Public Board of Directors - 4 January 2018

Schedule	Thursday 04 January 2018, 09:00 AM — 11:00 AM GMT
Venue	Large Training Room, Learning & Development Centre, Calderdale Royal Hospital
Organiser	Kathy Bray

Agenda

10:09 AM	13.	Guardian of Safe Working To Approve - Presented by David Birkenhead	136
		APP H1 - Guardian of Safe Working Annual report.pdf	137
		APP H2 - Guardian of Safe Working Annual report - Appendix - Annual report GOSWH Dec 2017.pdf	139
10:19 AM	14.	Update from sub-committees and receipt of minutes and papers	150
		APP I1 - UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES.pdf	151
		APP I2 - UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - Appendix - combined update from sub-cttees and receipt of mins.pdf	153
	15.	a. Quality Committee - minutes of 4.12.17 and verbal update from meeting 3.1.18 To Note - Presented by Linda Patterson	164
	16.	b. Finance and Performance Committee - minutes of 28.11.17 and verbal update from meeting 2.1.19 To Note - Presented by Phil Oldfield	165
	17.	c. Workforce Well Led Committee - verbal update from meeting 13.12.17 To Note - Presented by Karen Heaton	166
10:29 AM	18.	Date and time of next meeting - 1.2.18 commencing at 9.00 am in the Large Training Room, LC, CRH To Note - Presented by Andrew Haigh	167

1. Welcome and Introductions - Brian Moore, Rosemary Hedges, Dr Peter Bamber

To Note

Presented by Andrew Haigh

Calderdale and Huddersfield NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 4 January 2018 at 9.00 am
Venue: Large Training Room, Learning Centre, CRH

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE	TIMING (INDICATIVE)
1	Welcome and introductions: Brian Moore, Lead Governor Rosemary Hedges, Public Elected Governor Dr Peter Bamber, Staff Elected Governor	Chair	**VERBAL**	**Note**	**1 min**
2	Apologies for absence: Richard Hopkin	Chair	**VERBAL**	**Note**	**1 min**
3	Declaration of interests	All	**VERBAL**	**Receive**	**1 min**
Standing items					
4	Minutes of the previous meeting held on 7 December 2017	Chair	**APP A**	**Approve**	**1 min**
5	Action log and matters arising:	Chair	**APP B**	**Review**	**5 mins**
6	Chairman's Report	Chair	**VERBAL**	**Note**	**5 mins**
7	Chief Executive's Report	Chief Executive	**VERBAL**	**Note**	**5 mins**
Keeping the base safe					
8	High Level Risk Register	Executive Director of Nursing	**APP C**	**Approve**	**10 mins**
9	Preparation for the General Data Protection Regulations presentation from Helen McNae, Information Governance & Registration Authority Manager - Inform	Managing Director – Digital Health	**APP D and presentation**	**Note**	**15 mins**
10	Governance Report a. Risk Management Strategy	Company Secretary	**APP E**	**Approve**	**5 mins**
11	Integrated Performance Report	Chief Operating Officer	**APP F**	**Approve**	**10 mins**
Financial Sustainability					
12	Month 8 – 2017-2018 – Financial Narrative	Executive Director of Finance	**APP G**	**Approve**	**10 mins**
A workforce for the future					
13	Guardian of Safe Working Annual	Executive Medical	**APP H**	**Approve**	**10 mins**

	Report	Director/ Dr Anu Rajgopal			
Transforming and improving patient care					
14	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 4.12.17 and verbal update from meeting 3.1.18 ▪ Finance and Performance Committee – minutes of 28.11.17 and verbal update from meeting 2.1.18 ▪ Workforce Well Led Committee – minutes (to follow) and verbal update from meeting 13.12.17		**APP I**	**Receive**	**10 mins**
Date and time of next meeting Thursday 1 February 2018 commencing at 9.00 am **Venue: Large Training Room, Learning Centre, CRH**					**89 mins**

Resolution

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

2. Apologies for Absence - Richard Hopkin

To Note

Presented by Andrew Haigh

3. Declaration of Interests

To Note

Presented by Andrew Haigh

4. Minutes of the previous meeting held on 7.12.17

To Approve

Presented by Andrew Haigh

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 4th January 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 7.12.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 7 December 2017	
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 7 December 2017

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 7 December 2017

Appendix

Attachment:

DRAFT BOD MINS2 - PUBLIC - 7.12.17-2.pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 7 December 2017 at 9am in the Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

Andrew Haigh	Chairman
Owen Williams	Chief Executive
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Brendan Brown	Executive Director of Nursing and Deputy Chief Executive
Jason Eddleston	Executive Director of Workforce & OD
Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates and Facilities
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director
Dr Linda Patterson	Non-Executive Director

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance and Procurement
Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary (minute taker)
Mandy Griffin	Director of The Health Informatics Service
Juliette Cosgrove	Assistant Director of Quality and Safety (for item 4 & 9)
Andrea McCourt	Head of Governance and Risk (for item 4)
Cornelle Parker	Deputy Medical Director
Victoria Pickles	Company Secretary

OBSERVER

Brian Moore	Publicly Elected Governor – Lead Governor
Charlie Crabtree	Staff Elected Governor

180/17 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, particularly Alastair Graham, Non-Executive Director who had taken up post on the 1 December 2017.

181/17 APOLOGIES FOR ABSENCE

Apologies were received from:
Dr David Birkenhead, Medical Director
Gary Boothby, Executive Director of Finance and Procurement
Phil Oldfield, Non-Executive Director

182/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

183/17 PATIENT STORY/QUALITY REPORT: DEEP DIVE – SERIOUS INCIDENT REPORTING

The Assistant Director of Quality and Safety and Head of Governance and Risk gave a detailed presentation to the Board on the Trust's Serious Incident reporting.

The presentation highlighted that for the period 2016/17 there had been a total of 8054 incidents, of which 7% had been green or yellow incidents (near miss incidents with no or low level harm to patients). 1% of all incidents reported were serious incidents. The presentation included a breakdown of the serious incidents together with assurance on the

ulation times involved. The duty of candour regulations, to be honest with patients' families when things go wrong, contacting them within 10 days of becoming aware of an incident was discussed. It was noted that significant assurance that the Trust is learning from serious incidents and moderate harm incidents had been reported by internal auditors in November 2017.

The Board heard how the clinical audit team were helping to support investigators to improve the number of serious incident reports delivered in a timely way.

The Deputy Medical Director reported that more use was being made of medical staff with a number of colleagues expressing an interest to help with this work and although this was not formally part of the job plans, this was under review.

Opportunities for EPR to help facilitate information capture in a more timely way was discussed. It was agreed that the Assistant Director of Quality and Safety and the Chief Executive would discuss this outside the meeting.

The Board thanked the team for their informative presentation and assurances on the process within the Trust for investigating serious incidents.

OUTCOME: The Board RECEIVED and NOTED the work of the Trust on Serious Incident Reporting.

ACTION: JC/OW

184/17 MINUTES OF THE MEETING HELD ON 2 NOVEMBER 2017

The minutes of the previous meeting were approved with the amendment to Page 2 to record the minutes of the last meeting being held on 5 October rather than 5 September 2017.

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

185/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG

177/17 - FRACTURED NECK OF FEMUR (FNOF)

The Deputy Medical Director updated the Board on the compliance with the standard for fractured neck of femur patients undergoing surgery – October stood at 73.68% and November was 92.31%. It was noted that this was a good response and a substantial amount of work around ring fencing theatre capacity, clinical protocols/co-morbidity conditions had been undertaken. Weekly meetings were now taking place and the team had appointed a lead. The Board were given assurance that this would continue to improve and be consistent going forward.

160/17 - EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRRR) & CORE STANDARDS ANNUAL SUBMISSION

It was noted that amendments had been circulated to the Board outside the meeting.

There were no other matters arising which had not been actioned or included on the agenda.

162/17 – IPR – GREEN X PATIENTS

It was noted that this item would be reported in more detail within the February 2018 meeting report.

ACTION: Action Log - February 2018

165/17 – BOARD ASSURANCE FRAMEWORK

It was agreed that the next update would be brought to the February 2018 Board Meeting.

ACTION: Action Log - February 2018

a. Feedback from BOD/COG Workshop 15.11.17
It was noted that the feedback from the Workshop on the 15.11.17 had been circulated for information.

b. Update from NHS Providers Chairs and Chief Executives' Meeting
The Chair updated on the NHS event where two presentations had been received on workforce and strategic issues. The new Chair for NHS Improvement had asked for feedback on the presentations. It was agreed that the slides from the event would be shared with the Board in due course.

ACTION: AH

Discussion took place regarding nurse staffing and it was noted that the Trust had secured a number of nurses to commence in the new year from the Philippines. The challenges of recruiting international nurses due to entry problems were noted.

OUTCOME: The Board NOTED the Chairman's report

187/17 CHIEF EXECUTIVE'S REPORT

a. WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS (WYAAT) UPDATE – The Chief Executive advised that WYAAT was now entering a phase of testing relationships with the evolving discussions on location of services. The current position with progress on vascular services and acute stroke units were noted.

Internally discussions had commenced with the Consultant Surgeons to look at a broader narrative around the WY footprint. It was noted that any improvements in services which could be made now would put the Trust in a good position for negotiations on services in the future.

The Chief Executive that further discussion on the WYAAT work would take place in the private Board agenda later that day.

b. STAFF SURVEY/FLU – The Director of Workforce and OD reported that 2,300 colleagues had participated in the staff survey which equated to 40% of the workforce. Early indications were good although the formal announcements were not expected until late February/early March 2018. Thanks were given to staff who had contributed to this.
With regard to flu vaccinations within the Trust, it was noted that 58% of front line health workers had received vaccinations. Further work was underway to achieve the target of 70% to comply with CQUIN requirements.

c. CARDIOLOGY, RESPIRATORY AND ELDERLY MEDICINE SERVICES UPDATE
The Chief Executive reported that a total of 40 patients/5 wards had moved between the two sites. Thanks were given to all staff involved including Yorkshire Ambulance Service personnel and volunteers.

It was agreed that a further update would be brought to the Board from the Quality Committee in February when a review of the impact/success and embedding of the services had been undertaken.

ACTION: Report to BOD via Quality Committee

Brian Moore, Governor raised the recent media coverage regarding the moves. The Board confirmed that the moves were interim to ensure patient safety. They were dependant on the decision regarding the full business case and were not linked to winter.

OUTCOME: The Board NOTED the contents of the Chief Executive's report

188/17 QUARTERLY QUALITY REPORT

The Executive Director of Nursing presented a paper which summarised the progress on quality for the period April 2017 to September 2017 and provided assurance to Board members regarding the work to improve quality of services and an opportunity to present quality data relating to Q2 2017/18.

The report had previously been discussed at the Quality Committee and summarised the information which had been shared with the Board on quality over the last six months. This included three deep dives on progress with CQC actions in maternity services, critical care and paediatrics. It also detailed information shared with the Board on Learning Disabilities, via a patient story, naso-gastric tube feeding and falls. It was noted that the deep-dive on serious incidents discussed earlier on the Board agenda also formed part of the quality reporting to Board members.

Information on the 2017/18 quality account priorities of sepsis screening for in patients, discharge planning and learning from complaints was noted.

Discussion took place regarding Sepsis and the Associate Medical Director confirmed that now that a sepsis bundle was available on the Electronic Patient Record, improvements were being seen in early diagnosis.

Linda Patterson requested that the outcomes in the report were monitored against the other initiatives being undertaken in the Trust. It was noted that the Quality Committee would be undertaking a deep-dive in February/March and the outcomes would be brought back to the Board.

ACTION: Report to BOD via Quality Committee

OUTCOME: The Board NOTED the Quarterly Quality Report and Data at Q2 2017-18 and the update on the three quality account priorities.

189/17 QUARTER 3 – LEARNING FROM DEATHS PUBLICATION

It was noted that this was the first Learning from Death report provided to the Board of Directors. Nationally it was estimated that approximately 3% of in-hospital deaths are preventable. In September 2017 the Trust published its revised Learning from Death (LfD) Policy. The policy was in accordance with the National Quality Board (NQB) March 2017 framework which outlines how we will identify, investigate, report on and demonstrate learning from deaths that occur at the Trust.

The contents of the policy which also outlined the process for Initial Screening Reviews and Structured Judgement Reviews (SJR) were noted. The new process in place, effective from 1.12.17 required all deaths to be reviewed. Richard Hopkin asked whether 100% compliance was achievable. The Deputy Medical Director advised that a robust system was in place with a designated doctor being identified in each speciality to allocate cases.

Concern was expressed that as a result of increased data the Duty of Candour requirements would increase and discussion took place regarding whether sufficient capacity was available.

Two cases had been identified as avoidable and it was agreed that learning would be included in the next report in March 2018.

OUTCOME: The Board approved the Learning from Deaths quarterly report

190/17 HIGH LEVEL RISK REGISTER

The Executive Director of Nursing 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.

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

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

Risks with reduced scores
There were no risks with a reduced score.

New risks
There are no new risks added to the risk register this month although it was noted that Risk 6971, endoscopy is being revised to include issues identified in risk 6857 currently on the Surgery and Anaesthetics divisional risk register regarding loss of accreditation for endoscopy units following discussion at the Risk and Compliance Group on 21 November 2017. This will be shared in the December high level risk register report.

Closed risks
There were no closed risks during the month.

Discussion took place regarding the impact of loss of JAG accreditation, bowel screening income, together with the fact that issues appeared to be stagnant on the register. It was agreed to review the contents of the register outside the meeting, to review whether further narrative was required and this would be fed back to the Board.

ACTION: Director of Nursing/Company Secretary and ARC Chair

It was noted that compliance with mandatory training was good although this was challenging and the Divisions had plans in place to deliver 98% by the end of March 2018 via the appraisal system. A message had been sent to managers to roster time for this to be completed, although the pressures on staff were noted.

Due to the volume of issues on the agenda the Risk Appetite discussions had been deferred to a future meeting.

OUTCOME: The Board APPROVED the High Level Risk Register

191/17 GOVERNANCE REPORT

The Company Secretary presented the Governance Report which brought together a number of governance items for review and approval by the Board:

a. Board Workplan
The Board work plan had 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.
OUTCOME: The Board APPROVED the work plan with no further amendments.

b. Board Skills/Competencies
The Board of Directors were asked to undertake a self-assessment of their skills and competencies as part of an annual review. A copy of the form to be completed was attached with the papers. It was noted that this would be used to help identify any required development and also the assessment of what skills are required when

n to future board vacancies. A composite of the assessment brought back to the Board in March.

OUTCOME: The Board Members present AGREED to complete their assessment in order that a composite assessment can be brought back to the 1 March 2018 Board of Directors Meeting.

ACTION: ALL AND BOD AGENDA ITEM 1.3.18

c. Use of Trust Seal

The Board noted that two documents had been sealed since the last report to the Board. These were in relation to:

- Deeds of Variation for St Luke's, Section 73, Planning Application and
- Elmdale and Ashdale anti-ligature shower installation.

OUTCOME: The Board NOTED the use of the Trust Seal.

192/17 SAFEGUARDING UPDATE – ADULTS AND CHILDREN

The Executive Director of Nursing presented the Safeguarding Update for Adults and Children.

The update provided information from April 2017 to September 2017. The report provided an overview of activity and outlined key achievements and developments on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009), Safeguarding Training Compliance, Mandatory Children's Safeguarding Supervision requirements and actions; recent CQC inspections and any potential inspections, and the Children Looked After Service Specification update.

The report provided an update since the introduction of the new EPR and how this has impacted upon the safeguarding agenda.

The report also outlined innovative developments and further plans and arrangements for safeguarding adults and children.

Discussion took place regarding the increase in reporting which was felt to be due to a consequence of impact on the social fabric and demographic rises. It was agreed that this was challenging for the Safeguarding Team but that safeguarding issues were the responsibility of all and training of colleagues was important rather than relying solely on the safeguarding team.

OUTCOME: The Board APPROVED the Safeguarding Update – Adults and Children.

193/17 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the key points of operational performance for October 2017. 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:-

- October's Performance Score had fallen to 59% for the Trust.
- The SAFE domain was now RED due to a reported Never Event.
- The EFFECTIVE domain had maintained its GREEN rating.
- The RESPONSIVE domain had maintained AMBER, although the cancer 62 day GP referral to treatment target had not been achieved..
- FINANCE remained RED with variance from plan moving to Red in-month.
- WORKFORCE had deteriorated to RED due to higher short-term sickness absence.

It was agreed that a narrative would be included within the report to outline the areas of change and their impact over the last 6 months.

ACTION: Chief Operating Officer

OUTCOME: The Board RECEIVED the Integrated Board Report and NOTED the key

194/17 MONTH 7 – 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance presented the Month 7 Financial Narrative which had been submitted to NHS Improvement and had been discussed in detail at the last Finance and Performance Committee.

The Month 7 position is a deficit of £20.50m on a control total basis, a £2.48m adverse variance from the planned deficit of £18.02m. This excludes year to date Sustainability and Transformation funding (STF) of £2.70m.

The final planning submission made to NHSI on 30 March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had a number of concerns regarding the scale of this challenge. . For 2017/18, the impact associated with the 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 initially assessed at £8m plus any subsequent loss of STF funding.

As at Month 7 these concerns have increased as the underlying financial position has continued to deteriorate. The underlying operational performance would drive an adverse financial variance of £11.7m to the year to date planned position and in the first 6 months of the year the planned position was only achieved through a number of non-recurrent income and expenditure benefits totalling £7.2mThis is in addition to the release in the year to date of the full £2m contingency reserve available for this financial year. In Month 7 the Trust is unable to report delivery of the financial plan due to a further adverse variance from plan in month of £2.5m. 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 income variance of almost £7m year to date.

There remains a very high risk that the Trust will not be able to achieve the 17/18 control total due to a combination of factors including: slower than expected recovery of clinical activity levels and therefore income following EPR implementation; reduced operational capacity whilst resolving implementation issues; income values being lower than planned for the actual activity delivered and assumed within the HRG4+ test grouper: and remaining unidentified CIP of £3m. 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. A recovery action plan has been implemented which aims to tackle: the recovery of clinical income at risk due to issues with capture and coding in EPR; the development of Divisional financial recovery plans; a Trust wide establishment review and further tightening of budgetary controls. In addition, an EPR stabilisation plan has been put into action to regain activity performance levels to the maximum achievable. This in itself drives additional cost requirements. Every effort will be made to deliver the financial plan, including pursuing innovative technical accounting benefits, but in this context full recovery may not be possible.

Delivery of the financial plan remains the highest risk on the Trust risk register scoring the maximum of 25. The Board noted the Financial recovery plans being implemented which were detailed within the report

It was agreed that the Board needed to be more sighted on a timeline when the EPR and activity levels would return to expected levels and this would be discussed in detail at the next Finance and Performance Committee.

ACTION: F&P COMMITTEE AGENDA

OUTCOME: The Board NOTED the contents of the report.

195/17 SINGLE OVERSIGHT FRAMEWORK

Following submission of a paper to the Board and Finance and Performance Committee in September 2016, the paper updated the Board on the confirmed changes to the Single Oversight Framework (SOF).

The first version of the SOF was published in September 2016. The high level purpose of developing the SOF was:

- One consistent approach to overseeing NHS Trusts and NHS Foundation Trusts
- The provider licence is the basis for NHS Improvement's oversight
- The SOF treats NHS Trusts and Foundation Trusts in similar positions similarly
- SOF replaces Monitor's Risk Assessment Framework and TDA's Accountability Framework
- The SOF does not apply to independent providers.

In summary the SOF aimed to provide an integrated approach for NHS Improvement (NHSI) to oversee both foundation trusts and NHS trusts, and identify the support they need to deliver high quality, sustainable healthcare services. It aims to help providers attain and maintain CQC ratings of 'good' or 'outstanding'.

Following consultation, NHSI had amended the SOF and the Board noted the changes and clarifications made.

It was noted that the Integrated Performance Report will incorporate the updated SOF reporting requirements going forward. More information is available at NHS Improvement Single Oversight Framework

OUTCOME: The Board noted the changes to the Single Oversight Framework

196/17 SAFE STAFFING BI-ANNUAL REPORT (HARD TRUTHS REQUIREMENT)

The Executive Director of Nursing presented the Safe Staffing Bi-Annual Report. It was noted that the National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England had continued to issue guidance from November 2013 onwards, building upon the ten key recommendations made to optimise nursing, midwifery and care staffing capacity and capability. The aim of the report was to give assurance to the Board of Directors that robust mechanisms were in place to set and monitor nursing and midwifery staffing levels. It was noted that work was underway to meet the expectations set out in the NQB national recommendations.

The Chairman set a challenge to the organisation to consider undertaking a similar report to include other disciplines and if possible expand this to include Estates and Facilities staff in each ward area.

OUTCOME: The Board NOTED the contents of the Safe Staffing Bi-Annual Report.

197/17 UPDATE FROM SUBCOMMITTEES 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 items discussed at the meeting held on 4 December 2017 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- Performance Report
- Reports from Divisions:
  Medicine - Ward moves, Stroke metrics, Assessment clinic in A/E
  Surgery: Fractured Neck of Femur work
- Community – new lymphodemia clinic tender won in Harrogate.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 30 October 2017 and the verbal update of the meeting held on 4 December 2017.

b. Finance and Performance Committee

Richard Hopkin, on behalf of Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 28 November 2017 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- Month 7 position discussed in detail
- Presentation on local system recovery plan and actions to address
- Presentation on elective care improvement board – workstreams
- Benchmarking on community – information being evaluated
- EPR – stabilization plans and benefits to deliver

OUTCOME: The Board RECEIVED the minutes from the meeting held on 31 October 2017 and verbal update from 28 November 2017 meeting.

c. Audit and Risk Committee

Richard Hopkin, Chair of the Audit and Risk Committee presented the minutes from the Audit and Risk Committee Meeting held on the 18 October 2017 which had been discussed at the last meeting**.**

OUTCOME: The Board RECEIVED the minutes from the meeting held on 18 October 2017.

d. Workforce Well-Led Committee

Karen Heaton, Chair of the Workforce Well-Led Committee presented the minutes from the meeting held on the 9 November 2017. The key items discussed at the meeting included:

- **Staff Survey**
- **Appraisal Update**

The Chief Executive advised that a piece of work was underway and a snapshot of staff experiences around Appraisals would be brought to the February BOD meeting

ACTION: BOD AGENDA – FEBRUARY 2018

OUTCOME: The Board RECEIVED the minutes from the meeting held on the 9 November 2017.

DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 4 January 2018 commencing at 9.00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair closed the public meeting to commence the meeting of the Trustees of the Calderdale and Huddersfield NHS Foundation Trust Charitable Trust Funds.

Calderdale and Huddersfield NHS Foundation Trust

MINUTES OF THE MEETING OF THE TRUSTEES OF THE CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE TRUST FUNDS

Thursday 7 December 2017

1. Apologies
Apologies were received from Phil Oldfield, Gary Boothby and David Birkenhead

2. Declaration of Interests
There were no declarations of interest.

3. Letter of Representation
All present approved the letter of representation.

4. Report and Accounts 2016/17
Those present at the meeting approved the Annual Report and Accounts for 2016/17 and agreed that these should now be registered with the Charities Commission.

5. Minutes of the meeting held on 20 November 2017
The minutes of the meeting held on 20 November 2017 were received and approved.

5. Action Log and Matters Arising

For Review

Presented by Andrew Haigh

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 4th January 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 January 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 January 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 January 2018

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 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
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		Jan 2018		
7.12.17 186/17	**CHAIRMAN'S REPORT** The slides from NHS Providers would be shared with the Board	AH		Jan 2018		
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		March 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		March 2018		
7.12.17 190/17	**HIGH LEVEL RISK REGISTER** The narrative for the risk register will be reviewed to ensure issues are not stagnant and are properly explained	BB / VP		Feb 2018		
7.12.17 191/17	**GOVERNANCE REPORT** All Board members to complete their self-assessment and return to the Board Secretary	ALL		Jan 2018		
7.12.17 193/17	**INTEGRATED PERFORMANCE REPORT** It was agreed that a narrative would be included within the report to outline the areas of change and their impact over the last 6 months.	HB		Feb 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
7.12.17 194/17	**MONTHLY FINANCIAL NARRATIVE** It was agreed that the Board needed to be more sighted on a timeline when the EPR and activity levels would return to expected levels and this would be discussed in detail at the next Finance and Performance Committee.	MG / HB		Jan 2018		
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 the February BOD meeting	JE		Feb 2018		
165/16 3.11.16	**BOARD ASSURANCE FRAMEWORK** It was agreed to bring the Board Assurance Framework to the Board in February and for the Company Secretary to review other organisations' BAFs to assess the types of risks included	VP	**2.11.17** Updated BAF received. MD-Digital Health and Co-Sec undertaking work around identifying IMT dependency/resilience and this would be included when the BAF was next updated in February 2018. **7.12.17** It was agreed that the next update would be brought to the February 2018 Meeting.	Feb 2018		
1.6.17 87/17	**HOSPITAL PHARMACY SPECIALS (HPS) ANNUAL REPORT** The Annual Report was received and production development noted. The DoF reported that in order for the service to	GB		Early in New Year 2018		

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
	undertake large scale products, significant investment was required and a Business Strategy would be brought to the Board later in the summer.					
7.9.17 141/17	**HIGH LEVEL RISK REGISTER** The Executive Director of Nursing reported that work was on going to broaden the number of investigators available to undertake SI investigations. It was agreed that a deep-dive report would be brought to the December 2017 BOD Meeting.	BB/JC				7.12.17
5.10.17 162/17	**IPR – GREEN X PATIENTS** The Board agreed that the IPR did not accurately record the number of Green X Patients to reflect the improvement journey. The Chief Operating Officer agreed to review this at the December 2017 Board Meeting.	HB	**7.12.17** **It was noted that this item would be reported in more detail within the Feb 2018 meeting report.**	Feb 2018		
5.10.17 162/17	**IPR – SAFER PATIENT PROGRAMME** Arrangements had been made for 'Discharge Lounge' to be included on the Council of Governors agenda in October. It was noted that the Safer Patient Programme would be brought to the Board in January 2018.	HB		4.1.18		

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
2.11.17 147/17a.	**ESTATES – CAP FUNDING REDUCTION** Exec Director Planning, E&F agreed to discuss with Exec DoF the balancing of works and a paper would be brought to a future meeting.	LH/GB		TBC		
2.11.17 177/17	**IPR – FRACTURED NECK OF FEMUR** Concern was expressed that FNOF remained an issue. Although it was noted that this had not caused harm to any patient the Board asked for the reasons for the breach. It was agreed that something would be brought back to the next meeting.	DB	**7.12.17 – Update received.**			7.12.17
5.10.17 160/17	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRRR) & CORE STANDARDS ANNUAL SUBMISSION** The Board requested that further work be undertaken on the submission to ensure an audit trail before submission to the Yorkshire and Humber Local Health Resilience Partnership.	LH	**2.11.17** It was noted that amendments had been made to the submission and it was agreed that this would be circulated to the Board. **7.12.17** It was noted that amendments had been circulated to the Board outside the meeting.			7.12.17
2.11.17 174/17	**BOARD ASSURANCE FRAMEWORK –** Richard Hopkin noted that the cash flow risk should be removed as it had been downgraded. It was also noted that the two new risks required amending.	VP				7.12.17

6. Chairman's Report

To Note

Presented by Andrew Haigh

7. Chief Executive's Report

To Note

Presented by Owen Williams

8. High Level Risk Register

To Approve

Presented by Brendan Brown

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, 4th January 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 22 December 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Group 19 December 2017	
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 is 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.

The Issue:

The attached paper includes:

i. This report routinely identifies 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 22 December 2017.

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

iii. There are no new risks added to the high level risk register during December 2017.

Next Steps:

Work is continuing to capture and confirm risks relating to the Electronic Patient Record (EPR) through the EPR Risk Panel, Divisional Digital Boards and the Risk and Compliance Group. EPR related risks with a score of 15+ will be reviewed at the Risk and Compliance Group meeting on 15th January 2018, with any risks agreed as high level risks reported to the Board of Directors at the meeting of 1st February 2018.

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:

High Level Risk Register 22 12 17.pdf

HIGH LEVEL RISK REGISTER SUMMARY OF CHANGES

Risks as at 22nd December 2017

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 7062 (20): Capital programme 6903 (20): Estates/ ICU risk, HRI 7049 (20): EPR financial risk 5806 (20): Urgent estates schemes not undertaken 2827 (20): Over-reliance on locum middle grade doctors in A&E 6345 (20): Nurse staffing risk 7078 (20): Medical staffing risk 6658 (20): Patient flow 6441 (20): Divisional income Surgery and Anaesthetics The Trust risk appetite is included below.
RISKS WITH INCREASED SCORE
None
RISKS WITH REDUCED SCORE
None
NEW RISKS
None
CLOSED RISKS
None

DECEMBER 2017 – BOARD - SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 22.12.17

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
Safety and Quality Risks										
007	4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=16	=16	=16	=16	=16	=16
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	=15	=15	=15	↑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 (JE)	=16	=16	=16	=16	=16	=16
014	6977	Keeping the base safe	Mandatory training 2017/18	Director of Workforce and OD (JE)	=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
007	6971	Keeping the base safe	Endoscopy provision	Associate Director of Nursing, Surgery and Anaesthetics (JM)	=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
007	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)		!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

Finance Risks										
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
022	7062	Financial sustainability	Capital programme 2018/19	Director of Finance (GB)			!20	=20	=20	=20
021	6441	2017/18 income	Divisional income surgery and anaesthetics	Associate Director of Nursing, Surgery and Anaesthetics (JM)			!16	↑20	=20	=20
Performance and Regulation Risks										
007	6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (BB)	=16	=16	↑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
People Risks										
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 and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce	=20	=20	=20	=20	=20	=20

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

TRUST RISK PROFILE AS AT 22/12/2017

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	= 6345 Nurse Staffing = 7049 Financial risk arising from EPR = 6658 Inefficient patient flow = 7078 Medical Staffing	= 6967 Not delivering 2017/18 financial plan
Likely (4)				= 4783 Outlier on mortality levels = 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	= 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)					= 6829 Pharmacy Aseptic Unit = 6924 Misplaced naso gastric tube = 6971 Endoscopy provision = 6011 Blood transfusion process = 5747 Vascular /interventional radiology service
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 scoring 15+

Risk No	Div	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6967 (Board Assurance Framework 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 leaves the Trust with a planning gap of £3m that has been added to the £17m CIP target. At 5.3% efficiency is proving to be extremely challenging to deliver. The organisation currently has plans for £18.17m of the £20m CIP target, but £4m of this forecast saving is currently considered at a high risk. The year to date position has continued to deteriorate, with activity and income well below the planned level. EPR implementation has had a significant impact on the capture and coding of activity. It is very likely that the reduced activity and changes to case mix seen year to date will persist into future months. The corresponding underlying expenditure is above plan and in Month 8 the Trust reported a position that is £3.79m 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. Achieving the full year 17/18 Control Total currently relies on identifying additional recovery plans of the magnitude of £11m in the final five months of the year. £2.4m of recovery plans have currently been identified. Failure to achieve the Control Total in future months would also result in the loss of a further £6.57m of Sustainability & Transformation funding.	Jan-2018	Mar-2018	FPC	Gary Boothby	Philippa Russell

6903 (BAF ref 011)	Estates & Facilities	Dec-2015	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 [illegible] to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.This includes: 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	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. October 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. Resus has completed a small refresh i.e. removal of X-Ray equipment. November 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Estates have re-developed the old plaster room into a Rapid Assessment Area.	Jan-2018	Dec-2018	RC	Lesley [illegible] / David McGarrigan	Chris Do es
7049 (BAF risk 021 & 022)	Trustwide	Aug-2017	Financial 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 **December Update** Weekly data quality meeting reviews data capture and system issues with Divisional, Finance and THIS representation - ongoing. Divisional financial recovery plans to address activity maximisation. Negotiations with commissioners have concluded to secure estimated income which had been at risk in Months 1-6. Additional costs incurred being monitored with approvals to be taken through Commercial Investment Strategy Group and monthly financial monitoring. Discussions taking place with regulators, NHSI with regards to the exceptional financial pressure incurred as a result of EPR implementation in-year and the potential impact on achievement of control total.	Jan-2018	Mar-2018	FC	Gary Boothby	Kirsty Archer

7062 (BAF ref 022)	Trustwide	Sep-2017	Finance 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	2018/19 Capital plan to be finalised, with detailed risk assessment by scheme. Any shortfall in Capital funding to be confirmed and risk rated.	Jan-2018	Jun-2018	FPC	Gary Bi[illegible]by	Philippa Russell

7078 (BAF ref 012)	Corpo	Oct-20	Keepi the base safe	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	**December 2017** We are now starting to receive the names of the next cohort of trainee doctors that will commence work with us in February 2018. Work schedules are being prepared in accordance with the 2016 Junior Doctor Contract requirements, and pre-employment checks are being undertaken. The Guardian of Safe Working will be chairing the Junior Doctors Forum in the first week of December 2017. This is an opportunity for doctors in training to discuss any issues and to determine where the monies from any fines that have been issued as a result of exceptions can be spent for the benefit of doctors in training. The Trust wide BMJ advert for consultant posts was published Saturday 7 October. This was a full page colour advert promoting opportunities within the Surgical and Medical Divisions. A consultant Stroke Physician has been appointed who is expected to start in post in April 2018. There are also interviews arranged for a Consutlant Anaesthetist and a Respiratory Physician. On Monday 27th November a CESR event was organised for our current SAS doctors. Speakers came from Derby Teaching Hospitals and Airedale NHS Foundation Trust. There were also speakers from within CHFT who shared their own personal experience of gaining specialist registration through the CESR process. There is a possibility that CHFT will become a National Pilot site for Health Education England as we are trying to roll out CESR posts across a number of specialties.. The rolling programme of recruitment and retention meetings focusing on medical and dental staff continues and has proved a useful method to ensure that all opportunities to fill vacancies have been explored . The meetings are chaired by the Deputy Medical Director and are intended to support Divisional colleagues to review vacancies and the costs associated with them, such as agency costs, bank costs and waiting list initiatives.	Jan-2018	Jan-2018	WF	David E enhead	Pauline rth

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 risk 4783 should 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	**December 2017** Some improvement in fill rates for Christmas week, but likely requirement for on-call Consultant cover overnight. Nov 2017 CESR applications being progressed. 2 MTI doctors recruited.. applications being progressed. Currently aware of significant shortfalls in night provision for Christmas week. Alternative strategies being explored Oct 2017 2 doctors appointed to CESR post, Recruitment in process.6 ACPs in post at varying stages of training	Jan-2018	Aug-2018	WEB	David E enhead	Dr Mari avies/Mrs Caroline Smith
6345 (BAF ref 012)	Corporate	Jul-2015	Keeping 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	**December 2017** Applicants from International recruitment trip to the Philippines are progressing. 119 offers were made in country, since March 2017; 10 candidates have withdrawn, 101 are completing their training for the International English Language Test System (IELTS) including 16 with their IELTS exam booked before the end of December. The Trust is also looking into the Occupation English Test (OET) following the announcement from the NMC that the OET will be accepted as an alternative to IELTS. 57 applicants would meet the criteria to move over from IELTS however there is a cost associated with training and an additional cost for the exam. The OET process has a turnaround of 4 - 6 weeks for students currently averaging 6 in their IELTS so there is potential these applicants could be in post by April 2018. In addition to those in training we have 8 candidates who have passed their IELTS and are progressing with their NMC application, 3 of which has been successful with their NMC application started with the Trust on 4 December 2017. The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has continued following the success of applications received in October. The current adverts are due to close 22 December. A further Physician Associates (PAs) vacancy for 2 additional PAs in Medicine is currently being advertised. The post will close on 6 December 2017 with interviews planned for early January 2018.	Jan-2018	Jan-2018	WF	Brendan Brown, Jason Eddleston	Rachael Pierce

6441 (CR-F ref 021)	Surgery & Anaesthetics	May-27	Financial 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	**December 2017 update** Risk score remains at 20. The underlying forecast remains in the region of £9m adverse to plan. Although improvements to expenditure and activity, income are forecast for the last quarter these are being off set with risks associated with the CRH theatre refurbishment and high risk CIP schemes. Change control notices are being developed in relation to the CIP schemes with a stop moment planned for the CRH theatre refurbishment plan as discussed at the Surgery PRM 4.12.17. November 2017 update Risk score remains at 20 with Division forecast remaining as per month 5 re forecast. Weekly Theatre scheduling meeting has been reviewed and agenda and approach amended to incorporate additional KPI's in order to drive out the in efficiencies. Month 7 reported financial position is inline with reforecast plan. October 2017 Update Detailed work reviewing year end forecast position led to re-assessment of risk score with impact score increased from 4 to 5 using 5x5 risk matrix. Increased risk score of 20 agreed at SAS divisional board meeting on 23.10.17.	Jan-2018	Mar-2018	DB	Jo Midd on	Joanne urdcastle

6658 (CRR ref 007)	Corpo	Mar-2(	Keepir 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	**December 2017** Winter Plan in place and being implemented, within the plan are specific actions to reduce 'exit block' and improve flow. Internal Silver Tactical Command in Place Winter monies available to support increased medical staff, weekend discharges and tracking clinical pathways. November 2017 Work initiated to meet the discharge CQUIN will have a positive impact on this risk by reducing the LOS for complex patients, improve clinical pathway management. Implementation of the SAFER Bundle across the clinical divisions starts this month. October 2017 Delay in the additional cubicle space being created - should be in place by November Introduction of Urgent Care Action Cards- to aid good flow, prevent exit block- work on-going with the divisions to embed. Discharge Improvement week took place in September. Introduction of a whole system partner working group to improve transfer of care (medically fit patients waiting for discharge)	Jan-2018	Jan-2018	BOD	COO H n Barker	Bev We r

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	**December 17 Update** Current Mechanical and Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. The Capital Plan continues to progress on track which includes covering all statutory compliance i.e. Fire Safety, Water Safety, Ventilation, Structural Safety etc. The plan for 18/19 is now at the final stages of planning. November 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Estates have re-developed the old plaster room into a Rapid Assessment Area. October Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. The Capital Plan continues to progress on track.	Jan-2018	Mar-2018	RC	Lesley / David McGarrigan	Paul Gi / Chris Davies
5862 (BAF ref 007)	Medical	Aug-2013	Keeping the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. 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. Staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12 4 x 3	16 4 x 4	9 3 x 3	**December update** Results of National Audit of Inpatient Falls audit report 2017is now available,with CHFT practice below 50% compliance in the target interventions of visual screening, lying and standing blood pressure, access to mobility aids and medication review. These will influence further improvement work through the Collaborative work. Falls incidents increased in total for Nov -155 with an increase noted in OPD and CHFT community areas in month.One harm fall in month. October update Work continues as per plan, continued input from clinical leaders and engagement with clinical teams. November update Work continues as plan however further engagement is required for implementing consistently safety huddles on clinical areas . Falls incidents are reducing in numbers in the last 2 months (N=137). ESR falls prevention now available as mandatory clinical training.	Jan-2018	Jan-2018	PSQB	Brendan Brown	Janette Cockroft

6300 (CR-F ref 007)	Trustwide	May-25	Keepin 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 yet have the Insight Report from the CQC which details the data that they hold regarding our services. 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	**December 2017:** Formal notification of Well Led Inspection received and data for Provider Information Request provided as required. A number of KLOE's have been identified as a result and plans are being developed to respond to these. Clear evidence of progress since the last inspection is also evident. A Trust Board workshop to be held in December to brief the Board on next steps. November 2017: Trust wide CQC group reviewing responses from the self assessments commenced with well led domain, next will be safe domain. Populating plan with issues identified. Trust wide Regional Leadership Event delivered by Ted Baker, Chief Inspector of Hospitals October 2017: Meetings re-established for the Trust-wide CQC group with an initial focus on reviewing outputs from the mock well led PIR and core service self-assessments. Plan being established for key lines of enquiries (KLOEs) identified.	Jan-2018	Apr-2018	WEB	Brenda rown	Juliette sgrove

6596 (CR-F ref 007)	Corpo	Jan-2(	Keepir	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	**December 2017** Quality deep dive on serious incidents presented to Board meeting 7 December 2017. Need to identify and train 25 medical staff investigators shared with Deputy / Associate Medical Directors to progress. November 2017 Continued focus on meeting with appointed investigators to support completion of report and / or timely investigation and scheduling within divisional panels prior to SI panel. October 2017 Significant assurance from internal auditors confirming a good system is in place for learning lessons from incidents. Continued focus on improving quality of serious incident reports.	Jan-18	Mar-18	QC	Directo Nursing, Brendan Brown	Juliette sgrove

6598 (DF ref 014)	Corpo	Jan-2(	Keepi	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 historically inconsistent and patchy. 2/ Target audiences setting to allow compliance monitoring across all but 1 essential skill was completed in December. 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/ Now all clinical staff have been issued a bank contract there are some discrepancies with competencies assigned to bank position but not their substantive post. These are small in number. 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 reported. 7/ Some maternity specific subjects were set as essential in the early stages	16 4 x 4	16 4 x 4	12 4 x 3	**December 2017** As all but 1 of the essential skills now has a target audience set and are live in ESR, the description of this risk has been changed. The risk is no longer that we are unable to compliance report against the essential skills, instead it is that we are at risk of reporting low levels of compliance. The details have therefore been amended to reflect this change. A communications strategy has now been agreed and applied to the latest essential skill to go live - IV therapies. The remaining outstanding essential skill not yet set is Food Hygiene level 1. Issues with the e-learning assessment allowing a pass with 0 correct answers and a late change to the target audience have created delays. This is linked to a recent SI for which there is a datix action of training to be rolled out by March 2018. We are on schedule to achieve this. A plan is in place to engage SMEs and HR BPs to help drive up compliance across the range of essential skills with progress reviewed on a fortnightly basis in the short term. BI colleagues will support the necessary reporting process. All essential skills compliance rates have now been RAG rated and targets set for improvements in compliance for each. November 2017 Target audiences set for falls, food hygiene level 2 and NGT placement. Athena training removed from the maternity essential skills list. Data captured in line with EPR training data. A plan is being developed to work collaboratively with subject matter experts and HR BPs to drive up compliance across the suite of essential skills. October 2017 Safeguarding Level 3 inc. MCA/DoLs package is uploaded and live on the system. The target audiences for the few remaining essential skills are being set. Following this, managers will be targeted by email to request compliance information for their team members and to confirm dates for planned activity.	Jan-2018	Mar-2018	WF	Jason E leston	Ruth M n

4783 (BAF ref 007)	Corpo	Aug-2 1	Transf ning and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risk 2827 should be read in conjunction with this ris and the BAF risk on transformation..	3 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine, Stroke and Complex Medicine which will give guidance on areas of further improvement. Action plans for these areas being developed based on preliminary report findings. Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised 2016 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Improvement to standardised clinical care not yet consistent. Care bundles not reliably commenced and completed	20 4 x 5	16 4 x 4	12 4 x 3	**December 2017 update** HSMR and SHMI both remain in the expected range. No current alerts. The SJR are now being completed in a more timely manner but still catching up on an accumulated backlog with a plan to have these completed in a two week timeframe by January. Initial screening reviews (ISR) compliance remains around 25% with a plan to allocate to all consultant from December. November 2017 update Initial screening compliance is improving with 24% of September deaths reviewed. All SJR allocated for September deaths and training for the new reviewers almost complete. No current alerts October 2017 update HSMR and SHMI remain in the expected range with no current alerts. 8 consultants appointed (covering 4 PAs) to perform SJR. Training is being arranged for these reviewers and it is envisaged that it will take a couple of months to address the backlog of outstanding SJR. Initial screening reviews are now being allocated weekly but performance still remains low. Plans to move to consultant led reviews is on-going.	Jan-18	Jan-18	COB	David E enhead	Juliette sgrove

6977 (BAF ref 014)	Corpo a	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 [illegible] 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. A pay progression policy approach including mandatory training compliance is now in place.	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	**December 17** The upload of the training by Junior Doctors is complete and they are now compliant in 3 out of the 5 key focus areas. For the remaining 2, a guide is in development to assist this section of staff. HRBP's and other key stakeholders are meeting on the 5 December to establish a plan to address non-compliance November 17 A 'deep dive' into the reasons for non-compliance is being undertaken by the mandatory training lead. Areas of high levels of non-compliance are being contacted to discover what the reasons are and to offer support in achieving compliance. This is an on-going action as colleagues can drop out of compliance for any of the 5 key subjects at any point in the year, this is dependent on when their previous learning expires. October 17 Mandatory training completed by Junior Doctors at induction to CHFT had not been recognised and therefore left unrecorded. This indicates low compliance from this staff group. This will be rectified December 17.	Jan-18	Mar-2018	WF	Jason E leston	Ruth M n
6990 (BAF ref 007)	Corporate	Jun-2017	Transforming and improving patient care	CQUIN target at risk of not being met for 2017/18 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 November update In-depth analysis of sepsis prompts being undertaken to prepare guidance for staff. Policy review underway Focussed work with ED teams to take place over the coming weeks October update Training for Health Care Assistants in recording clinical observations taking place Performance reports to clinical teams	Jan-2018	Mar-2018	SC	David Birkenhead	Juliette Cosgrove

7046 (DMF 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 BTHFT readiness 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	16	0 0 x 0	**December Update** Cerner are visiting the Trust to understand and assist to resolve issues on the 5th and 6th December Some SOPs have been updated and will be shared with the Ops Group early December Each specialty to meet with EPR Team and a Director to ensure all concerns identified and plans agreed. Quality Directorate to attend each Digitial Modernisation Board for assurance of appropriate escalation and mitigations. BAU team capacity and operational capability being reviewed. Change Board TORs reviewed to ensure operational/clinical led prioritisation. Further formal escalation to EPR partner regarding speed of resolution. Introduce thematic review of incidents, complaints, PALS etc. Submit change requests for system build. Formal review of roles and development of these on EPR to refine access rights. Identify training needs. Work with clinical leads to develop information and support tools. **November Update** EPR risk panel reviewing risks derived from EPR clinical hazards log. October Update Migrated appointment data issues mostly resolved Access / Roles – current work on cleaning up access / roles – majority have access to perform job but often excess or dual roles Electronic Discharge Summary process tracked on a daily basis with improving performance BTHFT now live and EPR Back Office team now able to focus on stabilisation activities 45 days	Jan-18	Mar-2018	QC	David Benhead	Alistair Harris

7047 (BAF ref 009)	Trustwide	Aug-2017	Keeping 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	16	0 0 x 0	**December Update** 3 of 4 scope types contained in DM01 data validation complete and external return for November will be made. Regular data quality reports and performance reports now issued weekly to service for these areas. Cystoscopy validation now underway in earnest and first draft position expected end of December in hope that fully validated will be ready end of January 2018. Key reporting issues impacting on Trust iIncome and patient safety worked through with Cerner at two day session w/c - 4/12/17. Action Plan anticipated. Access to diagnostic CDS expected for the first time from w/c 11/12/17 – will help with recovering income for Cystoscopy and other di+O1+9agnostic activity income. November Update Cymbio expertise reintroduced. Data Quality Board Terms of Reference completed Data Quality Structure completed October RTT return saw “Admitted completed” sent for first time since April submission. Incomplete RTT has been returned every month since go live. Non Admitted completed for the last 3 months. Monthly Activity Return (MAR) was sent in full for first time since April submission as a result of process to remove A&E Clinical Decision Unit chair only (results and awaiting transport) admissions continues to be issued. Quarterly Activity Return was issued for Quarter 2 17/18 after not issuing a Quarter 1 statement. Diagnostic Monthly Return (DM01) – still not reported waits or activity for Endoscopy diagnostic procedures. Validation processes fell just short of required quality for October to be returned. Much progress	Jan-18	Mar-2018	QC	Helen E ker	Division Directors
6924 (BAF ref 007)	Corporate	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	15	8 4 x 2	No December update November 2017 Update Training package sourced by essential skills team from Preston and is currently being reviewed to ensure content suitable for target audience. When this has been done Dr Uka will work through Comms plan and THIS will lease with Preston team to transfer onto CHFT e learning. Package is aimed at any staff member who is responsible for initial placement check through interpretation of Xray. Support from radiology to identify target audience has been sourced. Class room sessions continue for nursing staff. Uptake remains variable as not mandatory however Comms plan has been rolled out regarding ‘ No training , No touching ‘ in terms of access of NG tubes. High use areas all have a key trainer identified who is responsible for ensuring that nursing staff are trained as per NPSA guidelines. 2 further areas have been identified as increased use since original areas were identified – these are ward 10 and 15. Nursing staff booking onto training however areas have been asked to identify key trainers. October Update Meetings re-established for the Trust-wide CQC group with an initial focus on reviewing outputs from the mock well led PIR and core service self-assessments. Plan being established for key lines of enquiries (KLOEs) identified.	Jan-18	Dec-17	QC	Brendan Brown,	Jo Middleton

6971 (CRF ref 007)	Surgery & Anaesthetics	Apr-20	Keeping the base safe	Business continuity risk relating to reduced endoscopy provision / capacity and hysteroscopy capacity (risk 6993) due to increased demand on the Automatic Endoscope Reprocessing (AER's) machines at HRI following fire in endoscopy at CRH and additional workload for AER machines at HRI, which increases the risk of machine failure and potentially fire resulting in further reduction in capacity / service delivery if machines need to be turned off. The risk of a complete equipment failure would result in a seizure of endoscopy services at CHFT due to individual AER failures reducing service delivery and disruption of the service., adversely impacting achievement of access targets, list down time, reputational damage, complaints/litigation associated with poor patient experience/delayed diagnosis, delayed / cancelled procedures may cause distress to patients, extended waiting time in the Endoscopy Department for procedures and additional cost in resource and repairs could result in escalation of costs and further cancellation of procedure. Patient safety risk due to impact of reduced endoscopy provision and an increasing back log of patient's awaiting flexible sigmoidoscopy under the bowel cancer screening programme (BCSP) , diagnostic cystoscopy's, fast track haematuria's and gastro intestinal activity. Due to data quality it is impossible to assess a accurate back log position this is impacting on the ability to outsource patients to identified providers. Loss of JAG accreditation due to not meeting required standards resulting in:- Loss of income from JAG status Loss of bowel scope / bowel screening status Loss of training status JAG accreditation now lost due to 3 deferred	Machines checked and monitored daily by endoscopy technicians whilst in use and all cycles are now conducted under physical supervision. The trust fire officer has ensured that there is adequate fire fighting equipment and decontamination staff are compliant in their use. Increased estates support and improved access to gettinge (HRI) Cantel (CRH) (maintenance contractor) technicians in place for all AER's A full downtime 36 hour period for maintenance schedules to be completed and all relevant tests to ensure all compliance is met. In sourced provider (medinet) is continuing to support service delivery through 2 CRH theatres on Saturdays, meetings with providers with a view to out source patient back log have commenced (Living Care/Yorkshire Clinic) these providers have offered capacity that will clear the back log by November. Continued support through medinet and in house weekend support will enable 3 theatres at CRH to deliver service lists and reduce the current back log. Discussions (meeting 29/09/17) with Living Care for the delivery of BoSs lists that run parallel to in house delivery increasing to a potential 9 lists per week. CRH decontamination now have replacement AER's in place, commissioned and operational For the next 9 weeks we will be running additional hysteroscopy weekend sessions (mixture or consultant and nurse-led sessions) which will start to reduce the waiting list (the first of these is this coming Saturday) Now the women's health unit is up and running we are planning to run additional sessions during the week the limiting factor here is staff to run additional lists but we're working to resolve this.	Data Quality	20 5 x 4	15 5 x 3	4 4 x 1	**December Update** Dedicated developmental Matron appointed start date 02/01/18 to mitigate current leadership issues All un-appointed patients now have a TCI date or received a procedure regaining endoscopy 6 week diagnostic target, fast track position maintained Plan for Jan to deliver services through CRH for planned Update November 2017 Plan in place for unit manager Increased Medinet use will have back log cleared by Dec 17 (plan with Chief Operating Officer). To replace all AER's as part of the endoscopy decontamination replacement scheme, by expediting the scheme the risk will be mitigated. October Update 2017 Refurbishment plan is on track. risk regarding backlog / outsourcing - patients have been identified for repatriation to outsourced provider. Staffing - resignation of Endoscopy Unit Manager Band 7 at CRH. Plan to review staffing structure. patients weekend 13/14th Jan	Jan-2018	Mar-2018	DB	Jo Midd on	Jason Ebby

5747 (BAF ref 007)	Family Specialist Services	Mar-2(3	Keepi 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. 1. Continue to seek long term locum cover; 2. Continue to try to recruit to the vacant post; 3. Progressing a regional approach to attract candidates to work regionally; 4. Progressing approach to further contingency using regional-wide approach.	Jan-2018	Apr-2018	DB	Rob Ait son	Sarah (nton
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 (WBIT) 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	**December 2017** we have accepted delivery of some of the Haemonetics equipment over the past week and is currently being installed, 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) November 2017 Apex upgrade postponed - will not impact on planned go-live of phase 1 of project (April 18). Overall project progressing to timescales. October 2017 Project continues. Apex upgrade has commenced and should conclude early November allowing project to progress to next stage of implementation.	Jan-2018	Mar-2019	PSQB	Julie O'Riordan	Sarah Ramsden

6715 (BAF ref 007)	Corpo	Apr-20	Keepi	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	Establish clinical documentation group **December 2017** Bespoke training is being offered when documentation issues are identified, for example this month the team are concentrating on infection control. Documentation now being audited through the ward assurance tool. Nov 2017 No change to existing controls	Dec-2018	Dec-2018	WEB	Brenda rown	Jackie phy
6829 (BAF ref 007)	Family & Specialist Services	Aug-2016	Keeping the base safe	The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately 50,000 pa ready to administer injectable medicines with short expiry dates for direct patient care. Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service(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	**December 17** discussions ongoin re solution - meeting with HPS Fri 15th Dec to hopefully bring a resolution November 2017 Re-audit 15/11/17 - still high risk with some actions taken to mitigate short term. still pursuing BC and possible use of PMU as an alternative October 2017 The business case was taken to The Commercial Investment and Strategy Committee and was approved in principal with the need to find the best financial solution. The possible use of the PMU as part of the business case is to be considered.	Jan-2018	Jan-2018	DB	Brendan Brown	Fiona Smith

9. Preparation for the General Data Protection Regulations - Presentation from Helen McNae, Information Governance & Registration Authority Manager

To Note

Presented by Mandy Griffin

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Julian Bates, Chief Information Officer
Date: Thursday, 4th January 2018	**Sponsoring Director:** Linda Cordingley, Executive Assistant to Chief Executive
Title and brief summary: General Data Protection Regulation Update - To provide overview of GDPR requirements and position statement as to CHFT progress	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Helen McNae attended the Executive Board on 23 November 2017	
Governance Requirements: Keeping the base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Data Protection Act is to be replaced with General Data Protection Regulations from 25 May 2018. This paper provides an overview of this regulation alongside the preparatory work undertaken by the Trust.

Main Body

Purpose:

To give the Board an overview of the New Regulation that is superseding the Data Protection Act on 25 May 2018. To highlight the work undertaken by the Trust in preparation for the regulation and to provide assurances to the Board of the steps taken and planned to ensure compliance.

Background/Overview:

On 25 May 2016, the General Data Protection Regulation ("GDPR") came into force initiating a 2 year implementation period, with the deadline for compliance being 25 May 2018. The changes which are to be ushered in by the GDPR in 2018 are substantial and ambitious. At over 200 pages long the Regulation is one of the most wide-ranging pieces of legislation passed by the EU in recent years, and concepts to be introduced such as recruiting a Data Protection Officer, data portability, data breach notification, identifying data flows, reviewing contracts, IT systems, procurement processes and privacy by design will take some getting used to. Even its legal medium - a regulation not a directive - makes the GDPR an unusual piece of legislation for data protection experts to analyse.

The Issue:

Understanding and embedding the GDPR throughout the Trust. Non compliance could result in enforcement action by the Information Commissioner's Office, damage to public Trust and reputational damage.

Opportunities include the Trust selling IG Services, including a shared Data Protection Officer role, to other organisations generating income for the Trust.

Next Steps:

Monthly updates to the Executive Board from January 2018.

Recommendations:

The Board is asked to:
Acknowledge and accept the content of the report
Approve the 12 step plan (see appendix 2 in the attached report)
Approve, recruit and appoint a DPO
Agree a governance structure
Receive monthly updates to on the compliance plan

Appendix

Attachment:

General DP Regulation and Brexit Board of Directors.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

General Data Protection Regulations (GDPR)

On the 25th May 2016, the General Data Protection Regulation ("GDPR") came into force initiating a 2 year implementation period, with the deadline for compliance being the **25th May 2018**.

The outcome of the UK's referendum on its membership of the European Union has left many organisations unclear about the future landscape for data protection. Despite Brexit, the UK will need to implement the GDPR in to UK law. This is because the GDPR applies to organisations outside the EU selling goods and services to people in the EU and covers the processing of their personal data. Therefore, this will include any UK company processing personal data about customers in the EU.

The UK Government did not wish to start from scratch in drafting a new data protection law, as it would be unhelpful for organisations working in both the UK and the EU to face slightly differing sets of rules. By far the easiest way to ensure that UK companies achieve compliance with the GDPR, and are able to continue to trade, is to pass equivalent UK legislation. When also considering that the UK Information Commissioner had significant input in to the wording of the GDPR, it was difficult to see how the UK could not implement privacy laws that are at least comparable.

This will include the health sector in its scope (both public and private), as it would be extremely unusual for the stronger protections under the GDPR, not to apply to the very sensitive data used within the health arena.

In any event, the effect will be the same: the material provisions of the GDPR will survive Brexit.

Therefore, it is prudent for CHFT to continue to prepare for and implement the organisational environment that will allow compliance with the GDPR.

Practical steps

The IG Service recommended that CHFT take preparatory steps, so that when an announcement was made about the application of the GDPR in the UK, the Trust was ready to move quickly.

The Key steps to take included:

1. Identifying data flows
2. Reviewing contracts to see which ones would need to be amended
3. Reviewing data sharing protocols to see if they would be effected
4. Making sure IT and procurement teams understand that any new IT systems or software should be GDPR compliant
5. Appoint a data protection officer

1. **Identifying data flows**

Although the Trust currently complete an annual Data Flow Mapping exercise, the GDPR requires this to go further, including auditing the type of data being held, where the data resides, who 'owns' the data, who has access to the data and with whom the data is shared.

Data mapping involves the mapping out of all the organisations' data flows, which is a process of drawing up an extensive inventory of the data to get a comprehensive understanding of where the data flows from, within and to.

By taking this all-important step, CHFT will have better visibility of their data, enabling them to come up with effective ways to protect the information they hold and mitigate privacy-related risks.

2. Reviewing Contracts

CHFT need to 'future-proof' their contracts, by including clauses that will be triggered when GDPR provisions become UK law. There is often a long lead-in time for amending contracts, as negotiations typically take place either when a contract is first entered into, or at the end of its original term, as a precursor to renewal. It would be sensible to start this work now. Other GDPR obligations, e.g. the new rights for data subjects, can be dealt with more quickly and nearer the time when the anticipated legislation comes into force.

3. Reviewing data sharing protocols

One of the key changes in the GDPR is that data processors have direct obligations for the first time. These include an obligation to maintain a written record of processing activities carried out on behalf of each controller.

CHFT must assess and identify the legal basis for carrying out processing and sharing data. This must be documented in data sharing agreements. Under the GDPR, some individuals' rights will be modified depending on the legal basis for processing their personal data. The most obvious example is that people will have a stronger right to have their data deleted, where the Trust uses consent as a legal basis for processing.

CHFT will also have to explain their legal basis for processing personal data in privacy notices and when the Trust responds to subject access requests. The legal bases in the GDPR are broadly the same as those in the Data Protection Act (DPA), so it should be possible to look at the various types of data processing the Trust carries out, to identify the legal basis for doing so. Again, this should be documented in order to comply with the GDPR's 'accountability' requirements.

4. IT systems / procurement/ privacy by design

The GDPR imposes a high duty of care upon data controllers in selecting their personal data processing service providers, which will require procurement processes and request for tender documents to be regularly assessed. Contracts will need to be implemented with service providers, which include a range of information (e.g. the data processed and the duration for processing) and obligations (e.g. assistance where a security breach occurs, pseudonymisation and encryption measures taken and audit assistance obligations). This will also be applicable where a service provider hires a sub-processor.

The GDPR will also apply to the organisation that provides the data processing services to the data controller, meaning that any service provider who works with personal data will need to comply with the rules. The ICO is likely to publish approved service provider contract clauses in the future and it seems likely that, from a service provider's point of view, these will be onerous. The Trusts approach to pricing contracts will therefore need to be reviewed.

4.1 IT Systems/privacy by design - In summary, privacy by design means that each new service or business process that makes use of personal data, must take the protection of such data into consideration. An organisation needs to be able to show that they have adequate security in place and that compliance is monitored. In practice, this means that an IT department must take privacy into account during the whole life cycle of the system or process development. Data Protection will become an integral part of both the technological development, as well as the organisational structure of a new product or service. While the legislation is not incredibly detailed, with regard to which specific steps companies should take on a technical level, it is clear that both principles will need to play a role in current and future developments within the Trust.

5. Data protection officer

Under the GDPR rules, CHFT **must** appoint a data protection officer (DPO), as the Trust is a public authority and should be reporting to someone at senior level, which should be board level management. The Data Protection Officer does not receive any instructions regarding the exercise of those tasks. He or she shall not be dismissed or penalised by the controller or the processor for performing [the] tasks. The Data Protection Officer shall directly report to the highest management level of the controller or the processor.

CHFT may however, appoint a single data protection officer to act for a group of public authorities, taking into account their structure and size.

The DPO's minimum tasks are defined in Article 39 (appendix I), but in summary, the role is to inform and advise the organisation and its employees about their obligations to comply with the GDPR and other data protection laws. The role will also monitor compliance with the GDPR and other data protection laws, including managing internal data protection activities, advising on data protection and privacy impact assessments, training staff, conducting internal audits and to be the first point of contact for supervisory authorities, and for individuals, whose data is processed (employees, patients etc).

CHFT must ensure that the DPO reports to the highest management level in the organisation and ensure that the DPO operates independently and is not dismissed or penalised for performing their duties. The Trust must ensure that adequate resources are provided to enable DPOs to meet their GDPR obligations e.g. training.

CHFT can allocate the role of DPO to an existing employee as long as the professional duties of the employee are compatible with the duties of the DPO and do not lead to a conflict of interest. The GDPR does not specify the precise credentials a data protection officer is expected to have, but it does require that they should have expert level professional experience and knowledge of data protection law. This should be proportionate to the type of processing the organisation carries out, taking into consideration the level of protection the personal data requires.

The data protection officer as standard will perform the following tasks:

- Inform and advise the controller or the processor and the employees who carry out data processing of their obligations pursuant to the General Data Protection Regulation (GDPR)
- Monitor compliance with the GDPR and with the policies of the controller or processor in relation to the protection of personal data, including the assignment of responsibilities, awareness-raising and training of staff involved in processing operations, and related audits

- Provide advice, where requested, regarding the data protection impact assessment (PIAs) and to monitor its performance pursuant to Article 35
- Cooperate with the supervisory authority (ICO)
- Act as the contact point for the supervisory authority on issues related to data processing, including the prior consultation referred to in Article 36, and to consult, where appropriate, on any other matter.
- Be aware of the organisation-specific risks that may arise in relation to personal data and processing issues (including security issues). Depending on the sector, there may also be code of conduct and/or certification issues for the data protection officer to be concerned with. Data protection seals and certification are meant to help organisations demonstrate compliance.
- Have due regard for the risks associated with processing operations, taking into account the nature, scope, context, and purposes of processing.

Shared DPO

CHFT may wish to 'share' a Data Protection Officer as a means to transform and maintain compliance with the GDPR within their organisations. Although there are some differences in how organisations operate, they are facing similar challenges for compliance with the new regulations.

The objectives for the shared service can be summarised, in general order of priority as:

- Reduce overall recruitment costs and demand issues
- Provide a service that can proactively engage with users and has the "critical mass" to develop innovative and novel solutions to support the organisations in delivering services more efficiently
- The DPO broadly can offer the same scope of services to all of their customers
- The organisations face the same financial pressures, although to different degrees, with the continuing stretch of central government funding.

CHFT – Position

12 step action plan formulated covering ICO recommended GDPR readiness measures – **summary in appendix 2**
The action plan has designated 'owner's' of particular actions and these are communicated at the 8 weekly IG Group meetings.
Gant chart included in the action plan showing progress against plan -**see appendix 2**
Updates at 8 weekly CHFT IG and Records Strategy Committee meeting
Information Asset Owner programme underway by the IG Team – **relating to step 2**
Data flow mapping underway by the IG Team– **relating to step 2**
Draft Privacy notice written and ready for review at the January IG Group meeting– **relating to step 3**
Privacy impact assessments in place within the project management office – **relating to step 10**
IG Team being upskilled on GDPR (IG Manager, Assistant Manager and 2 IG Officers are qualified to practitioner level in GDPR) – **relating to step 11**
Awareness raising sessions booked throughout CHFT beginning in January– **relating to step 1**

Representation (January 2018 onwards) at Trust Board reporting progress

Recommendations for the board

- Acknowledge and accept content of report
- Approve 12 step plan. (see appendix 2)
- Approve recruit and appoint a DPO
- Agree governance structure
- Receive monthly updates to Board on compliance plan

Appendix I

Article 37

Designation of the data protection officer

1. The controller and the processor shall designate a data protection officer in any case where:

(a) The processing is carried out by a public authority or body, except for courts acting in their judicial capacity;

(b) the core activities of the controller or the processor consist of processing operations which, by virtue of their nature, their scope and/or their purposes, require regular and systematic monitoring of data subjects on a large scale; or

(c) The core activities of the controller or the processor consist of processing on a large scale of special categories of data pursuant to Article 9 and personal data relating to criminal convictions and offences referred to in Article 10.

2. A group of undertakings may appoint a single data protection officer provided that a data protection officer is easily accessible from each establishment.

3. Where the controller or the processor is a public authority or body, a single data protection officer may be designated for several such authorities or bodies, taking account of their organisational structure and size.

4. In cases other than those referred to in paragraph 1, the controller or processor or associations and other bodies representing categories of controllers or processors may or, where required by Union or Member State law shall, designate a data protection officer. The data protection officer may act for such associations and other bodies representing controllers or processors.

5. The data protection officer shall be designated on the basis of professional qualities and, in particular, expert knowledge of data protection law and practices and the ability to fulfil the tasks referred to in Article 39.

6. The data protection officer may be a staff member of the controller or processor, or fulfil the tasks on the basis of a service contract.

7. The controller or the processor shall publish the contact details of the data protection officer and communicate them to the supervisory authority.

Article 38

Position of the data protection officer

1. The controller and the processor shall ensure that the data protection officer is involved, properly and in a timely manner, in all issues which relate to the protection of personal data.

2. The controller and processor shall support the data protection officer in performing the tasks referred to in Article 39 by providing resources necessary to carry out those tasks and access to personal data and processing operations, and to maintain his or her expert knowledge.

3. The controller and processor shall ensure that the data protection officer does not receive any instructions regarding the exercise of those tasks. He or she shall not be dismissed or penalised by the controller or the processor for performing his tasks. The data protection officer shall directly report to the highest management level of the controller or the processor.

4. Data subjects may contact the data protection officer with regard to all issues related to processing of their personal data and to the exercise of their rights under this Regulation.

5. The data protection officer shall be bound by secrecy or confidentiality concerning the performance of his or her tasks, in accordance with Union or Member State law.

6. The data protection officer may fulfil other tasks and duties. The controller or processor shall ensure that any such tasks and duties do not result in a conflict of interests.

Article 39

Tasks of the data protection officer

1. The data protection officer shall have at least the following tasks:

(a) To inform and advise the controller or the processor and the employees who carry out processing of their obligations pursuant to this Regulation and to other Union or Member State data protection provisions;

(b) to monitor compliance with this Regulation, with other Union or Member State data protection provisions and with the policies of the controller or processor in relation to the protection of personal data, including the assignment of responsibilities, awareness-raising and training of staff involved in processing operations, and the related audits;

(c) To provide advice where requested as regards the data protection impact assessment and monitor its performance pursuant to Article 35;

(d) To cooperate with the supervisory authority (ICO);

(e) To act as the contact point for the supervisory authority on issues relating to processing, including the prior consultation referred to in Article 36, and to consult, where appropriate, with regard to any other matter.

2. The data protection officer shall in the performance of his or her tasks have due regard to the risk associated with processing operations, taking into account the nature, scope, context and purposes of processing.

Calderdale and Huddersfield NHS Foundation Trust

Appendix 2

GDPR Action Plan - August 2017 to December 2018

No.	ACTION	Team Responsible	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	**AWARENESS** - Decision Makers and Key staff within the Trust must be made aware of the GDPR project and responsible "owners" of these actions chosen	SIRO/Trust Board																	
2	**INFORMATION WE HOLD** - Identify data flows, maintain ann internal record of all processing activities and the legal basis for all listed processing (Article 30)	Trust Board/IAO's/IAA's/ DPO																	
3	**FAIR PROCESSING NOTICES** - Complete a new Fair Processing notice following ICO Guidelines with an easily understood version for children	DPO																	
4	**INDIVIDUALS RIGHTS** - Ensure that all relevant procedures/systems conform to GDPR requirements	Medical Records/SAR's/IT Team/DPO																	
5	**SUBJECT ACCESS REQUESTS** - Cannot charge for SAR's so need to mitigate income concerns. New information needs communicating to requestors	Medical Records/SAR's																	
6	**CONDITIONS FOR THE LAWFUL PROCESSING OF PERSONAL DATA (Article 4/5/6)** - to conform with the requirements of the GDPR	Trust Board/IAO's/IAA's/DP O																	
7	**CONSENT** - Complete review of how we seek, obtain and record consent	Caldicott Guardian/IT Team																	
8	**CHILDREN** - Ensure all relevant systems verify ages and gather and store consent	Safeguarding/IT Team																	
9	**DATA BREACH AND ENFORCEMENT - (Article 33)** review of how data breaches are reported and investigated	SIRO/Caldicott Guardian/DPO/Risk and Datix team																	
10	**PRIVACY IMPACT ASSESSMENTS (PIA's)** - (Article 35) New document required to conform with the GDPR	DPO																	
11	**DATA PROTECTION OFFICER** - (Articles 37 to 39)This post is required by the GDPR for all Public Authorities	SIRO/Trust Board																	
12	**PRIVACY BY DESIGN AND BY DEFAULT** - An approach to projects that promotes privacy and data protection compliance from the start (Article 25)	Contracts/Purchasing/ IT teams																	

10. Governance Report - Risk Management Strategy

To Approve

Presented by Victoria Pickles

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 4th January 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - JANUARY 2018 - The Board is asked to approve the Risk Management Strategy	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk & Compliance Group	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Risk Management Strategy

Main Body

Purpose:

The Board of Directors approved the Risk Management Strategy in January 2017 and set a one year review date. Audit and Risk Committee and the Risk and Compliance Group have reviewed the Strategy and the proposed changes are tracked on the attached document.

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Risk Management Strategy

Appendix

Attachment:

Risk Management Strategy 2018-19 -draft.pdf

UNIQUE IDENTIFIER NO: G-101-2017
Review Date: January 2018
Review Lead: Head of Governance and Risk

NHS
Calderdale and Huddersfield
NHS Foundation Trust

RISK MANAGEMENT STRATEGY

2018-2019

Approved by Board of Directors

compassionate care

UNIQUE IDENTIFIER NO: G-101-2017
Review Date: January 2018
Review Lead: Head of Governance and Risk

Document Summary Table		
Unique Identifier Number	G-101-2017	
Status	Ratified	
Version	1	
Implementation Date	January 2018	
Current/Last Review Dates	N/A	
Next Formal Review	January 2019	
Sponsor	Chief Nurse	
Author	Head of Governance and Risk	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Board of Directors	5 January 2017	
Executive Board	22 December 2016	
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Risk and Compliance Group	Assistant Director of Quality and Safety	~~11.10.16.~~ 21.11.17
Quality Committee	Non-Executive Director	31.10.16.
Audit and Risk Committee	Non-Executive Director	November 2017
Other Stakeholders Consulted		
Senior HR Advisor		28.10.16.

Comment [a1]: To update once revew dates known

Does this document map to other Regulator requirements?	
Regulator details	
CQC	Regulation 12: Safe care and treatment Regulation 13: Safeguarding Regulation 15: Premises and Equipment Regulation 16: Complaints Regulation 17: Good Governance Regulation 19: Fit and Proper Persons
NHS Improvement	Single Oversight Framework

Document Version Control	
Version no	
1	Risk Management Strategy incorporating Raising Concerns / Freedom to Speak Up

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Review Lead: Head of Governance and Risk

CONTENTS

Appendices

UNIQUE IDENTIFIER NO: G-101-2017
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1. Introduction

The purpose of this Risk Management (RM) Strategy is to confirm the objectives and organisational framework for risk management systems within the Trust. It details roles, responsibilities and processes for risk management in order to reduce harm, create safer environments for care and achieve the Trust's strategic objectives.

The underpinning risk management processes will ensure that risks are identified and managed, and reported appropriately through the organisation as part of the Trust's system of internal control. Definitions of risk and risk management are given at Appendix 1.

The strategy is relevant to all staff, including those on temporary contracts, contractors, membership councillors, and bank/agency staff, volunteers and Private Finance Initiative (PFI) partners. It is also relevant to all those who partner with or work with the Trust.

2. Vision and Statement of Intent

2.1 Risk Management and Strategic Objectives

The stated aim of Calderdale and Huddersfield Foundation Trust is:

Together we will deliver outstanding compassionate care to the communities we serve.

Our strategic objectives to deliver this aim are to:

- Transform and improving patient care
- Keep the base safe
- Have a workforce fit for the future
- Ensure financial sustainability

Risk management is central to implementing this strategy as the business of healthcare is by its very nature a high risk activity. The process of risk management is an essential control mechanism to identify and manage risks which may threaten the ability of the Trust to meet its objectives, and, as a consequence it increases the likelihood of the Trust achieving its objectives and strategic aim.

Risk and risk management is not about doing nothing for fear that we might make a mistake. Rather, risk policy and risk management are concerned with promoting an understanding of an organisation's strategy, operating environment and the associated risks and putting in place appropriate processes and procedures to identify, assess and manage risk. Risk identification, assessment, management and assurance is best understood as a constant cycle of activity: risks emerge, alter their significance and scale

and may disappear without warning. Anticipation and early action to manage risk is the best defence. Her Majesty's Treasury offers guidance to all organisations in receipt of public funding as to how they may incorporate good practice. This guidance concludes it is essential that an organisation should:

- Understand the risks associated with all elements of its strategy and operating environment;
- Have in place a framework for risk identification, risk assessment, risk management and assurance and the assignment of responsibilities;
- Have a clear policy and attitude to risk appetite and ensure that these are defined and communicated to all relevant parties;
- Review the adequacy and effectiveness of control processes for responding to risks

The Trust recognises that providing healthcare and the activities associated with the treatment and care of patients incurs clinical and non-clinical risk, both for the organisation and its stakeholders: our patients, staff, visitors, partners in the health and social care community and commissioners.

Risk Management is an integral part of the Trust's Board system of internal control and its effectiveness is reviewed annually by internal and external auditors. Key strategic risks are identified and monitored by the Board and operational risks are managed on a day to day basis by staff throughout the Trust. The Board Assurance Framework and Corporate / high level Risk Register provide a central record of how the Trust is managing its risks.

The Trust has a Maternity Risk Management Strategy within the Family and Specialist Services Division which sets out the strategic direction for risk management within maternity services. It details accountability, roles and responsibilities for the management of maternity risks to ensure that women and their families experience safe, clinically effective care at all times to ensure a positive birth experience and a healthy outcome for mother and baby.

2.2 Risk Management Three Lines of Defence

To ensure the effectiveness of the Trust's risk management processes the board and senior management team need to be able to rely on three lines of defence, including the monitoring and assurance functions with the organisation. This is depicted overleaf and explained below:

First line of defence – our front-line staff are the first line of defence. They must understand their roles and responsibilities for risk management using Trust processes and they must own and manage risk, as well as implementing operational management at directorate and divisional level. These are the teams with ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.

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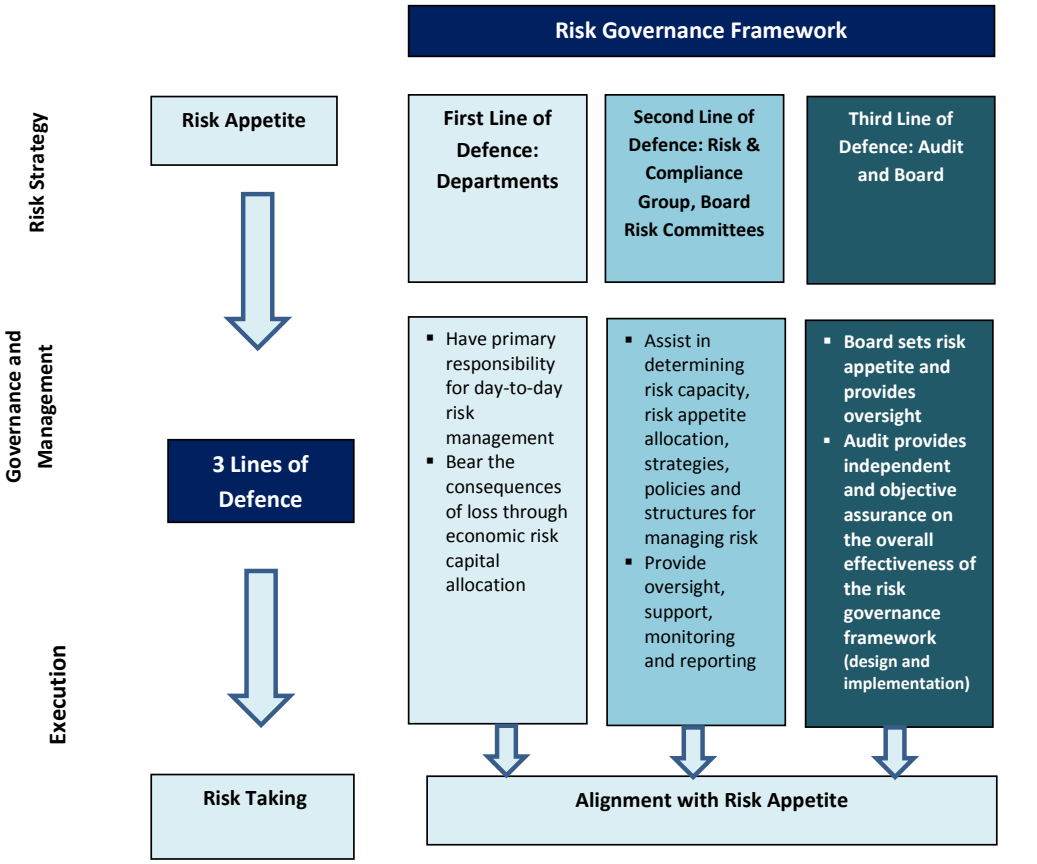
Second line of defence – the second line of defence consists of the functions that reflect risk management, quality and compliance (which monitors and facilitates the implementation of effective risk management practices by operational management) and the processes that assist the risk owners to report adequate risk related information up and down the organisation. This line of defence includes the governance and management committees that provide assurance that risks are actively and appropriately managed.

Third line of defence – the third line of defence is provided by independent audit, such as internal and external auditors, who through a risk-based approach provide independent assurance to Board and senior management team about how effectively the Trust assesses and manages its risks, how effective the first and second lines of defence are and looks at all aspects of risk across all organisational objectives.

Figure 1 – Risk Management Three Lines of Defence



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The Trust will ensure that its risk management arrangements meet the requirements of a number of national bodies including NHS Improvement, the Care Quality Commission (CQC), the Health and Safety Executive (HSE), Environmental Agency, NHS Resolution, our insurers, other agencies and systems supporting a safety culture, such as the National Reporting Learning System and all other regulatory and scrutiny bodies.

On behalf of the Board, the Chief Executive signs annually, a Governance Statement for the Department of Health which outlines how the organisation identifies, evaluates and controls risks together with confirmation that the effectiveness of the system of internal control has been reviewed.

2.3 Vision and Statement of Intent

The Trust's vision of this strategy is for risk management to be regarded as a highly valuable and useful tool to help the Trust achieve its objectives, with:

Risk management systems understood by staff
Risk management systems embedded into everyday working practice across all parts of the organisation
The Board and its committees assured that risks are managed to achieve the Trust's objectives

The Trust will aim continually to improve the content and maturity of the risk management framework.

2.4 Risk Management Objectives

The overall objectives for risk management at the Trust are to establish and support an effective risk management system which ensures that:

- Risks are identified, assessed, documented and effectively managed locally to a level as low as possible, using a structured and systematic approach. Risk may adversely affect patients, staff, contractors, the public and the fabric of buildings. In managing risks the Trust is providing a safe environment in which patients can be cared for, staff can work and the public can visit.

- Risks are managed to an acceptable level as defined in the Trust risk appetite (see section 6), meaning that staff have a clear understanding of exposure and the action being taken to manage significant risks

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- Risks are regularly reviewed at team, directorate, division and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated. A flowchart of risk escalation is given at section 9.4.

- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, manage and monitor risks effectively – see section 9 for further details

- All staff recognise their personal contribution to risk management

- Assurance on the operation of controls is provided through audit, inspection and gaps in control and risks are identified and actively managed

2.5 Risk Scope

This Risk Management Strategy and the Risk Management Policy apply to all categories of risk, both clinical and non-clinical risks. These include, though are not limited to:

Clinical quality / patient safety risks	**Operational / performance risks**	**Financial risks**
Health and Safety Risks	**Project Risks**	**Patient Experience Risks**
Business Risks	**Reputational Risk**	**Regulatory risks**
Governance risks	**Workforce Risks**	**Partnership risks**
Information risks	**External environment risks**	**Risks from political change / policy**

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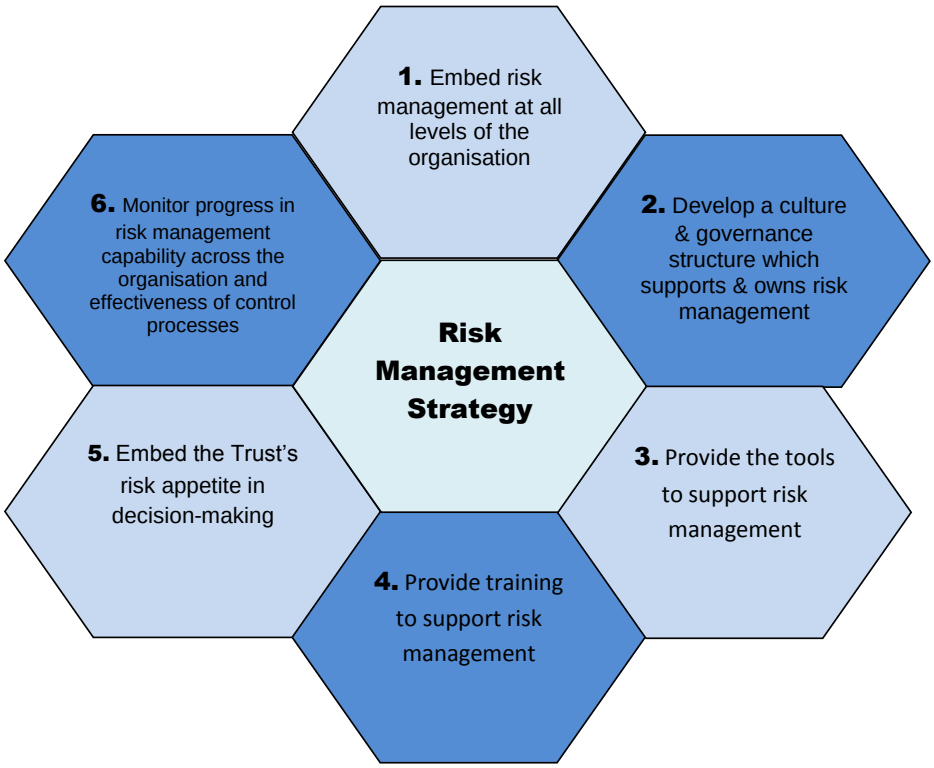
3. Components of the Trust Risk Management Strategy

The components of the Trust's Risk Management Strategy to deliver this vision are given below.

These components will enable the organisation to manage inherent risks within the current systems and processes. The organisation will decide how to manage these risks in line with its risk appetite (see section 6) and risk management processes, see Appendix 1. It is acknowledged that risks may emerge from external sources, particularly during times of change or when new systems or revised regulation is introduced, and the organisation will remain alert to these sources of risk.



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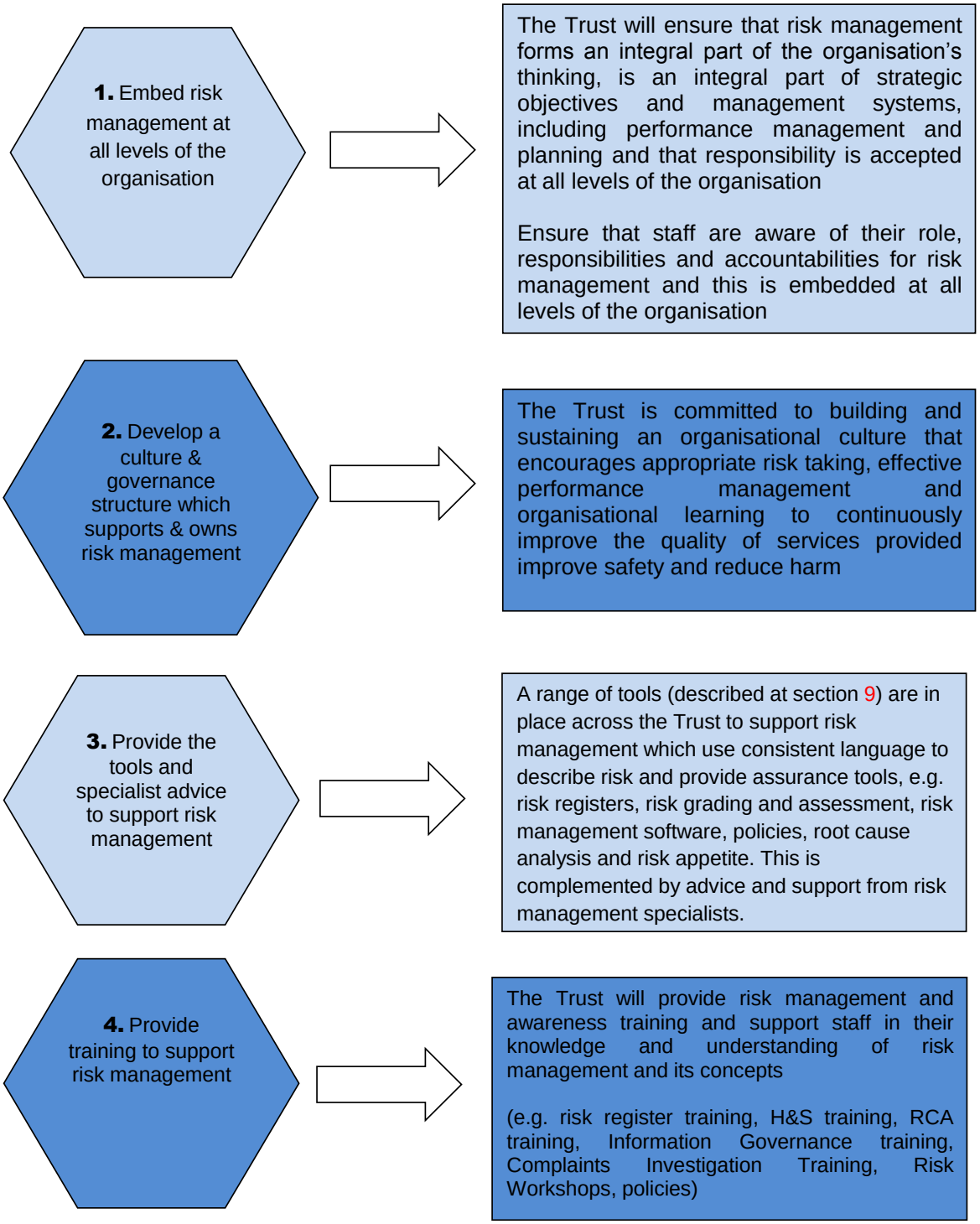
Details of each component are given below:



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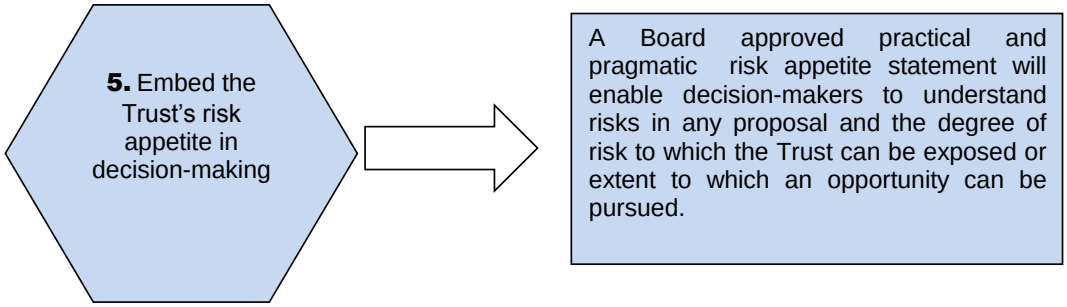

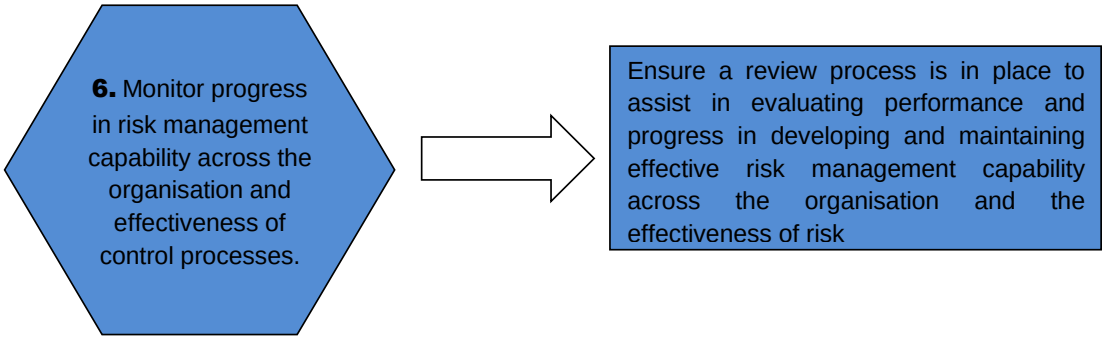

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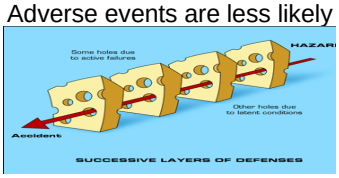
4. Benefits of managing risk

The Trust is committed to the effective management of risks which, among others, has the following benefits for the Trust:

Achievement of objectives is more likely

Adverse events are less likely



Opportunities can be better identified and explored

Outcomes are better: safety, effectiveness, efficiency

We reduce firefighting and fewer costly surprises and re-work.

Performance is improved.

Decision-making is better informed, more open and transparent.

Reputation is protected and enhanced.

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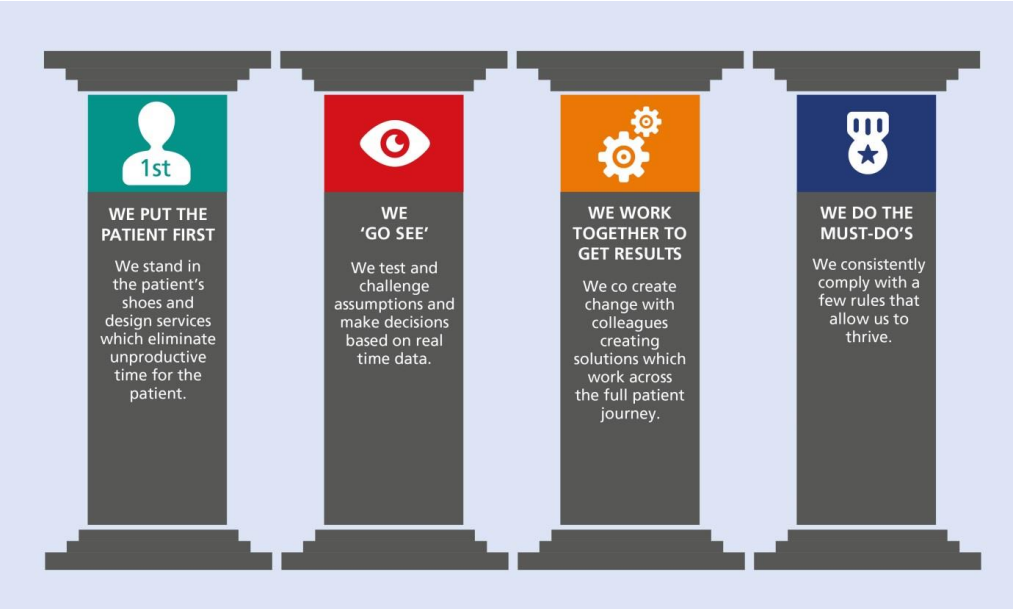
5. The way we work

The four behaviours expected of all staff to deliver our strategic objectives are:



A pro-active approach to managing risk
The Trust aims to embed a culture in which true pro-active risk reduction takes place by aiming to anticipate and prevent risks, complementing the more traditional reactive approach to risk management by looking ahead and managing upcoming risks. This is achieved by staff and teams identifying pro-actively risks to avoid adverse events or by managing risks as far as reasonably practicable to minimise the consequences of adverse events, for example for patient outcomes or preventing harm and reducing losses for the organisation. A key part of this pro-active approach to risk management is the use of risk assessment which is detailed as a key risk management tool in the organisation (see Appendix 4).

All members of staff have responsibilities and an important role to play in identifying, assessing and managing risk using the risk management strategy policy and supporting policies and procedures to guide them.

This means:

Staff should pro-actively identify and assess risks and manage these to avoid / minimise adverse events. *(We Do The Must Do's)*

To support staff in their role in managing risk the Trust seeks to provide an open, fair and consistent environment, encouraging a culture of openness and a willingness to admit mistakes and learn from them.

This means:

Staff are open about incidents they have been involved in and feel able to talk to their colleagues about any incident *(We Do The Must Do's)*

All staff, and others associated with the Trust, should report any situation where things have or could have gone wrong through the incident reporting process. Balanced with this approach is the need for the Trust to provide information, counselling, support and training for staff in response to such situation.

This means:

The organisation is open with patients, the public and staff when things have gone wrong and appreciates and explains what lessons can be learned (*We Put The Patient First)*

The Trust wants to learn from events and situations in order to constantly improve management processes, take a systems approach to learning, looking at contributory factors, including human factors to make changes to improve quality and safety. Where necessary and/or appropriate, changes will be made to the Trust's systems to enable this to happen.

The Duty of Candour and Being Open policy is a key tool to support this and to engage with families where things have gone wrong. Staff should be informed of feedback on actions taken as a result of an incident being reported.

This means:

Staff and organisations are accountable for their actions and are treated fairly and are supported when an incident happens (We Do the Must Do's)

In the interests of openness and candour, responding to concerns raised and learning from mistakes, formal disciplinary action will not usually be taken as a result of an investigation into an adverse event. However, the Trust's Disciplinary Policy outlines circumstances in which disciplinary action will be taken, e.g. professional misconduct. Should disciplinary action be appropriate this will be made clear as soon as the possibility emerges from an investigation and advice would be taken from the Workforce and Organisational Development department.

6. Risk appetite

No organisation can achieve its objectives without taking risks. An organisation's risk appetite is the amount and type of risk that the organisation is willing to take in the pursuit of its strategic objectives.

The risk appetite can help the Trust by enabling the organisation to take decisions based on an understanding of the risks involved. The organisation will communicate expectations for risk taking to managers.

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The Trust uses the risk appetite matrix for NHS organisations developed by the Good Governance Institute to express its risk appetite.

There are 5 levels of risk appetite (excluding no risk appetite) which are detailed overleaf.

Risk level / appetite	Key Elements
MINIMAL (as little risk as possible)	Preference for ultra-safe delivery options with a low degree of inherent risk and only for limited reward potential
CAUTIOUS	Preference for-safe delivery options with a low degree of inherent risk and limited potential for reward
OPEN	Willing to deliver all potential delivery options and choose while also providing an acceptable level of reward and value for money.
SEEK	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk
MATURE	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Expressing the Trust's Risk Appetite

In line with best practice in corporate governance and risk management, the Trust will clearly express the extent of its willingness to take a risk in order to meet its strategic objectives through a risk appetite statement.

The risk appetite will be agreed by the Board and reviewed at least annually or as needed, as risk appetite levels may change depending on circumstances.

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Risk Categories

Risks need to be considered in terms of both opportunities and threats and are not usually confined to clinical risk or finances – they are much broader and impact on the capability of the Trust, its performance and reputation. The risk appetite is also influenced by the overall objectives set by the Trust.

The Trust will agree categories of risk when defining its risk appetite and will publish these, which will cover the over-arching areas of:

- Quality, innovation and improvement, safety
- Financial
- Commercial
- Regulation
- Reputation
- Workforce

The risk appetite statement will be communicated to relevant staff and risks throughout the Trust should be managed within the Trust's risk appetite. Where this is exceeded, action should be taken to reduce the risk.

The Risk and Compliance Group will review the significant risks on the high level risk register to ensure that risks are acceptable within the Trust risk appetite.

The Quality Committee (for clinical risk), Audit and Risk Committee (for all clinical and non-clinical risk) and the Board will also review significant risks and ensure that the Trust's overall portfolio of risks is appropriate, balanced and sustainable.

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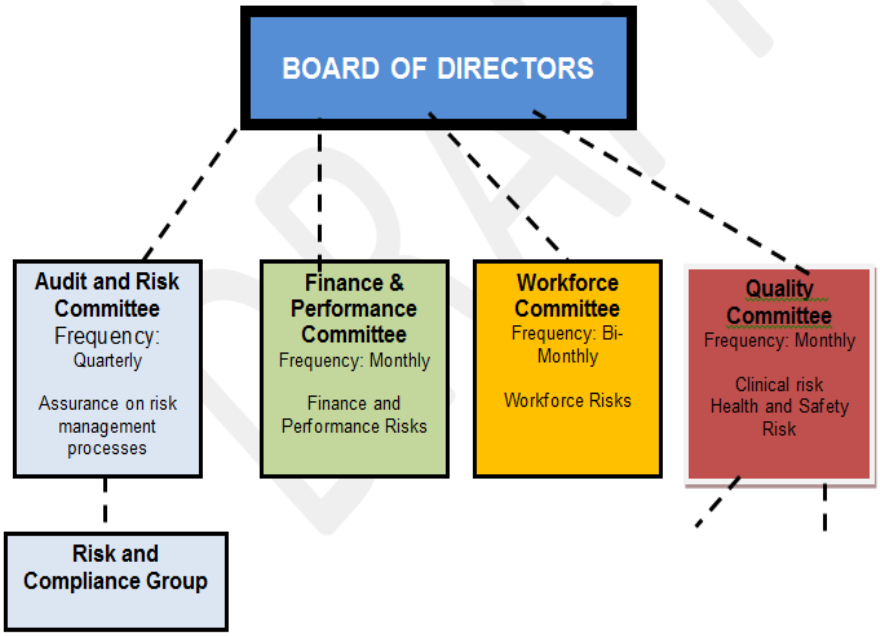
7. Organisational Structure for Risk Management

7.1 Organisational Structure

A full organisational structure, to help manage delegated responsibility for implementing risk management systems within the Trust is given at Appendix 2. The key committees are given below:



NB: Needs two groups adding to feed into Quality Committee – Divisional Patient Safety Quality Boards and Health and Safety Committee.

*For a full list of sub groups reporting to Board Committees please refer to Appendix 2.

7.2 Roles and responsibilities of Committees responsible for risk

Board of Directors

The Board of Directors is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to all NHS organisations. This includes the development of systems and processes for financial control, organisational control, governance and risk management.

Board members must ensure that the systems, policies and people that are in place to manage risk are operating effectively, focused on key risks and driving the delivery of objectives.

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In the context of this Risk Management Strategy the Board will:

- Demonstrate its continuing commitment to risk management through the endorsement of the Risk Management Strategy, participating in the risk assurance process and ensuring that appropriate structures are in place to implement effective risk management

- Be collectively responsible for determining the Trust's vision, mission and values.

- Set corporate strategy and priorities and monitor progress against these; the Board must decide what opportunities, present or future, it wants to pursue and what risk it is willing to take in developing the opportunities presented.

- Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks.

- Set the Trust's risk appetite and review on an annual basis.

- Simultaneously drive the business forward whilst making decision which keep risk under prudent control

- Effectively hold those responsible for managing risk to account for performance through assurance processes and continuous improvement through learning lessons and ensuring these are disseminated into practice from complaints, claims, incidents and other patient experience data.

- The Company Secretary is responsible for the work of the Board and its Committees and for ensuring integration of their activities, particularly the governance and regulatory responsibilities.

Audit and Risk Committee

On behalf of the Board the Audit and Risk Committee provides an independent and objective review of financial and corporate governance, assurance, systems of internal control and risk management. These activities apply across the whole of the Trust's clinical and non-clinical activities and they support the achievement of the Trust's objectives. The Audit and Risk Committee also ensures effective external and internal audit, monitors the performance of auditors and re-tenders for auditors' services.

The Risk and Compliance Group, chaired by the Assistant Director of Quality and Safety, reports to the Audit and Risk Committee. Its role is to promote effective risk management and to establish and maintain a dynamic Board Assurance Framework and Risk Register through which the Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality.

The Information Governance Group also reports to the Audit and Risk Committee.

To ensure that Board Committees are effectively managing risks within their remit, each Committee undertakes a self-assessment of performance annually and share these assessments with the Audit and Risk Committee.

Finance and Performance Committee

The Finance and Performance Committee has delegated authority from the Board to oversee, co-ordinate, review and assess the financial and performance management arrangements. This includes monitoring the delivery of the 5 Year Plan and supporting Annual Plan decisions on investments and business cases. It is responsible for identifying any financial and performance risks.

Workforce Committee

The Workforce (Well Led) Committee provides assurance to the Board of Directors on the quality of workforce and organisational development strategies and the effectiveness of workforce management in the Trust and is responsible for identifying any workforce and training risks.

Quality Committee

The Quality Committee provides assurance to the Board of Directors that there is continuous and measurable improvement in the quality of the services provided and that the quality risks associated with its activities, including those relating to registration with the CQC are managed appropriately.

There are 9 groups that support the work of the Quality Committee and directly report to it, including the Health and Safety Committee, as depicted in the governance structure at Appendix 2.

8. Accountabilities, Roles and Responsibilities for Risk Management

8.1 The **Chief Executive** is the Accountable Officer of the Trust and as such has overall accountability for ensuring it meets its statutory and legal requirements and has effective risk management, health and safety, financial and organisational controls in place.
The Chief Executive has overall accountability and responsibility for:

- ensuring the Trust maintains an up-to-date Risk Management

Strategy, is committed to the risk management principles in the Trust statement of intent and has a risk appetite endorsed by the Board

- promoting a risk management culture throughout the organisation
- ensuring an effective system of risk management and internal control is in place with a framework which provides assurance to the Trust management of risk and internal control
- ensuring that the Annual Governance Statement contains the appropriate assurance requirements for risk management
- ensuring priorities are determined and communicated, risk is identified at each level of the organisation and managed in accordance with the Board's appetite for taking risk.

8.2 The Chairman is responsible for leadership of the Board and ensuring that the Board receives assurance and information about risks to the achievement of the organisation's strategic objectives.

8.3 Non-Executive Directors

All Non-Executive Directors have a responsibility to challenge the effective management of risk and seek reasonable assurance of adequate control.

The Audit and Risk Committee, Quality Committee, Finance and Performance Committees and Workforce Committee are chaired by nominated Non-Executive directors.

The Senior Independent Non-Executive Director is the Trust's Freedom to Speak Up Guardian in accordance with the Trust's Raising Concerns Policy.

8.4 Executive Directors

The following Executive Directors have particular responsibilities in respect of assurance and the management of risk summarised below. The Chief Executive will delegate responsibilities in relation to partnership working as appropriate.

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Lead Executive Director	Risk Area
Chief Nurse The Chief Nurse is the Executive lead for risk management and patient safety in partnership with the Medical Director. They ensure organisational requirements are in place which satisfies the legal requirements of the Trust for quality and safety, patients and staff. This includes delivery of processes to enable effective risk management and clinical standards. The Board Assurance Framework lead is the Company Secretary.	• Board lead for clinical risk management: – Risk Management Strategy and Policies – Risk appetite – Monitoring the management of risks across divisions and escalate as needed • Serious Incidents and Incident Reporting • Patient Advice and Complaints Service • Patient Experience • Quality and Quality Improvement • Safeguarding and Deprivation of Liberties • Quality regulatory compliance
Medical Director The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Director of Nursing and leads the quality improvement strategy. Responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation. The Medical Director is supported in this by the Deputy Medical Director and Associate Medical Directors.	• Clinical medical risk • Infection Prevention and Control • Caldicott Guardian information risks – delegated to the Associate Medical Director • Responsible Officer for GMC • Medicines Management – delegated to Chief Pharmacy Officer • Clinical audit and effectiveness • Compliance with NICE guidance • Quality Improvement • Research & Development
Director of Finance The Director of Finance has executive responsibility for financial governance and financial systems, is the lead for counter fraud and responsible for informing the Board of the key financial risks within the Trust and actions to control these.	• Financial risk • Procurement risk • Counter fraud and reporting to NHS Protect • Financial regulatory compliance
Chief Operating Officer The Chief Operating Officer has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation and management of performance of all clinical services through divisional management teams.	• Performance risks • Performance regulatory compliance • Safe and sustainable operational services

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Director of Workforce and Organisational Development The Director of Workforce and Organisational Development has executive responsibilities which include identification and assessment of risks associated with recruitment, employment, supervision, training, staff development and staff well – being.	• Staffing risks including training, workforce planning, recruitment and retention, • Workforce Policies • Professional registration • Staff Well Being
Director of Planning, Estates and Facilities The Director of Estates and Facilities: has executive responsibilities which include health and safety across the organisation, the estates and facilities infrastructure, including Medical Engineering and PFI sites.	• Health and Safety, including external reporting for RIDDOR • Security Management • Trust Resilience • Fire safety • Compliance with regulations / guidance on specialised building and engineering technology for healthcare • Estates and facilities and contractor risk • Medical Engineering • PFI contract

8.5 Board Directors

The following Board Directors also have responsibilities for assurance and management of risk.

Director of Transformation and Partnerships The Director of Transformation and Partnerships has lead responsibility for service redesign and reconfiguration and working together with our partners across the local health and social care economy.	• Risks in relation to service reconfiguration and transformation • Partnership risks
Managing Director – Digital Services The Director of Health Informatics promotes the need to manage information and IT risks, for the security of patient records and IT business continuity arrangements.	• Information governance risks and external reporting to the Information Commissioner • Senior Information Risk Officer – delegated to head of informatics, is responsible for ensuring the Trust manages its information risks, through the development of information asset owners and information asset administrators. • Electronic Patient Record.

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8.6 Assistant Director for Quality

The Assistant Director for Quality supports the Director of Nursing and Medical Director in their clinical quality and safety and risk management responsibilities as well as quality improvement. This includes overseeing the risk management function, including the risk register and compliance with the requirements of CQC standards.

8.7 Clinical and Divisional Directors

Clinical and Divisional Directors have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They are responsible for ensuring effective systems for risk management within their division and directorates and ensuring that their staff are aware of the risk management policy and their individual responsibilities.

In addition to Divisional Directors and Clinical Directors the divisional management team includes an Associate Director of Nursing and Associate Divisional Director.

They are responsible for demonstrating and providing leadership of risk management within their division, directorates and teams. They are accountable for:

- Pro-actively identifying, assess, managing and reporting risks in line with Trust processes
- Establishing and sustaining an environment of openness and learning from adverse events to prevent recurrence and creating a positive risk management culture
- Seeking assurance through their governance arrangements of the effectiveness of risk management
- Ensuring clinical risks, health and risks, emergency planning and business continuity risks, project and operational risks are identified and managed.
- That general managers, operational managers, matrons, ward managers, departmental team managers are responsible for ensuring effective systems of risk management and risks registers are in place at all levels.

8.8 All Staff

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that are affected by Trust business
- Be aware of, identify and minimise risks, taking immediate action to reduce hazards or risks
- Identify, assess, manage and control risks in line with Trust policies and procedures

- Be familiar with local policies, procedures, guidance and safe systems of work
- Be aware of their roles and responsibilities within the risk management strategy, policy and supporting policies, eg comply with incident and near miss reporting procedures
- Be responsible for attending mandatory and essential training and relevant educational events
- Undertake risk assessments within their areas of work and notify their line manager of any perceived risks which may not have been assessed

8.9 Contractors and Partners

It is the responsibility of any member of Trust staff who employ contractors, and their partners, to ensure they are aware of the Safe Management of Contractors policy and undergo Trust induction via the relevant Estates Department at either HRI or CRH. This will ensure that all contractors working on behalf of the Trust are fully conversant with CHFT's health and safety rules staff member responsible is fully aware of the contractors activity for which they are engaged and, if applicable, are in possession of the contractors risk assessment and method statement for their activity.

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9. SYSTEMS and PROCESSES for MANAGING RISK

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9.1 Policies DN: Proposed we move this list to an Appendix

There are a number of key policies which support the effective management of risk, including the risk management policy which provides operational details of how we manage risk across the organisation. Other key policies include:

This policy/procedure should be read in accordance with the following Trust policies, procedures and guidance: Updated and re-ordered

Risk Management / Corporate

- Being Open / Duty of Candour Policy
- Complaints policy
- Control of Substances Hazardous to Health (COSHH)
- Claims policy
- Emergency Preparedness, Resilience and Response Policy
- External Visits Police
- Fire Safety Strategy
- Health and Safety policy
- Incident Reporting, Investigation and Management policy
- Major Incident policy
- Inquest Policy
- Information Governance Strategy and associated policies
- Policy for Developing Policies
- Risk Management Policy
- Safe Management of Contractors
- Safeguarding
- Security Strategy
- Waste Management Policy

Workforce and Organisational Development

- Capability policy
- Freedom to Speak Up: raising Concerns Policy
- Induction policy
- Mandatory Training Policy
- Personal Development Review
- Policy on the Appointment of Medical locums
- Promoting Good Health at Work Policy
- Race Equality Scheme

Clinical

- Blood Transfusion policy
- Consent Policy
- DOLS
- Electronic Patient Record Standard Operating Procedures
- Falls Prevention and Management policy
- Infection Control policies
- Maternity Risk Management Strategy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Policy on the implementation of NICE guidelines
- Safeguarding Adults Policy
- Safeguarding Children Policy

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All operational policies, procedures and guidance also support the effective management of risk. These can be found on the Trust intranet.

9.2 Incident Reporting

The formal reactive method of identifying risks within the Trust is through the electronic risk management system, Datix where all staff can report incidents accidents and near misses in a timely way, with incidents graded for type and severity. This enables the organisation to investigate and identify learning to make quality improvements in patient safety at all levels of the organisation.

An Incident Reporting Policy is in place which details the processes for grading, reporting, investigating and learning from incidents and serious incidents and is a key part of our effective risk management processes.

RIDDOR (Reporting of Incidents, Injuries, Diseases and Dangerous Occurrences Regulations 2013) should be reported on Datix and to the Health and Safety Executive (HSE) via the HSE link on Datix.

Staff wishing to raise concerns in accordance with the Freedom to Speak up: Raising Concerns Policy should utilise the reporting facility in that policy.

The Trust is committed to continue to improve its reporting culture throughout all professional groups of staff and others who work with it. It achieves this by ensuring that action is taken, changes in practice are implemented and services are improved as a direct result of the review and investigation of incidents and by identifying and reacting to themes.

9.3 Board Assurance Framework (BAF)

The Board Assurance Framework provides the Board of Directors with an oversight of the strategic risks to meeting the Trust's objectives together with the controls and methods of providing assurance that controls are effective. Risks on the BAF are owned by Trust Directors.

The BAF maps out the controls already in place and the assurance mechanisms available so that the Board can be confident that they have sufficient assurances about the effectiveness of the controls. The risks are cross-referenced to the risks on the corporate risk register.

All risks from the BAF are presented to the Board at its public meetings. All other Board committees may make recommendations for including or amending strategic or significant risks. The BAF forms part of the evidence to support the Annual Governance Statement produced as part of the Annual Report and Accounts.

The assessment of risk within the BAF is reviewed at the Risk and Compliance Group. The risks on the BAF are scrutinised each quarter by the Board of Directors with input from the Quality Committee, the Finance and Performance Committee and the Workforce Committee. Oversight of the

system of risk management, including the BAF, is provided by the Audit and Risk Committee.

The Board Assurance Framework is closely linked with the high level risk register (HLRR), which reflects significant risks identified at both a corporate department and divisional level. The Company Secretary and the Head of Governance and Risk ensure that the link between the High Level Risk Register and the Board Assurance Framework is maintained, and that the Audit and Risk Committee is satisfied that this is occurring.

9.4 Risk Registers

All areas assess record and manage risk within their own remit, reporting on the management of risks through the risk register, using the risk grading system detailed at Appendix 4. All risks are linked to strategic objectives.

A database is used to capture all risks to the organisation including clinical, organisational, health and safety, financial, business and reputational risks. A framework is in place for assessing, rating and managing risks throughout the Trust, ensuring that risks are captured in a consistent way. Risks can be analysed by risk score, division, directorate and team. Further detail on the process for populating the risk register is given in the Risk Management Policy.
It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the Corporate Risk Register which is an integral part of the Trust's system of internal control.

The High Level Risk Register includes those significant risks which may impact on the Trust's ability to deliver its objectives, with a risk score of 15 or above. These are reviewed on a monthly basis by the Risk and Compliance Group and presented to the Board of Directors.

Divisional, directorate and team risk registers are managed and reviewed by the Divisions, with divisional risk registers reviewed on a regular basis by the Risk and Compliance Group. The performance framework for divisions also includes scrutiny of risks within divisions. The Risk Management Policy details the process for risk register reporting.

The diagram overleaf depicts the flow of risks throughout the organisation from identification to assessment and management according to severity throughout the Trust.

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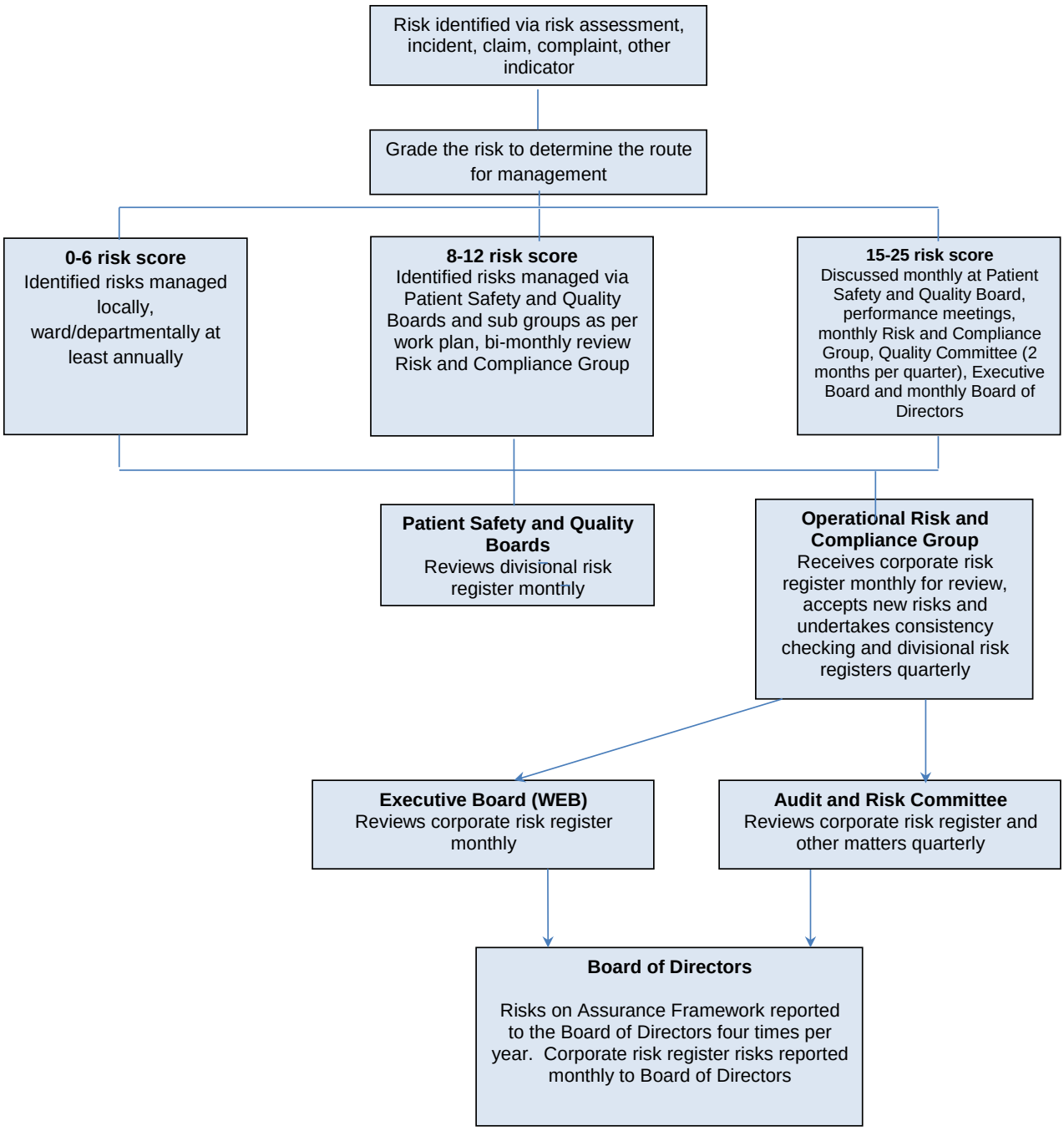
Structure and flow chart for the management of assurance and risk



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9.5 Compliance Register

Each division will maintain a Register of Compliance, which records details of all external assessments, inspections and accreditations.

The register will include the due date of the inspection, and record whether any recommendations from previous visits are outstanding and identify any risk areas. These are reviewed every other month by the Risk and Compliance Group.

9.6 Risk Management Specialists

The Trust has risk management specialists who possess and maintain appropriate qualifications and experience so that competent advice is available to staff. As well as supporting staff manage risks, these specialists create, review and implement policies, procedures and guidelines for the effective control of risks.

Responsibilities of staff at all levels for risk are given at section 8. Details of Trust risk management specialists are given at Appendix 3.

Role	Responsibility
Caldicott Guardian Senior Information Risk Owner (SIRO) Information Governance Manager Data Protection Officer	Information Governance Risks
Company Secretary	Strategic Risks Foundation Trust risks Central alert systems risks
Director of Nursing	Clinical Risk
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Head of Midwifery	Maternity Risks
Resilience and Security Manager	Emergency Planning and business continuity risks Security Manager
Fire Safety Manager Health and Safety Advisor Director of Planning, Estates and Facilities	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Patient Experience lead	Patient Experience Risks
Local Counter Fraud Specialist	Fraud Risks
Governance and Risk Team Assistant Director of Quality Head of Governance and Risk Senior Risk Manager and Risk Manager Complaints and Legal Services Manager	All risks and risk management tools, processes and training.

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Clinical Governance Support Managers / Quality and Safety lead	
Head of Safeguarding / Safeguarding Team	Safeguarding Risks

9.7 Risk Management Software

The Trust uses two risk management databases, Datix, for incident reporting, complaints, concerns, claims and inquests to support identification, management and investigation into adverse events and a bespoke database for the risk register. The Datix system allows the Trust to share information and triangulate data on an individual and aggregate basis. This provides an easy way for staff to report and get feedback on incidents, ensure an appropriate level of investigation based on severity, capture actions and learning from adverse events and analyse data to identify themes and trends for the whole organisation.

A bespoke database is used for the management of the risk register, which allows reporting and analysis at directorate, divisional and Trust-wide level.

9.8 Risk Identification and Assessment

Risk assessment is a systematic and effective method of identifying risks and determining the most effective means to minimise or remove them. It is an essential part of risk management within the Trust.

The formal pro-active method of identifying operational risks within the Trust is through the use of risk assessments. Clinical and non-clinical risk assessment is used to populate directorate, divisional and corporate risk registers. The Board of Directors is responsible for identifying strategic risks associated with the strategic direction of the organisation.

All risk assessments in all departments should be regularly updated and formally reviewed on an annual basis.

It is essential to identify the scale and significance of a risk. It is important to distinguish between these elements and to provide a clear and applied assessment; a risk may be extreme in scale without having great significance and vice versa. Equally it is important to assess and manage cumulative risk.

Guidance for staff on risk assessment is given in the Risk Management Policy.

9.9 Risk Grading Matrix

Staff should use the risk grading matrix, adapted from a national model by the National Patient Safety Agency for the NHS, to ensure a consistent approach to assessing risks.

The risk grading matrix provides a description of risk types and defines an impact score from 1 – 5 and a likelihood score from 1 – 5. The impact score multiplied by the likelihood score determines the actual grading of the risk – refer to Appendix 4 for details.

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The information produced from the risk assessment is used to populate the risk register.

For assessment of the severity of incidents, the Trust uses the grading scale given at Appendix 9 which grades no harm incidents as green, incidents with minimal harm as yellow, incidents with moderate or short term harm as orange and incidents where there is severe or long term harm or death as red incidents.

Complaints are assessed in line with the grading policy within the complaints policy which is based on patient experience.

9.10 Root Cause Analysis / Learning

Formal root cause analysis is used throughout the Trust providing a structured approach for the analysis and identification of learning from incidents, complaints and claims. This is used in investigations to identify how and why incidents occur and inform actions and learning to prevent harm.

The Trust uses the Yorkshire and Humber contributory factors framework, a tool from the Improvement Academy with an evidence-base to optimise learning and address causes of patient safety incidents from incidents within hospital settings. It takes a systems approach and identifies situational factors, local working conditions, latent/organisational factors and latent/ external factors and general factors that contribute to error, providing an opportunity to learn from error and prevent factors that cause harm to patients.

The Trust has a clear framework for undertaking root cause analysis for all moderate harm and severe harm incidents. This ensures that action is taken to prevent the potential for recurrence locally and at a corporate level. Specific root cause analysis processes have been developed for specific incidents, i.e. pressure ulcers, infection related incidents. These are detailed in the Incident Reporting Policy.

10. Risk Management Training

In order to develop a risk aware culture and to ensure successful Implementation of this strategy there needs to be training for staff.

Risk management training and awareness already occurs in a number of different methods, e.g. Board workshops, risk register training, root cause analysis training, complaints investigation training, Datix training as well as ad hoc training.

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11. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnership.

12. Monitoring the Effectiveness of this Strategy

The strategy will be reviewed on a three year basis or sooner as required.

A review process will be developed to assist in evaluating performance and progress in developing and maintaining effective risk management capability within divisions and corporate functions across the organisation and the effectiveness of risk management control processes. This will include leadership for risk management, local ownership of risk, equipping staff to manage risk well, governance arrangements to support the risk management framework, policies and procedures.

13. Associated Documents/Further Reading

The relevant policies and procedures listed in section 9.1 should be read in accordance with this strategy.

APPENDICES

1. Definitions of Risk, Risk Management. Risk Management Process
2. Governance Structure
3. Risk Management Specialists
4. Risk Grading matrix
5. Incident Grading Matrix

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Appendix 1 - Definitions

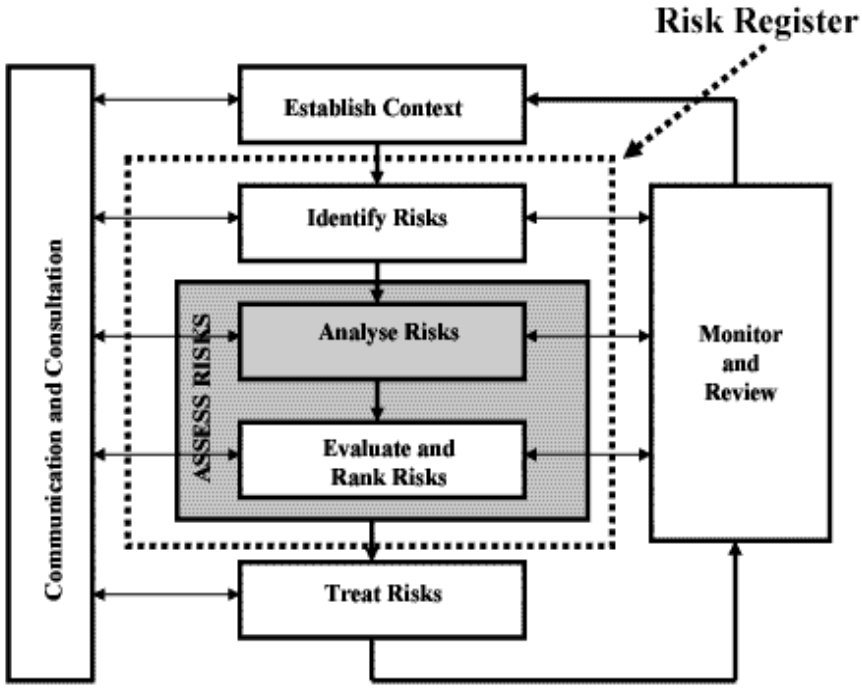
Risk is the chance that something will happen that will have an impact on the achievement of the Trust's aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the risk occurring). See section 9.8 and Appendix 4.

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

The **risk management process** is the systematic application of management policies, procedures and practices to the task of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk. It is described in the diagram below.

Significant risks are those which, when measured according to the grading tool at Appendix 4, are assessed to be significant, with a risk score of 15 or more. The Board will take an active interest in the management of significant risks.

Cumulative risks are individual risks from different areas which, when added together, may combine to become a significant risk.



Risk Management Overview from AS/NZS 4360:1999

GOVERNANCE STRUCTURE

A&E Board (System Resilience Group)

G-101-2017
8

[illegible] Governance and Risk

Elective Care Improvement Board

EPR Transformation Board

BOARD OF DIRECTORS

Charitable Trustee

Membership Council
Chair: Andrew Haigh
Frequency: Quarterly

Council of Governors

Nominations & Remuneration Committee
Chair: Andrew Haigh
Frequency: Ad hoc but at least once

Audit and Risk Committee
Chair: Richard Hopkin
Frequency: Quarterly

Charitable Funds Committee
Chair: Trust Chair
Frequency: Quarterly

Finance & Performance Committee
Chair: Phil Oldfield
Frequency: Monthly

Nominations & Remuneration Committee
Chair: Andrew Haigh
Frequency: Ad hoc but at least once annually

Well Led Committee
Chair: Karen Heaton
Frequency: Bi-Monthly

Quality Committee
Chair: Linda Patterson
Frequency: Monthly

Capital Planning Group

Commercial Investment & Strategy Committee

Risk & Compliance Group
Chair: **CN**
Frequency: Monthly

Information Governance Group
Chair: CIO
Frequency: Quarterly

Clinical Records Group

Divisional Performance Reviews Executive Lead &
Chair: **COO**
Frequency: Monthly

Performance Management

Strategic Development

Trust Executive Board
Frequency: Weekly

Chair: CEO
Frequency: Weekly
One meeting per month focused on performance

Divisional Management Boards and Patient Safety & Quality Boards
Chair: **DD**
Frequency: Monthly

Risk Management

Directorates (Speciality)

Turnaround Executive
Chair: **CEO**
Frequency: Weekly

Workforce Modernisation Programme Board

Resourcing Group

OD / Engagement Group

Workforce Systems Group

Research and Development Group
Chair: Medical Director
Frequency: Quarterly

Organ Donation Committee
Chair: Chair
Frequency: Quarterly

Safeguarding Committee
Chair: DofN
Frequency: Monthly

Medicines Management Group

Blood Transfusion Group

Falls Collaborative

Resuscitation Group

Thrombosis / VTE Group

Pressure Ulcers Group
Chair: Deputy CN
Frequency: bi- weekly

Point of Care testing Group

Radiation Protection Group

Medical Devices and Procurement Group

Patient Safety Group
Chair: AD Quality
Frequency: Monthly

Infection Prevention Group
Chair: Medical Director
Frequency: Monthly

Health & Safety Committee Chair: DofPEF
Frequency: Monthly

Dementia SG
Executive Lead &
Chair: **CN/COO**
Frequency: ¼ ly

Serious Incident Group
Chair: **CEO**
Frequency: Bi-monthly

CQC Response Group (task & finish)
Chair: CEO
Frequency: Fortnightly

Dementia Group

Family and Friends Group

Patient Experience Group
Chair: AD Quality
Frequency: Six Weekly

Deteriorating Patient Collaborative

End of Life Care Group

Clinical Effectiveness and Audit Group

Nutrition Steering Group

Clinical Outcomes Group
Chair: Medical Director
Frequency: Monthly

Appendix 3: Propose delete as included at 9.6 and has been updated

RISK MANAGEMENT SPECIALISTS

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Caldicott Guardian
The Caldicott Guardian is a senior health professional who oversees all procedures affecting access to person-identifiable health data, protecting the confidentiality of patient and service user information.

Senior Information Risk Owner
As the Trust Senior Information Risk Owner (SIRO), the Chief Information Officer is responsible for ensuring that the Trust creates and manages its information risks, through the development of a network of Information Asset Owners (IAAs) and Information Assess Administrators (IAAs).

Information Governance Manager
The Information Governance Manager is responsible for ensuring that the Trust has a robust Strategy of policies and procedures for the management of the Trust's information, both corporate and clinical/patient.

The Information Governance Manager liaises with the Trust's Caldicott Guardian and Senior Information Risk Owner to ensure that the Trust meets and complies with the standards set out in the Information Governance Toolkit.

Data Protection Officer – to add

Company Secretary
The Company Secretary is responsible for ensuring the strategic risks for the organisation are captured in the Board Assurance Framework and that there are effective processes in place for managing central alerts. The role also ensures that the supporting Committee structure of the Board and their terms of reference reflect the Committee's risk responsibilities system. This role also ensures that compliance issues, i.e. NHS Improvement, are appropriately reported throughout the organisation.

Chief Nurse
The Director of Nursing is the Executive lead for risk management and patient safety in partnership with the Medical Director, ensuring organisational requirements are in place which satisfy the legal requirements of the Trust for quality and safety, patients and staff, including delivery of processes to enable effective risk management and clinical standards.

Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) has the following role and responsibilities: oversee local control of infection policies and their implementation; responsibility for the Infection Prevention and Control Team within the healthcare organisation, report directly to the Chief Executive and the Board, challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions; assess the impact of all existing and new policies and plans on infection and make recommendations for change; be an integral member of the organisation's clinical governance structures.

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Medical Director
The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Director of Nursing and leads the quality improvement strategy. The Medical Director is responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation.

The Medical Director is also responsible for managing safety incidents in NHS screening programmes where the Trust is involved.

Head of Midwifery
The Head of Midwifery is the professional and management lead for midwives and is responsible for the co-ordination of clinical risk, providing expert advice for risk management within maternity services and responsible for supporting and embedding the implementation of risk management within maternity services. A Maternity Risk Management Strategy supports the continual improvement of the quality of clinical care through effective management of clinical risks and details roles and responsibilities for maternity risk management.

Fire Safety Manager
This includes the provision of a fire safety strategy and fire training for all staff in terms of prevention, fire precautions and safe evacuation. The role also includes ensuring each area has a current fire risk assessment. They also provide specialist advice to design consultant/architects in respect of statutory structural fire safety incorporating the requirements of health technical memorandum 05 Fire Safety requirements.

Health and Safety Advisor
The Health and Safety Advisor is responsible for monitoring all staff related incidents on a regular basis and ensuring this is reported to the Health and Safety committee.. They will organise health and safety training and education of staff to support CHFT's compliance with health and safety requirements. Duties of all employees are detailed in the health and safety policy.

Resilience & Security Manager
The overall objective of the Trust Resilience and Security Management Specialist is to serve two separate functions as a designated Emergency Planning/Business Continuity Manager and the Local Security Management Specialist (LSMS) is to identify the work programs required to comply with both the Civil Contingencies Act (2004) and the NHS Protect Security Management Standards, as dictated by national service provision contract standards. The associated corporate work programs will form the basis of ongoing developmental work and an implementation plan to deliver compliance against legislation and standards.

Director of Planning, Performance, Estates and Facilities
The Director of Estates and Facilities has executive responsibilities which include health and safety across the organisation, security management, the estates and facilities infrastructure, including Medical Engineering and PFI sites.

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Controlled Drugs Officer
The Clinical Director of Pharmacy is the controlled drugs accountable officer for the Trust (CDAO) in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006) and has responsibility for all aspects of controlled drugs management within the Trust, including standard operation procedures for controlled drugs, procurement and storage arrangements and oversight of the safe practices for prescribing and administration of controlled drugs, investigation of medication incidents.

The Clinical Director of Pharmacy is also the Chief Pharmacist and is responsible for policy and strategy in respect of medicines management.

Medication Safety Officer
The Trust has a Medication Safety Officer who oversees medication error incident reporting and learning to improve medication safety.

Radiation Protection
The Trust has a Radiation Protection Board chaired by the divisional Director, with specialist and technical advice on radiation provided by the Radiology department and external radiation protection advisors.

Freedom to Speak Up Guardian
The Guardian acts as an independent and impartial source of advice for staff on raising concerns and will signpost staff to other sources of advice where necessary. In addition, the Guardian will help to support the Trust to become a more open and transparent place to work.

Head of Risk & Governance - has day-to-day responsibility for risk management process, quality governance and safety management including:

- the development of risk management strategy and policies;
- administration of risk management systems;
- oversight of risk exposures facing the business;
- provision of risk management training and support to divisions
- the maintenance of the corporate risk register
- support the development of local risk registers
- lead in triangulating and sharing lessons for learning from adverse events
- risk management training
- management of legal services

The Senior Risk Manager and Risk Manager also provide advice and support on risk management to staff

Head of Safeguarding - has day-to-day responsibility for ensuring risks relating to safeguarding adults and children are managed in line with local policies and through collaborative working with other agencies and safeguarding practitioners.

UNIQUE IDENTIFIER NO: G-101-2017
Review Date: January 2018
Review Lead: Head of Governance and Risk

Appendix 4 - Risk Grading Matrix

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

UNIQUE IDENTIFIER NO: G-101-2017
Review Date: January 2018
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2 Likelihood score

What is the likelihood of **the impact / consequence** occurring?

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
How often might or / does this happen	Not expected for years	Possible Annual Occurrence	Possible Monthly	Possible to occur weekly	Expected to occur daily
Probability	< 1 in 1000 chance	≥ 1 in 1000 chance	≥ 1 in 100 chance	≥ 1 in 10 chance	≥ 1 in 5 chance

Table 3 Risk scoring = Impact / Consequence x likelihood

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risks on the risk register, the scores obtained from the risk matrix are assigned grades as follows

1- 6	Low Risk
8-12	Moderate Risk
15-25	Significant Risk

NB: Change to reflect flow chart at p 26

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Appendix 5

Incident Grading Matrix

Degree of Harm (	Description	Severity grading
No harm / near miss Impact prevented (near miss)	An incident that might have had the potential to cause harm but was prevented, resulting in no harm	Green
No harm Impact not prevented	An incident that occurred but no harm resulted	Green
Low / Minimal harm	An unexpected or unintended incident where patient (s) required extra observation or minor treatment and caused minimal harm to one or more persons	Yellow
Moderate / Short term harm	An unexpected or unintended incident where patient(s) required further treatment or procedure which caused significant but not permanent harm (e.g. increase in length of hospital stay by 4-15 days)	Orange
Severe / permanent or long term harm	An unexpected or unintended incident that appears to have resulted in permanent harm	Red
Death caused by the patient incident	An unexpected or unintended incident that directly resulted in death	Red

11. Integrated Performance Report

To Approve

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 4th January 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: INTEGRATED PERFORMANCE REPORT - The Board is asked to approve the Integrated Performance Report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board, Quality Committee, Finance and Performance Committee	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

November's Performance Score has improved to 62% for the Trust.
The SAFE domain is back to AMBER having deteriorated to RED following a reported Never Event last month.
The EFFECTIVE domain has maintained its GREEN rating for the third month running.
The RESPONSIVE domain has maintained AMBER with improved performance seen across the Cancer metrics.
EFFICIENCY & FINANCE has improved in the Efficiency metrics but remains RED. WORKFORCE remains RED with all 5 Mandatory Training focus areas missing target.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

November's Performance Score has improved to 62% for the Trust.
The SAFE domain is back to AMBER having deteriorated to RED following a reported Never Event last month.
The EFFECTIVE domain has maintained its GREEN rating for the third month running.
The RESPONSIVE domain has maintained AMBER with improved performance seen across the Cancer metrics.
EFFICIENCY & FINANCE has improved in the Efficiency metrics but remains RED. WORKFORCE remains RED with all 5 Mandatory Training focus areas missing target.

Appendix

Attachment:

IPR Board Report Nov 2017 v2.pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Quality and Performance Report

November 2017

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 example last month **September's** performance increased from **60% to 63%** which was quite unusual but due to several factors. Cancer: Breast Symptomatic originally missed target but then achieved the target following further validation. The Category 4 pressure ulcer originally recorded was validated out for September. In addition we had been reporting Stroke one month in arrears due to capacity issues but this was resolved last month and September's performance was better than August's therefore this resulted in further improvement.

For **October's** performance there have been no such changes and performance remains at 59%.

Comparing November 2016 performance to November 2017 performance

November 2016 performance **(67%)** was **5 percentage points (32 points)** better than **November 2017 (62%)**. The main areas of deterioration are **Mandatory Training (48 points)**, Finance (10 points) and Activity (8 points). On the contrary we had a Never Event in November 2016, SHMI and HSMR were worse and sickness was worse.

Comparing 6 months' performance to October with previous 6 months' performance

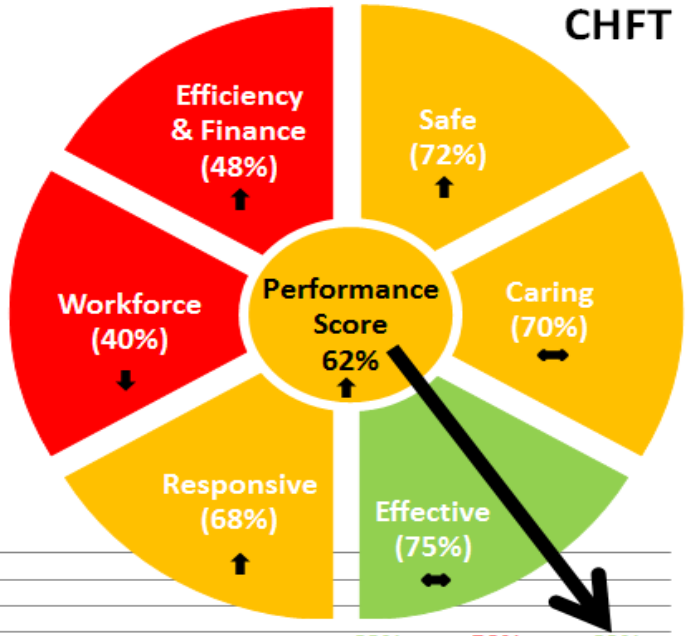
May to October 2017 (6 months) versus previous 6 months **November 2016 to April 2017**. **November to April's** performance **(65%)** was **7 percentage points** better than **May to October (58%)**. Again the main area of deterioration was **Mandatory Training (4 percentage points)**, this is only compensated by an equivalent improvement in **Sickness (4 percentage points)**. **Cancer 2 week waits (2 percentage points)** and **Activity (1 percentage point)**. **SHMI and HSMR** have improved **(2 percentage points)**.

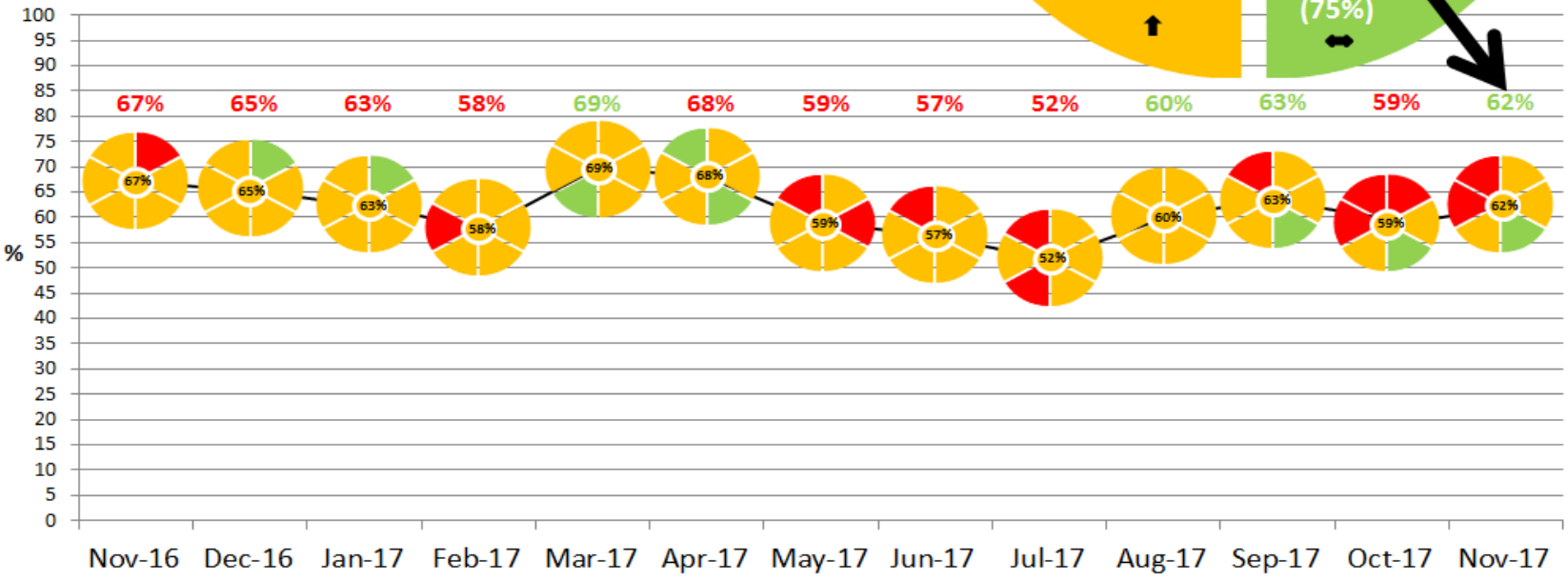
Performance Summary

November

RAG Movement

November's Performance Score has improved to 62% for the Trust. The SAFE domain is back to AMBER having deteriorated to RED following a reported Never Event last month. The EFFECTIVE domain has maintained its GREEN rating for the third month running. The RESPONSIVE domain has maintained AMBER with improved performance seen across the Cancer metrics. EFFICIENCY & FINANCE has improved in the Efficiency metrics but remains RED. WORKFORCE remains RED with all 5 Mandatory Training focus areas missing target.





SINGLE OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	FFT A&E
FFT OP	FFT Maternity FFT IP FFT Community
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
CDiff Cases	Avoidable Cdiff
MRSA	SHMI
HSMR	HSMR - Weekend

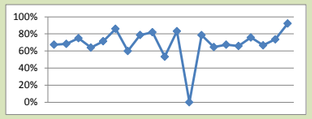
RESPONSIVE	Diagnostics 6 weeks
RTT Incomplete Pathways	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	96.8%	97.1%	↓	96.3%
	Inpatient Complaints per 1000 bed days	2.5	2.5	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	4.24	4.38	↑	5.17
	Delayed Transfers of Care	2.38%	3.51%	↑	3.5%
	Green Cross Patients (Snapshot at month end)	119	90	↓	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	91.47	91.08	↓	100
	Theatre Utilisation (TT) - Trust	83.5%	82.3%	↑	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.69%	0.89%	↑	0.6%
	Emergency Care Standard 4 hours	90.96%	94.17%	↓	95%
	% Incomplete Pathways <18 Weeks	92.45%	92.08%	↑	92%
	62 Day GP Referral to Treatment	88.3%	83.8%	↑	85%
SAFE	% Harm Free Care	93.41%	93.90%	↓	95.0%
	Number of Outliers (Bed Days)	627	516	↓	495
	Number of Serious Incidents	5	5	↔	0
	Never Events	0	1	↑	0

MOST IMPROVED

Improved: Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - Best performance in the last 18 months at 92%.



Improved: Delayed Transfers of Care - reducton in month to 3.01%, well below monthly target of 3.5%.

Improved: Average time to start reablement has significantly improved from 15.3 to 8.6 days. There has been some work undertaken with the reablement teams by social care managers to support the movement of patients through reablement, thus enabling a reduced wait for this service.

MOST DETERIORATED

Deteriorated: Emergency Care Standard 4 hours at 91% (92.2% including types 2 and 3) worst performance since May following last month's best performance since April. However still 8 percentage points above the England average.

Deteriorated: All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days. Breach of Patient Charter - The patient was cancelled for an emergency patient. Under the Patient Charter regulations the patient was given a new date within 28 days (day 27). However, the patient was cancelled again on day 26 due to an emergency case. The patient was cancelled following advice from the consultant.

Deteriorated: Mandatory Training is now behind on all 5 agreed topics with Fire Safety moving to Red.

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

ACTIONS

Action: The ECS recovery and sustainability Plan actions continue to be worked through and implemented. The directorate continues to work with the divisions and flow team to embed the action cards. The GM and Operational manager have been in "containment" in the department during November.

Action: The escalation process is being reviewed.

Action: Divisions, led by the HR Business Partners, are developing action plans to improve mandatory training compliance by March 2018. This includes standing items at Divisional Board and Directorate PRMs, promotion of open learning sessions, FAQ guidance issued to all line managers and compliance lists sent to all line managers. The action plans will be taken to Executive Board in January 2018. A weekly paper will be presented at Executive Board from 21st December giving an update on mandatory training compliance.

Arrow direction count ↔ 2 ↑ 9 ↓ 8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.5	7.5	↔	
Sickness Absence Rate	4.07%	4.02%	↓	4.0%
Turnover rate (%) (Rolling 12m)	12.81%	12.95%	↑	12.3%
Vacancy	318.08	333.55	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	79% (Q2)	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) Q1	57% (Q2)	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£9.95	-£8.70	
Expenditure vs Plan var (£m)	£3.42	£4.50	
Liquidity (Days)	-22.00	-28.52	
I&E: Surplus / (Deficit) var - Control Total basis (£m)	-£3.79	-£2.48	
CIP var (£m)	£0.38	£0.75	
UOR	3	3	
Temporary Staffing as a % of Trust Pay Bill	13.02%	14.52%	

Executive Summary

The report covers the period from November 2016 to allow comparison with historic performance. However the key messages and targets relate to November 2017 for the financial year 2017/18.

Area	Domain
Safe	• **% Harm Free Care** - Performance deteriorated slightly in-month to 93.4%. Within the Medical division a number of initiatives continue to be strengthened (changes to the format of the pressure ulcer panel, progress with the falls action plan) to impact on improving the position.
Caring	• **Complaints closed within timeframe** - Of the 74 complaints closed in October, 53% of these were closed within target timeframe. CHFT aims to have backlog of complaints closed by 6th January with complaint panels and aid from corporate staff aiming to close 15 complaints per week. With senior divisional support this model will sustain an effective complaints procedure. 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 is still not achieving target. The task and finish group established by the ADN has identified 2 clinical specialty areas to work with and test improvements and is also undertaking Go-See reviews. Healthwatch have been invited to undertake a more detailed study which has been scoped by the Chief Nurse. • **Friends and Family Test A & E Survey -** Response Rate has remained at 11% in-month whilst % would recommend has fallen just below target. The directorate continues to work with the teams in department and CDU to improve both of these indicators. The "you said, we did" board implemented last month continues to provide information to patients on improvements undertaken and the customer service training for A&E reception staff continues to be rolled out.
Effective	• **Clostridium Difficile Cases** - There were 6 cases in-month, highest number in the last 12 months, with 4 in Medicine and 2 in Surgery. The Infection control plan continues to be worked through, the Perfect Ward application trial has generated feedback which has been fed back to assist in the development of the local ward assurance tool. Performance from this will go to PSQBs in the future. • **Mortality Reviews** - The new Learning from Deaths policy was approved in August which describes the ambition to perform initial screening reviews on all deaths plus Structured Judgment Reviews (SJR) on selected cases from September. As expected there were some improvements in performance in October, an additional measure will appear to record the % of applicable cases undergoing SJR. • **% Sign and Symptom as a Primary Diagnosis** - Improvement on previous month and lowest position since EPR go-live. There is significant variation at specialty level and only FSS are achieving the target. The audit work continues within specialties and specific S&S groups e.g. patients discharged with a sign/symptom primary diagnosis or patients with a sign/symptom as a primary diagnosis who die within 30 days of discharge.

Background Context

Medicine has continued with the reconfiguration of Cardiology, Respiratory and Elderly services, gaining approval from QIA, Quality Committee, DMB, Trust Board and the Joint Overview and Scrutiny Committee. This resulted in 7 significant ward moves over a 3-4 week period. Overall the ward moves were successful thanks no end to the fantastic effort and attitude of all colleagues involved in the process.

On Saturday 2nd December YAS implemented the new pathways and protocols in terms of directing crews to HRI for Elderly Care patients and CRH for Cardiology and Respiratory patients. Initial assessment is that patients are being taken to the correct site however short stay frailty is proving difficult to differentiate leading to increased volume at the HRI site and capacity is being reviewed.

Throughout this period both EDs and acute medical teams again did a great job supporting patients and colleagues throughout the go-live period and ensuring the delivery of safe care. The ECS performance throughout November was extremely challenged and whilst there were occasional flow issues related to the ward moves and bed availability the key issue was medical AED staffing, independent of reconfiguration.

Both sites have continued with the implementation of the action cards; as expected this has been challenging to roll out across all divisions but all teams continue to drive this initiative.

Executive Summary

The report covers the period from November 2016 to allow comparison with historic performance. However the key messages and targets relate to November 2017 for the financial year 2017/18.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** deteriorated to 90.96% in November, worst performance since May - The ECS recovery and sustainability Plan actions continue to be worked through and implemented. The directorate continues to work with the divisions and flow team to embed the action cards. • **% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival/% Stroke patients scanned within 1 hour of hospital arrival -** these 2 indicators continue to miss target month on month. The stroke team continue to explore the opportunity to create an assessment area in ED to improve the overall management of stroke patients. If the assessment area is created patients who self-present or initially appear to be a minor Neurological condition should be seen promptly by a Stroke Consultant to rule in/out a Stroke and the need for any intervention. Without a change in practice the standard will remain static and the percentage variance will only change with the amount of patients that enter the service. • **All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days. Breach of Patient Charter -** The patient was cancelled for an emergency patient. Under the Patient Charter regulations the patient was given a new date within 28 days (day 27). However, the patient was cancelled again on day 26 due to an emergency case. The patient was cancelled following advice from the consultant. The escalation process is being reviewed. • **% Diagnostic Waiting List Within 6 Weeks** - missed the 99% target for 4 out of the last 5 months. Validation continues with the first submission of Endoscopy waiting times since EPR go-live impacting on performance. • **38 Day Referral to Tertiary** - deteriorated for the second month to 45% following its peak in September. This is being addressed at the weekly escalation meeting.
Workforce	• **Overall Sickness absence** has deteriorated slightly in-month due to an increase in long-term sickness although still within LT sickness target. Monthly attendance management sessions supporting line managers are scheduled until March 2018. • **Mandatory Training** is now behind on all 5 agreed topics with Fire Safety moving to Red. Divisions, led by the HR Business Partners, are developing action plans to improve mandatory training compliance by March 2018. This includes standing items at Divisional Board and Directorate PRMs, promotion of open learning sessions, FAQ guidance issued to all line managers and compliance lists sent to all line managers. The action plans will be taken to Executive Board in January 2018. A weekly paper will be presented at Executive Board from 21st December giving an update on mandatory training compliance.
Finance	• **Finance**: Reported year to date deficit position of £17.85m, an adverse variance of £3.79m compared with the control total of £14.07m; • Delivery of CIP is above the planned level at £10.35m against a planned level of £9.97m; • Capital expenditure is £5.17m below plan due to revised timescales; • Cash position is £1.99m, just above the planned level; • A Use of Resources score of level 3, in line with the plan. The Month 8 reported position is a deficit of £17.85m on a control total basis. The financial position has continued to deteriorate with activity and income significantly below the original planned level and growing cost pressures. The underlying financial shortfall against the financial plan in the year to date is £13.4m excluding the impact of STF. The Trust continues to report a forecast in line with the Control Total deficit of £15.94m, however the deteriorating position leaves the Trust with the requirement to deliver recovery plans of the magnitude of £11m, to cover the growing underlying gap between the planned deficit and operating position. The size of this gap is unlikely to be resolved quickly enough to achieve the control total over the next 4 months and the Trust is now forecasting an adverse variance from plan during Months 7-11. STF funding of £6.57m for Quarters 3 and 4 remains at risk and will only be made available if the Trust can deliver full recovery back to plan.

Background Context

FSS received delivery of equipment in November which will be used for the Trust's Electronic Blood Tracking System. Stage 1 of the project will go live in April 2018.

This month FSS formally launched the new Familial Hypercholesterolemia service. CHFT is one of four Trusts across Yorkshire to host this service which highlights and screens those patients at risk of future heart attack due to hereditary factors.

The Radiology team presented a business case for the replacement of the CRH MRI scanner at the Trust's Commercial Investment Group this month. The case was approved in principle and the scheme will now move into the planning phase including options for financing.

There was a significant amount of work undertaken in November on supporting the Community Place to ensure that the service can deliver 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 future strategy for therapy services is being developed and is anticipated to be complete by March 2018.

There has been further work undertaken on the recovery at home programme of work - this is to enhance the already established Reablement team with support from registered therapists to enable people to be discharged from hospital quicker. Waiting for commissioners to give approval to proceed.

Due to Surgery's urgency to recover its performance and financial position it has prioritised the following areas: Supporting ECS, Cancer, Complaints, #NoF, IP/OP workforce capacity and its utilisation, Endoscopy recovery plan and JAG accreditation, Large Value off Track CIPs and Data Quality.

Budget has been agreed for Surgery to appoint 2 additional operational managers who are due to commence in post 2nd January with temporary additional management capacity from November to accelerate improvement in performance in the high priority areas.

Safe, Effective, Caring, Responsive - Community Key messages

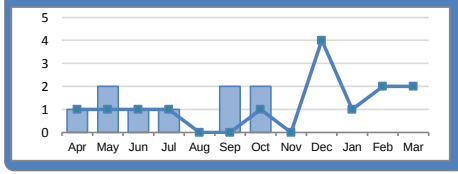
Area	Reality	Response	Result
Safe	Grade 3/4 pressure ulcers We are maintaining a low prevalence of grade 3/4 pressure ulcers with two grade 3 being reported in October.	Grade 3/4 pressure ulcers Continued work is progressing with tissue viability. We have released one senior nurse to focus more dedicated time on wound care and pressure ulcers. Orange panel continues to review all grade 3 and 4 pressure ulcers.	Grade 3/4 pressure ulcers Continue to maintain and improve performance in this area. By when: Review December 2017 Accountable: ADN
Effective	Admission Avoidance Our new frailty service that started in October continues to support admission avoidance for frail and elderly patients who can be supported effectively in their own home.	Admission Avoidance The frailty team identify patients in A&E and on short stay or assessment wards. They meet together for a daily MDT to ensure patients have the right level of MDT input and follow up. This is proving to be a very successful pilot and it is hoped that sufficient evidence is available to continue after the 12	**Admission Avoidance** **The pilot will be reviewed in January with an expectation that there will be continued service due to its early successes.** **By when: January 2017** **Accountable: Matron Intermediate Tier Services**
Caring	FFT The new method of recording FFT has been implemented in October. We have increased response rate from 2% to 4% in November. The would recommend performance stands at 97% with the new reporting method.	FFT We have chosen one day a month for staff to collect FFT via the web form or paper forms that are then inputted onto web forms for reporting. Our response rate has increased in the second month of undertaking this new process. It provides a more realistic view of FFT "would recommend" as it directly relates to the community service experience rather than hospital or primary care which the previous system captured.	FFT We will continue to monitor the response rate and would recommend and drill down into comments so we can develop responses for improvement. By when: Review March 2018 Accountable: Director of Operations
Responsiveness	Waiting Time for Children's services Orthotics waiting times, particularly for children improved for our Calderdale patients in November. The current wait for children at Calderdale has reduced significantly to 39 days from 121 days. The Huddersfield service continues to be challenging however with the maximum wait for children at 128 days. Children's Therapies waiting times are long due to the increased demand and static capacity available in the teams. There are particular issues in SALT in Calderdale due to the current commissioning arrangements and OT in Huddersfield for similar reasons.	Waiting Time for Children's services Additional Orthotics clinics have been put on and some adult clinics have been converted to children's clinics to improve the situation. Commissioner dialogue continues to occur to get to a point where we can agree a model of delivery that supports the level of demand experienced. Terms of reference for an external review are being developed.	Waiting Time for Children's services An improved position in Orthotics is hoped to be available by January. An external review is hoped to be commissioned to commence in early 2018. By when: January 2018 Accountable: Head of Therapies

Dashboard - Community

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

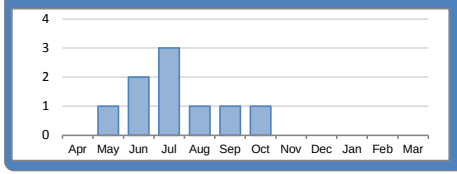
Safe

Community acquired grade 3 or 4 pressure ulcers



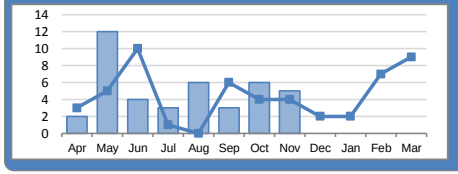
One month in arrears

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

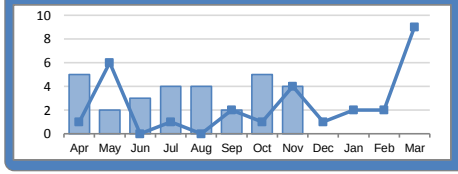


One month in arrears

Incidents - New Harms

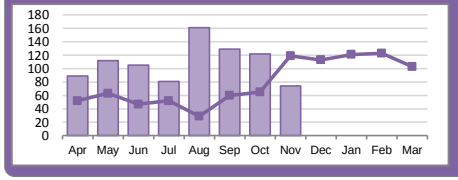


Medication Incidents

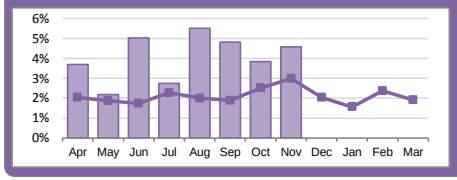


Effective

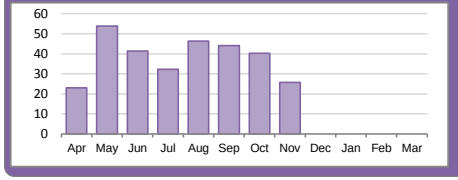
Number of Hospital admissions avoided by Community Nursing services



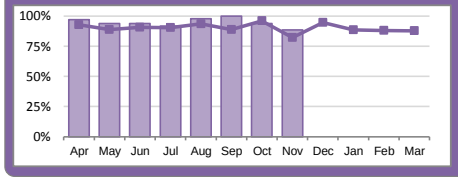
Patients who attended A&E while on a Community Matron Caseload, who readmitted within 30 days



Intermediate Care Bed base (Average Days)

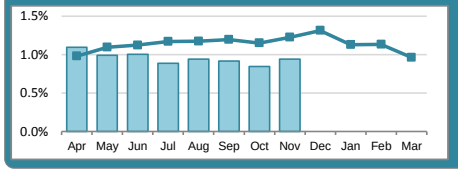


House Bound leg ulcers healed within 12 weeks

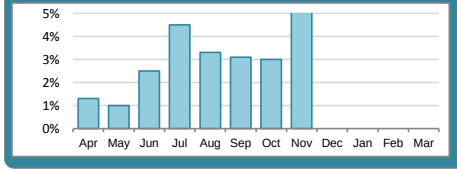


Caring

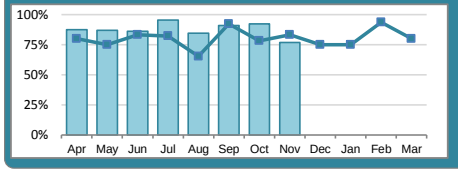
Community No Access Visits Adult Nursing



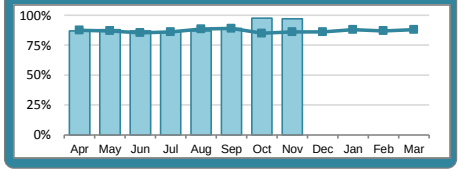
Intermediate Care Readmission rate



End of life patient died in preferred place of death

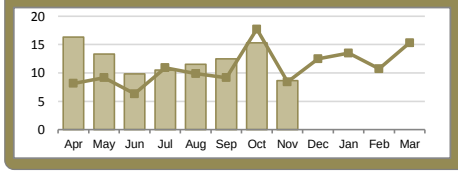


Friends and Family Test- Likely to recommend

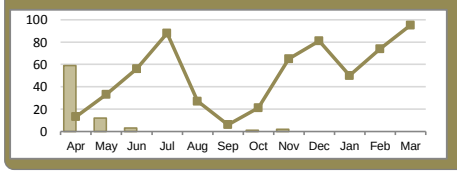


Responsive

Average time to start of reablement (days)

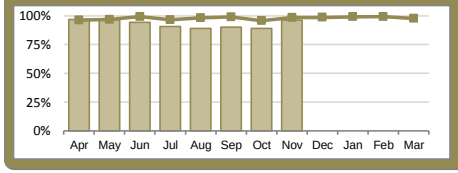


Appointment Slot Issues for MSK & Podiatry

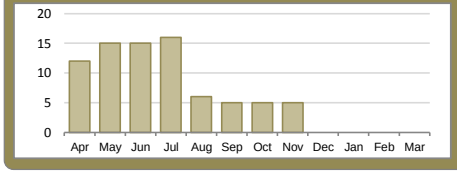


MSK Podiatry

Waiting Times - 18 week RTT

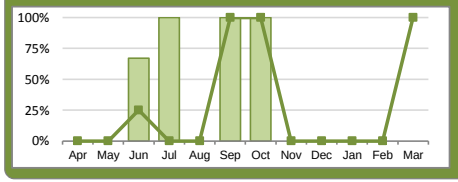


Waiting Times - Physiotherapy Routine (Weeks)

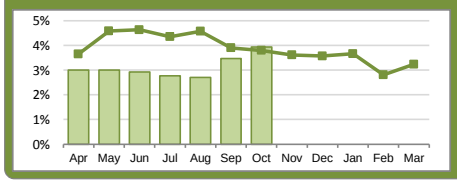


Well Led

% Complaints closed within target timeframe

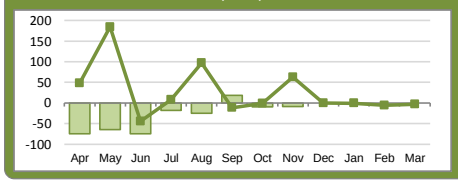


Staff sickness rate

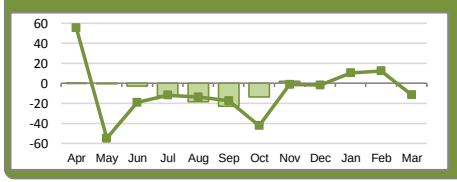


One month in arrears

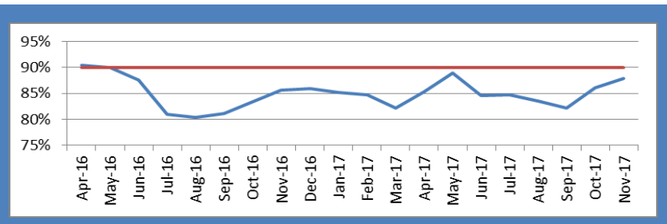
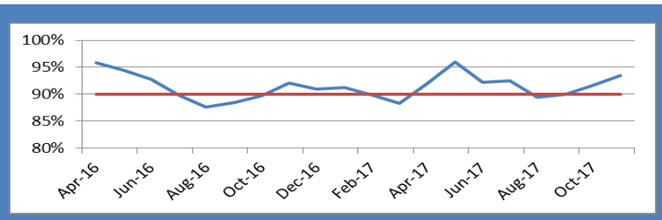
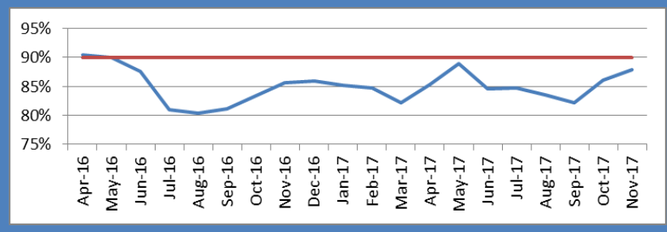
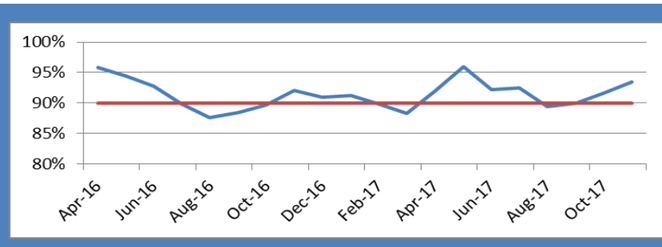
Finance - Planned variance against actual (£'000)



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.	87.87% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - WARD 12: 72.0% - WARD 20: 71.5%	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 to ensure safe staffing against patient acuity and dependency is achieved. The low fill rates reported in November are attributed to a level of vacancy, teams not achieving their WFM and supporting additional capacity wards.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	93.5% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% -WARD 7C : 74.2% -WARD 8AB : 74.4% -WARD 10 : 66.4%	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 November are attributed to a level of vacancy, and staffing deployment as a result of reduced bed occupancy + patient acuity.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	102.95% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% -WARD 6A : 72.0% - WARD 8AB: 73.3% - WARD LDRP : 66.7% - WARD NICU : 68.3%	The low HCA fill rates in November are attributed to fluctuating bed capacity and a level of HCA vacancy within the FSS division. 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.	113.53 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75%	There have been no shifts with fill rates below 75% recorded in November on either site. 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

Ward	DAY						NIGHT						Care Hours Per Patient Day							
	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	% Bed Occ	MSSA (post cases)	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies
	Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual											
CRH MAU	1980	1866	1170	1179	94.2%	100.8%	1320	1503.5	990	842	113.9%	85.1%	14.7	14.5	51.90%				4	5.96	2.83
HRI MAU	1980	1919	2070	1888.5	96.9%	91.2%	1650	1646	1320	1427	99.8%	108.1%	12.5	12.3	62.40%			1	14		
WARD 2AB	1845	1508.5	1170	1519.5	81.8%	129.9%	1320	1320	660	671	100.0%	101.7%	6.3	6.3	84.10%			2	8	6.6	3.84
HRI Ward 5 (previously ward 4)	1620	1377.5	1170	1441	85.0%	123.2%	990	1012	990	1378	102.2%	139.2%	5.7	6.2	111.70%				4	0.07	
HRI Ward 11 (previously Ward 5)	2017.5	1735	982.5	1097.7	86.0%	111.7%	1320	1306.5	660	726	99.0%	110.0%	6.3	6.2	100.80%			1	9	4.74	
WARD 5AD	2070	1884	1530	1663.24	91.0%	108.7%	1320	1122	1320	1144	85.0%	86.7%	6.6	6.1	101.20%			5	12	4.33	
WARD 5C	1035	964.5	810	780	93.2%	96.3%	660	660	330	341	100.0%	103.3%	5.6	5.5	106.50%			1	3	4.28	
WARD 6	1620	1525	1170	1100	94.1%	94.0%	990	1001	660	693	101.1%	105.0%	7.0	6.8	92.20%			1	8	0.86	2.3
WARD 6BC	1620	1536.3	1170	1184	94.8%	101.2%	1320	1329	660	700	100.7%	106.1%	5.0	5.0	100.00%				5		
WARD 5B	1092	867.5	672	952.5	79.4%	141.7%	616	616.5	616	800	100.1%	129.9%	5.5	6.0	112.70%			1	3	3.65	0.02
WARD 6A	945	798.5	945	680	84.5%	72.0%	660	663	330	353	100.5%	107.0%	6.0	5.2	107.10%				3	1.2	2.68
WARD CCU	1620	1536.3	1170	1184	94.8%	101.2%	1320	1329	660	700	100.7%	106.1%	18.1	18.0	67.70%				2		
WARD 7AD	1620	1354.5	1530	1692	83.6%	110.6%	990	1001	990	990	101.1%	100.0%	7.3	7.2	92.90%				5	3.01	1.19
WARD 7B	810	867	810	1022	107.0%	126.2%	660	704	330	473	106.7%	143.3%	7.5	8.8	96.70%				3	2.02	
WARD 7C	1620	1265	810	824	78.1%	101.7%	1320	979	330	660	74.2%	200.0%	11.7	10.7	78.10%						
WARD 8	1395	1167	1170	2042.55	83.7%	174.6%	990	979	990	1408	98.9%	142.2%	5.6	6.9	126.40%			2	6	5.11	
WARD 12	1620	1167	810	1018.5	72.0%	125.7%	990	871	330	638	88.0%	193.3%	6.4	6.3	98.30%			2	1	1.62	2.05
WARD 17	1980	1566.5	1170	1036	79.1%	88.5%	990	998.5	660	674.5	100.9%	102.2%	5.9	5.3	112.70%			1		2.91	
WARD 8C	432	413	432	441.5	95.6%	102.2%	286	268.5	143	180	93.9%	125.9%	8.5	8.5	99.40%						
WARD 20	1615.5	1155	1134.5	1301.5	71.5%	114.7%	787.5	765.5	787.5	811.5	97.2%	103.0%	6.0	5.6	85.90%				4	6.92	1.94
WARD 21	1129.5	908.5	1017	1106.6	80.4%	108.8%	860	804	860	851	93.5%	99.0%	9.8	9.3	71.50%			1	5	3.69	0.79
ICU	3900	3403.75	795	701.5	87.3%	88.2%	4140	3337.5	0	23	80.6%	-	47.0	39.7	42.20%			1	1		
WARD 3	915	911	735	716	99.6%	97.4%	690	690	345	345	100.0%	100.0%	6.6	6.6	90.40%			1	3		1.59
WARD 8AB	1034	859.5	945	693	83.1%	73.3%	943	701.5	253	391	74.4%	154.5%	9.2	7.6	41.20%					1.57	0.79
WARD 8D	795	773.5	795	731.5	97.3%	92.0%	690	517.5	0	172.5	75.0%	-	8.2	7.9	66.40%				2	2.07	0.77
WARD 10	1260	1141.5	735	888.5	90.6%	120.9%	1035	687	345	690	66.4%	200.0%	6.6	6.6	85.50%					6.02	
WARD 15	1520	1502.5	1214	1175	98.8%	96.8%	1035	1012	345	667	97.8%	193.3%	5.7	6.0	95.80%			2	2	2.66	
WARD 19	1590	1343.5	1140	1362	84.5%	119.5%	1035	1023.5	1035	1149.5	98.9%	111.1%	7.5	7.7	96.40%			6	2	2.53	
WARD 22	1140	1063.5	1140	1057	93.3%	92.7%	690	690	690	690	100.0%	100.0%	5.9	5.6	90.40%			1	1	1.55	2.47
SAU HRI	1830	1414.5	943	842.5	77.3%	89.3%	1380	1368.5	345	356.5	99.2%	103.3%	9.2	8.2	82.00%			3	1	2.36	0.29
WARD LDRP	4140	3586	915	610.5	86.6%	66.7%	4140	3535	690	528.8	85.4%	76.6%	19.1	15.9	82.70%						
WARD NICU	2175	1815.5	900	615	83.5%	68.3%	2070	1828.5	690	540.5	88.3%	78.3%	11.2	9.2	57.00%					4.39	1.11
WARD 1D	1200	1175.5	345	387	98.0%	112.2%	690	644	345	345	93.3%	100.0%	4.4	4.4	129.70%					1.72	0.11
WARD 3ABCD	3045	2876.5	1170	902.5	94.5%	77.1%	2415	2545.5	345	471	105.4%	136.5%	7.2	7.1	56.50%						2.36
WARD 4C	690	690	450	373	100.0%	82.9%	690	690	345	356.5	100.0%	103.3%	7.2	7.0	80.90%				3	5.51	1.9
WARD 9	1035	950	345	333.5	91.8%	96.7%	690	690	345	333.5	100.0%	96.7%	5.1	4.9	103.40%				2	1.66	
WARD 18	767	694	132	121.5	90.5%	92.0%	690	658.5	0	20	95.4%	-	19.1	18.0	26.30%						
Trust	58702.5	51582.35	35612	36664.1	87.87%	102.95%	44382.5	41498	20734.5	23540.8	93.50%	113.53%	7.9	7.6							

Hard Truths: Safe Staffing Levels (3)

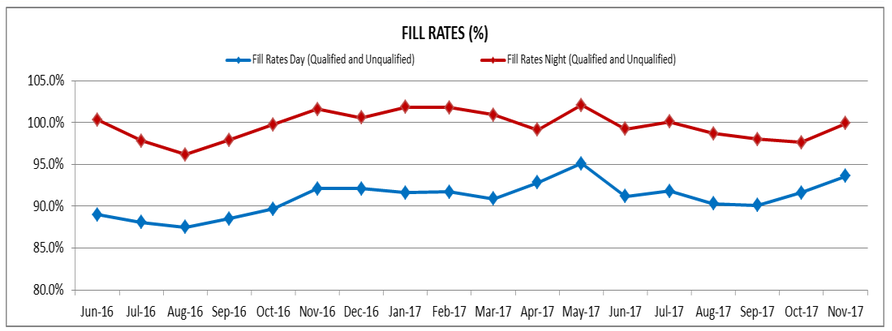
Care Hours per Patient Day

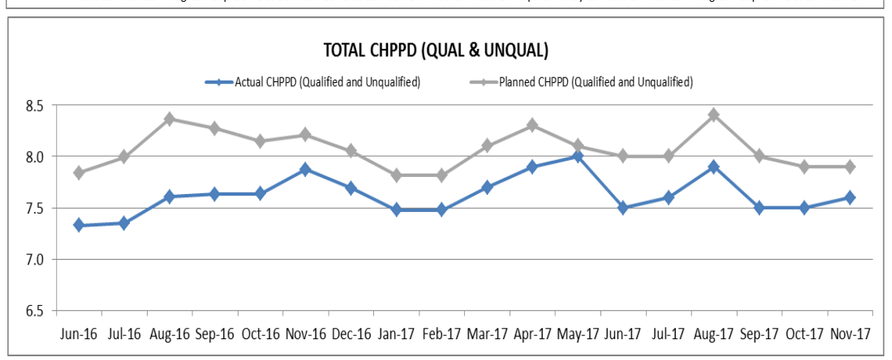
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Sep-17	Oct-17	Nov-17
Fill Rates Day (Qualified and Unqualified)	90.10%	91.60%	93.60%
Fill Rates Night (Qualified and Unqualified)	98.00%	97.60%	99.90%

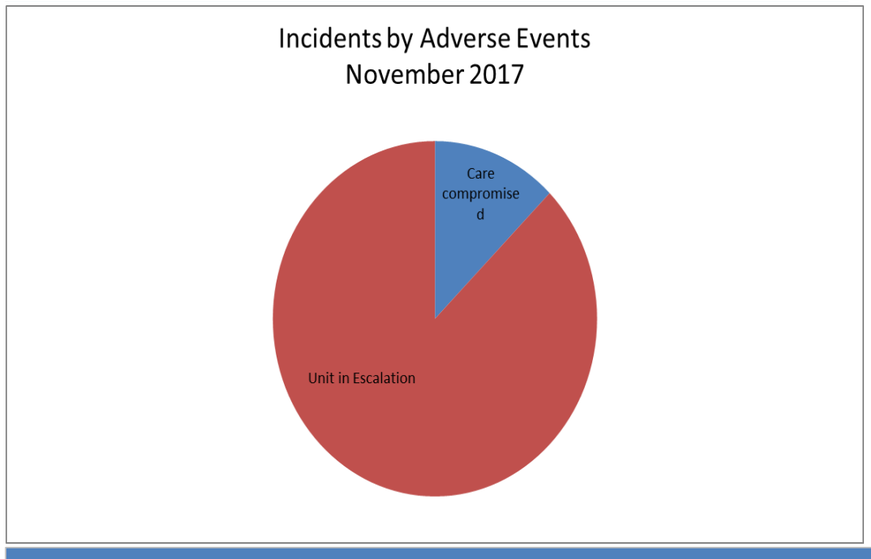
Planned CHPPD (Qualified and Unqualified)	8.0	7.9	7.9
Actual CHPPD (Qualified and Unqualified)	7.5	7.5	7.6

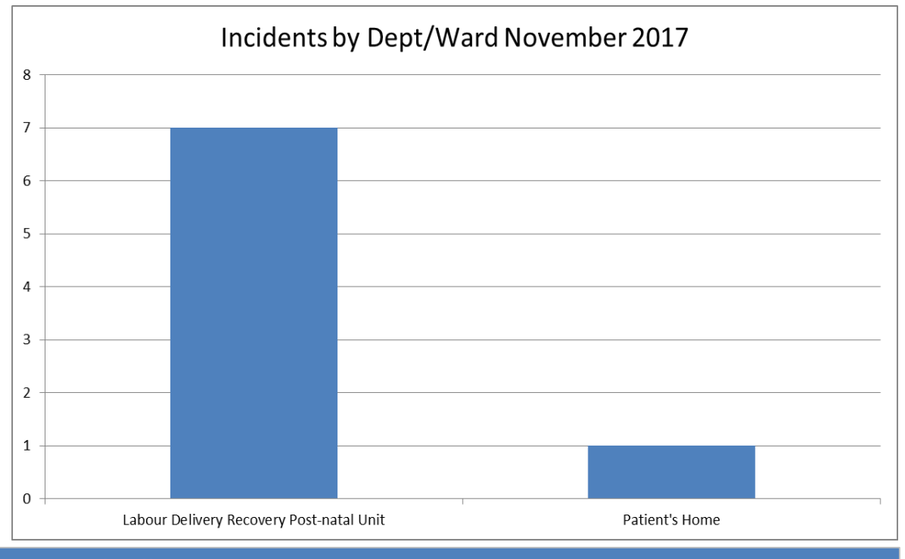
A review of November CHPPD data indicates that the combined (RN and carer staff) metric resulted in 26 clinical areas of the 37 reviewed had CHPPD less than planned. 6 areas reported CHPPD as planned. 5 areas reported CHPPD slightly in excess of those planned. Areas with CHPPD more than planned were 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 correct 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 review monthly through the Nursing workforce strategy group.

There were **8 Trust Wide Red shifts** declared in **November**. The Red flagged shifts were resolved within the Divisions. Each incident is investigated with feedback given to individuals and actions taken to address concerns where appropriate. The 8 incidents have been recorded as no harm to patients at the point of reporting.

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 3 nurses have arrived in Trust, with a further 9 planned for deployment in January 2018

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 expedite 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 being developed to up-scale the project in line with the national & regional workforce plans.

6. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment & retention of the graduate workforce. This is being 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 & 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

12. Month 8 - 2017-18 Financial Narrative

To Approve

Presented by Gary Boothby

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 4th January 2018	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Financial Commentary for NHS Improvement - Month 8 - The attached commentary was submitted to NHS Improvement on the 15th of Dec 2017 alongside the Month 8 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:

See attached

The Issue:

See attached

Next Steps:

-

Recommendations:

To note

Appendix

Attachment:

NHSI Financial Commentary Month 8_Final 2.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 8 NOVEMBER 2017, 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 November 2017.

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 8 position is a deficit of £23.41m on a control total basis, a £3.80m adverse variance from the planned deficit of £19.61m. This excludes year to date Sustainability and Transformation funding (STF) of £2.70m.

The final planning submission made to NHSI on 30th March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had a number of 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 initially assessed at £8m plus any subsequent loss of STF funding.

As was discussed with NHSI in the Financial Recovery meeting with the Trust on 4 December, in year these concerns have increased as the underlying financial position has continued to deteriorate. The underlying operational performance would drive an adverse financial variance of £13.4m to the year to date planned position (excluding the impact of lost STF funding) and in the first 6 months of the year the planned position was only achieved through a number of non-recurrent income and expenditure benefits totalling £7.53m, including a £3.5m negotiated settlement with the PFI facilities management provider in support of CIP delivery. This is in addition to the release in the year to date of the full £2m contingency reserve available for this financial year.

In Month 7 and 8 the Trust has been unable to deliver the financial plan reporting an adverse variance of £3.80m of which £1.30m related to Month 8. 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 just over £7m year to date.

As already 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 and remaining unidentified CIP of £1.8m. 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.

A recovery action plan has been implemented which aims to tackle: the recovery of clinical income at risk due to issues with capture and coding in EPR; the development of Divisional financial recovery plans; a Trust wide establishment review; further tightening of budgetary controls and the consideration of a

number of technical recovery options. In addition, an EPR stabilisation plan has been put into action to regain activity performance levels to the maximum achievable. This in itself drives additional cost requirements. Every effort will be made to deliver the financial plan, including pursuing innovative technical accounting benefits, but in this context full recovery is unlikely to be possible. Delivery of the financial plan remains the highest risk on the Trust risk register scoring the maximum of 25. Financial recovery plans are being implemented details of which are shown below in section 4.

Month 8, November 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	249.62	239.67	(9.95)
Expenditure	(246.97)	(243.55)	3.42
EBITDA	**2.65**	**(3.88)**	**(6.53)**
Non-operating items	(30.66)	(16.87)	13.78
Surplus / (Deficit)	**(28.00)**	**(20.75)**	**7.25**
Less: Items excluded from Control Total	13.94	0.04	(13.89)
Less: Loss of STF funding	0.00	2.85	2.85
Surplus / (Deficit) Control Total basis	**(14.07)**	**(17.85)**	**(3.79)**

- Delivery of CIP of £10.35m against the planned level of £9.97m.
- Contingency reserves of £2.00m have been released against pressures.
- Capital expenditure of £7.39m, this is below the planned level of £12.56m.
- Cash balance of £1.99m 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 £9.95m below plan year to date.

NHS Clinical Income

The year to date NHS Clinical income position is £211.94m, £10.72m below the planned level.

The Clinical Contract income position for Month 8 is £7.07m 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. An agreement has been reached with Commissioners to secure the Month 1-6 income position. However £0.2m of the Month 7 and 8 income is estimated income, in light of EPR capture issues and will rely on a further Commissioner agreement. The year to date position also assumes receipt of the full 2.5% of CQUIN including the STP and Risk Reserve elements, with the exception of £0.15m linked to Sepsis.

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 £4.5m 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 £0.7m year to date and beyond the control of the Trust.

Maternity pathway and NICU income which naturally fluctuate are both below plan with a combined impact of £0.18m 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. Delays in the delivery of a CIP / QIPP scheme to reduce inpatient capacity which was planned to result in a reduction in both cost and income is also contributing to higher than planned Non Elective income of around £0.80m.

In addition, there is an adverse variance of £3.65m on NHS Clinical income that is outside of contract, off which £2.85m 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 £1.5m (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 £2.01m Month 7 and 8 planned STF funding 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. Performance in Quarter 2 improved significantly; at Trust level 92.7% of patients were seen within the 4 hour target and at Delivery Board level performance was 94.33%, just below the 94.56% target. However, performance in Month 8 was below trajectory at 90.96%. The Quarter 1 deterioration compared to the very high levels reported in 16/17 were as a direct result of both the implementation of EPR and the adherence to IR35 guidance, and as such should be considered to be exceptional.

Other income

Overall other income is above plan by £0.77m year to date. Increased sales activity within our commercial operations, in particular the Pharmacy Manufacturing Unit (£1.0m) and Health Informatics Service (£0.37m), and assumed income for the Endoscopy fire insurance claim, have been offset to some extent by slippage in recovery of the Apprentice Levy of £0.3m compared to plan and lower than planned Car Parking income of £0.6m.

Operating expenditure

There is a cumulative £3.42m favourable variance from plan within operating expenditure across the following areas:

Pay costs	£0.44m adverse variance
Drugs costs	£0.31m adverse variance
Clinical supply and other costs	£4.17m 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. The total of non-recurrent benefits in the year to date position is £7.53m.

Employee benefits expenses (Pay costs)

Pay costs are £0.44m 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. The underlying pressure on pay expenditure is therefore £3.26m. There are a number of cost drivers including £0.50m due to the impact on Nursing pay of opening additional unplanned capacity, £0.9m due to delays in CIP / QIP schemes to close further beds 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 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 £11.41m year to date, with total Agency expenditure of £10.35m.

Drug costs

Expenditure year to date on drugs is £0.31m above the planned level. The income and corresponding spend on 'pass through' high cost drugs is £1.61m below plan, offset by additional costs of £1.51m 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 £0.21m.

Clinical supply and other costs

Clinical Support costs are £2.36m lower than planned. This underspend reflects an activity related underspend in clinical supplies of £1.54m, as well as a non-recurrent benefit of £0.82m relating to prior year creditors as described above.

Other costs are £1.81m lower than planned due to 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 £1.0m 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 £0.26m 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 the Board believes is extremely challenging.

£10.35m of CIP has been delivered this year against a plan of £9.97m, an over performance of £0.38m. This position includes non-recurrent CIP of £3.5m relating to the refund of PFI facilities management costs

mentioned above. The Trust has now identified £18.17m of savings, including further non- recurrent savings of £1.9m linked to a project to launch a Special Purpose Vehicle for Estates. The reported forecast assumes that the full £18.17m will be delivered, but this remains extremely challenging with a number of schemes currently flagged as high risk, in particular the £0.5m QIPP based scheme to close 48 beds.

Statement of Financial Position and Cash Flow

At the end of November 2017 the Trust had a cash balance of £1.99m, just above the planned level.

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	7.25
	Non cash flows in operating deficit	(13.64)
	Other working capital movements	(5.02)
	Sub Total	**(11.41)**
Investing activities	Capital expenditure	5.19
	Movement in capital creditors / Other	(2.19)
	Sub Total	**3.01**
Financing activities	Net drawdown of external DoH cash support	9.08
	Other financing activities	(0.63)
	Sub Total	**8.45**
	Grand Total	**0.04**

Operating activities

Operating activities show an adverse £11.41m variance against the plan. The impact of the I&E variance of £3.90m and loss of £2.85m STF funding, (Quarter 1 &2 A&E 4 hour performance and all of Month 7 and 8's allocation), plus the adverse cash impact of £5.02m working capital variances less the cash benefit of higher than planned Depreciation charges of £0.26m. Both the deficit and non-cash flows figures should be considered net of a £14m planned impairment which will now take place later in the year. The adverse working capital variance is driven by: an increase in receivables, due to the accounting of the £3.5m PFI credit described above, (the cash benefit of this credit is likely to fall at least in part into the next financial year), and an increase in NHS receivables of £0.5m; a reduction in the level of creditors of £2.34m; offset by higher than planned deferred income of £1.5m, due to the under-trade on some commissioner contracts which are paid upfront based on contract values. 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 £5.19m lower than planned and the resulting cash benefit has offset some of the pressure on working capital described above. However, this cash benefit has been partially offset by a reduction in Capital creditors 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 £22.12m of Revenue Support linked to deficit and STF funding requirements and a further £5.70m of working capital support. This is £9.08m more than planned: £3.80m linked to additional deficit

funding requirements, £2.25m due to the timing of STF payments and working capital support that is £3.03m higher than planned.

3. Use of Resources (UOR) rating and forecast

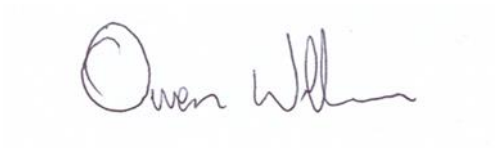
Against the UOR the Trust stands at level 3 in line with plan in year to date and forecast terms.

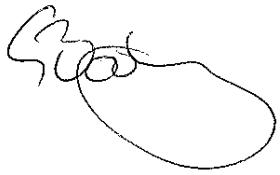
The reported forecast at Month 8 continues to report that the Trust will achieve its Control Total and secure STF allocation funding of £9.26m. However, the risk of failing to achieve our target deficit of £26.04m (excluding STF funding) remains, despite the Trust taking action to improve the financial position. The current position leaves the Trust with the requirement to deliver recovery plans of the magnitude of £11.1m plus secure the £1.9m benefit contingent upon the establishment of the Estates SPV. This is in addition to the ongoing CIP challenge and other risks, to cover the underlying gap between the planned deficit and operating position. As such, as discussed with NHSI, the Trust anticipates that the year-end forecast will move away from the control total deficit at the end of Quarter 3.

A number of recovery plans have been identified, although the majority are non-recurrent in nature and do not therefore address the underlying deficit position that will be carried forward into the next financial year. They are also not of a sufficient magnitude to address the full scale of this year's problem and in particular those elements of the deficit of an exceptional nature that have been driven by the implementation of EPR. The Trust would wish to continue with the open dialogue with NHSI around recognition of this position. The latest view of the recovery plans is shown in summary below and will be discussed in more detail with NHSI as scheduled on 18 December.

Recovery Actions	**Further recovery opportunity** £'000
Recovery Actions previously discussed with NHS I	
Enhanced Vacancy Control	250
Discretionary Spend: Hospitality etc (£75k included in forecast position)	25
Course Fees outside of Apprentice Levy (£75k included in forecast position)	75
Multi-professional staffing model review	40
Sub Total:	**390**
Further recovery Actions	
Supplier Discounts	150
Depreciation reduced due to SPV / asset lives	500
PDC reduced due to SPV	200
Further in year benefit from ISS	700
CCG Funding property rent increases (Yr2)	202
Sub Total:	**1,752**
Technical accounting recovery opportunities	
Sub Total:	**300**
Grand Total: Recovery actions	**2,442**

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 span the two year planning timeframe of 2017-2019.





Owen Williams
Chief Executive

Gary Boothby
Executive Director of Finance

13. Guardian of Safe Working

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Anu Rajgopal, Consultant Medical Microbiology
Date: Thursday, 4th January 2018	**Sponsoring Director:** Linda Cordingley, Executive Assistant to Chief Executive
Title and brief summary: Guardian of Safe Working Annual report - To provide assurance to the Board that doctors in training (junior doctors) under the new terms and conditions of service are working safe hours and to highlight any areas of concern.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

See attached report

Main Body

Purpose:

See attached report

Background/Overview:

See attached report

The Issue:

See attached report

Next Steps:

See attached report

Recommendations:

See attached report

Appendix

Attachment:

Annual report GOSWH Dec 2017.pdf

Annual report: (1st Dec 2016-18th Dec 2017)

Guardian of safe working hours, CHFT

Introduction

This is the first annual report of the Guardian of Safe working (GOSWH) to the board following the introduction of the 2016 terms and conditions of service (TCS) for doctors and dentists in training. This contract sets out to ensure that junior doctors are working in ways that are safe and fair whilst accessing their training programme to the full. The role of the GOSWH is referenced in the 2016 terms and conditions of service as the following:

- To ensure the confidence of doctors that their concerns will be addressed
- Require improvements in working hours and rotas for doctors in training
- Provide boards with assurance that junior medical staff are safe and able to work, identifying risk and advising boards on the required response
- Ensure that the fair distribution of financial penalty income, to the benefit of doctors in training.

The Board has received quarterly reports from the guardian to provide assurance that doctors are safely rostered and their hours are compliant with the TCS. The annual report will provide an aggregate of data compiled throughout the year and issues arising or any areas of concern and follows the suggested format provided by NHS Employers.

Executive summary

All doctors in training (junior doctors) at CHFT are now on the 2016 TCS. In the past 12 months, there has been considerable variation in the number of exception reports but consistently the vast majority of these are from FY1s in general surgery seemingly due to a heavier workload in these specialities. Four fines have been issued by the previous GOSWH on the general/urology/vascular surgery F1 rota in Q2 and further fines will be imposed on the surgical division for the same rota due to breeches in Q3. There is a reasonable awareness among Educational and Clinical supervisors about exception reporting and the 2016 TCS however there are a small number that need further support and training around the software for Allocate.

There has been a decrease in the unfilled shifts in the latter half of this last year with an increased use of bank staff to fill these. This should lead to improved junior doctor wellbeing. 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.

The regional Guardians' forum of Health Education England working across Yorkshire and the Humber has suggested that 1 WTE administrator is needed to support the Guardian from August 2017. The lack of dedicated administrative support is hampering the ability of

the Guardian to undertake their role and may prevent us from being able to effectively monitor breeches particularly those arising in relation to the 48-hour average working week.

Poor attendance at the quarterly junior doctor forums is worrying and an action plan has been drafted by the Guardian with support from medical education and human resources.

High level Data

Number of doctors / dentists in training (total):	Approx 222
Number of doctors / dentists in training on 2016 TCS (total):	Approx 222
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
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee
Amount of job-planned time for clinical supervisors:	None

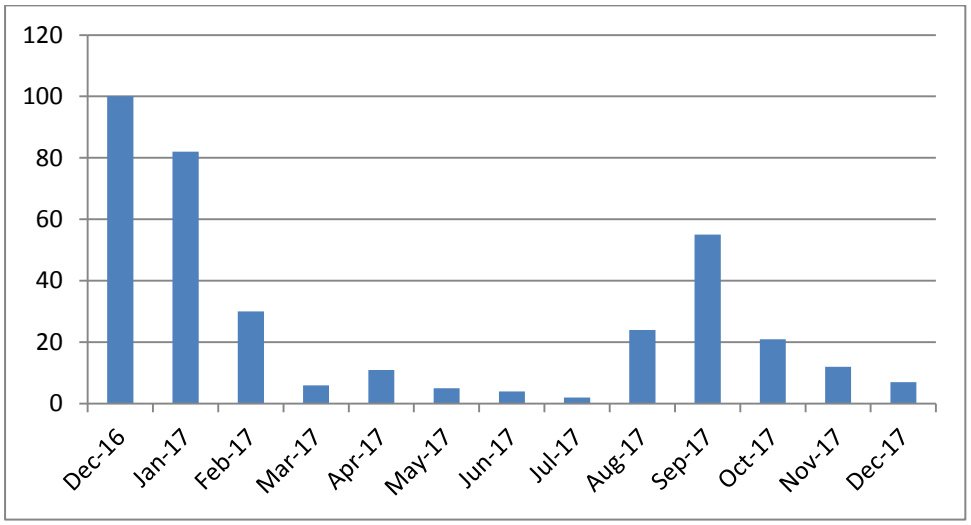
a) Exception reports (with regard to working hours) : 1st Dec 2016 to 1st Dec 2017

At the start of Dec 2016, the foundation year trainees (45 in total) were the only grade on 2016 TCS at CHFT. By October 2017, all doctors in training at CHFT have moved to the new contract. Since the Trust moved from the DRS system to Allocate in August 2017, the data on exceptions has been collected on 2 different software systems.

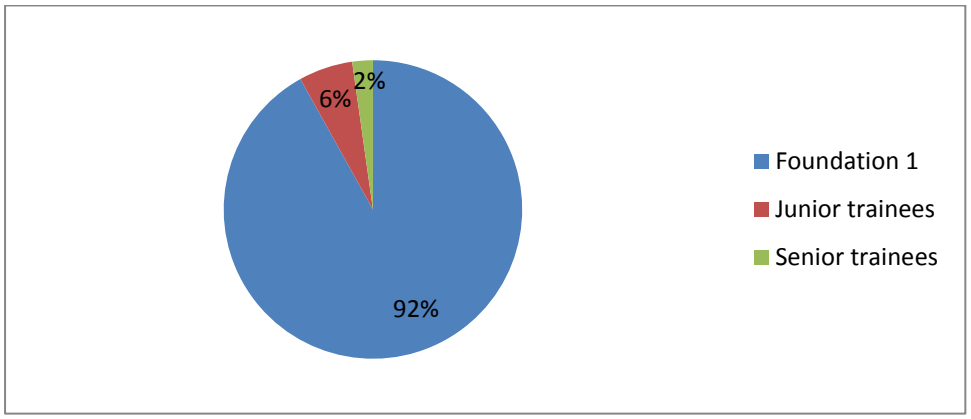
The charts below represent combined DRS and Allocate data since December 2016;

There were 359 exception reports over this 12-month period (18/12/17).

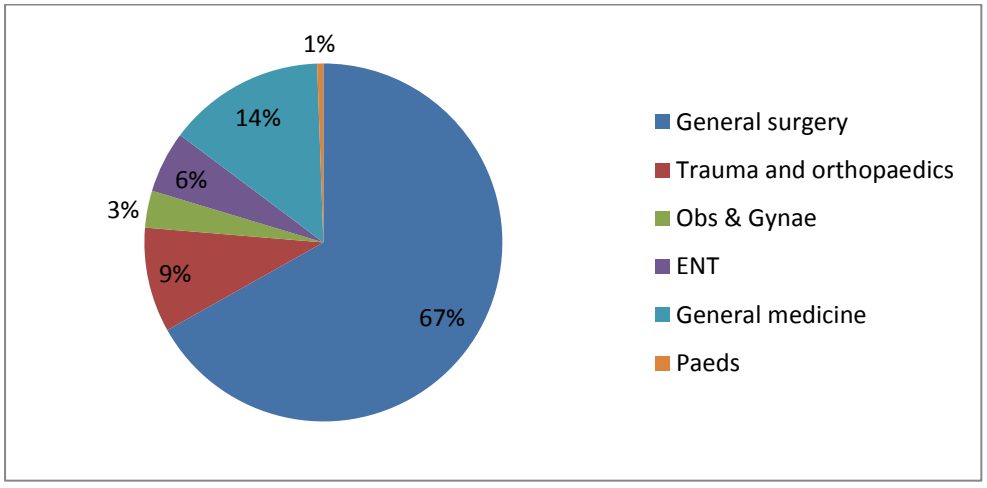
- Exceptions reports by month



- Exception reports by training grade



- Exception reports by speciality



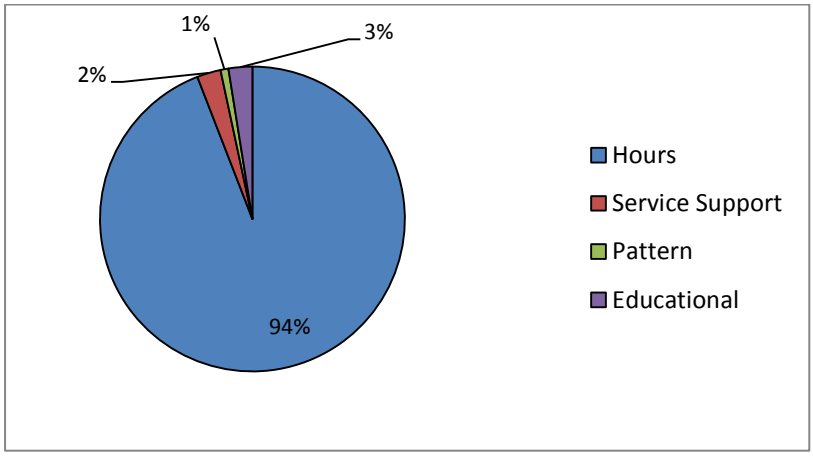
Over two-thirds of reports were from the general surgical directorate and over 95% of these were from FY1s.

There was a dramatic decrease in exception reporting in the second and third quarter with an increase in Q4 seen with the intake of new training doctors, now all on the 2016 TCS. In the early part of the year, some of this decrease was due to work schedule reviews, for example in vascular surgery and ENT. However, there was also a difference in the reporting culture of doctors on the surgery F1 rota – with a lower proportion reporting in Q2 and Q3 (despite encouragement to do so).

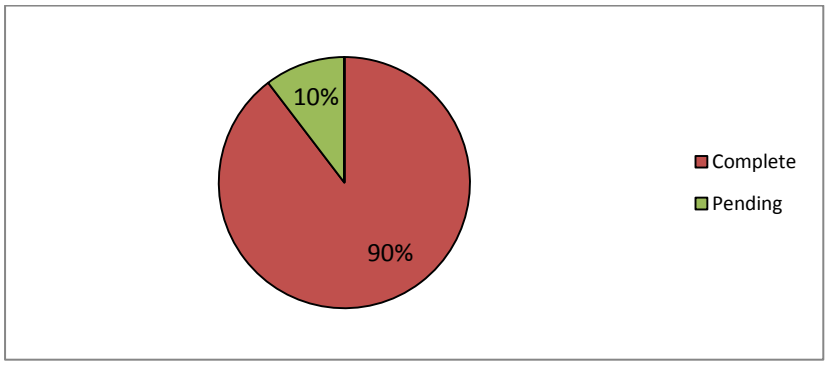
In Q4, the pattern from August shows a lower than expected reporting rate, particularly amongst core and higher trainees. We had anticipated that this group, who had been working at the time of the 2016 industrial action, would at least initially have a high rate of reporting, but so far this does not appear to be the case. Majority of the exceptions in August and September 2017 were reported by the surgical year 1 foundation trainees and this showed a rapid decline following a group work schedule review

Since moving on to Allocate software, it is now possible to look at further data on reports submitted. Hence the three charts below represent data from August to December 2017.

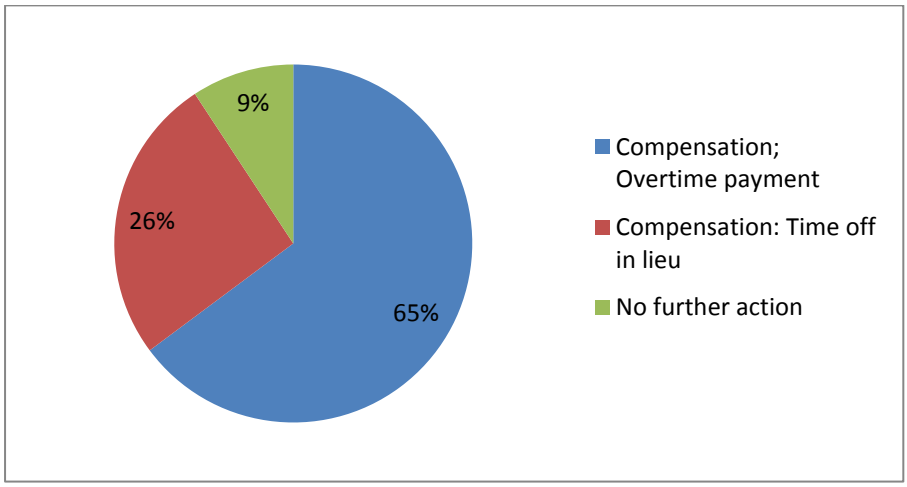
- Exception reports by Type



- Exception reports by state



- Exception reports by outcome



The vast majority of exceptions reported are due to busy shifts. Only one of these was flagged as an immediate safety concern. This was by an FY2 in urology (August 2017) who reported a lack of consultant support over a weekend. The guardian advised that this should be dealt as a clinical supervision incident via Datix.

Two thirds of exception reports led to overtime payment as the tight surgical FY1 rota does not allow flexibility for time off in lieu. However, if the system of work scheduling and exception reporting is working correctly then most reports should be compensated with time off in lieu as the spirit of the agreement is that the junior doctor hours are not working excessive during the course of a week and extra payments and fines kept to a minimum. I am currently in conversation with payroll to ascertain the exact amount of compensation given as a result of these.

b) Work-schedule reviews

There have been 2 individual work-schedule reviews in Q2 in ENT and vascular surgery which led to a favorable outcome with a decrease in exception reporting. Furthermore following a spike in exception reports by FY1s on the surgical rota in Aug and Sept 2017, there was good engagement from educational supervisors within the surgical directorate leading to a group work schedule review and resulting in a substantial fall in exception reporting from this cohort.
There was an additional review requested in trauma and orthopaedics for an FY1 in Q3 which was not completed.

c) Locum bookings

Data on this was provided to the guardian only from March 2017 (Q2 onwards).
The graphs below cover the period from w/c 24/7/17 to 4/12/17.
Compared to the Q2, there was an increase in bank shifts and a decrease in unfilled shifts in Q3 which has been sustained in Q4. The weekly cost for these shifts in Q4 has decreased compared to previous months and remains at an average of £ 90,000. The increase in bank

versus agency shifts is a positive one for the organization and a decrease in unfilled shifts will have improved the working lives of those junior doctors who would be otherwise covering for two roles.

There has been a decrease in deanery vacancies and an increase in other vacancies in Q4 compared with the last 2 quarters

Average hourly cost:
The average cost of bank shifts for junior doctors from May-July ranged from £60-75 per hour. For agency-filled shifts it was £82-90.

d) Vacancies

Information on gaps in the junior doctor rota was obtained from medical HR for changeover in Feb 2017 and August 2017 as a comparison. However, this doesn't necessarily capture all the people that work on the rota as some of those will be trust doctors and I couldn't get complete information on cover provided for these gaps from a single source. Reports on this element will improve with E-rostering when it goes live.

Specialty	Gaps Feb 2017	Gaps Aug 2017	Usual cover (if known)
A&E	4	1	Agency locum
Acute Medicine	0	0	Long term agency locum
Cardiology	3	1	
Diabetes & Endo	1	0	
Gastroenterology	1	0	
General Medicine	3	0	
Geriatric Medicine	4	2	
Haematology	0	1	
Medical Oncology	1	0	
Neurology	0	0	
Rehabilitation	0	0	
Respiratory	1	0	
Histopathology	0	0	
Microbiology	0	1	Consultant covered
O&G	8	3	
Paediatrics	1	2	
Radiology	0	0	
Anaesthetics	3	2	Often consultant covered
General Surgery	2	0	
Ophthalmology	0	0	
ENT	0	0	
T&O	1	1	
Urology	0	0	
FY1/2 Psychiatry	1	2	
FY2 GP	0	0	
GP Hospice	0	0	

e) Fines

The total amount in the GOSWH fund till the end of August was £ 2191.59. This is the sum of fines imposed in Q2 and Q3 and all were due to breaches in the surgical FY1 rota. This rota runs at 47.76 hours so does not take much to warrant a fine if payment is awarded for an exception report. The recurring issues were having to stay late on normal days after consultants had been on-call due to heavy work load and being asked to stay for handover in the evening, which is not built into the rota.

In Q4, there will have been breaches in the same surgical rota but I have been unable to calculate the fines so far as I have not yet got access to individual doctor rotas which have moved on to Allocate.

None of the money in the guardian fund has been spent as yet.

Qualitative Information

In general our junior doctors at the Trust feel happy and well-supported, as evidenced by the GMC Training Survey. The guardian has attended the national meetings and training and is a member of the regional guardian network. A new GOSWH was appointed in Oct 2017 who addressed the junior doctors at induction and continues to work closely with the department of medical education, medical HR and the flexible workforce department.
The Trust has invested in Allocate in order to implement E-rostering of medical staff. This will enhance visibility within CHFT of where our doctors are and any gaps that may affect safe care. The system will provide a consistent source of live real time data, better visibility on skill mix and will facilitate better management of absence through live reporting, and ensure that rotas are compliant to 2016 TCS. Roll out has commenced from November 2017.
The medical HR team is currently developing an opportunity for 'FY3' doctors and has prepared a template job description and advert. They have also developed a survey to find out what aspects would be required by junior doctors to consider taking up these posts.

In October 2017 a cohort of 10 physician associates commenced in post. Some of these are in surgery and may impact positively on the FY1 workload in this area which is where the majority of our exception reports originate.

Issues arising and steps taken to resolve these

1) Data on rota gaps is challenging to obtain, as medical HR only hold central data on Deanery gaps, with most rotas being a blend of deanery doctors and trust-employed doctors. This would resolve when e-rostering goes live.

2) Since moving to Allocate, the guardian cannot close exceptions which are overdue, hence these remain pending. This functionality has been raised with Allocate during the product focus sessions and is one of their priority development items. Additionally, though we have had agreement from our LNC that clinical supervisors can be sent the exception report the educational supervisor still needs to be aware as specifically mentioned in the 2016 TCS. However, on Allocate software it is only

possible to nominate one supervisor, so the doctor would usually choose the appropriate supervisor depending on the issue. Hence all reports will not be copied to the educational supervisors. This has been raised at the regional guardian meeting but I am not aware of a resolution as yet.

3) We still have some problem rotas (eg surgical FY1 rota) where doctors are frequently staying late and exception reporting. The appointment of Physicians Associates (starting in September) may help with their workload, but the effect of this remains to be seen. Over two thirds of all exceptions resolved are given extra payment as compensation rather than time off in lieu which has been highlighted in the monthly divisional reports by medical HR.
4) Attendance at the junior doctor forum has been poor in the last 3 quarters and there was no junior doctor attendance at the meeting held earlier this month. This was only attended by the GOSWH, medical HR and the department of medical education. This is despite timely communication to the junior doctors and their rota masters and substantial interest expressed by them at induction. There has also been lack of engagement from the BMA and LNC members. This will be communicated to the members of the forum and there are plans by the GOSWH and medical education to try and capture doctors in training prior to their teaching sessions/in their mess/send out repeated email communication, encourage those engaged with the exception reporting process and work together with the FY1 and FY2 post-graduate tutors.
5) Though there has been an improvement in the engagement by the educational and clinical supervisors, there are still some who have needed support from the GOSWH to access Allocate and view reports. There are plans by the guardian to address supervisors regarding the new contract for junior doctors again in 2018 as part of a divisional rolling programme. We currently offer no SPA time to clinical supervisors (national recommendation 0.25PAs), and as the burdens placed on supervisors by the new contract increase, we could end up having problems recruiting to these roles.
6) Though the medical HR team has been hugely supportive, the lack of dedicated administrative support for the GOSWH role still needs to be addressed. This support will ensure that exceptions are dealt in a timely fashion, educational supervisors are copied in as required by the 2016 TCS, any potential breeches are identified or may be prevented in a timely fashion and trends in reporting may be spotted earlier and any risks mitigated. All quarterly reports since Dec 2016 have flagged this as a concern and it has been escalated to the medical director who has assured me that support will be identified going forward.
7) The Allocate system does not ‘speak’ to payroll so the GOSWH will write a protocol for the smooth payment of extra hours incurred via exception reporting to ensure that junior doctors are paid any monies owing on time. This will complement the current Trust guidance on work schedules and exception reporting. At present there is no written process and combined with the lack of administrative support for the

guardian, delays in payment and review of breeches and calculation of fines incurred are occurring.

Main risks

The issue of administrative support for the GOSWH needs to be addressed as a matter of priority. This should be a dedicated role rather than the current ad hoc support provided intermittently by medical HR and medical education.

The GOSWH has to identify whether a breach has occurred which incurs a financial penalty. In order to do this currently, the GOSWH needs access to multiple rotas and calculate the breach and work out fines manually. This invariably is leading to delays. We need to provide support for training on the Allocate e-rostering system for rota masters so that rotas are centrally viewable by HR and the GOSWH. This will allow for better data collection and potential resolution for rota gaps.

The last 2 junior doctor forum meetings were not quorate and this is a worrying development. There is an action plan to try and improve this and progress will be fed back to the board in the next guardian report.

Conclusions and recommendations

The trust has made good progress towards implementing the new Junior Doctors Contract. Since Oct 2017, all our doctors in training are on the 2016 TCS. Some junior doctors and supervisors have been engaging well with the exception reporting system. Work is ongoing in the trust to move to e-rostering which will help identify rota gaps and vacancies in a timely fashion. There are challenges in the areas of timely identification of breeches and resolution of exception reports, the tight FY1 surgical rota and attendance at the junior doctor forums.

The Board are asked to read and note this first annual report from the guardian of safe working hours.

Anu Rajgopal

Guardian of safe working hours

December 2017

14. Update from sub-committees and receipt of minutes and papers

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 4th January 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from 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 4.12.17 and verbal update from meeting 3.1.18
- Finance and Performance Committee – minutes of 28.11.17 and verbal update from meeting 2.1.18
- Workforce Well Led Committee - verbal update and minutes of 13.12.17 (to follow)

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 4.12.17 and verbal update from meeting 3.1.18
- Finance and Performance Committee – minutes of 28.11.17 and verbal update from meeting 2.1.18
- Workforce Well Led Committee - verbal update and minutes of 13.12.17 (to follow)

Appendix

Attachment:

combined update from sub-cttees and receipt of mins.pdf

QUALITY COMMITTEE

Monday, 4th December 2017

Discussion Room 3, Huddersfield Royal Infirmary

PRESENT

Dr David Anderson **(DA)**	Non-Executive Director ***(Chair)***
Asif Ameen **(AA)**	Director of Operations- Medicine Division
Brendan Brown **(BB)**	Executive Director of Nursing – Corporate
Paul Butterworth **(PB)**	Governor
Andrea Dauris **(AD)**	Associate Director of Nursing- Community Division
Alistair Graham **(AG)**	Governor
Lesley Hill **(LH)**	Director of Planning, Performance and Estates and Facilities
Laura Malik **(LMa)**	Directorate Secretary ***(Minute Taker)***
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Joanne Middleton **(JM)**	Associate Director of Nursing, Surgery Division
Lynn Moore **(LM)**	Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Cornelle Parker **(CP)**	Deputy Medical Director

204/17 WELCOME AND INTRODUCTIONS

The Chair welcomed members to the meeting.

205/17 APOLOGIES

Helen Barker	Chief Operating Officer
Dr David Birkenhead	Medical Director
Andrew Mooraby	Associate Director of Nursing - Medicine Division
Dr Linda Patterson	Non-Executive Director
Michelle Augustine	Governance Administrator
Rob Aitchison	Director of Operations - FSS Division
Juliette Cosgrove	Assistant Director of Quality and Safety - Corporate

206/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

207/17 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 30th October 2017 was approved as a correct record.

208/17 ACTION LOG AND MATTERS ARISING

There were no actions due at this meeting. Actions due for the next meeting were noted.

209/17 CLINICAL AUDIT PROGRAMME

Appendix C provided members of the meeting with a six month update on national and local audits within the Trust. These are overseen by the Clinical Effectiveness and Audit Group, chaired by Neeraj Bhasin (Associate Medical Director). CP commented that there are many audits ongoing but was not assured that national mandatory audits are prioritised over local audits. LR explained that there has been some work to streamline the audit programme and to tie it into the Quality Strategy.

ACTION: Neeraj Bhasin to feedback ongoing work on audits overall and provide assurance that national mandatory audits are being prioritised over local.

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

210/17 QUALITY AND PERFORMANCE REPORT

BB presented the report (Appendix D) and summarised that October's performance score has fallen to 59% for the Trust. The Safe domain is now red due to a reported never event. The effective domain has maintained its green rating. The responsive domain has maintained amber although cancer 62 day GP referral to treatment missed its target. Finance remains red with variance from plan moving to red in-month. Workforce has deteriorated to red due to higher short-term sickness absence. This is the first time that three areas have been red.

AG asked if there was a plan to improve the complaints response rate as the percentage of complaints closed is red. BB responded that this is expected to improve by the end of December and action has been taken to support this. Surgery have appointed a dedicated member of staff for complaints and despite sickness levels impacting on Medicine, they have reported an improvement. Corporate support has also been put into place. A plan needs to be put into place to sustain the improvement. AMcC added that colleagues dealing with complaints have been encouraged to keep complainants updated throughout the process.

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

211/17 ESTATES AND FACILITIES PATIENT SAFETY AND QUALITY (PSQB) REPORT

LH presented the Estates and Facilities report (Appendix E) and summarised:

- Business Redesign Programme is in the final phase and is due to complete in December 2017. A new manager for Cleaning Services at HRI has been appointed.
- Switch off Squad – Members of the Estates team visiting wards and departments to encourage staff to "switch off" appliances, lights etc. in an aim to save £100K on energy costs by Christmas. CP asked if motion sensor lights had been considered and LH responded that it had. It has been implemented in new builds but is hard to retrofit and would not be in clinical areas. An LED scheme is planned for CRH.
- Security Services team at HRI is to transfer to Leeds Trust in January 2018. A step change has already been seen in quality and the cost will remain the same.
- Moving and Handling training concerns were raised. ISS are supporting Estates & Facilities and there is a risk on the register regarding this.
- Further concerns were raised for high risk 6903 – following ventilation report from the Authorised Engineer for Resuscitation. It may be condemned and the upgrade will cost £1.5 million and take 6 months to complete.
- Work continues with the Full Business Case for the Estates and Facilities Arms-Length Company. This is due to go to the Board of Directors on 7th December 2017. Significant staff and union engagement is taking place.
- Won Client of the Year Award from Constructing Excellence in Yorkshire and Humber.
- A new patient food supplier has been appointed, Tillery Valley, following joint tendering with Bradford and Leeds, and good feedback about the food is being received from the patients.
- There has been a successful Security and Crime Prevention Roadshow at HRI in July 2017, with a further roadshow to take place at CRH in November 2017. (This included colleagues from the Trust, West Yorkshire Police, Fire, victim Support and Immigration and Counter Terrorism).
- The division continues to monitor its compliance against mandatory training at monthly divisional meetings. It is above the Trust average year to date for compliance, with the exception of Prevent, however further training needs to take place to achieve the 100% compliance.

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

Division on its award.

212/17 SURGERY AND ANAESTHETICS PATIENT SAFETY AND QUALITY (PSQB) REPORT

JM presented the Surgery and Anaesthetics report (Appendix F) and summarised:

- The division has identified ten key priorities which the team have been working through over the last quarter. Progress against these is reported monthly into the Performance Meeting and is tracked weekly through the divisional team meeting. The ten priorities form the key line of enquiry (KLOE) for CQC self-assessment against the responsive domain.
- The Endoscopy service is currently JAG (Joint Advisory Group) Accredited but has failed on the Global Rating Scale Domains (GRS). The GRS is a self-assessment which is required to be completed twice-yearly (April and October). A new lead has been appointed to work through the re-accreditation process and a comprehensive action plan has been developed which is being tracked through fortnightly meetings. Contact made with JAG team and it is expected that if all actions remain on track, will be on target to achieve a successful re-submission in April 2018. A substantial element to this is working through the backlog of patients following the fire and post EPR (Electronic Patient Record) implementation. The action plan is reported back and overseen by the Divisional PSQB.
- Work is ongoing to improve cancer performance across all tumour sites. A prostate clinic is being piloted based around the model of the one-stop breast clinic. 104 day breaches seem to being reported in batches and this is being investigated. A deep dive has been carried out and found that there was very little missed opportunity to reduce waiting times in all but one case, and the delays did not impact on the outcome. This has been shared with the Clinical Commissioning Group.
- Work to improve fractured neck of femur (#NOF) performance is ongoing - improvement in time to theatre at 73% in October and predicted to improve further in November. Excellent performance against all other elements of all Best Practice Tariff is reported. A surge plan has been developed to ensure orthopaedic cover into trauma 2 during high demand to avoid organisational breaches. New clinical guidelines continue to have appositive impact on the number of clinical breaches incurred. Developing predictor tool to pre-empt end of month performance based on current inpatient status. Deep dive performed and reported to Clinical Commissioning Group colleagues to explore whether there was any impact on patient outcomes for those patients who experienced a delay to theatre. No evidence of harm or adverse impact associated with delay was found.
- The division continues to be challenged in terms of the timeliness of complaint responses. This is one of the key priorities for the division and is being closely manged by the Associate Director of Nursing. There has been some improvement over quarter 2; however this has not been a sustained position. Additional training has been provided for divisional team members supported by risk and a patient experience and quality role has been recruited to support colleagues and embed more robust processes. It is expected that all overdue complaints will be closed by the end of quarter 3.
- There has been one pre-48 MRSA bacteraemia assigned following arbitration to trauma and orthopaedics. It was reported through Community and the root cause analysis did not identify any learning for theatre or ward teams. It was assigned to Surgical Division as wound broke down following hip replacement after discharge and was thought to be a deep seated infection. No learning was found after triangulated investigation for action plan.
- Work is ongoing with clinical teams in urology to standardise patient pathways. The team are working through a number of actions:
  - Short Stay Ward and Ambulatory – development of urology pathways
  - Job Planning - Consultant and middle grade
  - Theatre Timetable and Rotas – Theatre timetables and rotas have been reviewed to ensure the right work is going through the right area.
  - New to Follow Up ratio and Outpatients- lists being scrutinised and reviewed as

- Workforce – No applicants for recent advert. Recruitment on hold until spring 2018 when potential opportunity identified. Gap filled with two locum consultants in the interim.

- Mock inspections took place in Critical Care and Operating Services at CRH in quarter 2. Critical Care was largely positive with the team noting a lot of improvements in terms of training plans, staff engagement, innovations and leadership.
- Colleagues from Chesterfield Trust invited to undertake mock review following anonymous whistleblowing to CQC regarding maternity theatres and feedback from exit interview. Overall care noted to be good with patients treated with dignity and respect. Improvements required regarding:

  - Leadership
  - Infection prevention and Control performance and assurance

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

213/17 COMMUNITY DIVISION PATIENT SAFETY AND QUALITY (PSQB) REPORT

AD presented the Community report (Appendix G) and summarised:

- The division continues to develop its structure and governance frameworks to support quality assurance across all services. Divisional PSQB has now separated from Divisional Board as the agenda had become too long and the amount of information meant messages became diluted. PSQB meetings continue to take place monthly with a core agenda reflecting the Trust standard terms of reference.
- Serious Incident (SI) Investigations – root cause analysis and investigation reports are completed for SIs and orange graded incidents. The division continues to hold weekly orange / Pressure Ulcer panels which is committed to trend analysis of pressure ulcers (PU) – the panels are supported by the Tissue Viability Nurse team.
- Complaints are monitored at weekly meetings and are cross-referenced to the weekly trackers supplied from Datix. The Community Division handled nine new complaints during quarter 1 and there were no overdue complaints at the end of the quarter.
- The new Community Division Clinical Governance Support Manager is now in post working with the division two days a week. The role will involve supporting the division to strengthen its governance and assurance processes.
- In August 2017, the division submitted a proposal to Harrogate and District Clinical Commissioning Group (CCG) to provide a service for them for non-palliative Lymphoedema patients. The proposal was accepted and the division met with the CCG in October to develop the implementation plan to start this service in December 2017.
- In September 2017, the team has been focussing on developing the frailty pathway and continues to develop the rehabilitation pathway. Both of these pathways rely on collaboration with partners. Reconfiguration is occurring to support this.
- Friends and Family Test (FFT) is now collected on one day of the month, which has significantly reduced the response rate but increased the quality.

OUTCOME: The Quality Committee received and noted the content of the report with particular reference to the frailty pathway and Lymphedema service.

214/17 MEDICAL DIVISION PATIENT SAFETY AND QUALITY (PSQB) REPORT

AA presented the Medicine report (Appendix H) and summarised:

- Reconfiguration began on 18th November 2017 and has gone well so far. Ambulances are taking patients to the right place following liaison with Yorkshire Ambulance Service. Visiting hours have been flexible and taxis have been put on for staff to support the new changes.
- The old plaster room has been converted into an ambulance triage, which has made the

m an average of 40-45 minutes to 20 minutes.

- Winter planning has included medical capacity, admission avoidance, extra doctor in frailty team and longer working hours.
- A stroke assessment area within Accident and Emergency for all patients with a neurological deficit is being explored. This model would ensure that work strokes and "possible" strokes are picked up quickly in Accident and Emergency by the stroke consultant and thrombolysis nurse therefore ensuring scans are requested in a timely manner. This would then have a positive impact on stroke patients being admitted to the stroke unit with 4 hours of hospital arrival, spending 90% of their stay on the stroke unit and the rate of thrombolysis within 1 hour. CP asked why the volume of stroke cases has declined and AA responded that it is not clear why but there has not been a significant amount of late strokes found.

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

215/17 FAMILIES AND SPECIALIST SERVICES (FSS) PATIENT SAFETY AND QUALITY (PSQB) REPORT

This report had been deferred to the next meeting.
ACTION: FSS to present their report at the next meeting.

216/17 SELF-ASSESSMENT OF COMMITTEE'S EFFECTIVENESS

The self-assessment will be circulated to all for completion before Christmas.
ACTION: MA to circulate the self-assessment for all to complete before Christmas.

217/17 ANY OTHER BUSINESS

LM raised that she had overheard a doctor speaking about a patient on the shuttle, which was inappropriate. LH said that she would remind colleagues about confidentiality and explore putting signs onto the shuttle also.

PB raised that the reports from divisional PSQBs displayed appraisal and mandatory training data in different formats and asked if this could be standardised.

218/17 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Acknowledge that development identified in appraisals should be followed up.
- That reports on PSQBs from Divisions should be standardised and data should be presented in the same way.
- That Medicine are undergoing reconfiguration of Respiratory, Elderly and Cardiology.
- That Estates and Facilities have received a Client of the Year award.
- That there was a detailed discussion regarding the resuscitation risk 6903.
- That a stroke assessment area within A&E for all patients with a neurological deficit is being explored.
- That the old plaster room has been converted into an ambulance triage, which has made the process quicker from an average of 40-45 minutes to 20 minutes.

219/17 EVALUATION OF MEETING

The effectiveness and evaluation of the meeting were acknowledged as good.

220/17 QUALITY COMMITTEE WORK PLAN

The work plan (Appendix J) was circulated and accepted.
ACTION: MA to circulate the work plan for 2018.

NEXT MEETING
Wednesday, 3rd January 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 Tuesday 28 November at 9.00am Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

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

IN ATTENDANCE

Mandy Griffin	Director of Health Informatics (in part)
Andrew Haigh	Chair of the Trust
Lesley Hill	Director of Estates & Facilities (in part)
Brian Moore	Lead Governor
Vicky Pickles	Company Secretary
Betty Sewell	PA (Minutes)

ITEM

181/17 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

182/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Kirsty Archer

183/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

184/17 MINUTES OF THE MEETING HELD 31 OCTOBER 2017

The Minutes of the meeting held 31 October 2017 were approved as an accurate record subject to the date of the QRM being amended to read “24 October 2017” on Page 2.

185/17 MATTERS ARISING AND ACTION LOG

172/17: Recovery to address the FBC Affordability Gap - A presentation outlining a System Recovery Plan (SRP) was received by the Committee. It was noted that the document has been co-authored with the Clinical Commissioning Groups (CCGs) and is still a working draft with further discussions taking place at a System Leadership event scheduled for later in the day.

The purpose and the background to the plan were outlined to the Committee. It was noted that the FBC had identified a system affordability gap for 2017/18, the plan sets out mitigating actions and schemes to close the gap, however, the full year financial impact of these schemes will be in 2018/19 and will therefore not fully

mitigate the 2017/18 in-year financial system risk. It was also noted that dialogue is taking place to consider alternative contract forms which may facilitate and enable further system cost reduction in future periods. The presentation also described key activities to improve ways of working to strengthen system leadership, structures and processes to enable delivery of system financial recovery schemes.

Following in depth discussions it was noted that the outline SRP gave the opportunity for all organisations to work together and explore all aspects of the health system which should be encouraged. However, the Committee pointed out that the report does not address taking cost out of the system which is an important message. The Committee also identified the need for a Project Managements Office to be established to drive the plan acknowledging the extreme challenge to get organisations working together with the governance required.

It was also noted that the document would be discussed further at the Private Session of the Board of Directors to be held 7 December 2017.

The Director of Finance updated the Committee with regard to the timing of several pieces of work confirming that a meeting to discuss the SRP has still to be scheduled. It is proposed to bring back to the F&P Committee a paper which will detail how we propose to bridge the gap of the 5 Year Plan which is due to be presented to the STP by the 30 November 2017 and then the STP to submit by end of December 2017.

ACTION: The bridging of the gap for the 5 Year Plan to be presented at the next meeting – **GB, 2/1/18**

177/16: Community Benchmarking – The paper which was received by the Committee was compiled by the Community Division, it included the benchmarking information available to compare the Trust against other providers with areas highlighted where we are an outlier.

Discussions took place and it was agreed that the variances identified are difficult to interpret and that further investigation is required, It was acknowledged that there is a challenge around data definitions.

The Committee were encouraged that benchmarking is available and that we appear to be better than Locala against many performance metrics. It was acknowledged that the Community service is a disparate service and is difficult to measure and that the evidence of less people being re-admitted to hospital is a strong point.

ACTION: A further benchmarking report is due to be published and it was requested that a further report should come back to the F&P Committee in February – **AB, 23/2/18**

173/16: EPR Benefits Realisation Programme – The Director of Health Informatics reported that the last update to this Committee was in August which addressed the change in the deployment timeline. The target is £26.2m return on benefits over 23 benefit schemes which were being monitored and tracked through the PMO process but associate them back to Divisions were there could be duplications. It was noted

that the original business case referenced £3.2m from Year 2 per year, this moved at the last update to £2.9m per year, which was signed off at the time.

It was also noted that running in parallel to this is a Stabilisation Plan which went to Board in September and as a result our ability to pull benefits together has been a challenge as the system in some areas is still not stable. There have been some compensating benefits where real change has taken place such as Clinical Records where we have deployed resource to different areas but on the other hand we have had to employ additional staff to run our appointments centre and to deal with process as well as a backlog. Part of our journey with EPR is becoming a 'paper light' organisation, we have seen a reduction but the quantity part of this benefit has not been captured. Managed print and scanning clinical records will be our starting point.

At the moment we are not in a position where we can prove benefit from a cash-releasing point of view. As part of the business planning day, EPR benefits were part of a 'world café' area, where we brought together colleagues from different areas to push EPR to realise the benefit from next year. From this process, it was established that there was confidence around the opportunity in finding cash-releasing benefits, however, until the current problems are fixed it would be difficult.

In conclusion, it was noted that we need to address the fixes within the next 4 months so that from 1st April going forward we could realise benefits but that this would also require investment for additional resource.

It was also noted that we need to work harder with our partner, Cerner, to deliver a better out/pts service and to address this, meetings are taking place on a weekly basis. Cerner are coming to walk the outpatient areas to see what they can do to get us to a place which will allow more time, Consultants are feeding back that it is taking longer which is having an impact across the organisation. The Committee were advised that in reality benefits will be seen in 18/19 and this will be the direction of travel over the next 4 months.

The Committee were informed about ongoing conversations with Cerner with regard to optimising the system and making CHFT/Bradford an exemplar. The proposal is being worked through, however, it does miss out the stabilisation plan and moves to Phase 2 & 3, it also describes some of the discounting which we could achieve.

ACTION: It was agreed that a further report which describes how we realise the benefits for next year, how we manage the future operating model and what is our vision to come back to the Committee in January – **MG, 30 January 2018**

Elective Care

The Chief Operating Officer presented a briefing paper to the Committee which described the Elective Care Improvement Board (ECIB) original Terms of Reference and the membership of the group. It was noted that following the replacement of the Systems Resilience Group by the Transformation Group, which has recently been disbanded, there are no current governance arrangements in place. The focus and priorities of the board were discussed but it was highlighted that it would not be possible to cross-reference the notes from the Board with the information within the

paper which is a governance risk for the Trust.

The benefits and risks for the Trust were also called out to the Committee. The paper recommends that all decisions from ECIB should be incorporated into the System Recovery programme thereby ensuring system agreement to financial impacts and resulting consequences. the Trust is to formally confirm this to CCG colleagues and future ECIB papers will be presented to the System Recovery forum and no longer presented to Board of Directors.

The Committee noted the contents and the recommendations within the paper.

186/17 INTEGRATED PERFORMANCE DEEP-DIVE

It was agreed that this item be deferred until the next meeting.

187/17 MONTH 7 FINANCE REPORT

The Director of Finance advised the Committee that the report is still in line with previous periods. In month we have reported a £2.5m overspend and we forecast a £2m challenge, YTD we are £2.5m away from plan. It was noted that an agreement of the Month 6 income has been reached with Commissioners removing that risk. It was also noted that CIP is now forecast at £17m which was agreed last month, however, this position includes the non-recurrent benefit relating to the Soft FM. We continue to have a number of cash challenges with 7,000 invoices approved for payment which have not been paid. The change in our STF payment this month has also had an effect on our cash position. Correspondence has been sent to the regulators asking them to clarify that if STF is now being mapped differently has this made a difference to STP and the regulators are still to respond. It was also reported that we are still forecasting, prior to recovery, a £13m overspend and there is still a challenge with regard to our CQUIN delivery.

188/17 FINANCIAL POSITION & FORECAST RECOVERY PLAN

The Director of Finance presented the papers for information referring to the documents which had been submitted to the Regulators in advance of the meeting which will take place on the 4 December 2017.

The Chief Executive asked for an item on the checklist relating to the top 10 earners around agency to be progressed prior to the next week's meeting.

189/17 NATIONAL FINANCIAL CONTEXT AT MONTH 6

The Director of Finance referenced the report in the papers which highlights the number of providers reporting a deficit. In terms of the income analysis it was noted that everyone has a challenge and that we may need to identify our challenge to the national picture. The schedule also highlighted that against the national picture, overall, our Trust has seen a 40% reduction in agency staff but there still remains a challenge with nursing staff for the organisation.

The Committee noted the contents of the paper.

190/17 CIP UPDATE

The Chief Executive acknowledged the discussions which have already taken place with regard to CIP within the meeting, it was reported that CIP planning for next year

has begun with a notional figure of around £14m. There is still quite a portion of the £17m identified savings which are high risk and in terms of how this is being managed, a review of the Private Patient Policy has taken place, there are also a number of schemes which sit within the Director of Finance leadership and a decision is still to be made with regard to how these should progress. It was noted that a change control notice has been received for Emergency Care which has been rejected.

Discussions took place with regard to the national and local picture regarding activity and our change in focus to cost out, however, it was agreed that we require a method which could get us to a cost out conclusion and this is being tested.

It was noted that there will be a session with General Surgeons to explore planning and the activity reality and what it looks like from their point of view and to discuss how we can be more effective in how we plan activity for next year.

It was also announced that Dave Thomas will come back to work individually with Board members, Non-Exec Directors and all Directors on a specific piece of work over the next few weeks which will require one-to-one meetings. It is anticipated that a summary and feedback will go to Board in January 2018 and priority in diaries for these discussions was requested from attendees of the Committee.

191/17 SPECIAL PURPOSE VEHICLE (SPV) BUSINESS CASE UPDATE

The Director of Estates & Facilities presented the background to WYAAT and the organisations behind the SPV project. An overview of the SPV model, Phase 1 and a more collaborative model for Phases 2 and 3 was presented to the Committee.

The Committee received and noted the presentation for information the full business case will be presented to the next Board of Directors for approval. It was agreed that prior to the Board of Directors a clearer understanding of the finances and what is being asked of the Board should also be clarified.

ACTION: It was agreed that it would be helpful for Lesley Hill to re-circulate the Case for Change to the Committee - **LH**

Several members of the Committee left the meeting to attend the System-wide Working Workshop as discussed earlier in the meeting.

192/17 MONTH 07 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee noted the contents of the paper for information.

193/17 WORK PLAN

The Work Plan was received by the Committee and it was noted that the IPR Deep-dive should be re-scheduled for the next meeting.

194/17 MATTERS TO CASCADE TO THE BOARD

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

- SRP and the action plan to bridge the gap
- Exposure – not in the Financial Plan Forecast

- Community Benchmarking discussions
- EPR Benefits into next year and the next steps for IT strategy and commercialisation plans with Cerner
- Background with regard to SPV – clearer understanding of the finances and clarification of what is being asked of the Board
- Finances – where we anticipated we would be, how this will be described to NHSI

195/17 REVIEW OF MEETING

Comments were received with regard to the number of items on the Agenda and the timing of the issuing of papers this were discussed and noted by the Chair.

196/17 ANY OTHER BUSINESS

As this was Jan Wilson's last F&P Committee, the Chair, on behalf of the Committee, thanked Jan for her valued contribution.

Apologies from Richard Hopkins were received and noted for the next meeting.

DATE AND TIME OF NEXT MEETING

Tuesday 2 January 2018, 9.00am – 12.00noon
Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

15. a. Quality Committee - minutes of 4.12.17 and verbal update from meeting 3.1.18

To Note

Presented by Linda Patterson

16. b. Finance and Performance Committee - minutes of 28.11.17 and verbal update from meeting 2.1.19

To Note

Presented by Phil Oldfield

17. c. Workforce Well Led Committee - verbal update from meeting 13.12.17

To Note

Presented by Karen Heaton

18. Date and time of next meeting - 1.2.18 commencing at 9.00 am in the Large Training Room, LC, CRH

To Note

Presented by Andrew Haigh