Working Group's recommendations. This analysis will

be done as part of the Quality Impact Assessment undertaken on a service line basis as changes are planned.

The independent manager of the Reference Group reports to the independent chair of the Working Group and attends Working Group meetings.

The group has provided input across a number of areas, including the development and promotion of travel information.

Address concerns around parking and impact on disabled people, due to current limited number of disabled parking bays.
The Working Group has considered this issue and identified the current position, recommendations and action to be taken. The information is included in the 'Car Parking' feedback grid.

Ensure that priority car parking is available to families of patients who require long stays in hospital.
The Working Group has considered this issue and identified the current position, recommendations and action to be taken. The information is included in the 'Car Parking' feedback grid.

Provide information in accessible formats about transport options for patients and visitors, to be available in a range of languages and formats.
The Working Group has considered this issue and identified the current position, recommendations and action to be taken. The information is included in the 'other transport themes' feedback grid.

Collaboration with voluntary and community advocacy services for those who require support when using public transport. Some respondents suggested the CCGs explore supporting volunteer car schemes, particularly in rural areas.
The working group has received presentations and information from 'Seamless Home from Hospital Service'.

People on low incomes should not be disadvantaged by travelling further to a specialist hospital site using public transport. Explore opportunities to support patients and visitors travelling to hospital sites using community transport services. The CCGs should play an active role in coordinating partners to explore possible improvements.
The Working Group has received presentations and information from 'Seamless Home from Hospital'.

The Working Group has made recommendations about reconfiguring the existing NHS shuttle service, advised by the Travel and Transport Reference Group and

including communication about any changes and information. They recommended developing a transport leaflet to support patients and carers understand options available in a range of formats.

Next Steps

In addition to the work outlined above and the agreed actions, and in line with the CCGs' continuous duties in relation to equality. As changes are planned to individual services, an equality impact assessment will be undertaken to understand if there are any potential negative impacts to be mitigated or positive impacts to be enhanced for protected groups.

Appendices

Section 10 of the EHIIA in relation to Travel and Transport and Accessibility.

SECTION 14
YORKSHIRE AMBULANCE SERVICE

The Terms of Reference for the Travel and Transport Working Group indicates that the work to identify the impact on resource and travel times for the Yorkshire Ambulance Service has been undertaken in parallel to the work of the Travel Group. Yorkshire Ambulance Service provided an overview to the Transport and Travel Group and a summary is set out below:

- YAS NHS Trust continues to engage and work with CHFT on their proposed reconfiguration of services to ensure that YAS can model the impact on our activity and patients, to ensure we can plan effectively to mitigate the impact.
- The main impact would be the increase in incident cycle time and the ambulance drift caused by conveying patients to another locality. We would need to plan additional conveying ambulance resources into the Kirklees area to mitigate these two factors.
- Sick patients will be conveyed for longer periods of time but they will be conveyed direct to a specialist centre where they can be treated immediately. This model of care works well with major trauma, heart attack patients and stroke and improves quality of care and patient outcomes.
- The workforce within ambulance services have been professionalised over the past 20 years and many of the first line treatments that previously could only be delivered by a doctor in A&E are now given to patients by ambulance staff in the pre-hospital phase.

Dr Mike Grady
Independent Chair: Travel and Transport Group, Calderdale and Greater Huddersfield CCG.
January 30th 2018.

A. CHAIRS BIOGRAPHY

Mike Grady was Principal Advisor at the Institute for Health Equity University College London and a member of the review team working with Professor Sir Michael Marmot, Chair of the Global, European and English reviews of health inequalities.

Mike led the dissemination of the strategic review nationally on behalf of the team at UCL He has presented at many national and international conferences.

He worked as an NHS PCT Chief Executive, Acting Chief Officer (Housing and Social Care) and Deputy Director of Social Services in a large northern Metropolitan Authority.

Mike has a M.A in Social and Community Work and a Doctorate from Middlesex University in “Exploring the parameters of Leadership” and specifically the impact of community development in improving health and wellbeing.

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[i] Calderdale CC2H update
[ii] Calderdale Primary Care update 050717 v2
[iii] Greater Huddersfield CC2H update
[iv] GH Primary Care Presentation
[v] Locala Current & Future Delivery Plans
[vi] CHFT CC2H
[vii] SWYFT services offered in Calderdale & Kirklees
[viii] Ref Group Event Report of Findings
[ix] T&T Ref Grp feedback from 19th June 17 event
[x] Car Parking travel and transport working group grids - Final
[xi] Public Transport working group Grid - Final
[xii] PTS Travel and Transport working Group grid - Final
[xiii] Grid other transport themes FINAL
[xiv] Public and Private Travel analysis
[xv] RCRTRP EHIIA V1

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, 5th April 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Data Quality Update - Calderdale and Huddersfield NHS Foundation Trust (CHFT) deployed the Cerner Millennium (CM) EPR system at the end of April 2017. Since its implementation the Trust has faced a number of data quality issues, but despite these, has managed to maintain its ability to report both internally and externally. Please refer to the attached report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board (Thursday 29th March 2018)	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

Calderdale and Huddersfield NHS Foundation Trust (CHFT) deployed the Cerner Millennium (CM) EPR system at the end of April 2017. Since its implementation the Trust has faced a number of data quality issues but despite these has managed to maintain its ability to report both internally and externally.

The establishment of a Data Quality Group immediately after EPR go-live, alongside the commitment of staff to meet the challenges, take on board external expertise and address high volumes of data quality errors, has meant that CHFT has not been destabilised by such an ambitious digital transformation. The potential for large scale data problems has been contained and with the focus now on correcting issues at source, the Trust should soon see a steady return to a business as usual day-to-day approach to data quality.

The Data Quality Group will become the Data Quality Board from 5th April 2018, with a clear remit around clinical risk.

Once RTT data quality issues are resolved at source it will take a further 9 months to clear the backlog.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

To note progress in relation to Data Quality since EPR go-live and to approve the recommendations.

Appendix

Attachment:

Data Quality Update - 29 03 18.pdf

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS	
PAPER TITLE: **DATA QUALITY UPDATE**	**REPORTING AUTHOR: P Keogh Assistant Director of Performance, R Aitchison Director of Operations FSS, J Bates Assistant Director - CIO**
DATE OF MEETING: 5th April 2018	**SPONSORING DIRECTOR: H Barker, Chief Operating Officer**
STRATEGIC DIRECTION – AREA: • Keeping the base safe • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • To note report and approve next steps
PREVIOUS FORUMS: Executive Board	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	

EXECUTIVE SUMMARY:

Calderdale and Huddersfield NHS Foundation Trust (CHFT) deployed the Cerner Millennium (CM) EPR system at the end of April 2017. Since its implementation the Trust has faced a number of data quality issues but despite these has managed to maintain its ability to report both internally and externally.

The establishment of a Data Quality Group immediately after EPR go-live, alongside the commitment of staff to meet the challenges, take on board external expertise and address high volumes of data quality errors has meant that CHFT has not been destabilised by such an ambitious digital transformation. The potential for large scale data problems has been contained and with the focus now on correcting issues at source the Trust should soon see a steady return to a business as usual day-to-day approach to data quality.

The Data Quality Group will become the Data Quality Board from 5th April 2018 with a clear remit around clinical risk.

Once RTT data quality issues are resolved at source it will take a further 9 months to clear the backlog.

FINANCIAL IMPLICATIONS OF THIS REPORT: N/A

RECOMMENDATION: To note progress in relation to Data Quality since EPR go-live and to approve recommendations.

APPENDIX ATTACHED: YES

Calderdale and Huddersfield NHS Foundation Trust

Data Quality Update

March 2018

1. Introduction

Calderdale and Huddersfield NHS Foundation Trust (CHFT) deployed the Cerner Millennium (CM) EPR system at the end of April 2017. Prior to go-live the Trust developed a mitigation plan to avoid any potential internal and external reporting problems following EPR implementation.

This paper provides an update on Data Quality progress since EPR go-live and how the Trust wide Data Quality function has responded to an ambitious programme that saw CHFT move from a Patient Administration System (PAS) and paper-reliant place to a digitised organisation. The Programme has changed the way that services are delivered with the aim of improving patient safety, quality of care and efficiencies.

During this period CHFT managed to maintain its pre-EPR reporting including regulatory reporting, operational reporting, performance/management reporting and the CHFT/commissioner financial contract reporting obligations.

2. Background

As it approached its EPR implementation CHFT had an excellent track record with regards statutory external reporting and internal reporting. Despite a 30 year old PAS both internal and external reporting were considered to be of a very high standard. Much of this high quality reporting resulted from the robust in-house data warehouse (built over the previous 15 years) and the Knowledge Portal business intelligence solution that had flourished over the past 4 years giving access to a variety of other Trust data sources, pushing forward a transparent and self-sufficient access to information approach.

CHFT has continued reporting despite some challenging data quality issues during the last 10 months.

In comparison to other NHS Trust organisations that have deployed EPR solutions replacing their traditional PAS, CHFT has not seen reporting problems to the same extent and has benefitted from excellent pre-planning plus a willingness to tackle issues head-on from day one of implementation using external expertise and lessons learned from these other organisations.

This work has been carried out with a relatively small core team alongside a number of (temporary with a case to make substantive) data validation staff. External support was provided by Cymbio (an organisation with extensive experience nationally working with NHS Trusts that have deployed EPR systems) and is now down to 2 days per week until the end of April from its peak of 16 full time staff during June and July. Cymbio worked with the Trust pre and post go-live to provide additional validation/data quality capacity and now provide expert Cerner Millennium advice. The next stage of this work is to ensure Trust teams are able to fully carry out the functions required.

The Cymbio dashboard solution was purchased pre-EPR and has helped with all data quality issues across the Trust including RTT. The Dashboard provides a view of operational process performance in near real-time, highlighting under-performance, operational inefficiency, data quality issues and bottlenecks in the operational process.

The objectives of deploying the Cymbio Dashboard and increasing data validation staff numbers were [illegible]:

1. To reduce the destabilisation often witnessed post-go-live
2. Minimise clinical risk of destabilisation
3. Minimise financial impact of destabilisation
4. Create a stable platform of patient administration to provide an environment conducive to delivering the benefits of Cerner Clinical modules
5. Return to stability quickly and provide platform for transformation

3. Establishment of a Data Quality Group

The Trust's Data Quality Group met for the first time in May 2017 and was chaired by the Chief Operating Officer initially to ensure that all data quality issues associated with the deployment and on-going support of the EPR Programme were effectively managed in line with the CHFT Data and Information Quality Protocol. The group meets weekly and is attended by operational representatives from each Division, the EPR business as usual (BAU) team, Information, Performance, Finance and Data Quality.

A formal **Data Quality Board** will be established from 5th April (final terms of reference to be agreed), which will be responsible for data quality issues across the Trust and will have a clear reporting line for **clinical risk** and incidents. In addition, the objective of the Board will be to ensure that CHFT is actively aware of, and working towards, the implementation and subsequent maintenance of the Information Governance Toolkit standards, ensuring that Divisions and individual users are engaged and focused on improving Data Quality.

4. Post-EPR Initial Challenges

Following go-live there were a number of areas that were initially impacted many of which have been resolved and closed:-

Current Position	Issue
Managed at Weekly Data Quality Group/ Weekly Performance Meeting (see graphs below)	Add Set Encounter Queue
	99 Codes on open RTT Pathways
	Unoutcomed Outpatient Appointments
	Outcomed as another appointment, but no order
	Endoscopy Waiting List Validations - closed
	Outpatient Procedures – Significantly improved
	RTT Pathways to breach in next 30 days
	Open RTT Pathways volume trend
	RTT Open Pathways - over 26 weeks
	RTT Open Pathways - over 40 weeks
	IP/DC Waiting List (Unplanned) with Closed RTT pathways
	MSK - Closed
	Electives coded as non-elective - Closed
	Historical TCI - Closed
Managed at Weekly Performance Meeting	A&E
	% Incomplete Pathways <18 Weeks
	% Non-admitted Closed Pathways < 18 weeks
	% Admitted Closed Pathways < 18 weeks
	ASIs
	EDS
	VTE
	Dementia
	Holding List

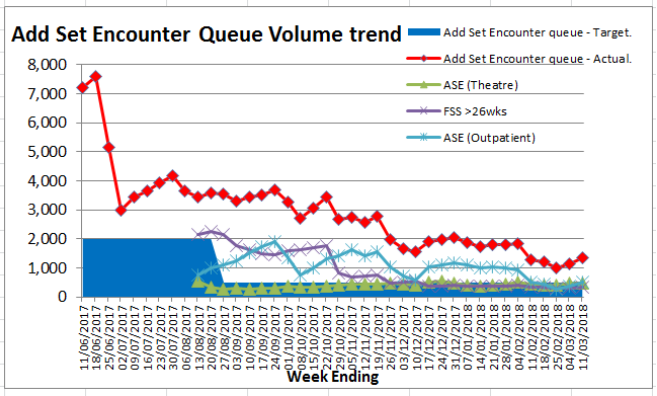
Cerner build	Regular Day Admissions Haematology and Oncology
nformation about the causes of the closure of the encounter, meeting to follow	Risk of closing all pathways if same FIN n
Business as usual (areas that have been resolved over the last 10 months)	Returned Letters to Appointment Centre
	Coding Co-morbidities
	Historic TCIs
	Non-elective to Elective
	Migrated pathways with open clock codes but stopped pathways – RTT
	Regular Day Admissions Urology - BCG/Lithotripsy
	WetMac Ophthalmology
	Orthoptic Activity not on EPR
	General Medicine AMU not on EPR
	Dermatology with no appointments on system, but outcome forms

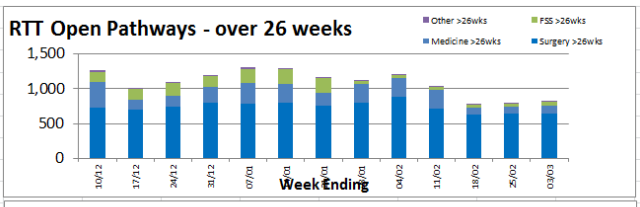
CHFT saw significant increases in data quality issues immediately after EPR go-live. Open RTT pathways increased from a baseline of 22,000 to 28,000 by the end of May. This then continued to climb steadily until it peaked at 38,000 at the end of October. This has since been contained and currently stands at 35,000. This reduction reflects the increased data validation capacity in place however issues still continue to be added at source meaning impact of validation is not as significant as anticipated.

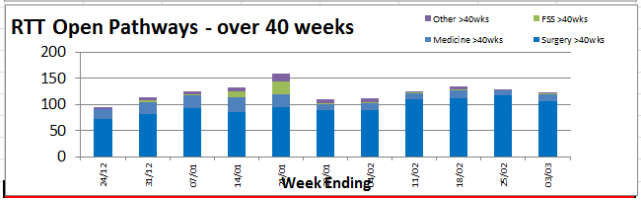
Through the work of the Data Quality Group combined with the validation team, Cymbio team, divisional operational teams, clinical validation etc. the above list has been reduced to around 12 standard areas for reporting in the weekly Data Quality Report which is managed at the Data Quality Group and also shared at the Weekly Performance meeting (The 'Business as usual' section in the table shows the number of areas that have already been tackled by teams over the last 10 months)

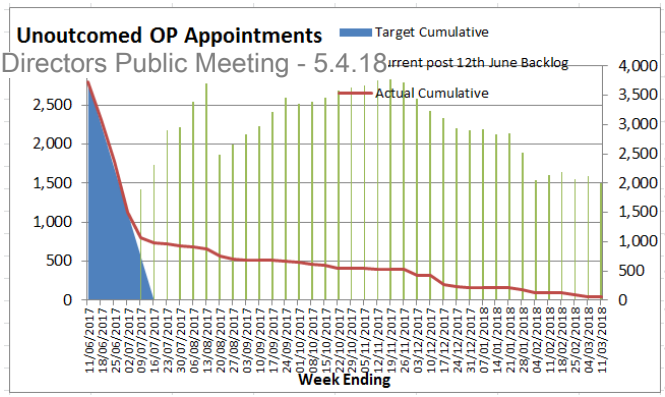
5. Current Position and Challenges

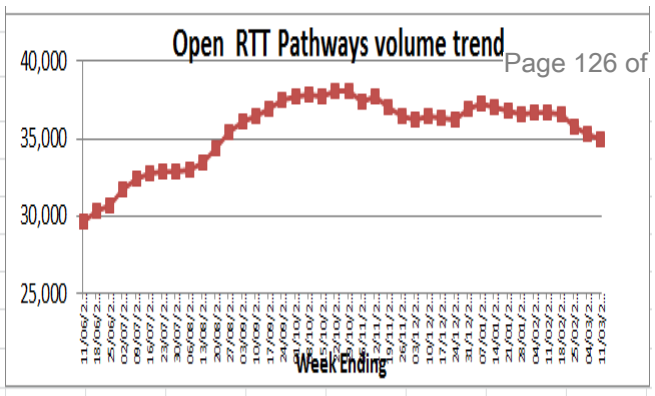
The Data Quality Group has established a weekly Data Quality report which details the extensive progress against each of the current biggest issues in terms of data quality and their impact. Once fully validated and at source solutions applied they are removed from weekly tracking with a routine sweep using the Cymbio software to ensure position maintained. The following graphs describe the current focus.

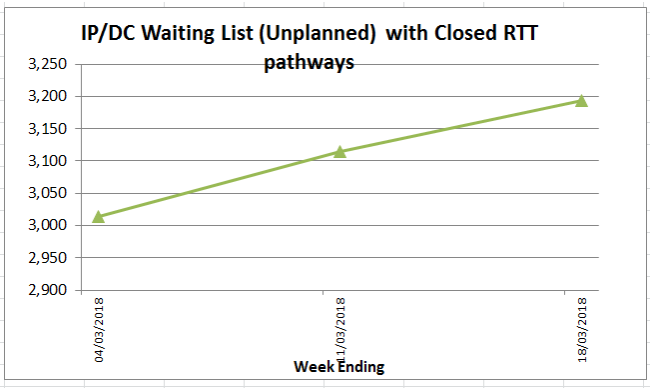


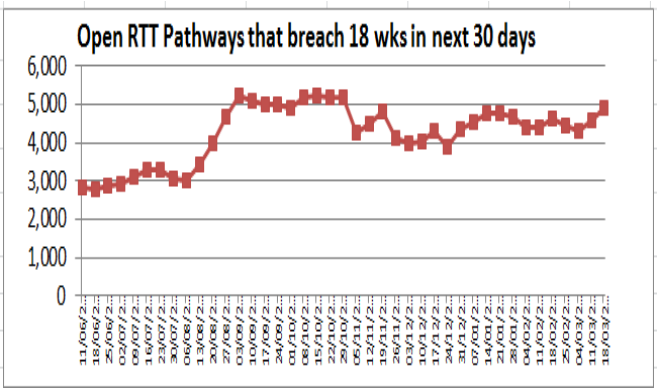


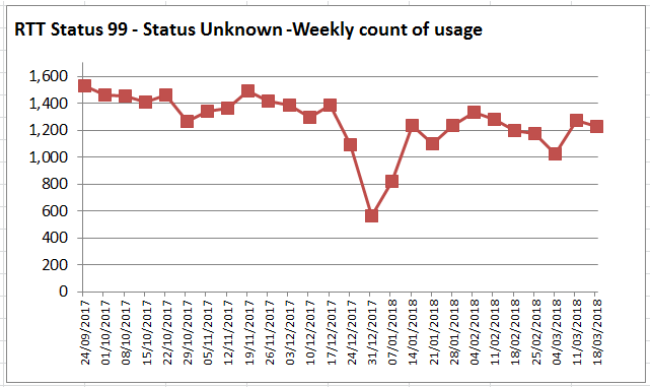


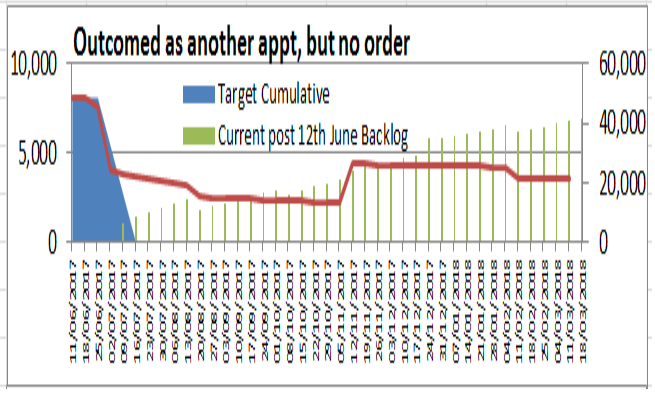


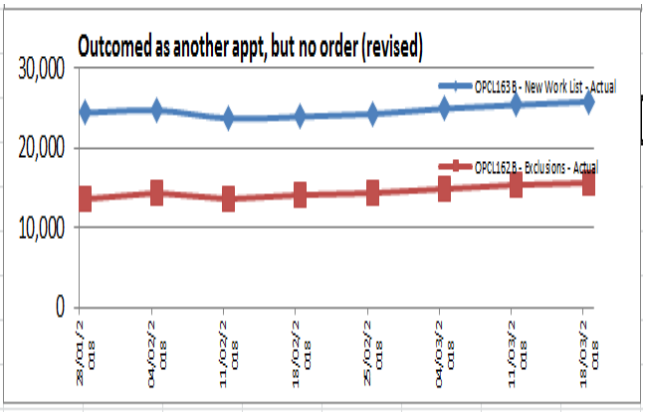










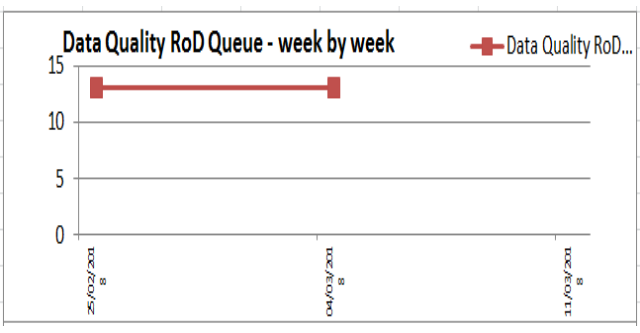


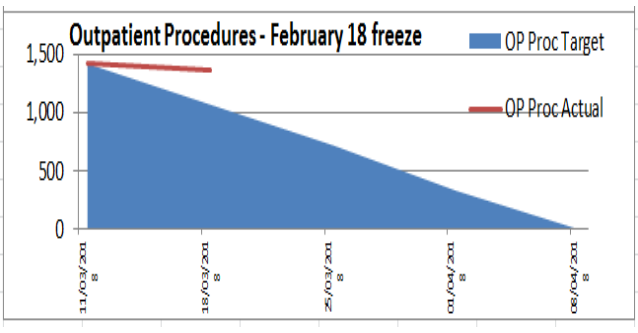
ENDOSCOPY VALIDATION

Week Grouping	(All)			
Inc/Exc	(Multiple Items)			

Count of MRN	Column Labels				
Row Labels	0 to 5 weeks	13 weeks+	6 to 12 weeks	Grand Total	%<6 weeks
Flexible Cystoscopy	162	34	43	239	67.8%
No TCI Date	114			114	
Date before current month end	22	12	9	43	
Date after current month end	26	22	34	82	
Grand Total	162	34	43	239	

Count of MRN	Column Labels				
Row Labels	FutApps	TBS	ASE	Grand Total	%age under 6 weeks
0<6	67	83	13	163	61.0%
6<12	50	1		51	
13+	50	3		53	
Grand Total	167	87	13	267	





There are a number of data quality areas which require urgent action to remedy the current position

RTT Open Pathways

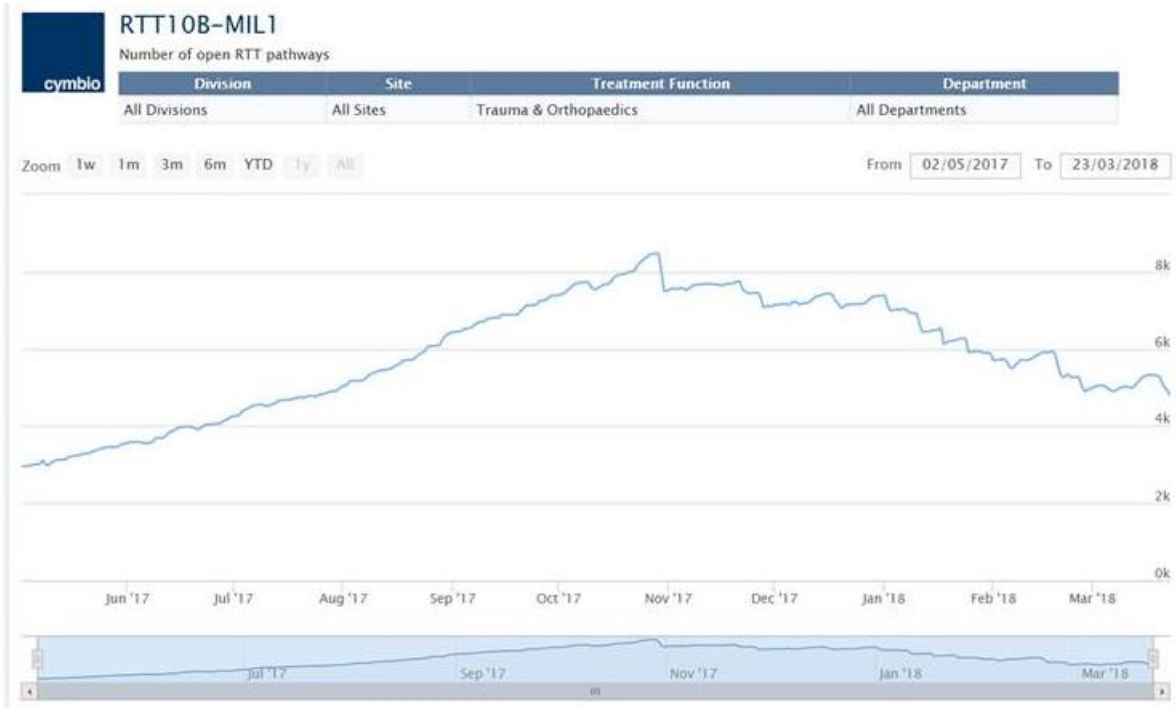
The most significant of these is the growth in RTT incomplete pathways where there has been an increase of 14,400 since go-live. Initial assessment deemed 6 WTE members of staff would be required for a period of 10 weeks in order to clear 11,500 pathways. However, in reality the introduction of these staff has enabled continual delivery of the 92% RTT standard but has not reduced the number of incomplete RTT pathways to similar levels seen pre-EPR. Delivery of further numbers has not been possible due to the lack of in-roads made into data quality issues being created at source.

To resolve this issue at source it is necessary to identify the issues that are resulting in invalid pathway recording. The full understanding of how this can be achieved is yet to be completely understood but inroads are being made by tackling the 'Low Hanging Fruit' open pathways. In this instance 'Low Hanging Fruit' is being used to reference open pathways that fall under certain characteristics (e.g. fracture clinic pathways, on a surveillance admitted pathway, discharged from consultant care etc.) and can make the biggest impact in the shortest time on overall numbers.

As validation of these pathways takes place then common theme feedback is required from the validation team to be then passed through the divisions to help staff capture RTT information accurately at source:

- An example of this is that of Fracture clinic pathways which do NOT (in the majority of instances) trigger an RTT pathway. Not all staff are aware of this and in terms of volume for the week commencing 19th March 700 RTT pathways were closed. A communication was sent out to operational staff entering the incorrect status code and from evaluation it can be confirmed whether further education training is required for staff or if this is a system issue. Assessment of the success of the awareness / assessment session will be via the Data Quality Board.

Below is an example of recent progress around Fracture clinic validation.



Outpatient procedure capture and PbR Tariff

There are approximately 1,000 procedures each month which are still being corrected and added at source (equating to 11 days work per month). In order to resolve this issue at source moving forward it is necessary to educate those staff still entering SNOMED codes via the appropriate training. Those colleagues who continue to be non-compliant have been identified and a programme of work to reduce this is to be monitored through the Data Quality Board. The majority of the SNOMED codes (87%) being entered that return a Payments by Results tariff using the appropriate OPCS procedure code fall within the specialties ENT (43%), Ophthalmology (33%) and Urology (11%).

Readmissions/Length of Stay

Two key indicators impacted upon as a result of data quality/capture issues since EPR are length of stay and readmissions. A significant amount of analytical work has been carried out and together with service support has helped to understand/confirm that at least part of the issue relates to activity within both Accident and Emergency department Clinical Decision Units (CDUs) now being recorded as admissions. A specification has been proposed to exclude these "new" admissions from external and internal reporting and should be signed off by the Trust in the next 10 days. This will result in increased length of stay due to the elimination of these short stayers plus reduced readmission numbers. The readmission performance has been formally illustrated in the "Use of Resources" section of the Model Hospital tool.

The CDU admissions only partly explain the increased readmission rate since EPR go-live. Other areas being considered are the Ambulatory Units where activity planned to come back to these units is being captured as acute admissions. Work continues with Information, Service Improvement and the service to further understand if this is a counting or clinical issue. This work should draw to a conclusion within 7 weeks.

The total amount of validation required is fully utilising the original and expanded capacity of the Data Quality team and is not reducing the overall numbers of DQ issues due to the constant additional at source. When all at source issues are resolved it will take the current capacity approximately 9months to return the incomplete RTT list back to pre EPR levels and reflecting the at source solution will take several weeks it is likely, with current capacity, that a cleansed position will take 12months. Once cleansed a review of activity will be required to ascertain long term capacity requirements of a DQ team.

6. Clinical Validation

The primary focus of data quality improvement is to ensure our patients are safe and receiving care at the appropriate times. Validation processes, led by clinicians and supported by administration teams, are central to this.

The Trust has developed robust processes to support all patients who are deemed to require outpatient follow-up getting this in a timely manner. When a patient's follow-up due date is reached, a communication is sent to the patient initially by text and then letter (if required) asking them to contact the Trust to make an appointment.

This validation process has two-stages:

- Administrative validation – this validation is undertaken by the appointment centre team, ensuring that all patients listed as requiring follow-up still require to be seen (e.g. ensuring they haven't already been seen under a different referral or discharged from a clinician's care).
- Clinical validation – in those instances where a patient cannot be booked into a follow-up appointment in a timely manner, the clinical team responsible for the patient's care is asked to review the follow-up request to determine a) if the patient is deemed safe to continue to wait for follow-up, b) whether the patient can be discharged back to their GP or c) whether their clinical condition necessitates the need to be seen urgently.

closely with the appointment centre team to ensure patients requiring follow-up are seen as close as possible to their appointment due date (and no longer than 12 weeks beyond this) and where an appointment cannot be offered within this timeframe ensuring clinical validation takes place.

During the last 3 months significant validation has been undertaken by the appointment centre team. This has resulted in a reduction in the number of patients waiting >12 weeks for a follow-up appointment to be offered. As of 26th March the number of patients waiting >12 weeks for follow-up was at 4,178 with approximately 2,500 of these with services for clinical validation. This is a much improved position. However, clinical divisions must continue to work closely with the appointment centre team to continue this improvement to a level which is acceptable.

7. Intensive Support Team Data Quality RTT Self-Assessment Toolkit

The work carried out by the Trust in relation to data quality has been reported to NHS Improvement (NHSI) on a regular basis via the Trust's relationship meeting (QRM). Progress to reduce volumes has been slower than hoped and the Trust has now been asked to undertaken a full self-assessment on our data quality for submission in Quarter 1. The Chief Operating Officer has requested Internal Audit review the self-assessment prior to submission to NHSI.

8. Recommendations

The Board are asked to agree the following:

- The establishment of a Data Quality Board reporting into F&P Committee.
- Review all datasets used for the safe and effective management of patients and services and incorporate into a single data quality process
- Targets to be set at specialty level within divisions for each of the indicators measured in the Data Quality report.
- Agree timeline for clearance of RTT incomplete and associated investment required to facilitate
- Receive the outcome of the NHSI Data Quality Assessment and associated recommendations

9. Conclusion

The Board is asked to note and consider the content of this report, including considerable progress made in recent months. The Board is asked to approve the recommendations.

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, 5th April 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report - An update on February's Performance	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board (Thursday 29/3/18) and Finance and Performance Committee (Tuesday 3rd April 2018)	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

February's Performance Score has deteriorated by 3 percentage points to 57%. All domains have deteriorated with the exception of RESPONSIVE and WORKFORCE, which saw improvements in 3 of the 5 Mandatory Training focus areas counterbalancing a deterioration in short-term sickness. Within the RESPONSIVE domain, Stroke and Cancer maintained good performance. The CARING domain has worsened due to FFT performance. The EFFECTIVE domain has returned to AMBER due to 2 MRSAs in-month. EFFICIENCY & FINANCE has deteriorated with a couple of efficiency targets being missed in-month.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to note the contents of the report and the overall performance score for February 2018

Appendix

Attachment:

Board Report Feb 2018.pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Board Report

February 2018

Report Produced by : The Health Informatics Service
Data Source : various data sources syndication by VISTA

Performance Summary

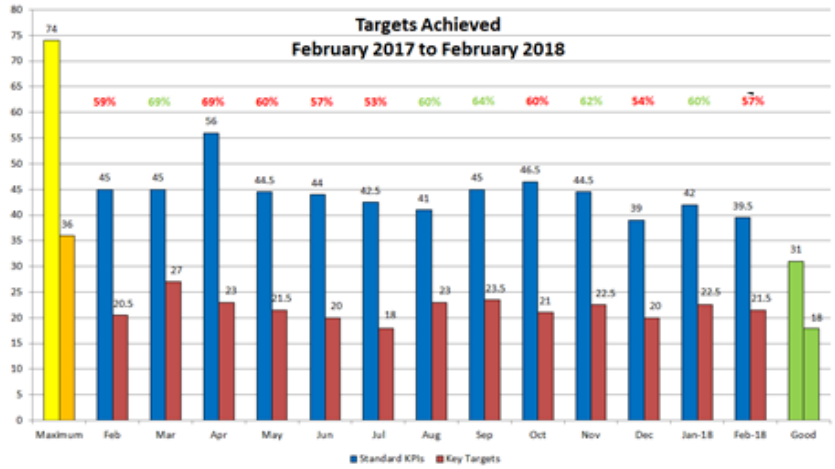
To Note

Sometimes the previous month's % in the Performance Summary is different in the next month's report. This usually happens when there are late changes to indicator values due to validation.

For **February's** performance the MRSA screening performance has been updated which has resulted in minor deteriorations in performance over previous months.

Comparing February 2018 performance to February 2017 performance

February 2018 performance **(57.1%)** was **1.6 percentage points (10 points)** worse than **February 2017 (58.5%)**. The main area of deterioration is Efficiency & Finance (18 points).



Comparing 11 months' cumulative performance to Febuary with same period in 2016/17

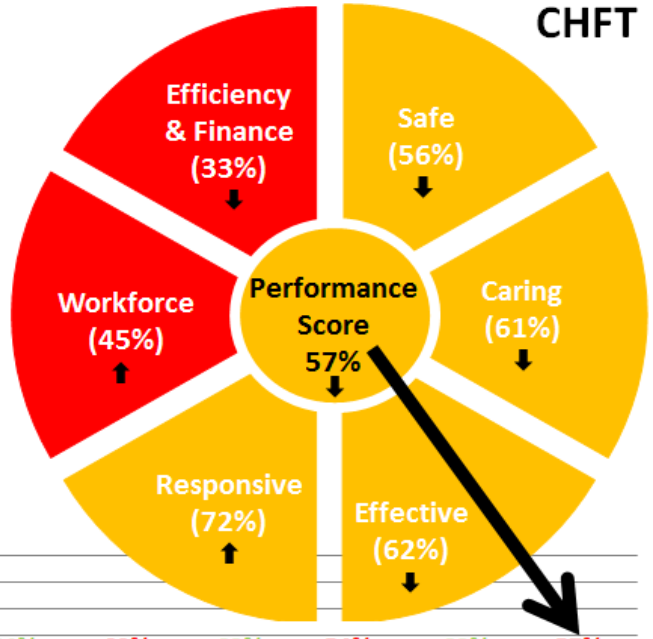
Period to February 2018's performance **(59.6%)** was **2.6 percentage points** worse than **period to February 2017 (62.2%)**. The main area of deterioration was **Mandatory Training**, this is only compensated by an equivalent improvement in **Sickness Absence**. Other contributory areas are **Cancer 2 week waits and 62 day RTT, Diagnostic Waits, FFT A & E Survey - Response Rate, I&E, CIP** and **Activity**. **SHMI and HSMR** have improved.

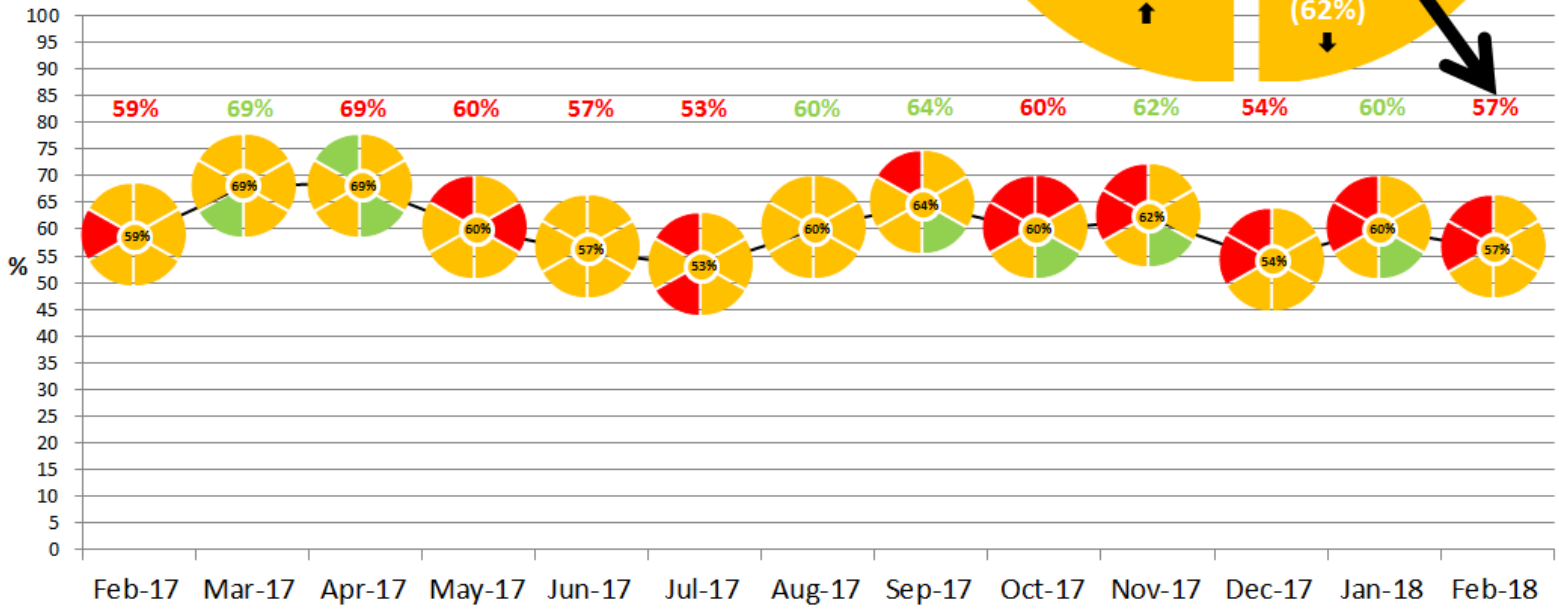
Performance Summary

February

RAG Movement

February's Performance Score has deteriorated by 3 percentage points to 57%. All domains have deteriorated with the exception of RESPONSIVE and WORKFORCE which saw improvements in 3 of the 5 Mandatory Training focus areas counterbalancing a deterioration in short-term sickness. Within the RESPONSIVE domain Stroke and Cancer maintained good performance. The CARING domain has worsened due to FFT performance. The EFFECTIVE domain has returned to AMBER due to 2 MRSAs in-month. EFFICIENCY & FINANCE has deteriorated with a couple of efficiency targets being missed in-month.





SINGLE OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	FFT IP FFT Maternity
FFT OP	FFT A&E FFT Community
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
CDiff Cases	Preventable Cdiff
MRSA	SHMI
HSMR	HSMR - Weekend
RESPONSIVE	Diagnostics 6 weeks
RTT Incomplete Pathways	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover

Carter Dashboard

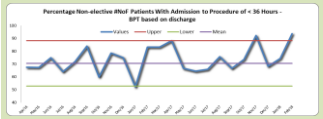
		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.6%	96.8%	↑	96.3%
	Inpatient Complaints per 1000 bed days	2.6	2.3	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	4.82	4.72	↓	5.17
	Delayed Transfers of Care	1.89%	2.05%	↑	3.5%
	Green Cross Patients (Snapshot at month end)	124	117	↓	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	86.16	87.79	↑	100
	Theatre Utilisation (TT) - Trust	80.7%	76.4%	↑	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.76%	1.09%	↑	0.6%
	Emergency Care Standard 4 hours	87.46%	90.76%	↓	95%
	% Incomplete Pathways <18 Weeks	92.76%	94.09%	↓	92%
	62 Day GP Referral to Treatment	87.9%	92.3%	↓	85%
SAFE	% Harm Free Care	92.30%	92.70%	↓	95.0%
	Number of Outliers (Bed Days)	907	1136	↑	495
	Number of Serious Incidents	6	4	↓	0
	Never Events	0	0	↔	0

MOST IMPROVED

Mandatory Training - Fire Safety green and both Data Security Awareness and Infection Control amber.

All key cancer targets maintained for the 4th consecutive month.

Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - At 93.75% against 85% target, best performance in over 12 months and process appears sustainable.



MOST DETERIORATED

Number of MRSA Bacteraemias – 2 in-month giving year to date position of 5 against 2 in total in 2016/17.

% Harm Free Care - Performance at 92.3% which is lowest in over 12 months is being driven by a high number of patients being admitted with a pressure ulcer plus the new VTE's recorded. We continue to see a high level of old harms and of the 57 harms seen in month, 29 are old pre-hospital harms which have been wrongly recorded.

% Complaints closed within target timeframe - at 31% lowest position in over 12 months.

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

MRSA Post infection review is undertaken for each case of MRSA bacteraemia, action plans are monitored via the divisions, learning is to be shared throughout the organisation.

The lead matron for pressure ulcers within the Medical division is meeting with tissue viability to confirm training arrangements for ward staff regarding entering the correct data. This will be amended for the next submission.

There are still more overdue complaints than originally anticipated at this point, however Directors of Operations still plan to clear the majority of backlogs by the end of March.

Arrow direction count ↔ 1 ↑ 8 ↓ 10

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.7	7.6	↑	
Sickness Absence Rate	4.81%	4.31%	↓	4.0%
Turnover rate (%) (Rolling 12m)	12.87%	13.06%	↑	12.3%
Vacancy	331.07	329.82	↓	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q2	79.0%	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) Q2	57.0%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£17.90	-£15.60	🔴
Expenditure vs Plan var (£m)	£1.36	£1.93	🟢
Liquidity (Days)	-23.92	-21.78	🟢
I&E: Surplus / (Deficit) var - Control Total basis (£m)	-£10.38	-£8.70	🔴
CIP var (£m)	-£1.02	-£0.58	🔴
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	14.97%	14.40%	🔴

Executive Summary

The report covers the period from February 2017 to allow comparison with historic performance. However the key messages and targets relate to February 2018 for the financial year 2017/18.

Area	Domain
Safe	• **% Harm Free Care** - Performance at 92.3% which is lowest in over 12 months is being driven by a high number of patients being admitted with a pressure ulcer plus the new VTE's recorded. It is made up of 8 new PE's, 1 new DVT and 2 new others. We continue to see a high level of old harms and of the 57 harms seen in month, 29 are old pre-hospital harms which have been incorrectly recorded. The lead matron for pressure ulcers within the Medical division is meeting with tissue viability lead nurse to confirm further training arrangements for ward staff regarding entering the correct data. This will be amended for the next submission. This does however leave a further 17 new harms which comprised of 7 new PU's, 6 falls and 4 UTI's. • **% PPH ≥ 1500ml** - Performance at 3.6% which was just above the 3% threshold. Robust analysis continues to be measured against the ARREST care bundle. YTD position is favourable. • **Category 4 Pressure Ulcers - There have been** 2 category 4 pressure ulcers in Medicine in January which are currently under investigation.
Caring	• **Complaints closed within timeframe** - Of the 49 complaints closed in February, 31% were closed within target timeframe. Given recent pressures CHFT still aims to have the majority of backlog of complaints closed by the end of March. Divisions have given assurance that contact is being made with complainants within 7 days. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 90.6% still below 95.7% target. The team continues to work across divisions, especially with the Matron for FSS addressing how we can work together to improve response rate and address feedback. The planned Q3 review was delayed and now a Q3 + Q4 review will take place in April to inform future patient experience plans. • **Friends and Family Test A & E Survey -** Response Rate is still around 10% which is below the 13.3% target. In A&E specifically, FFT has been added to the daily huddle board to remind staff to complete. • **Friends and Family Test Community -** Response Rate has increased from 1.6% to 3.4% but still needs to improve further. The % would recommend has fallen in-month to 96.4%. The division has undertaken a deep dive to understand performance. As a result a clear Standard Operating procedure will be written to provide a consistent approach to collection of FFT across community services. FFT 'look up's' to be amended to mirror the NHS England categories. FFT feedback process to be carried out every working day of the month. Teams/services to have an agreed target of gaining at least 10% responses from their active caseload. Benchmarking of other trusts' community services performance.
Effective	• **Number of MRSA Bacteraemias** - There were 2 cases in February. Investigations are underway into each of the MRSA bacteraemias and will be shared with MDT teams when complete. • **Clostridium Difficile Cases** - There were a further 3 cases in February which adds up to 20 in the last 4 months. The Infection control plan continues to be worked through, the local ward assurance tool is now in use. Performance from this will go to PSQBs in the future. • **E.Coli - Post 48 Hours** - There were 6 cases in February. E.Coli is being managed through a health economy action plan as they look to reduce incidences in the community and hospital environment. The Trust regularly feeds into this plan. • **Mortality Reviews** - A step by step guide has been developed to support consultants and SAS doctors to perform ISRs with face to face support where required. Structured Judgement reviewers are requested to be completed within 2 weeks of allocation and are being discussed at the LfD panel.

Background Context

The Health & Social care system continued to be busy in February with prolonged increased acuity and demand. The Trust was forced to operate fully in Silver command and control mode yet again for the full month.

Work on Expected Date of Discharges (EDDs) has remained a focus throughout the month to try to create additional patient flow. CHFT had a very challenging month in terms of the ECS with performance at 87.46% largely due to patient flow with admissions regularly higher than discharges.

All Divisions retained winter capacity at levels commenced in January meaning cancellation of routine electives and some outpatient activity for Medical specialties.

Escalation capacity remains high with over 80 additional beds open for most of the month driving agency usage and Birth Centre closures. This was compounded by periods of bad weather where we saw staff work together to ensure areas were safely covered.

Additional weekend capacity was implemented to support flow and those teams on site e.g junior doctors.

The impact of reconfiguration continued to be reviewed and monitored, with an increase in patients being managed through the frailty service and the centralisation of services facilitating the implementation of more specialty focused ward rounds.

Flu admissions remained high with a ward at each site required for isolation compounded by periods of Norovirus that restricted flow due to ward closures. The IPC Committee has increased its meeting frequency.

Full system support has been requested daily with significant pressure applied to ensure discharge numbers increased, this has had some impact but is not providing the step change required to reduce escalation capacity or LOS with stranded patient numbers increasing.

Executive Summary

The report covers the period from February 2017 to allow comparison with historic performance. However the key messages and targets relate to February 2018 for the financial year 2017/18.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours 87.46**% in February, (88.68% all types) - Silver command has remained in place throughout February, focus on additional out of hospital capacity remains in place but challenging increasing LOS in both acute beds and Community Place. Full winter plans remain in place including only operating on emergency, cancer and time critical patients; admission avoidance remains key with increases to frailty and ambulatory services. • **38 Day Referral to Tertiary** - at 30% lowest position since June. The Red2Green methodology is to be applied to Urology, Head and Neck and Lower GI pathways from April which will track pathways in relation to being on track and meeting key milestone dates (green) and those which are off track and in breach of key milestones (red). This additonal alerting system will give greater visability to the patients who are not progressing as quickly as they might through the pathways and enable further conversation to help expedite diagnostics and treatment.
Workforce	• **Overall Sickness absence/Return to Work Interviews -** Short term sickness for January is now at its highest rate for over 12 months resulting in an overall sickness rate of 4.81%. Return to Work Interviews have improved to 63.6% with more work to do. Attendance management sessions are being held across divisions. • **Mandatory Training** has improved in-month with Fire Safety on target, Data Security and Infection Control just below target. All Divisions have developed detailed action plans to improve compliance and ensure the 95% target is met. The weekly Executive Board paper presented on 15th February recommended colleagues who join the Trust with competencies in one or more of our mandatory training subjects, achieved at another NHS organisation, will have their compliance awarded against the relevant subject. The Executive Board agreed with this approach and this will now be implemented for all new starters.
Finance	• **Finance**: Reported year to date deficit position of £35.27m, on a control total basis (excluding the impact of loss of Sustainability and Transformation funding (STF)) the reported year to date deficit position is £28.98m an adverse variance of £10.38m compared with the control total of £18.6m; • Delivery of CIP is £14.53m below the planned level of £15.55m; • Capital expenditure is £2.7m below plan due to revised timescales; • Cash position is £1.98m, slightly above the planned level; • A Use of Resources score of level 3, in line with the plan. As at Month 11 the gap to CHFT's control total deficit is £10.38m. This is the level of financial improvement that the Trust required in order to be eligible for STF funding. £6.22m of STF funding has been lost based on Quarters 1 & 2 A&E performance and financial performance in M7-11. This is driving a total variance from control total of £16.6m, (excluding technical items excluded for control total purposes). However the reported position includes a number of non-recurrent benefits that in part offset the underlying operational deficit. The Trust is reporting a forecast deficit of £45.39m, an adverse variance to plan of £15.55m. This forecast position incorporates a gap to control total of £8.00m which in turn drives the loss of STF funding of £7.40m. The £8.00m gap remains unchanged from the position reported in month 11 and is contingent upon a number of recovery actions.

Background Context

Mandatory Training compliance has been a focus with weekly monitoring and the establishment of a level 1 module accessable via ESR for Moving and handling reflecting the restricted face to face capacity. This is moving the Trust closer to target numbers for March.

FSS services continued to see a peak in activity in February which matched that seen across the rest of the Trust. Services within the division continued to support this in a range of different ways.

The challenges of demand were also evident in Community services, managing demand in the community to keep people out of hospital, as well as supporting discharge.

The nursing teams experienced very challenging weather which impacted on them visiting some patients. All priority patients were seen, in some cases with nurses visiting patients on foot or by the support of family, other colleagues or volunteers with 4x4 vehicles.

The Head of Therapies has progressed the therapy strategy and a workshop is planned for March to support next steps in terms of enhancing patient pathways, reducing the number of handoffs and assessments across all of therapy services as patients move through their pathway.

Divisions have been asked to focus on activity and CIP schemes for 2018/19 and robust annual planning including CQC preparation.

There was considerable focus on developing Capacity and Demand plans for 2018/19 which highlighted a number of areas that needed realignment to ensure activity for the year ahead was robustly modelled.

Safe, Effective, Caring, Responsive - Community Key messages

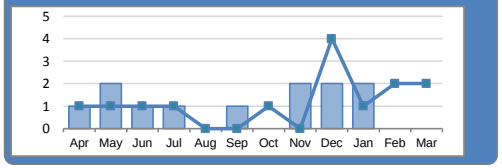
Area	Reality	Response	Result
Safe	**Medication Incidents** We are closely monitoring medication incidents within the community division to gain assurance that we have safe processes in place to monitor, measure, report, record and investigate these incidents. This month there were 4 medication incidents reported of which 2 could be directly linked to Community services.	**Medication Incidents** Each medication incident is reported via DATIX, each DATIX is reviewed by the community division senior pharmacist. Any actions are then picked up and relayed to community team or if education, training is required this is actioned by the community pharmacist. These are reported into Board on a monthly basis and PSQB via a quarterly report. For the 2 incidents this month, remedial action has been implemented.	**Medication Incidents** A review has been undertaken to understand what is required to reduce the waiting list. At a meeting with Calderdale CCG/Calderdale Council on 14/2/2018 it was agreed to jointly commission the service so we have been able to start the recruitment process to fill vacancies. We are looking for locum support and a person has been identified and we are awaiting confirmation of their start date.
Effective	**Leg Ulcer healing rate** There is one patient with a leg ulcer that has not healed within 12 weeks. This has improved from the previous month (3 patients).	**Leg ulcer healing rate** Each medication incident is reported via DATIX, each DATIX is reviewed by the community division senior pharmacist. Any actions are then picked up and relayed to community team or if education, training is required this is actioned by the community pharmacist. These are reported into Board on a monthly basis and PSQB via a quarterly report. For the 2 incidents this month, remedial action has been implemented.	**Leg ulcer healing rate** Continued focus on leg ulcers will maintain high rates of healing within 12 weeks and support achievement of the wound CQUIN. **By when: April 2018** **Accountable: ADN**
Caring	**FFT** The FFT result is 96.4% in February and showing 91.4% YTD. This has fallen from the previous month (99.1%). The response rate has increased from 1.6% to 3.4% this month. However, this is still too low.	**FFT** We are reviewing the process for collecting FFT. Staff are engaged in collecting responses, but we need to follow through the process to ensure that all feedback is being reported. We have set up a working group to review this urgently.	**FFT** We will continue to monitor the response rate and process of collecting and reporting data to ensure improvement in this measure. **By when: Review April 2018** **Accountable: Director of Operations**
Responsiveness	**Waiting Time for Children's services** This area continues to be highlighted as a high risk on our risk register. The main challenges are in Speech and Language therapies with 155 children waiting at Huddersfield and 262 at Calderdale. The Huddersfield waiting times have remained the same and the Calderdale waiting times have decreased by 4 weeks.	**Waiting Time for Children's services** A review has been undertaken to understand what is required to reduce the waiting list. At a meeting with Calderdale CCG/Calderdale Council on 14/2/2018 it was agreed to jointly commission the service so we have been able to start the recruitment process to fill vacancies. We are looking for locum support and a person has been identified and we are awaiting confirmation of their start date.	**Waiting Time for Children's services** We will continue to monitor the waiting times and prioritise new patient clinics to reduce waiting times. **By when: April 2018** **Accountable: Head of Therapies**

Dashboard - Community

Bar Chart = 17/18 figures Line graph = 16/17 figures

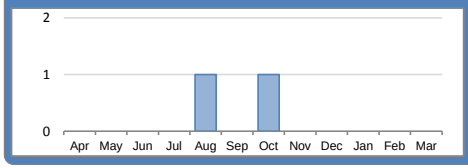
Safe

Community acquired grade 3 or 4 pressure ulcers



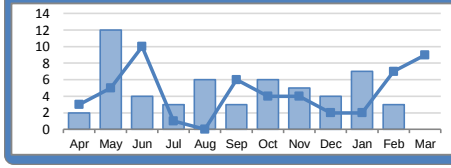
One month in arrears

Falls that caused harm whilst patient was in receipt of Community Services inc IC Beds & Comm Place

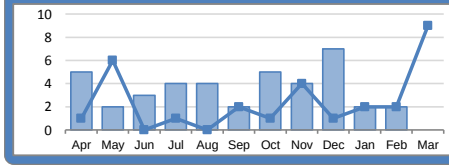


One month in arrears

Incidents - New Harms

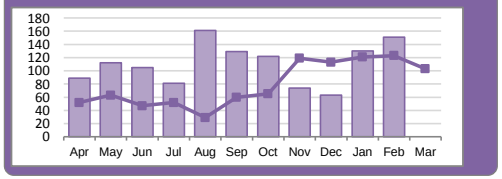


Medication Incidents

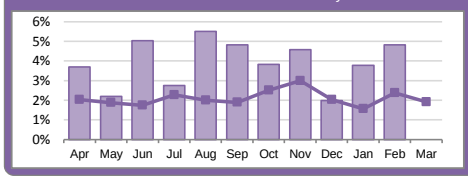


Effective

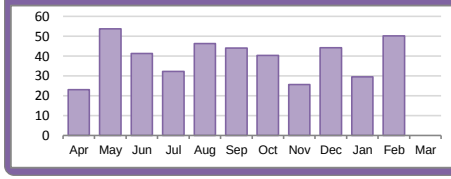
Number of Hospital admissions avoided by Community Nursing services



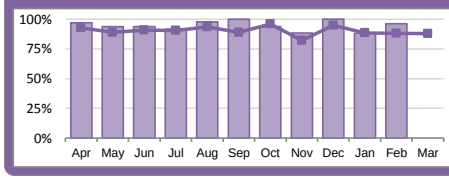
Patients who attended A&E while on a Community Matron Caseload, who readmitted within 30 days



Intermediate Care Bed base (Average Days)

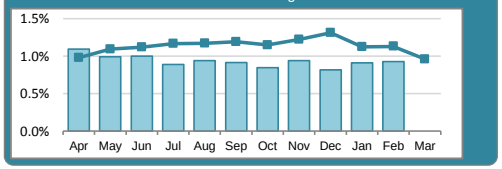


House Bound leg ulcers healed within 12 weeks

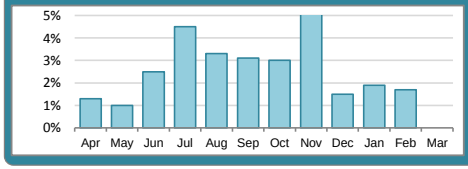


Caring

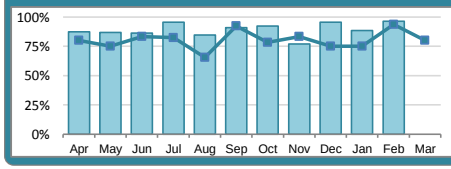
Community No Access Visits Adult Nursing



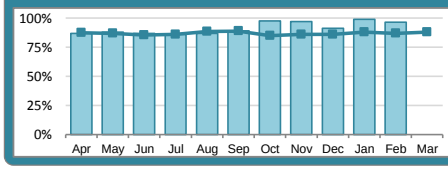
Intermediate Care Readmission rate



End of life patient died in preferred place of death

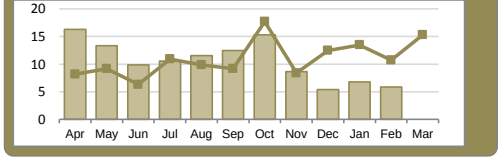


Friends and Family Test- Likely to recommend

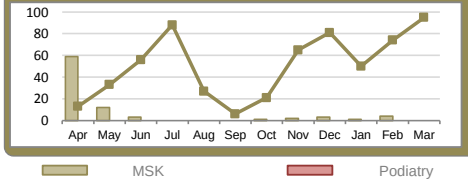


Responsive

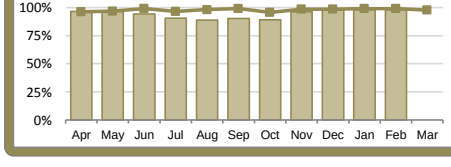
Average time to start of reablement (days)



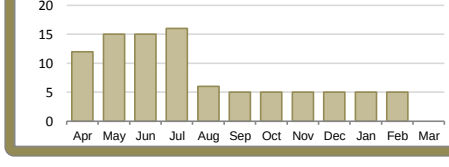
Appointment Slot Issues for MSK & Podiatry



Waiting Times - 18 week RTT

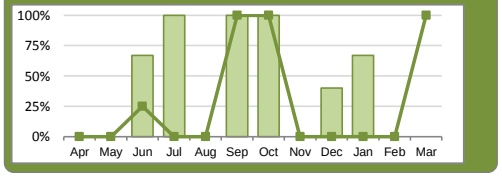


Waiting Times - Physiotherapy Routine (Weeks)

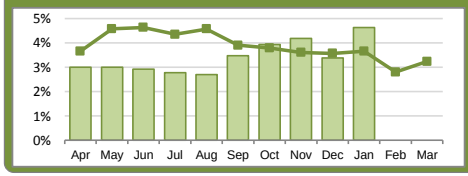


Well Led

% Complaints closed within target timeframe

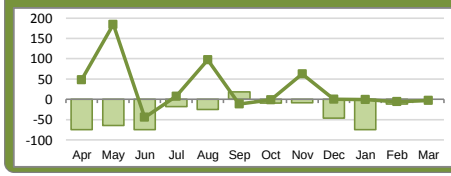


Staff sickness rate

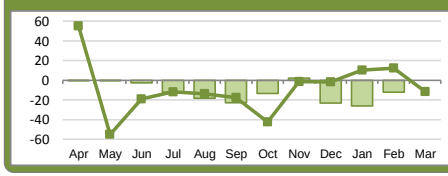


One month in arrears

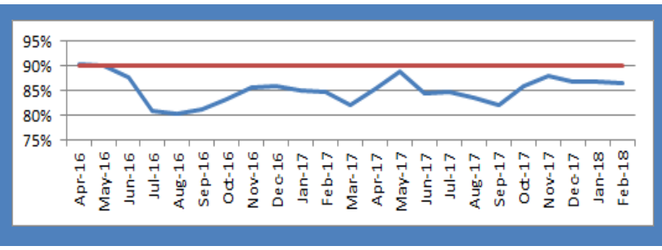
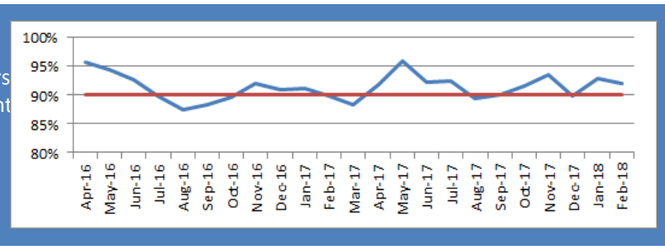
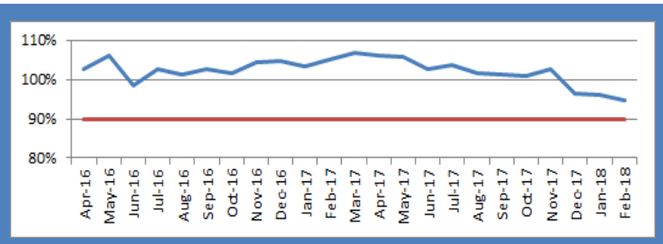
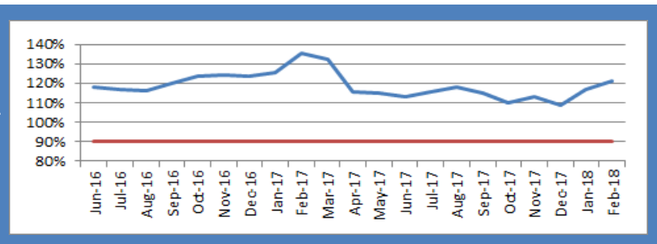
Finance - Planned variance against actual (£'000)



Finance - Planned CIP saving against actual savings (£'000)



Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation	Result
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	86.63% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 15 71.9% - 5b 66.4% - ward 17 73.3% - ward 20 74.4% - ward 8a/b 73.1%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates reported in January on ward 8a/b is due to the flexible staffing model in place to support the "variable" bed base. The other low fills are due to a level of vacancy and the teams not being able to achieve their WFM. Wards 20 and 15 are transitioning into new WFM and going forward the staffing position will improve.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	92.12% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - ward 5b 74.1% - ward 7c 71.4% - ward 8a/b 65.8% - ward 10 65%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates are due to teams supporting additional capacity beds, a level of vacancy, a level of sickness and embedding new WFM to support re-configuration of medical services. The low fill on ward 8a/b is due to the variable bed base.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	94.74% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - ICU 74.3% - 8A/B 61.4% - NICU 32.5% - Ward 3ABCD 66.1%	The low HCA fill rates in February are attributed to fluctuating bed capacity, support of additional capacity ward, a level of HCA vacancy within the FSS division and re-configuration of medical services. This is managed on a daily basis against the acuity of the work load. Recruitment plans are in place for all vacant posts. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; and support of reduced RN fill.
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	121.45% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% - NICU 60.7%	NICU had a fill rate of less than 75%. This is managed operationally by the senior team. Fill rate in excess of 100% can be attributed to supporting 1-1 requirements and support of reduced RN fill.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

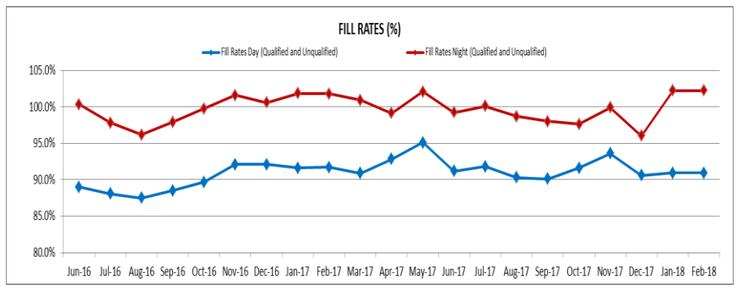
	DAY						NIGHT	Care Hours Per Patient Day							
Ward	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MSSA (post cases)	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies
	Expected	Actual	Expected	Actual											
CRH ACUTE FLOOR	2856	2633.42	2604	2183.67	92.2%	83.9%	101.9%	11.2	10.3		1	0	5	6.95	0
HRI MAU	1848	1716.5	1932	1676.83	92.9%	86.8%	95.4%	11.8	10.9			1	14	0	0
HRI Ward 5 (previously ward 4)	1512	1231.08	1092	1391.17	81.4%	127.4%	141.1%	5.6	6.0		1	0	13	2	0
WARD 15	1848	1328.67	1848	1866	71.9%	101.0%	99.1%	7.5	6.9			1	8	4.5	4.3
WARD 5C	966	918.75	756	689.5	95.1%	91.2%	143.2%	5.6	5.6			1	0	3.28	0
WARD 6	1512	1294.17	1092	1132.33	85.6%	103.7%	130.2%	8.4	8.4			2	12	2.4	2
WARD 6BC	1512	1339.48	1092	1080	88.6%	98.9%	103.6%	4.7	4.5		1	0	3	0	0
WARD 5B	1848	1227	966	867.17	66.4%	89.8%	98.2%	8.9	6.9			1	1	4.74	0
WARD 6A	882	733	882	805.5	83.1%	91.3%	135.7%	5.0	4.7			0	1	2.2	1.6
WARD CCU	1512	1256.83	336	283.67	83.1%	84.4%	-	8.9	7.9			1	1	0	0
WARD 7AD	1512	1159.67	1428	1914.08	76.7%	134.0%	131.0%	6.9	7.5			1	4	1.19	0
WARD 7B	756	726.7	756	844	96.1%	111.6%	114.3%	7.5	7.8			2	2	5.9	0
WARD 7C	1512	1134.18	756	801.5	75.0%	106.0%	200.0%	11.5	10.3			0	4	0	0
WARD 8	1302	1023.67	1092	1601.83	78.6%	146.7%	144.5%	6.5	7.4			1	5	7.11	0
WARD 12	1512	1135.5	756	739.5	75.1%	97.8%	139.3%	6.2	5.3			1	5	2.68	2.5
WARD 17	1848	1354.67	1092	920	73.3%	84.2%	98.2%	6.4	5.4			3	2	1.91	0
WARD 8C	756	732.33	756	799.5	96.9%	105.8%	193.3%	4.3	4.8			0	3	6.38	1
WARD 20	1848	1374.92	1848	1713.92	74.4%	92.7%	97.2%	7.1	6.2			6	9	4.5	0
WARD 21	1386	1214.8333	1386	1222	87.7%	88.2%	100.0%	9.1	8.4			3	10	7.15	2
ICU	3640	3319.75	742	551	91.2%	74.3%	-	40.4	35.3			7	0	3.77	0
WARD 3	854	915.75	682	706.5	107.2%	103.6%	215.8%	5.8	6.9			1	6	0.46	1.59
WARD 8AB	958	700.2	862	529.6333	73.1%	61.4%	119.3%	12.9	9.2			1	5	2.57	0
WARD 8D	742	736.08333	742	649.1667	99.2%	87.5%	-	6.1	7.2			0	2	1.87	0
WARD 10	1176	1011.1333	682	692	86.0%	101.5%	232.5%	6.0	5.9			1	1	7.81	0
WARD 11	1386	1338.75	1176	1014	96.6%	86.2%	270.5%	5.3	5.8			0	1	2.66	0
WARD 19	1484	1209.5	1064	1268.433	81.5%	119.2%	118.9%	8.2	8.3			2	7	1.92	0
WARD 22	1064	1047.1667	1064	1105.25	98.4%	103.9%	121.4%	5.2	5.4			1	3	1.55	2
SAU HRI	1708	1506.8333	874	822	88.2%	94.1%	110.6%	10.0	9.4			2	0	4.27	0
WARD LDRP	3864	3345.4167	854	675	86.6%	79.0%	85.9%	23.3	19.9			0	0	0	5.48
WARD NICU	2030	1853	840	276.5	91.3%	32.9%	60.7%	13.7	10.4			0	0	0.86	2.5
WARD 1D	1116	1020.6667	322	267.1667	91.5%	83.0%	100.0%	5.3	4.9			0	0	1.72	0
WARD 3ABCD	3538	3348.3333	1214	802	94.6%	66.1%	122.2%	9.9	9.6			0	0	0	3.5
WARD 4C	644	1048.25	420	351	162.8%	83.6%	92.9%	6.6	7.5			0	0	3	3.46
WARD 9	966	754.83333	322	282.6667	78.1%	87.8%	100.0%	6.0	5.3			0	0	2.14	0.57
Trust	**53898**	**46691.04**	**34330**	**32524.5**	**86.63%**	**94.74%**	**121.45%**	**8.1**	**7.7**						

Hard Truths: Safe Staffing Levels (3)

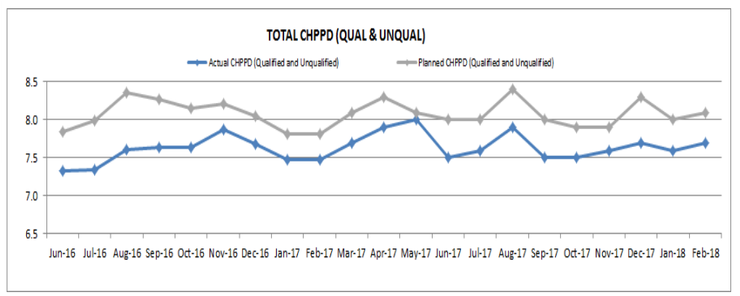
Care Hours per Patient Day

STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

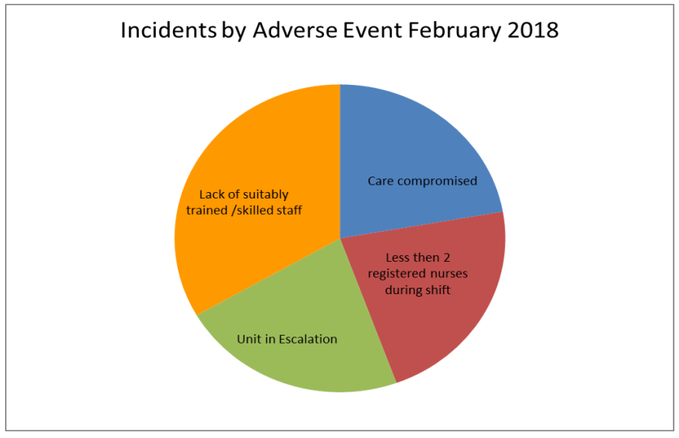
	Dec-17	Jan-18	**Feb-18**
Fill Rates Day (Qualified and Unqualified)	90.61%	90.96%	90.96%
Fill Rates Night (Qualified and Unqualified)	96.04%	102.24%	102.24%
Planned CHPPD (Qualified and Unqualified)	8.3	8.0	8.1
Actual CHPPD (Qualified and Unqualified)	7.7	7.6	7.7

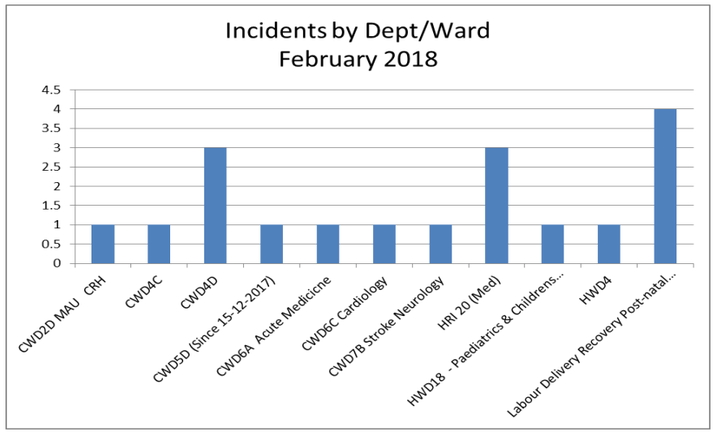


A review of February 2018 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 21 clinical areas of the 34 reviewed having CHPPD less than planned. 2 areas reported CHPPD as planned. 10 areas reported CHPPD slightly in excess of those planned. Areas with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.



RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correc t but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix. These are monitored daily by the divisions and reviewed monthly through the Nursing workforce strategy group.

There were **18 Trust Wide Red shifts** declared in **February 2018** . There has been an increase in red flagged incidents this month. Some attributed to the newly implemented Standard operating procedure (SOP) for high cost agency staffing which requires submission of a datix (2 reports).

Reports have been submitted from additional capacity wards (4) detailing reduced staffing levels and compromised care. These incidents have been managed operationally and support offered to areas from the site co-ordinators and support from across the floor.

The medical division have reported 7 incidents relating to sub-optimal staffing levels and compromised care. No datix's have resulted in patient harm.

FSS have reported 4 incidents of the unit being in escalation within maternity services and one staffing incident within Paed iatrics where staffing levels fell below planned levels. Clear escalation process put into action.

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

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

On-going activity:

1.The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce and going forward the fill rates for individual areas will improve as these team members become established in the workforce numbers. Focused recruitment continue for this specific area.

2. Further recruitment event planned for March 2018.

3. Applications from international recruitment projects are progressing well and the first 5 nurses have arrived at the Trust, with a further 5 planned for deployment in March/April.

4. A review of the English language requirements to gain entry onto the register has been completed following announcements from the NMC that they would also accept the OET qualification. The Trust is to work with the recruitment agent to transfer current candidates onto this assessment process with the aim being to expediate deployment to the UK.

5. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NA who started in post in April 2017. A proposal has been developed to up-scale the project in line with the national and regional workforce plans. A second cohort of 20 trainees will begin the programme in Spring 2018. Recruitment underway.

6. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment and retention of the graduate workforce. This has been further enhanced by the development of a year long graduate programme to support and develop new starters.

7. 4 Additional clinical educators have been recruited to the medical division. They will have a real focus on supporting new graduates and overseas nurses to the workforce.

8. A new module of E roster called safecare is currently being introduced across the divisions, benefits will be better reporting of red flag events, real-time data of staffing position against acuity.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 5th April 2018	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Financial Commentary for NHS Improvement - Month 11 - The attached commentary was submitted to NHS Improvement on the 15th of Mar 2018 alongside the Month 11 Monthly Monitoring financial return.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee	
Governance Requirements: Financial sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

For information - see attached

Main Body

Purpose:

See attached

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To note

Appendix

Attachment:

NHSI Financial Commentary Month 11 Final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 11 FEBRUARY 2018, 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 February 2018.

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;
- Use of Resources rating and forecast including recovery plans

1. Key Messages

The Month 11 position is a year to date deficit of £35.27m. On a control total basis this is an adverse variance from plan of £10.38m; excluding the impact of loss of Sustainability and Transformation funding (STF) of £6.22m that has been lost based on Q1 and 2 A&E performance and financial performance in Months 7-11. When loss of STF funding is included, the total adverse variance is £16.60m compared with a control total of £18.60m.

Since appealing the 17/18 £15.9m control total deficit in January 2017, the Trust's Board has continued to express concerns regarding the scale of this challenge. For 2017/18, the impact associated with the abnormal risk of EPR implementation was estimated at £5m, whilst only £17m of the required £20m CIP was believed to be achievable, leaving the Trust with a total risk which was assessed at the start of the year to be £8m plus any subsequent loss of STF funding.

As discussed with NHSI in recent Financial Recovery meetings, it is now clear that these concerns were well founded. Indeed, the underlying operational performance would drive a greater adverse financial variance due to a number of a number non-recurrent income and expenditure benefits supporting the forecast position, including a £4.2m negotiated settlement with the PFI facilities management provider in support of CIP delivery, non recurrent income and release of prior year accruals and £1.9m associated with the set up of the Estates SPV. This is in addition to the release in the year to date of the full £2m contingency reserve available for this financial year, central winter funding and capital support.

Since Month 7 the Trust has been unable to deliver the financial plan reporting a year to date adverse variance of £10.38m of which £1.68m related to Month 11. The implementation of EPR continues to have a significant impact on both productivity and the capture of activity data and is significantly contributing to a material clinical contract income variance of £12.0m year to date.

As reported since Month 9 and previously discussed with colleagues in NHS Improvement, the Trust does not expect to achieve the 17/18 control total due to a combination of: slower than expected recovery of clinical activity levels and therefore income following EPR implementation; reduced operational capacity whilst resolving implementation issues and associated cost pressures; income values being lower than planned for the actual activity delivered and assumed within the HRG4+ test grouper; cost pressures linked to the requirement to open additional beds, winter and remaining unidentified CIP of £2.0m. The Trust has undertaken a detailed forecast review of both activity and income which indicates that activity levels are unlikely to recover to planned levels during this financial year.

Whilst every effort continues to be made to improve the financial out turn, including pursuing innovative technical accounting benefits, the current forecast indicates that the Trust will end the year with a gap to control total of £8m, (excluding loss of STF funding). Delivery of the financial plan remains the highest risk on the Trust risk register scoring the maximum of 25.

Month 11, February Position (Year to date)

The year to date position at headline level is illustrated below:

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	342.33	324.43	(17.90)
Expenditure	(337.83)	(336.47)	1.36
EBITDA	**4.50**	**(12.04)**	**(16.54)**
Non-Operating items	(37.01)	(23.23)	13.78
Surplus / (Deficit)	**(32.51)**	**(35.27)**	**(2.76)**
Less: Items excluded from Control Total	13.91	0.07	(13.84)
Less: Loss of STF funding	0.00	6.22	6.22
Surplus / (Deficit) Control Total basis	**(18.60)**	**(28.98)**	**(10.38)**

- Delivery of CIP of £14.53m against the planned level of £15.55m.
- Contingency reserves of £2.00m have been released against pressures.
- Capital expenditure of £11.32m, this is below the planned level of £14.02m.
- Cash balance of £1.98m against a plan of £1.91m.
- Use of Resources score of level 3, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

Operating Income

Operating Income is £17.90m below plan year to date.

NHS Clinical Income

The year to date NHS Clinical income position is £286.36m, £19.26m below the planned level.

The Clinical Contract income position for Month 11 is £12.00m below plan. There remain a number of areas where activity is either not captured within EPR or a change to patient data is required in order to accurately price the activity. However, an agreement has been reached with Commissioners to secure the income position for both the year to date and forecast, which does provide a level of certainty.

The adverse variance is largely driven by both case mix and activity volumes due to a reduction in productivity following the implementation of EPR, in particular impacting on Outpatient, Daycase and Elective activity. The impact of EPR on income is calculated to be £6.7m in the year to date. The Trust has also seen an adverse variance due to HRG4+ Tariff changes, assessed to be in the region of £1.0m year to date and beyond the control of the Trust.

Direct Access, Maternity pathway, Adult Critical Care and NICU income which naturally fluctuate are all below plan with a combined impact of £0.82m and there has also been a reduction in income from Bowel Scope and Bowel Cancer screening following the Endoscopy fire earlier in the year. This is offset in Other Income by an assumed insurance settlement that is yet to be finalised, and bears an element of risk. The

cancellation of Elective and Daycase procedures due to winter pressures during January and February has resulted in the loss of income, offset to some extent by higher than planned Non Elective income. The net impact on income is assessed to be at least £0.8m.

In addition, there is an adverse variance of £7.34m on NHS Clinical income that is outside of contract, of which £5.04m relates to the loss of Sustainability and Transformation funding, with the remaining variance due to lower than planned Cancer Drugs and Hep C drugs income of £1.9m (offset within High Cost Drugs expenditure) and a number of other smaller variances, offset by non-recurrent Accelerator zone funding of £0.77m and a non recurrent benefit of £0.95m following a comprehensive review of all prior year accruals.

The year to date reported position includes the loss of the £5.38m planned STF funding for Months 7 to 11 due to failure to achieve the planned financial performance, plus £0.84m for Quarters 1 and 2 linked to the A&E 4 hour performance target. A&E performance in Month 11 remained below trajectory at 87.5%.

Other income

Overall other income is above plan by £1.36m year to date. Increased sales activity within our commercial operations, in particular the Pharmacy Manufacturing Unit (£1.4m) and Health Informatics Service (£0.4m), and assumed income for the Endoscopy fire insurance claim, have been offset to some extent by slippage in recovery of the Apprentice Levy of £0.4m compared to plan and lower than planned Car Parking income of £0.7m.

Operating expenditure

There is a cumulative £1.36m favourable variance from plan within operating expenditure across the following areas:

Pay costs	£3.00m adverse variance
Drugs costs	£0.22m favourable variance
Clinical supply and other costs	£4.14m favourable variance

The year to date position includes the benefit to pay of releasing unspent all of our £2.00m Contingency Reserve and a number of non-recurrent benefits including: a £3.5m credit relating to a negotiated non-recurrent refund of PFI facilities management costs, non-recurrent benefits of £0.82m relating to prior year creditors, £1.52m of prior year benefits following a full review of accruals, (£0.95m income and £0.91m expenditure), the release of £0.38m of Provisions and non-recurrent income of £0.97m. Further benefit comes from central winter funding and capital support.

Employee benefits expenses (Pay costs)

Pay costs are £3.00m higher than the planned level in the year to date, despite the release of Contingency Reserves of £2.00m and non recurrent benefits of £0.82m. Excluding these items and other material variances with an equal and opposite impact on Income, the underlying pressure on pay expenditure is around £4.6m. There are a number of cost drivers including the impact on Nursing pay of opening additional unplanned capacity, winter pressures, undelivered CIP and some higher than planned costs linked to EPR of up to £1m.

The Trust has seen a reduction in Agency costs compared to those reported in 16/17, particularly in Medical Staffing, where IR 35 has resulted in number of doctors transferring onto the payroll, although in some cases this has not resulted in a reduction in cost. However, nursing agency costs are higher than planned in part due to the demand from additional capacity, winter pressures and the requirements of one to one care and in part due to high agency premiums. The Trust is working with suppliers to reduce average agency rates and has implemented a number of measures to increase Bank availability including an increase in the rates offered and the option of weekly pay.

The Trust achieved the agency ceiling of £15.50m year to date, with total Agency expenditure of £14.91m.

Drug costs

Expenditure year to date on drugs is £0.22m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £2.63m below plan, offset by additional costs of £1.93m due to increased activity within the Pharmacy Manufacturing unit, (higher than planned sales are also generating additional income). Underlying drug budgets are therefore overspent by £0.48m.

Clinical supply and other costs

Clinical Support costs are £4.06m lower than planned. This underspend reflects an activity related underspend in clinical supplies of £3.24m, as well as a non-recurrent benefit of £0.82m relating to prior year creditors as described above.

Other costs are £0.08m lower than planned although this includes the £3.5m non recurrent benefit mentioned above and the release of £0.38m of provisions. Net of some profiling differences on CIP and higher cost of sales within commercial operations, the underlying cost pressure is £3.0m linked to EPR costs (£0.3m), diagnostic pressures, RPI inflationary pressures and higher than planned equipment maintenance costs.

Non-operating Items and Restructuring Costs

Non-operating expenditure is £13.78m lower than plan in the year to date. This variance includes the impact of the delay of a planned £14m impairment that is now forecast to be accounted for later in the year. The Trust has also seen higher than planned Depreciation of £0.27m following year end asset revaluations and an increase in PFI Contingent Rent due to March's high level of RPI on which the PFI contract uplift is based.

Cost Improvement Programme (CIP) delivery

In December 2016, the control total for 2017/18 of £15.9m was accepted, which drove the need for a challenging £17m (4.5%) CIP. At that point, the Trust had not agreed the two year 2017 – 2019 contract with its main commissioners. The successful resolution of the contractual position contributed to a further £3m challenge to the Trust's financial position as a result of a compromise reached. The revised income plans drove the need for a further £3m of efficiency savings, bringing the total CIP to £20m (5.3%), a position which has proved to be extremely challenging.

£14.53m of CIP has been delivered this year against a plan of £15.55m, an under performance of £1.02m. This position includes non-recurrent CIP of £3.5m relating to the refund of PFI facilities management costs mentioned above. The Trust is forecasting to deliver £17.93m of savings, including further non- recurrent savings of £1.9m linked to a project to launch a Special Purpose Vehicle for Estates.

It is also worth highlighting that almost half of the identified savings for this financial year are non-recurrent in nature and therefore do not improve our underlying operating position moving into 2018/19.

Statement of Financial Position and Cash Flow

At the end of February 2018 the Trust had a cash balance of £1.98m, just above the planned level of £1.91m.

The key cash flow variances for the year to date compared to plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	(2.76)
	Non cash flows in operating deficit	(13.57)
	Other working capital movements	0.60
	Sub Total	**(15.73)**
Investing activities	Capital expenditure	2.72
	Movement in capital creditors / Other	(1.59)
	Sub Total	**1.13**
Financing activities	Net drawdown of external DoH cash support	15.85
	Other financing activities	(1.21)
	Sub Total	**14.64**
	Grand Total	**0.04**

Operating activities

Operating activities show an adverse variance of £15.73m variance against the plan. This reflects the impact of the I&E variance of £10.38m and loss of £6.22m STF funding, less the favourable cash impact of £0.60m working capital variances, less the cash benefit of higher than planned Depreciation charges. Both the deficit and non-cash flows figures should be considered net of a £14m planned impairment which will now take place in March. The favourable working capital variance is driven by: higher than planned deferred income of £5.03m due in part to the under-trade on some commissioner contracts which are paid upfront based on contract values, offset by a reduction in the level of creditors of £1.83m and an increase in the level of debtors by £2.62m. The Trust has been able to reduce previously spiralling levels of Creditors, particular longer term outstanding debts, following the receipt of a Department of Health working capital loan in November.

Investing activities (Capital)

Capital expenditure year to date is £2.72m lower than planned, but this has been offset by a reduction in Capital creditors of £1.59m due to the payment of EPR related invoices that were accounted for in the 16/17 capital programme.

Financing activities

Borrowing to support capital expenditure is £8.00m in the year to date in line with plan. In addition the Trust has received £30.95m of Revenue Support linked to deficit and STF funding requirements and a further £5.70m of working capital support. This is £15.85m more than planned: £10.1m linked to additional deficit funding requirements and working capital support that is £5.7m higher than planned.

3. Use of Resources (UOR) rating and forecast

Against the UOR the Trust stands at level 3 in line with plan in year to date and forecast terms.

The reported forecast is a year-end deficit of £31.34m (excluding £14.05m technical adjustments that are excluded from Control Total), an adverse variance of £15.40m. This variance incorporates two elements: the gap to control total which is forecast to be £8.00m and the loss of Sustainability and Transformation Funding (STF) of £7.40m. The £8.00m gap remains unchanged from the position reported in Month 10 and is contingent upon a number of elements:

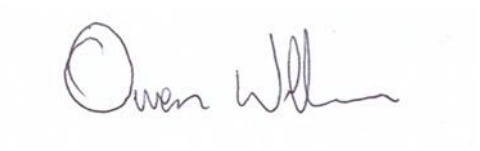
- This forecast position assumes receipt of £0.9m of Tranche 2 winter funding (not yet received); recognition of a further £1m winter funding which is in itself contingent upon delivery of the committed forecast; and £1.0m additional capital expenditure.

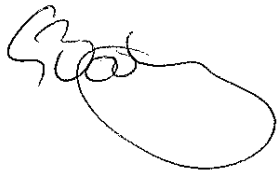
- In addition, the forecast assumes a £1.9m benefit (plus £0.7m associated reduction in technical finance charges) from the set-up of the SPV in-year; and £4.2m from the negotiated settlement with ISS which relies upon finalisation of contract agreements. These benefits are non-recurrent in nature and do not therefore address the underlying deficit position that will be carried forward into the next financial year.

- A year end settlement has been agreed with the two main local commissioners which removes a level of risk around securing CQUIN and winter funding in year.

- The forecast assumes continued delivery of recovery plans previously identified and the delivery of all forecast CIP.

These internal actions sit alongside a programme of system wide recovery that is being developed in partnership with commissioners with a view to minimising the overall local health system gap to plans. The mobilisation time required to implement a number of these wider health economy plans as well as the transformational internal schemes means that delivery is most likely to commence in 2018/19. .





Owen Williams
Chief Executive

Gary Boothby
Executive Director of Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Anu Rajgopal, Consultant Medical Microbiology
Date: Thursday, 5th April 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Guardian of safe working hours (GOSWH) Q1 Report 2018 - To give assurance to the board that the doctors in training are safely rostered and that their working hours are compliant with the junior doctors contract 2016 and in accordance with junior doctors terms and conditions of service (TCS). The report includes the data from 15.12.17 to 15.3.18	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The board is requested to acknowledge and approve the report

Appendix

Attachment:

final.pdf

Guardian of safe working hours (GOSWH); CHFT

Quarter 1 report 2018

Introduction

The purpose of this quarterly report is to give assurance to the board that the doctors in training are safely rostered and that their working hours are compliant with the junior doctors contract 2016 and in accordance with junior doctors terms and conditions of service (TCS). The report includes the data from 15.12.17 to 15.3.18.

Executive Summary

The trust is using Allocate to provide exception reporting software since August 2017. All junior doctors, educational Supervisors and clinical supervisors now have access to this.
The number of exception reports (ERs) remains low with the foundation year doctors still accounting for the highest number submitted. There has been a fall in the proportion of ERs submitted from the general surgical FY1 rota compared to the last annual report. This is likely due to the group work schedule review in colorectal surgery in the last quarter of the year.

Of concern is the proportion of ERs that remain unresolved despite repeated reminders (via email and telephonic) by the GOSWH. Some of these have been discussed and agreed with the trainee but not closed on Allocate. The Allocate software does not enable sign off by the GOSWH as did the previous DRS software.

All our junior doctor rotas are compliant with the 2016 TCS. Rota gaps remain challenging, and a majority of these are covered by bank/agency locums out of hours with the junior doctors cross-covering during the day. This quarter has seen a slight increase in ERs submitted related to service support particularly during February which is the foundation doctor changeover month and may reflect overall increased activity in the hospital due to winter pressures.

There continues to be a decrease in the unfilled shifts in this quarter with an increased use of bank staff to fill these. The decrease in unfilled shifts will have improved the working lives of those juniors who would otherwise have to cross cover. However it has come with a slightly increased financial burden. Combined data around specific junior doctor rota gaps and how these have been covered is not currently available from a single source and this would improve with e-rostering which is currently being rolled out within CHFT

Administrative support for the GOSWH role was approved at board in January 2018 and has been identified within medical HR but it has not been provided as yet.

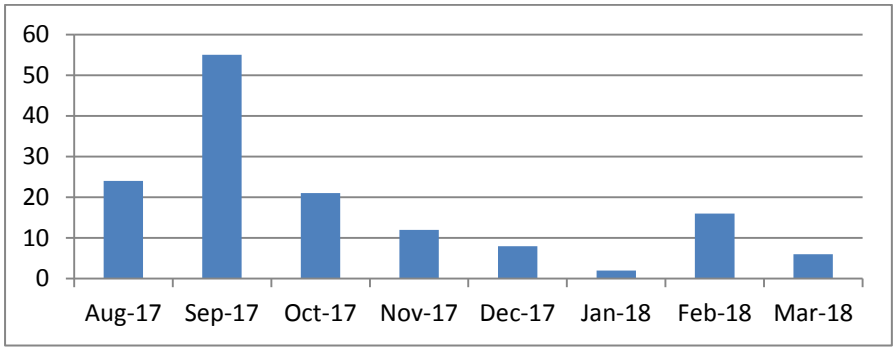
High level Data

Number of doctors / dentists in training (total):	224
Number of doctors / dentists in training on 2016 TCS (total):	224
Amount of time available in job plan for guardian to do the role:	2 PAs
Admin support provided to the guardian (if any):	No formal support as yet
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee
Amount of job-planned time for clinical supervisors:	None

a) Exception reports (December 2017-march 2018)

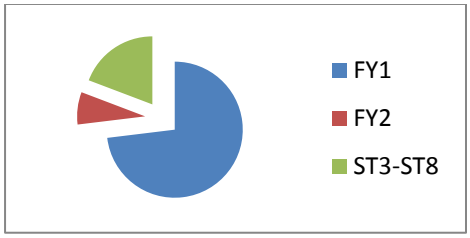
There were 26 exceptions reported during this period.

Exception reports by month

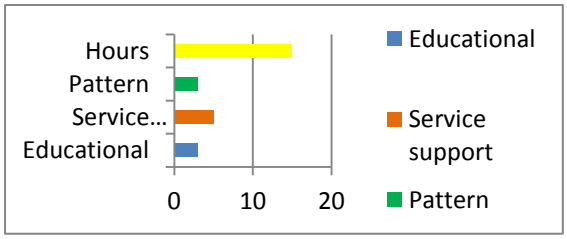


Exception report by grade

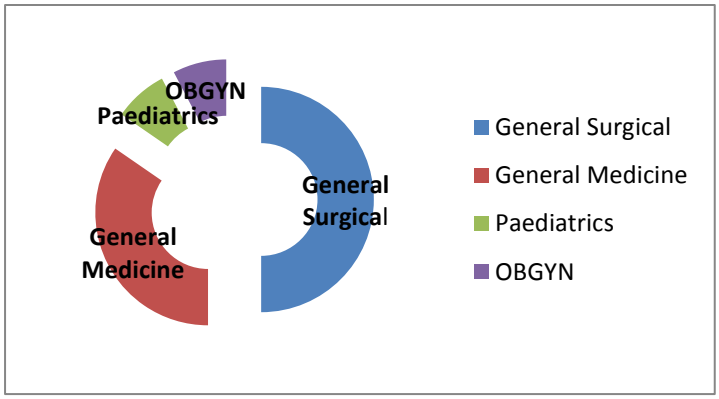
There has been a slight increase in the proportion of ERs from higher grades, mainly around service support and educational opportunities



Type of report



Exception report by rota



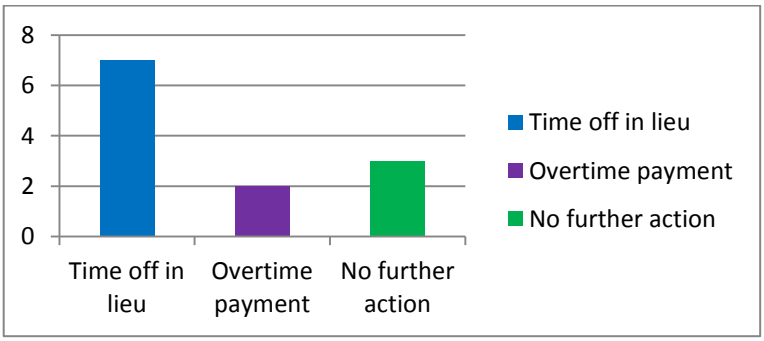
There was one ER in February which was around service support and education and was flagged up as an immediate safety concern. This was over a very busy weekend in February with one trainee off

sick but the required complement of staff was maintained. It was dealt promptly by the consultant on-call who had a very busy on-call as well. There was no risk to patient safety. The junior doctor has agreed with the actions taken and no further follow up is required.

This quarter there was a slight increase in the proportion of ERs from general medicine. These were split between service support, pattern and hours worked. I will be looking into this with the division in the next few months.

Exception report outcomes

Only 12/26 reports have been completed. The rest are pending. Of these 12, the graph below shows the outcomes agreed.



Exception report response time (target in contract is 7 days)

≤ 48 hours	≤ 7 days	>7 days
4	4	4

Some of the pending reports (4/14) have been agreed but are awaiting closure on Allocate. These should be sorted soon.

For the remainder, I have been repeatedly sending email reminders and tried calling the relevant supervisors but have been unsuccessful so far.

b) Work schedule reviews

1 FY1 personalised work schedule review was requested in colorectal surgery which has taken place.

A group work schedule review has been requested in gastroenterology as the junior doctors reported a trend of often working beyond their rostered hours. This has been highlighted to the Clinical lead in the area who will be investigating further. No exception reports have been submitted so far from the area.

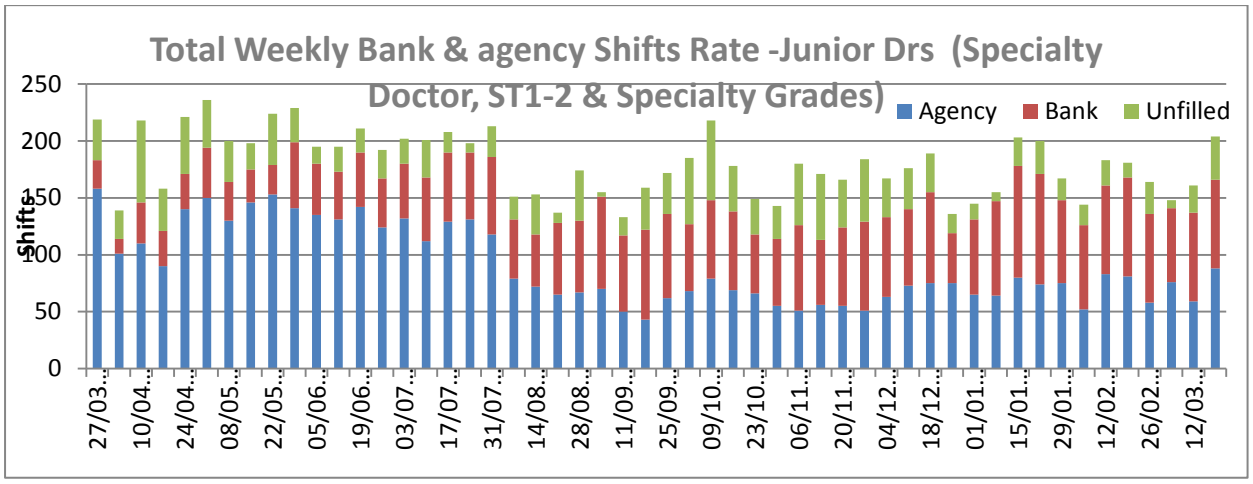
c) Communication with trainees

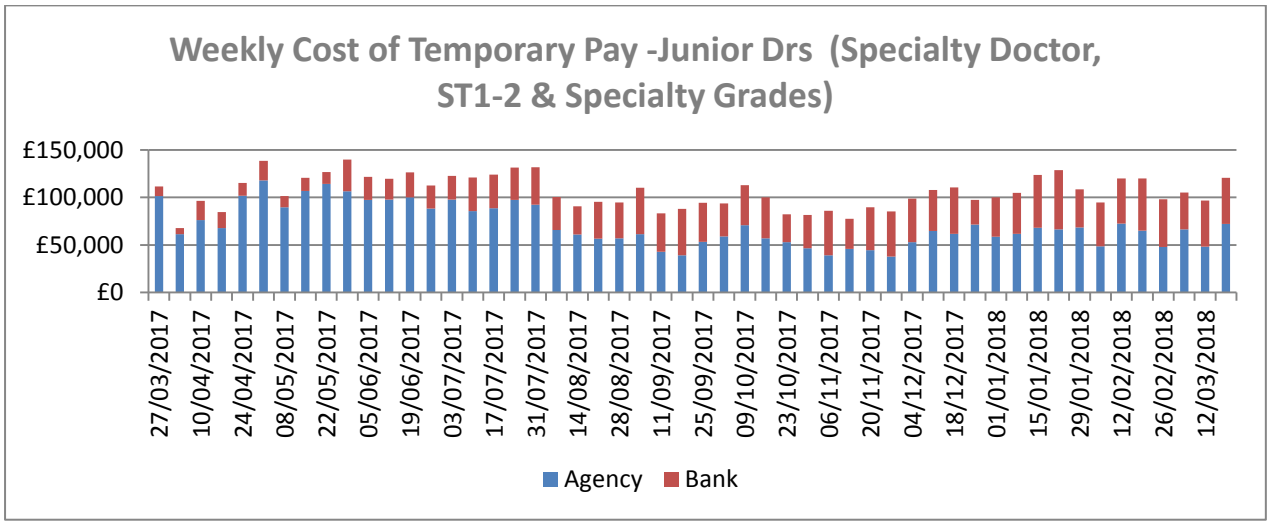
I have a regular slot at the junior doctor induction days and my presentation includes the key changes in the new contract, rota rules, work schedules, exception reporting and the role of the GOSWH and the junior doctor forum.

I regularly email trainees both collectively and individually to gather more information about their duties, either following on from exception reports or in response to more general concerns. I have met with a few trainees to encourage exception reporting when indicated.

d) Locum bookings

This data has been provided by the flexible workforce analyst





Compared to the previous quarters, the number of unfilled shifts has decreased and the use of bank locums has increased which is a good trend and contributes to the well-being of our junior doctors. This however has come at a slightly increased financial burden to the Trust.

Average hourly cost:
The average cost of bank shifts for junior doctors was £60/hour compared to agency-filled shifts which was £81/hour.

e) Vacancies

This data has been provided by individual rota masters as existed in February 2018

Grade	Specialty	Number of gaps	Reason	Cover arrangements	Vacancy period
FY1	Medicine	4	1=LTFT 3-Deanery vacancy	On-calls covered by locums (cross-cover during the day)	April 18-Aug 18
	Surgery	2	1=LTFT 1=Deanery vacancy		Dec 17 to April 18
	Paeds	3.5			Till Aug 18
	OBGYN	1.5			Till Aug 18
Core Trainees	Medicine	2	1=Maternity 1=Deanery vacancy	On-calls covered by locums (cross-cover during the day	April 18-Aug 18
	Surgery	4	1=Deanery 3=Trust doctor		1 HRI Feb 2018 3 CRH long term
	Ortho	2	Deanery vacancy		Feb-Aug 2018
ST3 & above	Medicine	8	5= Deanery vacancy 2=acting up as consultant 1= maternity	On-calls covered by locums	Oct 17-Oct 18
	Surgery	2	1=maternity 1=trust doctor vacancy	On-calls covered by locums Daytime ward cover with SHO on bank contract	
	Orthopaedics	3	2-trust doctor 1-deanery vacancy	Agency locum Currently going through recruitment process of one appointee	Trust doctor till April 18 Deanery post till Oct 18
	Paediatrics	1		On-calls covered by locums (cross-cover during the day	Till Aug 18
	OBGYN	4.5			
Speciality doctor	A/E	7	vacancies	3x agency 1x MTI 3x Bank doctors	
	Orthopaedics	4	1=maternity 3=vacancies	Bank/Agency locum (on-calls only)	Ongoing x3 1 x contract ending in May
GPST	Medicine	3		Bank/Agency locum (on-calls only)	Till Aug 18
	A/E (includes FY2)	3		1x filled with ACPs 2x filled with bank doctors	Aug 18

f) Fines

There have been no fines imposed in this quarter. However, the lack of administrative support may prevent us being able to effectively monitor breaches, particularly of the 48 hour condition. The total amount in the GOSWH fund till the end of last year was £2191.59. None of this has been spent as yet and will be discussed at the next junior doctor forum.

g) Feedback from the regional GOSWH meeting (on 20/3/18)

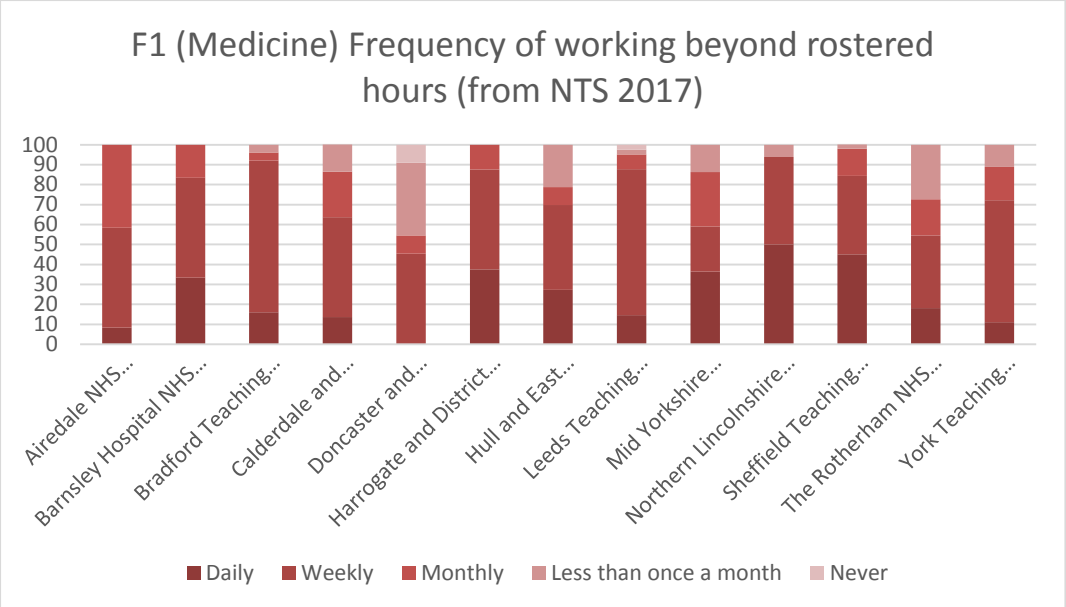
An online National GOSWH Network is being set up so the Guardians can share information and advice.

There is some further guidance due to come out on exception reports for non-resident on calls from the BMA and NHS employers.

Results of the National training survey of Foundation year 1 (FY1) doctors in Medicine

The National Training Survey (NTS) is carried out in April each year and one of the questions in this is "In this post how often (if at all) have you worked beyond your rostered hours?"

Trusts in Yorkshire and Humber were ranked per their National Training Survey (NTS) 2017 report for F1s in medicine regarding frequency with which they worked beyond their rostered hours. It can clearly be seen from the chart below that there are one or two trusts significant better and one or two significantly worse than others but the majority are very similar.



Each trust was then scored multiplying each percentage in a category by 4 points for daily, 3 for weekly, 2 for monthly and 1 for less than once a month. In this way trusts can be ranked from 1 to 13 with 1 being the lowest scoring best performing trust.

The results are below:

Trust	Score	Rank
Airedale NHS Foundation Trust	267	4
Barnsley Hospital NHS Foundation Trust	317	10
Bradford Teaching Hospitals NHS Foundation Trust	304	9
Calderdale and Huddersfield NHS Foundation Trust	264	3
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	191	1
Harrogate and District NHS Foundation Trust	325	11
Hull and East Yorkshire Hospitals NHS Trust	276	6
Leeds Teaching Hospitals NHS Trust	295	8
Mid Yorkshire Hospitals NHS Trust	282	7
Northern Lincolnshire and Goole NHS Foundation Trust	338	13
Sheffield Teaching Hospitals NHS Foundation Trust	327	12
The Rotherham NHS Foundation Trust	245	2
York Teaching Hospital NHS Foundation Trust	272	5

Health Education England then compared the NTS data with quarterly data from all trusts within Yorkshire and the Humber (Y&H) submitted by GOSWH. However at present we are not in a position to use raw numbers of reports or even reports per trainee to compare trusts. The NTS data is probably a far better indicator of the frequency at which the junior doctors work beyond their rostered hours.

h) Junior doctors forum (JDF)

This is scheduled for the 26/4/18. I will feedback in the next GOSWH report.

Main issues rising and work done to resolve these

The large proportion of ERs (>50%) that remain pending are of concern. I have verbally discussed this with the medical director and will draft a policy of escalation within the divisions and if required to the medical director. Some of these are due to supervisor unfamiliarity with the Allocate software system and I will try (with support from medical HR) to have some further training sessions.

The on-going lack of administrative support for the GOSWH is hampering my ability to follow up trends and calculate fines in a timely manner. There has been support identified within medical HR but this has not finalised as yet.

Rota gaps remain challenging as these are mostly covered only out of hours with the junior doctors cross-covering during the day. There has been a slight increase in ERs due to lack of service support and I will be following up any concerns within divisions.

Summary
Exception Reporting remains a relatively new process, it is important to continue to work with both the junior doctors and clinical /educational supervisors to ensure that they are being completed appropriately. A key aspect to achieving this is developing a positive reporting culture with a shared understanding of how it informs continuous quality improvement. According to the 2017 National training survey, our junior doctors feel happy and well-supported and the benchmarking data provided by Health Education England evidenced in this report supports that.
We do need to improve the timeliness of our response to exception reports and I will be prioritising this in the next quarter.
There are a number of rota gaps which are in the main being filled by either Trust doctors or out of hours Trust locums. The exception reports received have produced no patient safety concerns indicating the current staffing levels and working arrangements for the junior doctors are safe. However maintaining this continues to be a challenge to all involved with operational and educational delivery.

Anu Rajgopal

Guardian of safe working hours

March 2018

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th April 2018	**Sponsoring Director:** Kathy Bray, Board Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from the sub-committees.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: 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 the sub-committees:
Quality Committee – minutes of 26.2.18
Finance and Performance Committee – minutes of 23.2.18, 19.3.18 and verbal update from meeting held 3.4.18
Workforce Well Led Committee – minutes from meeting 16.3.18

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 the sub-committees:
Quality Committee – minutes of 26.2.18
Finance and Performance Committee – minutes of 23.2.18, 19.3.18 and verbal update from meeting held 3.4.18
Workforce Well Led Committee – minutes from meeting 16.3.18

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES.pdf

QUALITY COMMITTEE

Monday, 29th January 2018
Acre Mill Room 3, Huddersfield Royal Infirmary

037/18 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Dr David Anderson **(DA)**	Non-Executive Director
Helen Barker **(HB)**	Chief Operating Officer
Alistair Graham **(AG)**	Non-Executive Director
Lesley Hill **(LH)**	Director of Planning, Performance, Estates and Facilities
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Lynn Moore **(LM)**	Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Mel Addy **(MA)**	Director of Operations – Surgical Division **(for item 048/18)**
Asif Ameen **(AA)**	Director of Operations – Medical Division **(for item 050/18)**
Rob Aitchison **(RA)**	Director of Operations – FSS Division **(for item 046/18)**
Mr Neeraj Bhasin **(NB)**	Associate Medical Director **(for Dr David Birkenhead)**
Diane Catlow **(DC)**	Quality Improvement Manager **(for item 042/18)**
Andrea Dauris **(AD)**	Associate Director of Nursing - Community **(for item 049/18)**
Joanne Middleton **(JM)**	Associate Director of Nursing – Surgery **(for item 048/18)**
Andrew Mooraby **(AM)**	Associate Director of Nursing – Medical Division **(for 050/18)**
Dr Julie O'Riordan **(JOR)**	Divisional Director – FSS Division **(for item 046/18)**
Dr Ashwin Verma **(AV)**	Divisional Director – Medical Division **(for item 050/18)**

038/18 APOLOGIES

Dr David Birkenhead	Medical Director
Brendan Brown	Chief Nurse
Paul Butterworth	Governor
Juliette Cosgrove	Assistant Director of Quality and Safety

039/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

040/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 29th January 2018 were approved as a correct record.

041/18 ACTION LOG AND MATTERS ARISING

A copy of the action log (appendix B) can be found at the end of the minutes.

- Serious Incident Reports - Outstanding actions
  AMcC presented appendix C, which provided an update on outstanding actions from serious incidents completed since April 2017.

  The report highlighted the process for monitoring actions from serious incident reports though the Datix reporting module; divisional monitoring of actions from serious incident

reports; monitoring of actions where the action lead is within a different division and the position of overdue actions, by division.

The monitoring and completion of actions from serious incident reports is a significant workload for the medical division due to the division having the highest number of serious incidents.

Completing actions where there is a shared action lead or where the actions sit with another division to complete causes delays in action completion.

The Families and Specialist Services (FSS) division have a process in place to agree an extension which has been logged. A clear process for action extensions and amendments needs to be agreed and formalised across all divisions; this would improve engagement as it ensures actions remain realistic.

The Committee stated that it would be helpful to understand the criteria for extensions. JOR agreed to follow this up and circulate to other divisions.

Discussion ensued on whether it was reasonable that some actions take up to six months to be completed. It was stated that some actions are complex and can be difficult to achieve; however, it can sometimes be a small amount of evidence that is needed to close an incident. It was also stated that the actions that are set need to be smart and achievable.

The Committee welcomed the report and indicated that it would be useful to have more frequently. It was agreed that a summary or high level exception report to show how many incidents were outstanding and how many were cross-divisional could be incorporated into the quarterly report.

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

- Terms of reference
  The amended terms of reference (appendix D) were reviewed, with the following declarations made:

  - Should the workforce representative be the Executive Director or a deputy?
    Action: HB to follow-up with Suzanne Dunkley (Executive Director of Workforce and Organisational Development)

  - Safeguarding reports – LR requested that reporting is modified from 6-monthly to bi-monthly due to the nature of the report. This was agreed by the Committee.

  - Whether one Executive Director, along with one Non-Executive Director and two core members were sufficient in order for the Committee to be quorate
    Action: HB to follow-up with Vicky Pickles (Company Secretary)

  - That only job titles are listed for Committee members required in attendance.

  OUTCOME: The Quality Committee will receive the Terms of Reference once further amendments have been made.

042/18 CQC REPORT

DC was in attendance to present appendix E, which outlines progress in relation to the Trust's preparation ahead of the CQC inspection and details the content of the well-led action plan.

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

043/18 Q3 QUALITY REPORT

AMcC presented appendix F, which summarised the assurances on quality presented to the Board of Directors between October and December 2017; an update on the three quality account priorities for 2017/18 for quarter 3 and a presentation on quality indicators as at quarter 3 - 2017/18.

Five reports relating to quality were presented to the Board of Directors during the three month period October to December 2017. The reports included an update on the work of a multi-disciplinary community based team; stroke services; serious incident reporting; learning from deaths and safeguarding.

The three quality account priorities for 2017/18 were Sepsis screening for in patients; Discharge planning and Learning from complaints. Sepsis and discharge planning are also CQUINs (Commissioning for Quality and Innovation) for 2017/18.

The presentation (appendix F3) which shows the quality indicators, the quality accounts and CQUINs for quarter 3 will also be given to the Board of Directors on 1 March 2018.

OUTCOME: The Quality Committee received and noted report.

044/18 QUALITY ACCOUNT TIMELINE

Appendix G outlined the process and key dates for the production of the 2017/18 Quality Account and quality priorities for 2018/19.

13 December 2017	Workshop with Membership Councillors to: - Explain what the Quality Account is - Explain the process - Provide an update on progress with the 2016/17 priorities - Make a recommendation on long list of 2017/18 priorities
23 January 2018	Confirmation of short list of priorities
w/c 5 February 2018	Short list of priorities to go out to wider membership in Foundation News
w/c 19 February 2018	Deadline for selection of priorities
27 March 2018	Draft quality account to Quality Committee for review (meeting 3rd April)
4 April 2018	Draft quality account to stakeholders for comment
w/c 23 April 2018	Draft quality account to the Auditors
w/c 30 April 2018 (TBC)	Audit work begins
17 May 2018	Quality Account submitted to Audit & Risk Committee for approval (meeting 23rd)
31 May 2018	Quality Account uploaded on to Trust website

OUTCOME: The Quality Committee received and noted the timeline for the 2017/18 Quality Account.

045/18 QUALITY AND PERFORMANCE REPORT

HB presented appendix H which highlighted that January's performance score has improved by 5 percentage points to 60%. All domains have improved scores with the exception of efficiency and finance. The caring domain has improved significantly due to Friends and Family Test (FFT) performance. The effective domain has returned to green, although fractured neck of femur (#NoF) is still below target. The responsive domain has improved slightly with three out of four stroke targets now achieving target, plus cancer has maintained good performance for the third month running across all metrics. For Emergency

Care Standards, the score reflects failure to deliver the 95% standard but the Trust did achieve the NHS Improvement (NHSi) agreed trajectory for January. Efficiency and Finance have deteriorated with Day Cases and Accident and Emergency (A&E) both missing target in-month. Workforce has improved slightly with better sickness absence rates, although all five mandatory training focus areas are still missing target.

Discussion ensued on the concerns with increased incidences of Clostridium Difficile and MRSA bacteraemia cases, and the Infection Prevention and Control Performance Board is being reformatted in order to focus on these issues.

The Emergency Care Standard 4 hours performance has increased to over 90%, and performance with stroke and cancer have seen improvements.

The percentages of e-referral Appointment Slot Issues (ASI) are increasing due to the reduction in paper referrals. 94% of GP referrals are now made electronically. A deep dive report will be submitted to the Weekly Executive Board (WEB) in a few weeks on the outpatient metrics.

Discussion ensued on the impact of deferred operations, and it was stated that they are planned to be carried out in March pending agreement. The Committee commented on the work done to improve the Quality and Performance Report.

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

046/18 QUARTER 2 AND QUARTER 3 FAMILIES AND SPECIALIST SERVICES (FSS) PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT

A joint quarter 2 and 3 report was presented, due to the quarter 2 report being deferred.

AMH and RA presented the report (Appendix I) and summarised:

- The children's directorate working towards a Comparative Health Knowledge System (CHKS) accreditation. This process helped to direct the team to reassess the service against a bespoke set of nationally recognised standards and includes aspects of patient experience. No significant areas of risk have been identified in work undertaken so far, and are to be externally assessed in April 2018.
- Emergency Department (ED) breaches continue and practices are reviewed to ensure flow is robust.
- Managers from women's services and Estates and Facilities have met regarding a diversion on the physiotherapy corridor to reduce the footfall through the women's corridor at HRI which is impacting on infection control. This has been added to the women's services risk register and will be reviewed by April 2018.
- The checking-in kiosks continue to be a challenge for patients and work is ongoing regarding an upgrade.
- Feedback has been received from the audit of HRI Aseptic Unit, with a risk rating for the site as 'high', subject to further audit in six months' time and required remedial work. The capital plan business case has been put forward.
- Changes to the Ionising Radiation Regulations (IRR) and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) came into force in January and February 2018, and the directorate are working with the Radiation Protection Advisors (IRS Ltd) to look at what these changes will mean for CHFT and what actions may be required to ensure compliance.
- The division became a Royal College of Gynaecologists (RCOG) Obstetric Anal Sphincter Injury (OASI) Care Bundle pilot site
- CHFT stillbirth rate is reducing year on year, with a sustained reduction since 2011
- The pathology service is to lead on point of care testing in the Trust and working to set up a working group. The service will be looking for engagement with various committees.

AMH and RA were thanked for the progress made in the division during a time of no divisional director being in post.

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

047/17 QUARTER 3 ESTATES AND FACILITIES DIVISIONAL PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT

LH presented the report (Appendix J) and summarised:

- The Business Case for the Estates and Facilities Wholly Owned Subsidiary (WOS) was approved in principle by the Board of Directors in January.
- Staff in HRI Security transferred their employment on Thursday 1 February 2018 and will now be managed by Leeds Teaching Hospitals. Staff will remain based at HRI and this will provide improved supervision and service cover for CHFT.
- Cleaning Services, HRI have been reaccredited for BICS (British Institute of Cleaning Services)
- Approval was received at the Weekly Executive Board (WEB) in November 2017 to progress with the car parking survey to gather information in response to the challenges faced by patients, visitors and colleagues. This began week commencing 5 February 2018 and will last for one month.
- The division continue to monitor its compliance against mandatory training at monthly divisional board meetings, as well as weekly checks and prompts to managers.
- Appraisal compliance stood at 99.73% in December 2017, above the Trust figure of 96.10%. Compliance continues to be monitored through monthly divisional board meetings.
- There were two very high risks in the division – one regarding the HRI estate, which continues to be monitored through the annual authorising engineers / independent advisors report and subsequent action plan, and the second collective Intensive Care Unit (ICU) and Resuscitation risk regarding inadequate access granted to Estates Maintenance and Capital to carry out ward upgrades. Controls are managed and continue to be monitored through a Planned Preventative Maintenance (PPM) regime.

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

048/18 QUARTER 3 SURGERY AND ANAESTHETICS DIVISIONAL PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT

MA and JM presented the report (Appendix K) and summarised:

- The division's continued work on the ten key priorities over quarter 3. Progress against these is reported monthly into the Performance Meeting and is tracked weekly through the divisional team meeting.
- Developmental matron in post for six months to support and manage the Joint Advisory Group (JAG) standards in partnership with Bowel Screening manager. Newly appointed admin manager is looking at current ways of working to improve efficiency and patient experience during booking and scheduling process.
- Work has continued through quarter 3 to improve and maintain cancer performance across all tumour sites with ongoing focus on appointment slots.
- Investigation into 104-day breaches continued. 16 reported breaches were investigated in quarter 3. Issue identified with reporting of breaches have been addressed and every breach will be reported in real time during quarter 4 to improve data quality.
- A one-stop prostate clinic was set up once a week. The data will be analysed in March 2018 to ascertain the impact of this in reducing delays. Initial feedback from patients is positive particularly with regards to overall patient experience.
- In December 2017, there was a surge in general trauma admissions needing surgery

which led to a reduction in fractured neck of femur (#NOF) performance. This was weather-related and an additional 13 extra trauma theatre sessions were performed to deal with the increase in activity. There were also a larger number of delays to theatre for #NOF patients for clinical reasons, all have been analysed and the vast majority were for justifiable clinical reasons.

- The division secured support in December 2017 to manage complaints and also had further support with the appointment of Operational Managers into Head and Neck and General Surgery Services who will be supporting the management of complaints. The division noticed a reduction in the overall number of complaints open as well as an improvement in the quality of responses and general timelines overall.
- As part of improvement work, CRH main theatres underwent a programme of declutter. Concerns identified regarding assurance and visibility of leaders to check environment have been addressed and there is an action plan in place which is being closely monitored by the head nurse for surgery.
- Manual handling training was a challenge due to lack of clarity regarding the process, as well as a lack of trainers to deliver hands-on training. Compliance is now improving through the training and standardisation of record keeping post-Electronic Patient Record (EPR).
- As part of Care Quality Commission (CQC) preparation, the division identified a number of key areas where focused work is required to improve the position. All issues were identified from divisional key priorities, accountable leads have been identified and action plans are managed through weekly team meetings.

The division were congratulated on the good work carried out and improvements made

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

049/18 QUARTER 3 COMMUNITY DIVISIONAL PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT

AD presented the report (Appendix L) and summarised

- The significant amount of work undertaken in November 2017 on supporting the Community Place, to ensure that the service delivered safe and effective care to people who are medically stable and ready for discharge, but who require additional support that prevents them being discharged home. The division thanked corporate colleagues in providing the support required when requested.
- An interim head of therapies is now in post undertaking work in developing the future strategy for therapy services.
- Further work has been undertaken on the recovery at home programme. This is to enhance the already established reablement team with support from registered therapists to enable people to be discharged from hospital quicker.
- The Frailty team continue to in-reach and support the front-end hospital services. With the reconfiguration of hospital services for cardiology, elderly and respiratory, the frailty team noted a significant reduction in elderly patients attending at CRH. The division therefore increased their capacity at HRI to support Calderdale elderly patients who attended via ambulance. There have been 286 referrals between October 2017 and February 2018.
- The division held a recognition and success event on 20th December 2017, the purpose was to recognise people who had submitted an application to Celebrating Success, who had achieved national or local recognition through awards or through their work and also to recognise those who had received long service or star awards.
- The division participated in the Hard Truths agenda and the report provided an opportunity for the service to describe the workforce in detail and its response to demand on community nursing services in the context of its geographical footprint.
- There has been a specific focus across the directorate on sharing lessons learned as a result of incidents and investigations. Key messages arising from investigations are presented at the weekly divisional orange panel meetings.

- The division saw an overall improvement in quarter 3 for the percentage of people who would recommend the services and also a reduction in the percentage of people who wouldn't recommend, however the response rate dropped considerably. Because of the nature of contact with patients, the division made a decision to collect Friends and Family Test (FFT) feedback from all patients in contact with services on one day of the month. As response rates are based on number of total contacts per month (a patient could be seen by multiple teams multiple times a week) this has affected the response rate negatively. The division is currently reviewing opportunities to improve response rates.

Discussion ensued on the balance of staff within Community and the rest of the hospital, and whether there was a process in place for other divisions to support. It was stated that this is being worked through. It was also asked whether there were any plans for working with the local authority in Calderdale, and it was stated that the division are working in collaboration with the locality and testing various sites in Calderdale.

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

050/18 QUARTER 3 MEDICAL DIVISIONAL PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT

AM, AA and AV presented the report (Appendix M) and summarised:

- New processes to integrate sepsis management on the Electronic Patient Record (EPR). As the documentation of sepsis management has changed, the audit processes to monitor performance have been adapted. Early data analysis via EPR suggests screening performance has dropped significantly to 15%. Work is ongoing to understand and accurately report sepsis management via EPR, but it is clear screening has reduced. The division is aware that sepsis management has also been an issue outside its admission areas and that EPR has set some new challenges. A weekly reporting tool has been developed that will be used by clinical teams to monitor and enhance performance.
- The division saw an increase in falls during December 2017 with a total of 137 falls and 2 harm falls. This was in part due to extra capacity wards being open.
- The continual ongoing improvement programme on the targeted wards has had some impact in reducing the number of pressure ulcers in these areas, and the learning from this will be rolled out through quarter 4. The division expect to see a sustained reduction in the number of hospital acquired pressure ulcers, and as part of developing a robust and long term improvement plan, a trajectory will be developed.
- Some challenges with delayed diagnosis and delayed transfer of stroke patients. The team are still delivering good Sentinel Stroke National Audit Programme (SNAPP) data and still have further to progress.
- The division had a backlog of open incidents and made progress in closing.
- Harm-free care was a concern for the division although performance increased to 90.4% in December 2017. Data continues to be validated by matrons.
- Huge exercise undertaken to close risks during quarter 3 and the division continues to work on cleansing the risk register.
- Three services went through reconfiguration with no major setbacks and responses from teams were incredible. Following reconfiguration, there were huge winter pressures with around 120 extra patients and despite that, not seen any increase in complaints or harm falls. This could not have been done without the help from colleagues in other divisions.

Discussion ensued on the good work and shared learning done through the falls collaborative and whether this is being sustained. It was stated that achievements are now being seen from the safety huddle and Haelo work with levels being kept down.

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

051/18 ANY OTHER BUSINESS

Friends and Family Test (FFT)
LM raised a concern regarding FFT cards, and whether patients were identifiable from the bed allocation numbers that were included on the cards.
Action: LR to follow this up

Cancer Group
It was reported that a new Cancer Board is due to be formed, which will ultimately report to the Quality Committee. The governance arrangements are yet to be made, however, it was suggested that a representative from the Cancer Board attends the next meeting to give an update.
Action: Representative from Cancer Board to attend the next meeting.

Next Meeting
Mr Bhasin, who was due to attend the next meeting to present the NICE report and give an update on the clinical audit programme, gave his apologies and will pursue a deputy to present on his behalf.

052/18 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Five divisional reports received and each division commended for progress made
- Report received on the monitoring of actions from serious incidents
- Infection Control concerns
- Deep dive report due on outpatient referrals
- Overall improvement in Quality and performance wheel
- Thanks were conveyed to colleagues for work over the Christmas period

053/18 EVALUATION OF MEETING

What went well…..
- Meeting was well attended
- There was enough opportunity to speak and give point of view

What could be better…….
- There was nothing to report

054/18 SELF ASSESSMENT OF COMMITTEE'S EFFECTIVENESS

A copy of the Committee's self-assessment form will be forwarded to members for completion. The results from this will be included in the Quality Committee annual report due in July 2018.
Action: All forms to be returned to Michelle Augustine no later than Friday, 9th March 2018

055/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix O) was accepted.

NEXT MEETING

Monday, 30th April 2018
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday, 23 February 2018, 10.00am – 1.00pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnership
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)
Owen Williams	Chief Executive

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance
Andrew Haigh	Chair of the Trust
Brian Moore	Lead Governor (Observer)

ITEM

038/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

039/18 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Victoria Pickles, Company Secretary

040/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

041/18 MINUTES OF THE MEETING HELD 30 JANUARY 2017

The Committee approved the minutes of the meeting held 30 January 2018 as an accurate record following minor changes on Page 1 and Page 4.

042/18 MATTERS ARISING AND ACTION LOG

The deferred actions on the action log were discussed and it was agreed that these should be covered within the next 2 months.

The following Matters Arising were updated:
024/18: **Performance Indicators** - Initial discussions have taken place at WEB, further discussions are required to agree how this can be progressed – **HB/VP action carried forward**.

172/17: System Recovery Plan – Conversations have taken place between the Director of Finance and the Chair of the Committee, a lengthy report has been produced across the system and it was proposed that this would be shared with the Chair before sharing with the wider Committee, the Non-Executive members of the

Committee agreed with the proposal – **action closed**.

043/18 MONTH 10 FINANCE REPORT

The Deputy Director of Finance reported that year to date at Month 10 the Trust has a deficit on a control basis of £8.7m away from plan. It was noted that due to the deficit being away from plan the Trust will lose £5.0m of STF funding. The total deficit is £13.7m away from plan giving an overall deficit of £30,7m. The deficit is at expected levels and there is no movement in the forecasted year end position of an £8.0m deficit on a control basis, it was noted that Fixed Asset Impairments are excluded from this position. The delivery of the forecast relies on the following assumptions:-

- £1.9m of winter funding and £1m revenue to capital transfer both of which have been agreed with NHSI;
- £1.9m benefit (plus £0.7m associated reduction in technical finance charges) from the set-up of the SPV in-year;
- £4.2m from the negotiated settlement with ISS which relies upon finalisation of contract agreements;
- Full delivery of forecast CIP in future months

It was also noted that collective non-recurrent recovery actions mask a greater recurrent pressure for 2018/19 which will be picked up within the 2018/19 Plan Update agenda item.

Following a request by Andy Nelson the Director of Finance took the Committee through the background with regard to the ISS negotiated settlement. It was noted that the contract had been finalised and it is now with the Lenders for their approval. The risk that this will not proceed is minimal, however, there may be potential for some delays.

The Chief Executive requested that the Director of Finance reports back to the Committee with regard to the fair and equitable approach to the allocation of the £7.4m STF against other Trusts.

ACTION: The Director of Finance to report back to the Committee regarding the approach to the allocation of STF nationally – **GB, 3 April 2018**

Richard Hopkin asked about the level of risk associated with the highlighted assumptions and referred to discussions which had taken place at Turnaround Executive, the Director of Finance confirmed that he is relatively comfortable with the level of risk which is reducing as we approach year end.

The Committee **NOTED** the Month 10 financial position.

044/18 2018/19 PLAN UPDATE (TAKEN AS A PRIVATE AGENDA ITEM)

Due to the confidential nature of this item it was recorded in the Private Section of this Committee.

045/18 CONTRACT FORM OPTIONS

The Director of Finance presented a paper which outlined the proposal to sign up to a new contract form.

The Committee discussed the benefits and risks of changing from a full PbR (Payments by Results) Contract to an Aligned Incentive Contracts (AIC). Following full and frank discussions the Committee noted the timeline and were open to the approach but requested an understanding of our negotiation strategy.

The Committee **NOTED** the Contract Form proposal.

046/18 2018/19 FINANCIAL RISK REGISTER

The 2018/19 Financial Risks for inclusion into the Risk Register were reviewed and discussed, the following risk scores were agreed:-

I&E – 25 (remains the same)
Capital – 20 (increased)
Cash – 12 (remains the same)

The Committee **NOTED** and **AGREED** the level of Financial Risks.

047/18 REFERENCE COSTS BENCHMARKING 2016/17

The Committee received a paper which shows CHFT and neighbouring trusts' cost index compared to all other acute trusts. The Chair of the Committee agreed to feedback questions to the Director of Finance.

The Committee **RECEIVED** the benchmarking exercise.

048/18 CIP UPDATE

Due to the lack of time, this item was not covered.

049/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported that January's Performance Score had improved by 5% points to 60% with an improving picture over most of the domains, however, it was noted that February has been very challenging.

There has been a significant improvement in Stroke performance and Efficiencies are being looked at in more detail. It was recognised that more work is required with regard to Theatre Utilisation and in the context of Winter pressures length of stay has significantly improved. Transfer of Care is the lowest it has been in a long time; however, analysis of our 'trim point' has been requested. There will be an impact on RTT in relation to the lack of elective activity this quarter and a decision will need to be made with regard to March.

It was noted that Suzanne Dunkley, Director of Workforce & Organisational Development has started to review the Workforce element of the Performance Report which will include a review of KPIs. Suzanne will also be carrying out a vacancy deep-dive which will be discussed at Quality & Performance WEB.

Discussions took place with regard to staff morale, it was acknowledged that the protracted half-term within the area had impacted on colleagues; in particular Junior Doctors within the Medical specialties. Direct conversations are taking place with Junior Doctors to establish what additional help is required to provide them with extra capacity.

The Chief Operating Officer asked the Chair of the Committee if representatives from Outpatients could have time on the agenda in either April or May to present following the national benchmarking exercise.

ACTION: To schedule time on the May Work Plan for Outpatients to present to the Committee – **HB/BS**

The Committee **NOTED** the contents of the report and the overall performance score for January.

050/18 MONTH 10 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee received the Month 10 commentary on the financial return which would be submitted to NHS Improvement.

The Committee **APPROVED** the Month 10 commentary.

051/18 MINUTES FROM SUB-COMMITTIEES

The Committee received and noted the following sub-committee minutes:

- Draft Commercial Investment & Strategy Committee Minutes from the meeting held 25 January 2018.

Richard Hopkin asked if there had been movement with the 'Conflict of Interest' business case, the Director of Finance confirmed that a manual solution will be used this year.

With regard to the 'Nursing Associate Training' business case, Andrew Haigh suggested that Charitable Funds may be able to assist with funding and it was agreed to discuss further outside this forum.

052/18 WORK PLAN

The Chair of the Committee agreed to review with the Director of Finance.

Following discussions, the Committee agreed that an additional meeting should be diarised to cover items on the Work Plan that have been deferred so that scheduled F&P Committee meetings can focus on next year's plan.

ACTION: To diarise an additional meeting before the next scheduled F&P Committee meeting on the 3 April 2018 – **BS** (Post-meeting note, the meeting has been scheduled for 19 March)

053/18 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following for update to the Board:

- Significant challenge with regard to the 'gap'.
- More work required to explain the bridge, this year to next year
- Agreement to submit a draft plan to NHS I based around a £18m CIP
- Request from OW for feedback with regard to the treatment of STF
- Time frame for the submission of the Plan
- Contract Form – open to those discussions but need to understand our

negotiation position and strategy
- Financial Risk Register Scores

054/18 REVIEW OF MEETING

In summary it was felt that the meeting had had the right focus and had been productive. The view of Non-Exec Directors was appreciated.

055/18 ANY OTHER BUSINESS

There were no items to discuss.

DATE AND TIME OF NEXT MEETING

Tuesday, 3 April 2018, 9.00am – 12.00noon
Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Calderdale and Huddersfield NHS Foundation Trust

APP A2

Minutes of the Finance & Performance Committee held on Monday 19 March 2018, 11.45am – 1.45pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer (In part)
Anna Basford	Director of Transformation & Partnership (In part)
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)
Owen Williams	Chief Executive (In part)

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance
Brendan Brown	Director of Nursing (In part)
Andrew Haigh	Chair of the Trust
Brian Moore	Lead Governor (Observer)

ITEM

056/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to this additional meeting specifically scheduled to cover deferred items on the Work Plan.

057/18 APOLOGIES FOR ABSENCE

There were no apologies for absence to note.

058/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

061/18 NURSING COSTS

The Director of Nursing updated the Committee with regard to the two nursing reviews which have taken place to address nursing costs. It was noted that there had been an internal and external review, the reviews were rigorous and helpful and task and finish groups will formally report back in April, that report will come back to this Committee for review.

The work completed around Bank has had an impact, the Trust has increased the bank rate for all grades of nursing staff but surprisingly we have only seen an update in the Band 5 group. It was acknowledged that something different needs to be worked up for Band 2.

From a Model Hospital perspective there are some key pieces of work which are being reported on and this will also come back to the meeting in April. It has been reported that our nursing establishments have been set appropriately and had we not had additional beds open we would have seen most of the temporary staffing filled through bank and not agency, however, we will not get to a point where we can

totally negate agency staffing.
It was also noted that the Divisions will have to undertake a piece of work to look at our specialist and advanced clinical practitioner roles and their job plans. The easy wins have been completed and we now need to hold Divisions to account.

It was noted that FSS have seized the 'Confirm and Challenge process' and Medicine and Surgery are to be brought on board.

The Committee **RECEIVED** the update and **NOTED** that a report would come back to the Committee in April.

ACTION: To formally report back to this Committee in April – **BB, 27 April 2018**

059/18 COMMISSIONER REQUESTED SERVICES (CRS)

The Director of Transformation and Partnerships presented a paper to the Committee which provided a detailed update showing the service line position on CRS. The data had been extracted from the Trusts Service Line Reporting tool (SLR) and is based upon Month 10 data (April – January). The key pressure areas were discussed and it was noted that some of those areas do not make a contribution and have previously been part of conversations with regard to exiting those services however, overriding safety concerns have been raised.

Discussions took place with regard to the Geriatric Medicine and Rehab services and it was agreed that a trend analysis and budget breakdown should be provided to get a clearer picture also the question was asked as to what action was being taken to reduce the level of negative contribution. It was noted that we are impacted by not being able to have a better balance between our service line ability to generate profit and contribution which would outweigh some of the emergency and acute service, the construction of the tariff has also had an impact. In addition, it was requested that a comparison with peer groups would be useful but it was acknowledged that it is difficult to compare data.

Further discussions took place with regard to the reconfiguration and the transition period and whether it would change the look of this information. It was acknowledged that a reduction in length of stay is the key cost driver and also how the Trust compares with the national tariff which takes into account the performance of other organisations.

ACTION: The Chair asked for clarification in connection with Rehabilitation as to why we had agreed the change of tariff without an agreed alternative model for delivery, The Director of Finance agreed to look into the background of this decision.

ACTION: To provide trends over the last 2 years with benchmarking data at contribution level. also to look at what we would need to do to get to 20% cost based - **GB, 5 June 2018**

The Committee **NOTED** the contents of the report.

062/18 2018/19 PLANNING UPDATE

The Deputy Director of Finance took the Committee through a presentation describing where we were at the last meeting and how this has been progressed through the planning submissions. To help with the understanding of the submission, the 'bridge' was discussed in detail looking at the underlying 2017/18 position without the non-recurrent benefits. The following headlines were described as the reasons for the underlying 2017/18 deficit position:-

- Significant reduction in clinical contract activity and income
- Reduction particularly in Elective / Daycase
- Increase in Non Elective – driving highest cost additional capacity pressure at agency rates
- Reduction in ICU/NICU/Births with no costs out
- Shortfall in CIP vs plan
- Other cost pressures – sendaway tests / diagnostics
- Additional investments in EPR stabilisation – ongoing costs

The Committee were asked if the presentation had clarified the position and whether there was a common understanding of the scale of our position, following feedback it was agreed that we are part way there but there are still areas which require clarification and it was requested that against the points raised a description which describes how we have got to the current position and what are we planning to do going forward would be helpful.

ACTION: A further 2018/19 Plan Update will be discussed at the next meeting – **GB, 3 April 2018.**

The Committee **RECEIVED** and **NOTED** the presentation.

063/18 2018/19 CONTRACT UPDATE

The Director of Finance provided a presentation which outlined the option comparisons between a Payment by Results (PbR) Contract and an Aligned Incentive Contract (AIC). It was noted that the offer proposed either through a PbR or AIC should not make the deficit any worse at this point in time and following conversations with Executives we would be recommending a PbR contract. Further conversations are still taking place with our Commissioners with a potential revised offer to be negotiated. It was also noted that the National deadline for agreement of contracts 23 March 2018.

060/18 MODEL HOSPITAL BENCHMARKING

The Director of Transformation and Partnerships presented the information which had been provided to NHS I which gave an overview of the Trust's performance as at March 2018 based on our Use of Resources Assessment Framework Metrics. This information is part of our CQC assessment for the Use of Resource Visit which will take place on Wednesday 28 March 2018.

It was suggest that questions from the paper should be feed-back to Anna Basford at the earliest opportunity.

064/18 WORK PLAN

The Committee noted the contents of the Work Plan.

065/18 MATTERS TO CASCADE TO THE BOARD

There were no matters to cascade to the Board from this additional meeting.

066/18 REVIEW OF MEETING

The Chair called out the following discussion points:-

- Nursing Costs which is work in progress with the final report coming back to the Committee
- SLR – trend analysis and benchmark data was requested looking at what this means as we move forward?
- Trends and positions underpinning the Full Business Case, looking at length of stay, staffing and skill mix, out of hospital and revenue and commissioner base
- Opening position and understanding where we are with carry forwards
- Further work before we set the budget – review at next F&P Committee
- Commissioner contract – couple of options but PbR looks to be the way forward, subject to approval

067/18 ANY OTHER BUSINESS

There were no items to discuss.

DATE AND TIME OF NEXT MEETING

Tuesday, 3 April 2018, 9.00am – 12.00noon

Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Friday 16 March 2018, 10.00am – 12 noon, Room 4, 3rd Floor, Acre Mill Outpatients, Huddersfield

PRESENT:

Suzanne Dunkley	Director of Workforce and Organisational Development
Helen Barker	Chief Operating Officer
Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director (Chair)

IN ATTENDANCE:

Nigel Collins	ESR Manager (for agenda item 44/18)
Ruth Mason	Associate Director of Organisational Development (for agenda items 39/18 and 40/18)
Cornelle Parker	Deputy Medical Director (for David Birkenhead)
Lindsay Rudge	Deputy Chief Nurse (for Brendan Brown)
Claire Wilson	Assistant Director of Human Resources (for agenda item 38/18, 45/18 and 46/18)

32/18 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

33/18 **APOLOGIES FOR ABSENCE:**

David Anderson, Non-Executive Director
Stephen Baines, Council of Governors
David Birkenhead, Medical Director
Brendan Brown, Chief Nurse
Jason Eddleston, Director of Workforce and Organisational Development

34/18 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

35/18 **MINUTES OF MEETING HELD ON 14 FEBRUARY2018:**

The minutes of the meeting held on 14 February 2018 were approved as a correct record.

36/18 **ACTION LOG (items due this month)**

The action log for February 2018 was received. Items due this month were discussed in the meeting.

MAIN AGENDA ITEMS

FOR ASSURANCE

37/18 **2017 STAFF SURVEY RESULTS**
The report had been circulated with papers to the Committee meeting.

SD outlined the key outcomes of the survey.

Some concerns around the results were noted and it was agreed we must focus on what the results tell us.

An engagement process will be designed to help division take ownership and initiate actions.

The report will be taken to the April 2018 Board of Directors.

ACTION: SD to oversee engagement process design.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

38/18 **WORKING EFFECTIVELY SKILL MIX AND ROLE REVIEW – CALDERDALE FRAMEWORK (CF)**

A briefing paper was circulated to the Committee.

The CF Programme Board met on 1 March 2018 with Project Leads from all service areas except Elderly Medicine. The update from each service area is provided in the briefing paper.

HB confirmed Rob Moisey, Consultant in Acute Medicine, has a session on 23 March 2018 with consultants in Elderly Medicine for feedback regarding the reconfiguration.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

39/18 **COMPASSIONATE LEADERSHIP IN PRACTICE (CLIP) UPDATE**

RM provided an update to the Committee.

3 cohorts currently undertaking CLIP. Feedback has been very good. Other feedback is that it feels like a luxury to attend. 'Cross fertilisation' of having attendees from across the Trust has gone down really well – offers ability to network

Our learning as an organisation has been that, because of increased operational pressures we will not in future plan to deliver any major training courses in Q4.

Healthskills have been very flexible and based on attendees' feedback, the programme has been adjusted to build in experiential learning during the sessions.

Delegates and funding for cohort 4 have been identified.

A stocktake will commence after cohort 3 and to consider how this fits into the wider OD strategy.

RM confirmed formal evaluation of the programme would be shared with the Committee.

It was suggested this is incorporated in the Trust's Staff Survey to help define the type of people that we want as leaders.

OUTCOME: The Committee **RECEIVED** and **NOTED** the update.

40/18 **MANDATORY TRAINING**

RM provided an update to the Committee.

Compliance had improved, in particular fire training is at 95% compliant.

Training completed at other NHS organisations is now recognised and accepted by this Trust which has supported efficiency and compliance.

We know when peaks and troughs are which has helped us improve our approach
Our handling of the data is now very good

In rolling out the manager self- service this will help us with changing culture around responsibility

AG enquired about manual handling training. RM confirmed that level 1 could be done by e-learning and additional external resources had been sought in terms of level 2.
CP reminded the Committee of GDPR in terms of data security. RM confirmed extra sessions had been organised. By end of March 2018, 750 people will fall out of compliance, these colleagues have been targeted and 10 face to face classroom sessions have been created to support this training element.

KH questioned if any areas were of particular concern. RM confirmed the biggest concern was around language. Mandatory training shouldn't be seen as a 'chore', rather as colleagues taking pride in being up to date and practicing safely. Post 31 March, conversations will take place on how we manage learning going forward. This is what we do to keep ourselves safe. Work is already underway on how we reposition/rebrand based on the advice received from Ted Baker at the CQC.

HB expressed anxiety that we have none of training in 95%. HB suggested that senior leaders contact colleagues directly. RM to provide a list of colleagues to senior managers.

ACTION: RM to provide a list of soon to be/non-compliant colleagues to senior managers.

OUTCOME: The Committee **RECEIVED** and **NOTED** the update.

41/18 **EQUALITY AND DIVERSITY (E&D) BENCHMARKING**

SD posed the question of having E&D targets across the Trust knowing there is a variety of organisations against which we could benchmark ourselves (e.g. local authorities). Discussion took place regarding specifics which could be benchmarked.

HB raised concerns regarding the importance of getting the culture right – shouldn't be 'another target'. SD acknowledged the concerns and confirmed targets are useful and should be realistic but stretching. It is important to look at all protected characteristics not just a few of them. There must be a purpose of creating a more diverse workforce, not just a target to be hit. KH agreed targets need to be achievable within a realistic time frame and should note that we are competing in our recruitment with other local employers to attract the same diverse workforce.

AG queried how robust is the Trust's data? ESR can be amended by individuals therefore the data is not necessarily a true reflection.

ACTION: SD to progress work on targets.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the approach.

42/18 **APPRENTICE STRATEGY**

RM advised that 118 out of the Trust's target of 130 apprentices are already working in Trust. The plan is to refresh our approach to using the levy for 2018-19. The resource that goes into supporting apprentices needs to be examined. Currently the apprenticeship support team comprises 8 members of staff.

OUTCOME: The Committee **RECEIVED** and **NOTED** the update.

43/18 **FUTURE WORKFORCE (WELL LED) COMMITTEE**

KH advised members of a need to refresh the purpose and format of the Committee being mindful of retaining the assurance element. This is an opportunity to create a setting to discuss matters more strategically – for example apprenticeships, with a wider stakeholder group. A quarterly RAG workforce metrics meeting would also be scheduled. Matters can then be escalated to other forums such as PRMs and Executive Board. HB suggested that the dates are confirmed in diaries as soon as possible to encourage attendance.

AG expressed support in having time to 'hot house' key topics and look at how other elements such as IT issues connect in with the workforce issues. Other suggested topics included management training and leadership, specialisation of staff, what does 'quality' mean in our new future? LR thought it would be useful to discuss implications of WYAAT suggestions, workforce planning implications for instance funding nursing apprenticeships

KH reiterated the importance of workforce being a key element of future reconfiguration plans noting that some managers may not have experienced taking their colleagues through major change.

ACTION: SD to develop schedule for topic discussion and workforce metrics meetings.

OUTCOME: The Committee **SUPPORTED the approach**.

44/18 **ELECTRONIC STAFF RECORD (ESR) UPDATE**

The report had been circulated with papers to the Committee meeting.

NC reported the manager self-service training is going well with over 400 managers now trained. There are around 140 departments yet to undergo manager self-service training. The project is proceeding to plan with a high likelihood of completing earlier than the scheduled date of November 2018.

NC advised that 40% of sickness absence is recorded via ESR with E-roster also being used to record sickness absence. CP expressed concern that a high rate of doctor sickness absence is not being captured. CW agreed to analyse the usage of ESR to record doctors' absence.

NC informed the Committee that 60% of personal data changes are being recorded via ESR. Assignment changes such as recording appraisals during the appraisal season are evident.

As a Trust, we have 86% of staff accessing ESR currently. Tap and go computers experienced 5000 log in's last week. Each day the compliance on the 112,000 Trust training requirements moves upwards. Currently this is over 86%.

37% of NHS staff are using ESR. At CHFT 86% of staff have used ESR. We are in the vanguard of usage across the NHS and this is recognised by regional colleagues.

ACTION: CW to provide analysis of recording of doctors' sickness absence.

OUTCOME: The Committee **RECEIVED** and **NOTED** the update.

PERFORMANCE

45/18 **WORKFORCE PERFORMANCE REPORT (MARCH 2018)**

The report had been circulated with papers to the Committee meeting.

CW provided an overview of the main highlights from the March 2018 report:-

- Slight decrease in vacancies from 5.88% in January 2018 to 5.86% in February 2018
- Turnover improved to 12.84% in February 2018 from 13.11% in January 2018. It was noted in particular the decrease in turnover of healthcare scientists.
- Recording of return to work interviews increased in January 2018 to 74.5% from 49.8% in December 2017
- Time to hire has improved by 3.3 days from January 2018 to February 2018.

With regard to sickness absence, CW confirmed the HR BPs are working closely with the Divisions, for example a 'sick summit' has been arranged within the Surgery and Anaesthetic Division.

The Committee discussed the metrics currently measured within the report – are these the correct metrics? It was agreed the metrics should be triangulated, for example money, people and safety. The Committee requested the information to be available to report at the June Board meeting.

In addition, the Committee also agreed 'this time last year' information should be included in the report.

ACTION: CW to explore the triangulating of metrics
CW to add to the report 'this time last year' information

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

INFORMATION

46/18 **GENDER PAY GAP REPORTING**

The report had been circulated with papers to the Committee meeting.

CW described the new regulations in relation to gender pay gap reporting and outlined the Trust's figures on gender pay gap. CW advised the data had been published on the government's online reporting service and the Trust's website on 8 March 2018, ahead of the 31 March 2018 deadline.

The Trust reported a gender pay gap of 26.6%. This is due to an over representation of males within the medical workforce group. When omitting this group from the analysis, the Trust doesn't show a gender pay gap. CP queried the proportion of male to female consultants. CW agreed to examine the position.

ACTION: CW to examine the ratio of male to female consultants.

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

ITEMS TO RECEIVE AND NOTE

47/18 **ANY OTHER BUSINESS:**

No other business was raised.

48/18 **MATTERS FOR ESCALATION:**

There were no matters for escalation.

49/18 **DATE AND TIME OF NEXT MEETING:**

Following discussions – the schedule of future meetings will be advised as soon as possible.

The meeting scheduled to take place on Wednesday 11 April 2018 is stood down.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carol Harrison, Charitable Funds Manager
Date: Thursday, 5th April 2018	**Sponsoring Director:** Andrew Haigh, Chairman
Title and brief summary: Charitable Funds - Minutes of previous meeting - DRAFT - Minutes of meeting held on 21 February 2018. Draft as still to be agreed at next Charitable Funds Committee meeting. To be included as a fast track item.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Not applicable	
Governance Requirements: Governance	
Sustainability Implications: None	

Executive Summary

Summary:

Minutes of previous Charitable Funds Committee meeting (21 Feb 2018), in DRAFT form, to be noted by Board.

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 review for reference.

Appendix

Attachment:

Minutes 21 Feb 2018.pdf

Calderdale & Huddersfield NHS Foundation Trust Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Wednesday, 21 February 2017

Present: Andrew Haigh, Brendan Brown, David Birkenhead, David Anderson

In attendance: Zoe Quarmby, Lyn Walsh, Carol Harrison

Apologies: Gary Boothby, Kate Wileman

Andrew mentioned that Kate had stepped down from her role in this Committee and that Councillor Megan Swift had expressed an interest in replacing her. She was later confirmed as the replacement.

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Minutes of the last meeting
The minutes of the last meeting held on 20 November 2017 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

3. Matters arising
~ *Launch of new brand on Intranet* – this had not been actioned and Lyn was asked to chase.

~ *Fundraiser recruitment* – this is ongoing and Lyn was asked to chase Vicky re meeting with Brendan, taking the job spec to the vacancy control panel and getting the position out to advert.

~ *Prevention of Delirium further support* – the Committee agreed to extend this for a further year and Carol was asked to give the original paperwork to Brendan to enable him to put together the details for the new approval.

~ *Todmorden bids* – Gary chased for more bids but no response yet. Brendan agreed to chase with Community colleagues.

~ *CCLA restrictions* – Lyn clarified what these were in the minutes (item 9).

~ *Corporate Trustee training* – after Carol spoke to Hempsons, Andrew asked the Committee to choose between generic training in Harrogate in September (free of charge) or bespoke Corporate Trustee training which could be attached to a Board meeting (£750 + VAT for two hours). Zoe suggested that the latter would be preferable and the Committee agreed. Andrew said that Vicky can include this in the Board Development Schedule. Carol can forward Hempsons' email to Vicky to take forward.

~ *Todmorden sub committee, first instalment* – it was agreed to pay the first £10,000 and ask for expenditure updates at the six monthly meetings.

~ *Todmorden sub committee, arrange next meeting* – now that the new Chair has been appointed, Carol will arrange next meeting for end April.

~ *Todmorden sub committee, good news story* – Lyn to remind Vicky about Communications doing an article.

Action (1):
Lyn to chase Vicky re brand launch on Intranet.

Action (2):
Lyn to chase Vicky re fundraiser recruitment.

Action (3):
Carol to give Brendan documentation to progress setting up a new approval for POD position.

Action (4):
Brendan to speak to Karen Barnett re possible bids against the Abraham Ormerod fund.

Action (5):
Carol to email Hempsons information to Vicky re Corporate Trustee training within Board Development Schedule.

Action (6):
Carol to pay first instalment to Todmorden BC and put expenditure report on the sub committee agenda.

Action (7):
Lyn to remind Vicky re good news story for Communications.

4. Quarter 3 SOFA and Balance Sheet 2017/18
Lyn presented this paper and its contents were noted. It was agreed to include total commitments to give a more complete picture.

Action (8):
Carol to adjust format of paper moving forward.

5. Quarter 3 2017/18 Expenditure Summary
Lyn presented this paper and its contents were noted.

6. Risk Register Review
Lyn presented this paper and some amendments and additions were recommended regarding target scores, leads, etc. Lyn was also asked to take advice from Vicky about the changes.

Action (9):
Zoe and Lyn to amend Risk Register after consulting Vicky and bring back to the next meeting.

7. University Fundraising Report
Andrew summarised this and its contents were noted.

8. Minutes from the Staff Lottery Committee meeting held on 5 December 2017
These were noted.

9. Any other business
As this was Andrew's last meeting as Chair, the Committee formally thanked him for his time and dedication.

10. Date and time of next meeting
The next meeting will be on Tuesday, 22 May 2018 at 2 pm in Meeting Room 2, Acre Mills.

CHARITABLE FUNDS COMMITTEE MEETING
22 May 2018
Action Log - 2018/19

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	21.02 - 1	Chase VP re brand launch on Intranet	**LW**	Feb-18	
Matters arising	21.02 - 2	Chase VP re fundraiser recruitment	**LW**	Feb-18	
Matters arising	21.02 - 3	Give Brendan info to enable approval to be set up for POD further support	**CH**	Feb-18	completed
Matters arising	21.02 - 4	Talk to Community division re bids against A Ormerod fund	**BB**	Feb-18	completed
Matters arising	21.02 - 5	Give VP Hempsons info re Corporate Trustee training	**CH**	Feb-18	
Matters arising	21.02 - 6	Pay first instalment to Tod. BC and put expenditure report on next agenda for sub comm. Meeting	**CH**	Feb-18	
Matters arising	21.02 -7	Remind VP re good news story for Comms.	**LW**	Feb-18	completed
Q3 Sofa & BS	21.02 - 8	Adjust format of this summary paper	**CH**	Feb-18	completed
Risk Register review	21.02 - 9	Amend Risk Register after consulting VP	**ZQ/LW**	May-18	