Calderdale and Huddersfield NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 1 June 2017 at 9.00 am

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	Welcome and introductions: Lynn Moore, Publicly Elected MC Kate Wileman, " "	Chair	**VERBAL**	Note
2	Apologies for absence: David Birkenhead (Cornelle Parker, Deputy Medical Director to attend)	Chair	**VERBAL**	Note
3	Declaration of interests	All	**VERBAL**	Receive
4	Minutes of the previous meeting held on 6 April 2017	Chair	**APP A**	Approve
5	Action log and matters arising:	Chair	**APP B**	Review
6	Chairman's Report	Chair	**VERBAL**	Note
7	Chief Executive's Report: a. Electronic Patient Record (EPR) Update	Chief Executive	**APP C**	Note
Keeping the base safe				
8	CQC Update on Action Plan (Deep-dive) – Maternity Services presented by:- Martin DeBono Anne-Marie Henshaw Rob Aitchison	Executive Director of Nursing	**Presentation**	**Approve**
9	CQC Year End Report	Executive Director of Nursing	**APP D**	**Approve**
10	High Level Risks Register	Executive Director of Nursing	**APP E**	**Approve**
11	Governance report	Company	**APP F**	**Approve**

	- Board Workplan - Declaration of Single Sex Accommodation Compliance - Use of Trust Seal - Board to Ward Visits Feedback - Declaration of Interests - Constitutional Changes - Board Meeting Dates 2018	Secretary		
12	Integrated Performance Report	Chief Operating Officer (COO)	**APP H**	**Approve**
13	DIPC Report	Deputy Medical Director	**APP I**	**Note**
14	Safeguarding Adults and Children Update and Annual Report	Executive Director of Nursing	**APP J**	**Note**
15	Hospital Pharmacy Specials (HPS)Annual Report	Executive Director of Finance	**APP K**	**Approve**
Financial Sustainability				
16	Treasury Management Policy	Executive Director of Finance	**APP L**	**Approve**
17	Budget Book 2017-2018 Workings	Executive Director of Finance	**APP M**	**Approve**
A workforce for the future				
18	Nursing and Midwifery Staffing – Hard Truths	Executive Director of Nursing	**APP N**	**Approve**
Transforming and improving patient care – no items				
19	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – verbal update from meeting 31.5.17 ▪ Finance and Performance Committee – minutes of 4.4.17, 2.5.17 and verbal update from meeting 30.5.17 ▪ Audit and Risk Committee – minutes of 19.4.17 and verbal update from meeting 25.5.17 ▪ Board of Director Meeting dates 2018		**APP O**	**Receive**
Date and time of next meeting Thursday 6 July 2017 commencing at 9.00 am				

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital (Please note amended venue)

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).*

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st June 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 6.4.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 6.4.17.	
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 6 April 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 6 April 2017.

Appendix

Attachment:

APP A - draft BOD MINS - PUBLIC - 6.4.17 (2) hb-AH.pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 6 April 2017 in Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary.

PRESENT

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

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary (minute taker)
Juliette Cosgrove	Assistant Director of Quality (item 12)
Jackie Murphy	Deputy Director of Nursing-Modernisation
Jane Findlater	Clinical Lead – Podiatry
Vijay Bangar	Consultant Physician
Nicola Sheehan	Head of Therapy Professions

OBSERVER

Mrs Lynn Moore	Publicly Elected Membership Councillor
Mr Brian Moore	Publicly Elected Membership Councillor

56/17 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

57/17 APOLOGIES FOR ABSENCE

Apologies were received from:
Victoria Pickles, Company Secretary
Mandy Griffin, Director of The Health Informatics Service
Jan Wilson, Non-Executive Director

58/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

59/17 MINUTES OF THE MEETING HELD ON 2 MARCH 2017

The minutes of the meeting were approved as a correct record subject to the following amendments:-

53/17 – Financial Reporting – Key Messages – Delayed transfers of care and Agency Staff. The Chief Operating Officer requested that this item be amended to

read:

Operational performance linked to the STF has also been maintained in the year despite the challenge stepping up considerably in January, with 48 additional beds open and transfer of care delays. The Trust reportable Delayed Transfer of care performance has maintained a good level of performance but the non-reportable position has only seen a slight improvement. This is being worked on jointly with system partners as part of the WYAZ programme. It continues to be the case that, with high demand and high vacancy levels the Trust continues to rely on agency staff to maintain safe staffing levels and appropriate care for patients. *Despite Operational actions.*

OUTCOME: The minutes of the meeting were approved subject to the above amendment.

60/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG

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

61/17 PATIENT STORY – WOUND CARE TRANSFORMATION

Jane Findlater, Clinical Lead, Podiatry shared with the Board a patient's journey entitled 'Michael's story'. The Board heard about the increase in number of patients with a diagnosis of diabetes foot wounds. It was reported that in 2013 - 2.9 million there were people diagnosed with diabetes in the UK and by 2025 it is expected to rise to 5 million with an estimated 10% of these patients having a foot ulcer at some point.

Prior to the new casting technique of treatment, Michael had recurrent foot ulcer problems for 8 years following his first diagnosis of type 1 diabetes in 1994. Previously the wounds were being treated with a number conventional treatments and heavy foot brace 'Moon Boots'. Between July 2013 and commencing casting in July 2016 Michael had:

- 35 out-patient appointments
- 78 community podiatry appointments
- 12 podiatry home visits
- 10 district nurse home visits
- 1 hospital stay

Once the new casting had been applied, this resulting in less outpatient treatments. Michael had no cramping in his right leg during the treatment and within the first week of casting he had reduced the amount of analgesia taken for ankle pain. The chronic wound healed with 6 applications of the total contact cast.

Pictures of the progress of the wound healing was shared with the Board and the end benefit results were that Michael was able to wear more conventional footwear, the risk of infection had reduced and no more dressings were required.

Dr Bangar advised that the wounds were slow to heal using conventional treatments due to constant weight bearing on the wound. He reported that this new treatment would reduce the number of foot amputations in the future.

The Board thanked Jane, Vijay and Nicola for sharing this example of good practice and the patient benefits to be gained through the use of this new innovative casting treatment were noted.

62/17 CHAIRMAN'S REPORT

a. Feedback from Membership Council Meeting – 5.4.17

The Chairman updated the Board on the key issues arising from the Membership

Council Meeting held on 5 April 2017:-

- **Constitutional Changes** – amendments had been agreed and these would be brought to the next Board meeting for ratification. The main issue related to the change of the name from Membership Council to Council of Governors. This had been agreed by those present and was in line with the majority of other Trusts nationally, but due to not being quorate the remaining Membership Councillors would be asked for their views. Other issues which were discussed and approved included:
  - Catchment area to be amended to reflect the STP footprint
  - Retaining the Reserve Register
  - Balance of constituencies – review to be considered

b. Feedback from NHS Providers Chair/CE Meeting – 23.3.17

The Chairman updated on the key issues from the meeting which included:-

- Mission Impossible report discussed
- Pressures in the system
- Priorities for 2017 – financial pressures, emergency care system, priorities on cancer and mental health services. Workforce challenges.
- Key risks – volumes/activity
- C.Diff challenges
- Commissioning issues

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

63/17 CHIEF EXECUTIVE'S REPORT

a. 'Shifting the Balance of Care' – Research Summary – Nuffield Trust

The Chief Executive had circulated a report published by the Nuffield Trust which highlighted the challenges in achieving the STPs target of targeting more than 30% reductions in hospital activity. Discussion took place regarding shifting resources to enable reduced activity together with the Board's degree of appetite to lead change would possibly need to be examined going forward.

b. NHS Mandate Update – The Chief Executive advised that the March publication would be circulated to the Board. The updated mandate highlighted the rollout of 7 day services. It was anticipated that 90% target rate would be achieved by March 2018. It was noted that some key standards were being changed and this would be helpful information when the Trust is looking at their Strategic Plans for the future.

ACTION: Board Secretary

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

64/17 HIGH LEVEL RISKS REGISTER

The Executive Director of Nursing reported on the top risks scoring 15 or above within the organisation. These had been discussed in detail at the WEB, Quality Committee and Risk and Compliance Group.

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

Discussion took place regarding the urgent estates schemes not undertaken and it was agreed that this emphasized the need for the Trust to undertake a full business case on reconfiguration of services.

The Executive Director of Finance updated the Board on the capital expenditure which had been reduced and this would lead to further discussions around patient safety. The Chief Operating Officer reported that a group had been established to discuss the challenges.

Risks with increased score
There are no risks with an increased risk score in March 2017.

Risks with reduced scores
There are no risks that have been reduced in score on the high level risk register during March.

New risks
There is new risk that has been added to the high level risk register during March 2017 which is risk 6903 accepted at a rating of 16. This relates to the collective environmental and estates issues within ICU at HRI.

Closed risks
There were no risks which had been closed during the month.

Dr Linda Patterson reported that discussion had taken place at the Quality Committee regarding the nasogastric tube risk and it was noted that a task and finish group had been convened to oversee the outstanding work and a further report was expected to the June Board meeting.

ACTION: BOD AGENDA ITEM – JUNE 2017

OUTCOME: The Board **APPROVED** the High Level Risk Register.

65/17 GOVERNANCE REPORT

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

a. Board of Directors attendance register
The Trust's Standing Orders state that 'the names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors.' The attendance register from April 2016 to March 2017 was received and approved by those present.
OUTCOME: The Board **APPROVED** the contents of the attendance register.

b. The Nominations and Remuneration Committee (Membership Council) terms of reference
The Terms of Reference had been reviewed at the last meeting in March. It was noted that these had been approved by the Membership Council at its meeting on the 5 April.
OUTCOME: It was agreed that the Board would **RATIFY** the terms of reference.

c. Board Work Plan
The Board work plan had been updated and was presented to the Board for review.
OUTCOME: The contents of the workplan was **AGREED.**

d. Constitutional Changes

As discussed earlier in the meeting, at the meeting on Wednesday 5 April, the Membership Council considered a number of amendments to the Constitution. One of the items for discussion was the name of the Council to change the name to Council of Governors. This was in line with the majority of other Trusts nationally. It was agreed that the full amended Constitution would be presented at the next public Board of Directors meeting.

ACTION: BOD AGENDA ITEM

OUTCOME: It was **AGREED** that the amendments to the Constitution would be presented to the Board at the next meeting.

66/17 CQC UPDATE ON ACTION PLAN

The Executive Director of Nursing presented the updated CQC Action Plan and the Board noted the progress made which was on track. Regular reports would be presented to the Quality Committee and Executive Board to oversee actions now that the CQC Response Group had been disbanded.

It was noted that deep dives would be undertaken into the Action plan key themes:- Maternity, CDU and ICU to the next three Board meetings.

ACTION: BOD AGENDA ITEM – MATERNITY SERVICES

OUTCOME: The Board **APPROVED** the updated Action Plan and agreed to focus on the three key issues at forthcoming Board meetings.

67/17 QUARTERLY QUALITY REPORT – QUARTER 3

The Assistant Director of Quality gave a presentation which outlined the progress to date:-

- **Quality Account –** on track with all 3 priorities
  - Falls reduction – introduction of safety huddles
  - Patient experience in the community
  - Introduction of Hospital Out of Hours Programme
- **CQUINS**
  - Local – all local CQUINS achieved
  - National – all on track except sepsis (awaiting data)
- **Falls prevention**
  - falls prevention plan reviewed
  - MAU improvement team identified
  - review of learning from avoidable falls incidents planned
- **Sepsis** – small improvement in sepsis indicators being seen. New group established chaired by Dr Ashwin Verma
- **Maternity**
  - PPH < 1500 mls at lowest level all year 1.3% in November
- **Pressure Ulcers**
  - reduction in category 3 / 4 pressure ulcers in community
  - static position for hospital acquired pressure ulcers
- **Mortality**
  - HSMR continues to improve (102.9), 46% deaths (724) reviewed in 12 months from November 2015 , 98.8% not preventable
- **Safeguarding**
  - improvements in level 3 safeguarding children training rates
- **Reducing Hospital Acquired Infection**
  - 1 case MRSA bacteraemia in December in the Medical Division
- **Caring for frail patients**
  - community team strengthening services to prevent admissions
- **Clinical coding**
  - improved quality and depth of coding with better clinical engagement – 5.31 in Dec 16, up from 4.74 in Dec 15
- **Stroke** – Invited Service Review highlighted some areas of good practice,

action plan being developed.

- **Complaints**
  - backlog of overdue complaints responses cleared in early December
  - 109 complaints closed in November 2016
  - measures in place to ensure sustainability of responsiveness
- **Learning from adverse events**
  - staff survey on learning and barriers to learning completed
  - 4 focus groups held
  - findings and recommendations to Serious Incident Review Group (February 2017)
- **Incidents** – divisional orange incident panels working effectively resulting in improved learning
- **Emergency Care 4 hour standard** – 93.81%, 317 patients waited over 8 hours.
- **Medical outliers** - general improvement
- **Flu CQUIN** achieved
- **Safer community ward** – opening up of Community Place
- **Duty of candour** – sustained improvement with duty of candour in Q3
- **BME** – leadership course offered to staff
- **Sickness and absence** – increasing number of return to work interviews
- **Community PLACE** had been opened and was working well.

The Chairman asked those present if there were any issues which should be brought to the attention of the Board. The Executive Director of Nursing reported that Sepsis, falls, pressure sores and complaints were currently the key issues of concern.

Dr Linda Patterson as Chair of the Quality Committee confirmed that the Board had good assurance processes in place which would be able to identify issues at an early stage. It was felt that the spike in infection rates in the last quarter had prompted the Trust to convene a task and finish group to review this which was likely to be due to the increased activity and treatment of complex patients in the Trust.

OUTCOME: The Board approved the Quarterly Quality Report

68/17 EPR OPERATIONAL READINESS

The Chief Operating Officer reported that the paper had been produced to update the Board prior go live in early May 2017 and therefore this was the last opportunity for Board members to raise concerns.

In summary she reported that the Trust, in partnership with Bradford Teaching Hospitals NHS Trust (BTHFT) and Cerner commenced the work to build and implement an Electronic Patient Record (EPR) in May 2015. The CHFT had agreed a cutover date of the 28th April 2017 with a proposed go-live date of May 2nd 2017. The CHFT had made significant progress in the Programme since the last Board update in February 2017. The project status is currently rated as yellow; this is in line with the final GE Finnamore external gateway review carried out in February. Overall, the GE review team found evidence of good practice in the organisation and significant progress in preparing for a successful implementation. The overall delivery confidence assessment was amber /green, they state “this reflects the view that a successful go-live at CHFT is probable”.

The paper noted the progress on the implementation plans and business continuity plans. It was noted that drop-in sessions were being planned and it was agreed that these would include Board colleagues.

Discussion took place regarding the issue of extended clinics over the go live period. The Chief Operating Officer reported that mitigation plans for surgery was still awaited

and this would be confirmed to the Operational Board when the position was finalised.

It was noted that Cerner were also confident that the Trust was on track for the implementation and wished to thank all staff for their support.

ACTION: Chief Operating Officer

OUTCOME: The Board **RECEIVED** the update and supported the EPR Operational readiness.

69/17 INTEGRATED PERFORMANCE REPORT

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

February's Performance Score is 60% for the Trust which is a 5 point drop since January. A number of the Trust's higher weighted targets have deteriorated in month:- FFT (A&E response rate and Maternity would recommend), MRSA, Emergency Readmissions, 62 day screening to treatment and Fire Safety training. These higher weighted target areas are differential across the services and do not indicate any systemic failure.

The SAFE domain has maintained its Green rating for the third month running. All other domains with the exception of Efficiency and Finance have seen a drop in performance in month reflecting some of the pressures in delivery of performance in quarter 4, the winter quarter.

- **Emergency Care Standard 4 hours -** February's position was 93.45% which was above the STF trajectory and the Trust continued to deliver some of the strongest performance nationally.

- **Nurse staffing establishments** - 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.

- **A&E activity** - had fallen in month 11 to 5.6% below plan however cumulatively still 2.2% above plan.

- **Length of Stay** (LOS) - For non-elective admissions it was a busy month with LOS increasing to over 6 days (average). Agreement was reached between Medicine and Surgery to reallocate Ward 14 to Medicine and whilst there was a good impact from increased Package of Care provision in January there still remains a high number of patients on the Transfer of Care list. Medical outliers reduced in February reflecting the Ward 14 change and the internal use of escalation beds within the Division protecting Surgical capacity.

- **Accelerator schemes** - continued in February but some changes eg. increased medical staffing were a March implementation, reflective of funding allocation, so further positive impact is to be expected.

- **Non-elective activity** - overall was 1.8% above the month 11 plan, an increase in activity against plan compared to month 10. The in-month over-performance is mainly due to General Medicine and Paediatric emergency short stay.

- **Planned day case (DC) and elective activity (EL)** - had continued to be above plan in month 11 by 0.29% which is a reduction from the overperformance seen in

month 10. The month 11 position is driven by an overperformance in DC offset by a further reduction within DC Endoscopy and EL activity. This is mainly within Gastroenterology endoscopy and is due to the impact of the fire at CRH and the reduced decontamination capacity.

OUTCOME: The Board **RECEIVED** the Integrated Board Report and **NOTED** the key areas of performance for February 2017.

70/17 MONTH 11 – 2016-2017 - FINANCIAL NARRATIVE

The Executive Director of Finance reported the key financial performance areas. It was noted that this had been discussed in detail at the Finance and Performance Committee held on the 4 April 2017. The key messages and summary were noted:-

Key Messages

The year to date financial position stands at a deficit of £15.89m, a favourable variance of £1.71m from the planned £17.60m of which £1.88m is purely a timing difference on the accrual of Sustainability & Transformation Funding (STF) versus the planned quarterly profile. The underlying variance from Control Total is £0.12m favourable compared to the year to date plan. This is positive news as the Trust is continuing to maintain the financial position in the final quarter of the financial year where there was always acknowledged to be a greater challenge in terms of the timing of CIP delivery and in the face of operational pressures due to high levels of clinical activity, staff vacancies and Delayed Transfers of Care.

Operational performance linked to the STF has also been maintained in the quarter so far despite a challenging January which saw 48 additional beds open and increased Delayed Transfers of Care due to higher demand and system wide challenges outside of our control. The pressure has abated slightly in February, but it continues to be the case that, in order to deliver activity and access standards across the Trust with high vacancy levels, there remains reliance upon agency staffing to secure safe staffing levels. Total agency spend in month was £1.68m, a decrease of £0.27m compared to Month 10 and an improvement compared to the average for the first six month of the year which was in excess of £2.0m a month. Agency expenditure remains comfortably beneath the revised trajectory submitted to NHSI. It is also worth noting that within the agency spend £0.20m related to the Accelerator Zone funding which has been agreed as excluded from the Trajectory.

Summary

- EBITDA of £7.23m, a favourable variance of £1.33m from the plan.
- A bottom line deficit of £15.89, a £1.71m favourable variance from plan.
- Items excluded from Control Total include £0.23m for Loss on Disposal of properties.
- Delivery of CIP of £13.67m against the planned level of £12.41m.
- Contingency reserves of £1.36m have been released against pressures.
- Capital expenditure of £14.58m, this is below the planned level of £25.96m.
- Cash balance of £2.69m; this is above the planned level of £1.94m.
- Use of Resources score of level 3, in line with the plan.

OUTCOME: The Board **APPROVED** the Month 11 financial narrative

71/17 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 3 April 2017 which had not been previously covered on the

Board's agenda:

- Maternity – presentation including safeguarding, supervisory model and serious incident reporting
- Draft Quality Account priorities update
- Safer patient programme - priorities

OUTCOME: The Board **RECEIVED** the verbal update and the minutes of the meeting held on 30.1.17 and 27.2.17

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 4 April 2017:-

- Regulatory position – score 10
- Follow-up CNST – lessons learnt to Quality Committee – driving premiums through claims history.
- Finances – budget and discussions with NHSI
- CIP targets and pressures for next year acknowledged.
- IR35 review of affected staff being undertaken

OUTCOME: The Board **RECEIVED** the verbal update and the minutes of the meeting held on 28.2.17.

c. Workforce Well-Led Committee

Karen Heaton, Chair of the Workforce Well-led Committee reported on the items discussed at the meeting held on 16 March 2017, the minutes for which had been circulated with the agenda.

OUTCOME: The Board **RECEIVED** the verbal update from the meeting and the minutes of the meeting held on 16.2.17 and 16.3.17.

c. Draft Nomination and Remuneration Committee (MC) Minutes – 8.3.17

The Chairman reported on the items discussed at the meeting held on 8 March, the minutes for which had been circulated with the agenda.

OUTCOME: The Board **RECEIVED** the minutes and noted the contents.

72/17 DATE AND TIME OF NEXT MEETING

It was agreed that the May Board of Directors meeting would be cancelled in order that the Board could help support the staff during the EPR implementation.

The next meeting was confirmed as Thursday 1 June 2017 commencing at 9.00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair closed the public meeting at 10:50 am.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st June 2017	**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 June 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 Action Log for the Public Board of Directors Meeting as at 1 June 2017.

Main Body

Purpose:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 June 2017.

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 June 2017.

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 June 2017 / APPENDIX B

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
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	**1.12.16** It was agreed that the Company Secretary would undertake a deep dive of the top themes and bring back to the Board anything which would benefit changing on the BAF in February 2017. **2.2.17** Compliance with NHSI was discussed and the Board questioned whether this was still relevant. It was agreed that this would be further discussed through the Finance and Performance Committee. **2.3.17** Presented to the Finance & Performance Committee prior to Board in June.	1.6.17		
175/16 3.11.16	**UPDATE FROM SUB-COMMITTEES** **Audit and Risk Committee – Declarations of Interest** The Company Secretary explained that there would be a change to the declarations of interest policy as new guidance was due to be published in December. An update would be brought to a future Board meeting.	VP	**2.2.17** The Company Secretary advised that Guidance was still awaited. It was requested that this remain open on the Action Log for a report to come back in March 2017. **3.2.17** It was noted that this item would be taken to the Audit and Risk Committee in April with a proposed solution.	1.6.17		
31/17 2.2.17	**WHISTLEBLOWING ANNUAL REPORT** It was agreed that a greater awareness of the Raising Concerns/Whistleblowing process was	IW		1.6.17		

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
	required in the Trust and this would be taken through the Workforce Well-led Committee and reported back to the Board in 3 months' time.					
28/17 2.2.17	**RISK REGISTER** Board agreed that a review of the EPR risk and its relation to a potential CQC re-inspection be considered alongside a review of the narrative at year-end in order to archive risks as appropriate and identify tolerance ratings for endemic risks. It was agreed that this would be undertaken by BB and VP and would be taken through the Audit and Risk Committee for review before returning to Board in June 2017.	BB/VP/ARC	**2.3.17** Discussion took place regarding the nasogastric tube risk and it was agreed that a position statement would be brought to the Board in June. **6.4.17** Dr Linda Patterson reported that discussion had taken place at the Quality Committee regarding the nasogastric tube risk and it was noted that a task and finish group had been convened to oversee the outstanding work and a further report was expected to the June Board meeting.	1.6.17		
9/17 5.1.17	**INTERNATIONAL STAFF** The Acting Chief Executive reported that discussions had taken place regarding abuse towards international staff from patients or their families. The Board agreed that this would not be tolerated and the Executive Director of Workforce and OD agreed that a system would be put in place to safeguard against this via NHS Protect.	IW	**2.3.17** The Executive Director of Workforce and OD reported that work was still being undertaken nationally and once this was complete feedback would be brought to the Board.	TBC		
2.3.17 49/17	**CARE OF THE ACUTELY ILL PATIENT – CULTURE**	DB		1.6.17		

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
	The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report and reminded the Board on the overall aim of the programme to reduce mortality. It was noted that this is divided into six themes: 1) Investigating causes of mortality and learning from findings 2) Reliability in clinical care 3) Early recognition and treatment of deteriorating patients. 4) End of life care 5) Caring for frail patients 6) Clinical coding The Executive Medical Director reported that HSMR is currently falling and is now 103.76 however it remains a concern. There is evidence that the improvement work has contributed to the reduction of HSMR over the last year and this would continue to be monitored. Discussion took place regarding Sepsis and as discussed at the last meeting, the Executive Medical Director reported that work continued to be undertaken regarding this to ensure that all staff treated sepsis as a medical emergency. It was agreed that an update would be brought to					

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
	the Board to assure the Board that attitudes and behaviours were being addressed in the Trust to ensure that the care of the Sepsis patient was made a priority.					
6.4.17 65/17	**GOVERNANCE REPORT – CONSTITUTIONAL CHANGES** At the MC meeting on Wednesday 5 April, the MC considered a number of amendments to the Constitution. One of the items for discussion was the name of the Council to change the name to Council of Governors. This was in line with the majority of other Trusts nationally. It was agreed that the full amended Constitution would be presented at the next public Board of Directors meeting.	VP		1.6.17		
6.4.17 66/17	**CQC UPDATE ON ACTION PLAN** It was noted that deep dives would be undertaken into the Action plan key themes:- Maternity, CDU and ICU to the next three Board meetings.	BB		1.6.17 – Maternity Followed by CDU and ICU		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st June 2017	**Sponsoring Director:** Mandy.griffin, Director of THIS
Title and brief summary: EPR UPDATE - This paper provides a high level update in terms of the go-live of the Electronic Patient Record (EPR) at Calderdale and Huddersfield NHS Foundation Trust (CHFT).	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper provides a high level update in terms of the go-live of the Electronic Patient Record (EPR) at Calderdale and Huddersfield NHS Foundation Trust (CHFT).

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive and note the progress.

Appendix

Attachment:

EPR Board Update 1st June.pdf

EPR Update
CHFT Board of Directors 1st June 2017

Presented by:	Mandy Griffin	**Author:**	Mandy Griffin- The Director of the Health Informatics Service
Previously considered by:	N/A		

Key points	**Purpose:**
1. This paper provides a high level update in terms of the go-live of the Electronic Patient Record (EPR) at Calderdale and Huddersfield NHS Foundation Trust (CHFT).	To inform
2. In regards to the overall view or the cutover, go-live and early live support both Cerner and our external Cutover management team have been very complimentary	To Inform

Executive Summary

The Trust in partnership with Bradford Teaching Hospitals NHS Trust (BTHFT) and Cerner commenced the work to build and implement an Electronic Patient Record in May 2015. It was agreed that CHFT would be the first trust to go live with a cutover commencement date of the 28th April 2017 and a proposed go-live date of May 2nd 2017. CHFT delivered against this plan and were able to confirm that they were fully live in all areas by 7am Tuesday 2nd May 2017.

The cutover plan was to go live in stages, starting in A&E and inpatient areas followed by outpatient areas. The cutover progressed well and by Tuesday 2nd May all clinical and administration staff were fully using the system.

The Trust had put in place support and mitigation plans to manage issues as they emerged during go-live and early live support.

Both Cerner and our external cutover management team have complimented the Trust both on our state of readiness and the commitment and resilience demonstrated by our staff. The way in which colleagues have responded to and dealt with implementation over the last four weeks has been quite remarkable. Given the nature and scale of the cutover Cerner rate this as one of the best that they have ever seen in the UK.

Recommendation

It is recommended that the Board to NOTE the progress made in the implementation of EPR; ACKNOWLEDGE the significance of what has been achieved and the issues still to be addressed.

EPR Update Board of Directors CHFT
1ST June 2017

Purpose

This paper provides a high level update in terms of the go-live of the Electronic Patient Record (EPR) at Calderdale and Huddersfield NHS Foundation Trust (CHFT).

Background

The Trust in partnership with Bradford Teaching Hospitals NHS Trust (BTHFT) and Cerner commenced the work to build and implement an Electronic Patient Record in May 2015. It was agreed that CHFT would be the first trust to go live with a cutover commencement date of the 28th April 2017 and a proposed go-live date of May 2nd 2017. CHFT delivered against this plan and were able to confirm that they were fully live in all areas by 7am Tuesday 2nd May 2017.

The preparation for go-live had gone well and all criteria set out against each of the decision points were met. The final decision point was slightly delayed due to the regression testing for order comms (pathology). This meant the decision to switch on the system didn't take place until 7pm Sunday 30th April. This did not compromise our ability to achieve a full go-live by the agreed deadline.

Introduction

The cutover plan was to go live in stages, starting in A&E and inpatient areas followed by outpatient areas. By Tuesday 2nd May all clinical and administration staff were fully using the system.

Our A&E department during cutover was busy. As expected there were some longer waits for non-urgent patients as staff were adapting and becoming familiar with the system. This was managed through public messages about the potential for additional waits in the department and informing those patients waiting of the alternative options available to them.

The Trust had planned for how issues would be managed and mitigated as they developed over the first few days. A number of actions were put in place to resolve issues as they arose through small teams being deployed to identify root cause, provide support and agree temporary mitigation so the impact on patient care was minimised. The key issues were around access, patient flow, Appointments Centre, pre-op assessment, Ophthalmology, Endoscopy, Yorkshire Fertility Clinic, Oncology and Medical secretaries. Four weeks on we have made significant progress and we remain in a good position ahead of where we planned to be. However there remain some issues in these areas.

Our EPR friends did a great job and were an invaluable source of support and advice to colleagues across the Trust. The support from floorwalkers was inconsistent and some were not able to resolve the technical issues being presented. This brought some frustrations to colleagues.

The support desk worked well receiving on average 500 calls a day (1200 first day). Some issues were more complex than expected and we would have benefited from more timely feedback to those who had reported issues so that they were clear on when and how it would be resolved.

In regards to the overall view or the cutover, go-live and early live support both Cerner and our external cutover management team have been very complimentary about how our state of readiness has been played out in reality. Given the nature and scale of the cutover they rate this as one of the best that they have ever seen in the UK.
In particular they have recognised the commitment and resilience our staff have demonstrated over the last 4 weeks. It has really been quite remarkable.
Throughout the go-live and early live support period we have been encouraging staff to report any potential risks or incidents to patient care resulting from EPR. To date we have not received any serious incidents. This is important as it is a good guide to understanding risk more broadly rather than relying on purely anecdotal statements. We will continue to monitor this closely

We implemented a 'Lights On' facility which shows who is using the system and to what level. Through this we have been able to monitor that our staff have really embraced the system. Since the first week of go-live we have been seeing levels of 2800 unique users a day. This is being described as quite extraordinary.
As we move into business as usual (BAU) most of the EPR team will move to BTHFT. There is a plan in place to ensure there is full resolution of any remaining issues. This includes experienced trainers, patient administration experts, key personnel from the agreed BAU structure and a short extension of some of the floorwalkers with particular areas of knowledge.

The narrative below attempts to articulate some of the detail behind the information in this introduction.

Operational Arrangements:
Operational planning early for CHFT worked very well. There was good engagement from all divisions with clear actions; meetings continued weekly up to go-live with separate focus between Trust-wide issues and Divisional readiness. The final sign-off for operational readiness took place on the 26th April where all Divisions without exception completed all aspects of the agreed checklist. The development of the long list of queries and actions collected form the West Suffolk go-live was a big contributor to the successful deployment of the EPR, ensuring that issues and actions from all lenses were understood and prioritised.

The command centre:
To support cutover, go-live and early live support, we put in place command and control arrangements which were adapted as we progressed. We put in place a fixed command centre

structure, manned 24/7 with Silver lead senior manager and a loggist. These were supported by Divisional bronze leads with clear ownership of issues, ensuring appropriate escalation. Executive presence 24/7 was very well received by staff. All ward and departmental areas had down time packs which worked well. .

Data Migration

During the preparation for go live great care was taken to produce Data Migration tools, strategies, and practices that could be proven to work at the 99th percentile for most data being moved. After go live we needed to perform a reload of future appointments and develop new scripts to correct appointment locations and appointment types. Learning will be taken forward from this to improve the testing cycle. As a result the appointment centre was closed for four days. There is still work to do to address the remaining issues related to this.

Manual Data input

The manual data migration during cutover was completed ahead of time with a small number of issues. There is more work to do to understand how this will impact on reporting going forward.

Access

Password and access issues were encountered as expected. The initial problems were password related. The subsequent problems were related to access (users not having the functionality they wanted or expected). The access issues could be split into two main categories, the first being the understanding of what functionality each role has, and secondly around the personnel including access for locum, bank and agency staff. This will be on-going and processes are being developed to deal with training and access for temporary staffing.

Reporting

The deployment of the Cimbio Data Quality Dashboard and the presence of the Data Quality Support team has been invaluable. Their experience of working with Cerner many times has been very beneficial in moving forward at pace. Immediate visibility of issues regarding how we capture and report on data in addition to delivery of appropriate Standard Operating procedures (SOPs) has helped immensely. Support from the Cerner reporting lead has been impressive. In our third week since go live it is pleasing to report the live knowledge portal models are up and running as advised and key Sophia warehouse extracts to support Payments by Results etc., are now being made available to Trust staff as before. Coding overall has seen improved clinical information. There is a significant piece of work to complete to ensure complete recording of data for those patients who were in hospital at the time of go-live and enable full clinical coding to be carried out.

Training

Over 97% of colleagues rostered to work during go-live and early live support had been trained on the system. The process of ensuring a sufficient number of colleagues were trained to ensure a safe go live proved successful, this was driven by an effective communication and engagement strategy. Divisions managed training closely to ensure success. However some training issues were encountered during the go-live. There were particular challenges with locum and agency colleagues resulting in a number of colleagues requiring ‘on the job’ training. A small group is currently working on a long term solution for this issue and colleagues will be

further supported with an e learning package which is under development. It also proved difficult to engage with colleagues such as visiting consultants and junior doctors on rotation; again a long term solution is being considered.

Whilst role specific training was appropriate for nurses and doctors working in in-patient settings, teams in areas such as endoscopy, ED, outpatients and day surgery etc. would have benefited from team learning in conjunction with the change team and subject matter experts. Equally, the role based method did not prove effective for clinical nurse specialists and some colleagues who undertake clerical duties in clinical role or vice versa resulted in colleagues having to undertake more than one training session. Roles are now being built into the system with training being reviewed accordingly. Training in capacity management also needs to be strengthened.

Standard Operating Procedures

The Standard Operating Procedure's (SOPS) proved a valuable resource at go live with the teams constantly using them as a first line reminder for end users. Some SOPs have been modified post go live and additional ones have been created as colleagues have become more familiar with the system. It is important that the Trust agrees a governance process for the design, implementation, update and on-going use of SOPs

Business Continuity: 724

The carts were configured and rolled out during the week pre and post cut-over. This was in order to avoid the carts being misplaced or repurposed during the build up to cutover. There is learning from the placement of carts on different ward configurations, particularly at Calderdale Royal Hospital which will need to be addressed.

Service Desk:

A blended service desk approach worked well (THIS, Floorwalkers, HCI). The service desk floorwalkers tended to log all calls and THIS colleagues triaged or fixed the issue. Service desk colleagues working on the EPR would have benefited from more training prior to go-live along with information on role descriptions to address access issues.

The service desk received around 500 calls per day for the first week the majority linked to access issues. The call volumes were less than expected and the service desk were very quickly able to close more calls than they were logging. The feedback and performance of the desk has been commended. The communication back to the workforce should have been more regular to ensure that colleagues were clear when their issue would be resolved.

Device Management:

On the whole the hardware deployment has gone well. The majority of trolleys were delivered to the wards for go-live. Some trolleys had not arrived due to a manufacturing issue and alternatives had to be found and there are concerns about the type of trolley allocated in some areas. A meeting is planned with the supplier to try and address some of these issues. Wristband printers worked well and the issues identified with the processes for replenishing wristbands and labels were quickly resolved

Capacity / Activity / Outpatients
Majority of Consultants have been positive and arrangements for most clinics worked well once access issues were resolved. Clinic outcoming has been very positive. There are some coding issues which will be addressed over the coming weeks.

EPR Friends
The engagement and involvement of EPR friends proved very effective for the Trust. Developing the three types of friends helped to ensure all colleagues could contribute to the implementation of the EPR. By cutover we had over 700 trained friends or volunteers. This included the executive team in their leadership role, hospitality friends that included volunteers, and the friends who would be end users and the first point of contact for colleagues. It is recognised that more advanced training and practice would have helped colleagues feel better prepared over the go live and early life support period.

The pastoral support for patients and colleagues was crucial and hospitality friends were very well received over the cutover weekend and the feedback has been that tea and cake support and kindness made a huge difference. The visible leadership of the executive team and senior team has also been valued by colleagues and an approach to continue with this should be considered for the future.
Feedback suggests that

Floorwalkers
There has been a mixed view on floorwalkers. Expectations were that floorwalkers would be able to fix technical issues which was not the case as they were there to help with workflow issues. Some did not have the required knowledge and their induction to the trust was brief so it took some a while to orientate themselves. There were some good reports from outpatients. A two week extension for the most knowledgeable floorwalkers has been agreed for key areas such as ED and out patients to ensure workflows are maintained.

Backlogs pre and Post go-live:
The Trust was very well prepared for go-live by reducing backlogs down to >5% across most divisions and specialties. All out-patient clinic outcomes were completed by the 17:00 hrs turn off of PAS and start of the cutover activities. These meant there were no backlogs carried across and into go-live.

Backlogs post go-live:
Post go live, there was an increase in backlogs due to access and login issues in the first week. This has now been resolved and outcomes are being completed. Additional training is being offered to ensure clinic outcomes are properly completed on the system. Clinicians are being shown how to save their clinics into favourite lists. Admissions from a ‘To Come In’ (TCI) have not yet been completed. Communication has gone out to all staff with a link to the SOP’s on how to complete the admissions from a TCI list and further CapMan training is scheduled across the organisation.

E-Referral:
The Trust receives a high number of e-referrals. To help manage this, e-referrals were done as a bulk load (loaded 1 week prior to the cutover). This was very successful and all eReferral appointments and error resolutions were completed with no delay to the go-live.

Communications
As we moved towards cutover and go-live the Trust changed its approach to communication and engagement of colleagues. We employed the approach that had been successful in other internal communication campaigns, using the Trust's own staff to be the 'face' of the change. This involved a number of different channels including face to face briefings; newsletters; screensavers; social media; and ambient information around the organisation. In particular the use of Whatsapp and closed Facebook groups proved particularly effective in communicating with EPR Friends and the management community. This extended to providing support, advice and information during early live support. We also adopted 'red border' messages for important and urgent changes during early live support that were delivered by hand to wards and departments.

For the public we used social media; posters and leaflets to let people know that the implementation was taking place and that this may impact on waiting times within our services.

Conclusion
The deployment of the EPR is being described as successful. The Trust should recognise what has been achieved while recognising the outstanding issues to resolve. We need to be mindful that this is a significant change for our staff and that they need continued compassionate care and support as we further develop and embed the system.

Recommendation
It is recommended that the Board to NOTE the progress made in the implementation of EPR; ACKNOWLEDGE the significance of what has been achieved and the issues still to be addressed.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Michelle Augustine, Governance Administrator
Date: Thursday, 1st June 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: CHFT Care Quality Commission (CQC) Inspection - To provide a year-end position and highlight preparation for forthcoming re-inspection.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee - for Information	
Governance Requirements: Governance, Risk and Compliance	
Sustainability Implications: None	

Executive Summary

Summary:

Please see enclosed detail within attached paper

Main Body

Purpose:

To provide the Board of Directors with a position statement in response to the 2016 CQC Trust wide inspection, and an overview of next steps.

Background/Overview:

Please see enclosed detail within attached paper

The Issue:

Please see enclosed detail within attached paper

Next Steps:

Please see enclosed detail within attached paper

Recommendations:

Please see enclosed detail within attached paper

Appendix

Attachment:

End of year review - BoD.pdf

BOARD OF DIRECTORS

Calderdale and Huddersfield NHS Foundation Trust

PAPER TITLE: CHFT CARE QUALITY COMMISSION (CQC) INSPECTION	**REPORTING AUTHOR:** Alison Lodge
DATE OF MEETING: 1st June 2017	**SPONSORING DIRECTOR:** Brendan Brown
STRATEGIC DIRECTION – AREA: Keeping the base safe Transforming and improving patient care	**ACTIONS REQUESTED:** For information
PREVIOUS FORUMS: Quality Committee	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	

EXECUTIVE SUMMARY:

This paper provides an end of year review of the Trust's response to the CQC inspection carried out in March 2016.

The report details the Trust response to the CQC inspection report published 15th August 2016 and the concerns raised at the time of the inspection. It provides a year-end position against all of the must and should do actions and how the plan has been managed, including the role of the CQC Response Group and ongoing discussions with the CQC management team.

The report also provides information regarding the forthcoming re-inspection, detailing changes to the inspection regime and how the Trust has started to prepare for this.

FINANCIAL IMPLICATIONS OF THIS REPORT: None

RECOMMENDATION:

The Board of Directors are requested to:

1. Approve the year-end position against all of the actions in the plan, noting the current areas of concern and future governance arrangements.

2. Note the expected changes to the CQC inspection regime.

3. Support the approach that is being taken in preparation for a re-inspection which is being overseen by the Trust Risk and Compliance Group.

APPENDICES ATTACHED:

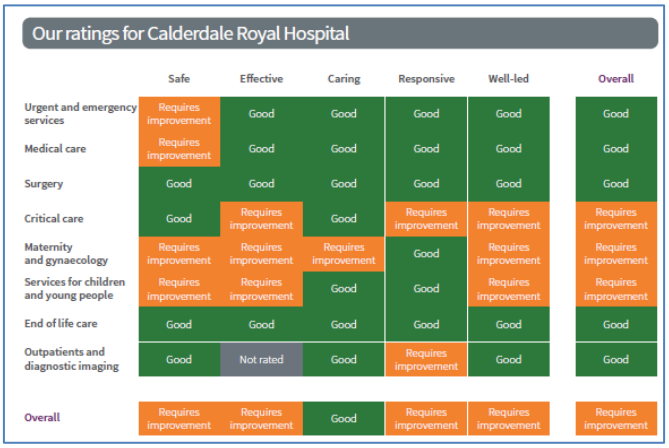
Appendix 1 – Overview of the CQC report
Appendix 2 – Year end position, must and should do actions
Appendix 3 – CQC revised inspection prompts

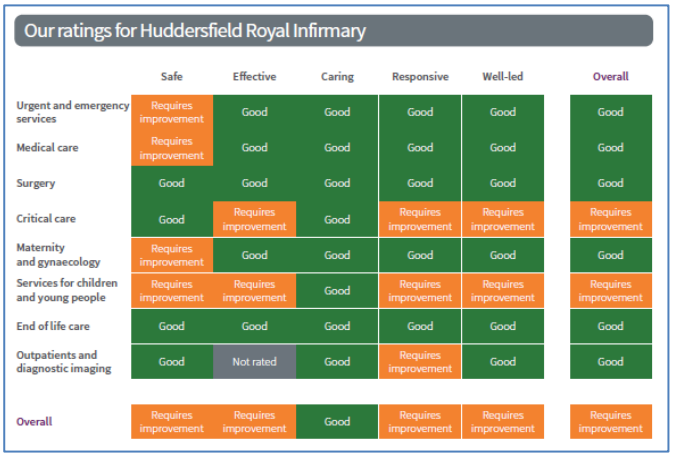
End of year review – CQC Inspection and action plan

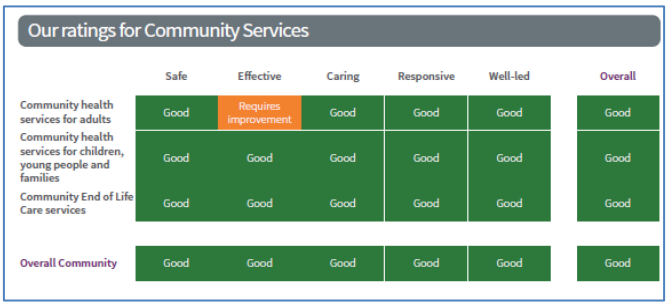
The CQC carried out an inspection of the Trust between 8th and 11th March 2016 as part of their comprehensive inspection programme. In addition, unannounced inspections were carried out on 16th and 22nd March 2016.

1. Report, ratings and regulatory requirements

The final report was published on the CQC website on Monday 15th August 2016, and whilst over 70% of the report was rated as good, the Trust received an overall rating of requires improvement. Both the caring and the responsive domain were rated as good.







The report set out 19 must do actions and 12 should do actions. Some of these were detailed as requirement notices that cross referenced to 3 CQC regulations.

The requirement notices were in relation to:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
  - Regulation 12 (1) Care and treatment must be provided in a safe way for service users

- Regulation 17 HSCA (RA) Regulations 2014 Good governance
  - Regulation 17 (1) Systems and processes must be established and operated effectively to: (2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.

- Regulation 18 HSCA (RA) Regulations 2014 Staffing
  - Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.
  - Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

Please see Appendix 1 for further detail of what the Trust report said.

2. The Trust's response to the report

2.1 Trust action plan

A detailed plan was developed for each of the must and should do actions. This was populated by the named Executive Directors and Implementing Officers with a high level narrative that described:

1. Action taken to date (since the CQC inspection)
2. Further actions required to address the recommendations
3. The outcome expected from completion of the action
4. Date of action completion
5. Date of sustained improvement/embeddedness.

A CQC Response Group, reporting to the Quality Committee, was established to oversee the delivery of the plan which along with the associated monitoring / governance arrangements was signed off by the Trust Quality Committee in Aug 16 and received approval from the Trust Board in Sept 16.

A blue / red / amber / green (BRAG) rating was applied to each of the actions within the plan, using the framework:

Delivered and sustained
Action complete
On track to deliver
No progress / not progressing to plan

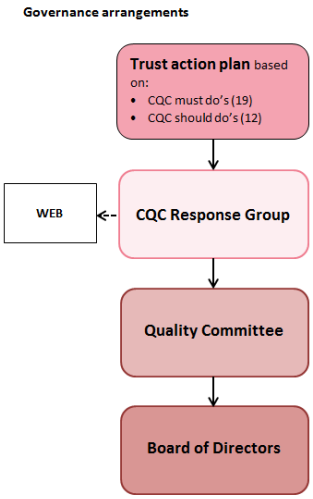
2.2 Core Service action plans

In addition to the Trust plan, each core service developed a separate plan based on any concerns raised against each of the 5 domains reviewed by the Inspection Team. These have been managed through the four Clinical Divisions and update reports provided to the CQC Response Group.

2.3 Governance arrangements

The governance arrangements to support the delivery and monitoring of the plan were agreed as following:

CQC Response Group: oversaw the delivery of the plan, monitored progress, signed off actions, and agreed submission of sustained position to the Trust Quality Committee (must and should do actions)
Trust Quality Committee: provided assurance to the Board that the plan was achieving the expected impact and gave final sign off for sustained actions.
WEB: received a monthly report ahead of the Quality Committee, in order to be informed of any emerging concerns and agree any actions required by WEB.
Divisional PSQBs: oversaw the delivery of the core service plans; escalated to Divisional performance meetings, by exception, any impacts on performance requiring Executive support and provided progress updates to the CQC Response Group.



2.4 Quality Summit

A Quality Summit was held on 17th October 2016. This was an opportunity to work with partners from within the health economy and local authority to take forward the recommendations from the inspection report.
Visits to services were subsequently arranged following the Quality Summit, with commissioning and Local Authority Colleagues focusing on any areas of concern they raised, in order to describe and demonstrate quality improvements, changes to working practice and further challenges faced by services.

2.5 CQC relationship meetings

Regular meetings have been held with the Trust's local CQC management team. These have involved visits to areas raised as a concern – either at the time of the inspection, or detailed in the final report. This has given the chance to share with the CQC team the changes being introduced into practice and approaches to quality improvement / initiatives, so validating the Trust's response to actions and considering future developments.

2.6 Initial feedback – assurance reports

At the time of the inspection the CQC raised two areas of concern with the Chief Executive and the Executive team:

- A number of areas within maternity services
- Some patients on the clinical decision units (CDU) in the emergency departments had an extended length of stay on the units whilst waiting for a general inpatient bed and also staffing levels on CDU

The Trust provided an immediate response, including plans as to how these concerns would be addressed.

2.6.1 Maternity: A detailed action plan was shared with the CQC immediately following the inspection. This has been monitored through 2 weekly assurance meetings between the senior management team within maternity services and the Medical Director and Chief Nurse office The plan included commissioning the Royal College Of Obstetricians and Gynaecologists to undertake an Invited Service Review; this took place at the end of July 2016 and provided assurance on areas of progress that had been made, confirmed concerns the CQC had raised and also provided an alternative view to some of the CQC findings. The actions following this report were incorporated into the Maternity Improvement Plan.

The final assurance meeting was held in August 2016, at which point the senior medical and nursing team were satisfied that all areas of concern had either been dealt with or that plans were sufficiently developed to deal with the outstanding concerns.

2.6.2 CDU: A formal update regarding the CDU was provided to the CQC at the end of June 2016, this included information regarding the use of a Standard Operating Procedure which described the 3 categories of patients cared for on the unit and the escalation procedures for any patient **not** on a CDU pathway, also a reduction in length of stay and that a core staffing team was in place at CRH.

The CQC management team has subsequently visited the CDUs and the Maternity unit as described in section 2.5.

3. Progress with the Trust plan

The CQC Response Group has received regular updates from Executive Leads / Implementing Officers against agreed timescales for the individual actions. Reports on progress have been provided monthly to the Trust Executive Board, the Quality Committee and the Board of Directors, detailing the movements of individual actions in line with the 'BRAG' rating methodology and any slippage against timescales. Progress has also been discussed with commissioners and the CQC Inspection Managers via regular relationship meetings.

These reports and discussions have also focused on levels of assurance, but with a challenge as to whether actions taken were embedded and sustained.

As at 30th April 2017 all but three actions have been delivered and sustained (blue). The three remaining actions are complete (green) but require further time to fully embed and deliver the impact required.

MD3	**Mandatory & Essential Skills Training and Appraisals**	**Issue:** The Trust target of 100% was not achieved for either mandatory training or appraisal at year end; however improved performance management arrangements including the cleansing / validation of data are now in place. The CQC Response Group remained committed to the requirement for all staff to have an annual appraisal and complete the required mandatory training, but recommended that the target is reviewed based on 2016 / 17 performance; this is being taken forward through the Well-led Committee and will reflect the introduction of an appraisal season and an improvement trajectory for mandatory training. ***Recommendation: Move embedded deadline from 31.3.17 to 31.10.17, BRAG rating remain green***
MD8	**Medicines**	**Issue:** Processes have been introduced to address the issues raised in the CQC report covering cold storage, out of date medicines and controlled drugs. Audits of current practice have shown improvement, but further work is required to achieve a consistent level of performance. A task and finish group has been established to take this forward. ***Recommendation: Move embedded deadline from 31.3.17 to 30.9.17, BRAG rating remain green***

SD9	**Seven day working in radiology**	**Issue:** The Trust is currently working with NHS England to map existing radiology capacity against national standards – this will form the basis of future service plans. The embedded deadline has been revised in line with the anticipated completion of this work - to establish the baseline and develop an associated plan ***Recommendation: Move embedded deadline from 30.4.17 to 30.9.17, BRAG rating remain green***

Whilst significant work has progressed in response to the inspection report, the majority of actions and indeed the Trust's response require a change in organisational behaviour / culture in order to achieve the shift from transactional change to sustained, embedded and transformed service and quality delivery. This remains the Trust's ambition in the continued drive for 'outstanding'.

In order to direct and monitor continued improvement each action has been mapped to existing assurance arrangements, providing a clear accountability and reporting structure. The governance and oversight of the plan has transferred to the Risk and Compliance Group, enabling an organisational overview to be maintained of any emerging risks or compliance concerns.

Appendix 2 provides an overview of all of the must and should do actions – detailing a summary of how the Trust has responded to the action and the governance arrangements going forward for the ongoing management and monitoring.

The following are current areas of ongoing challenges for the attention of the Board of Directors:

MD1 Staffing	The Trust remains non-compliant with elements of the professional standards for staff groups: – (GPICS 2015) Guidelines for the provision of Intensive care services (all staff groups), – (CEM) College of Emergency Medicine – wte consultants – (BTS) British Thoracic Standard guidelines re nurse staffing ratios for non-invasive ventilation patients
MD2 Governance processes	Significant changes in the Trust's middle management team impacting on the amount of progress achieved with the various 'governance' elements and the quality agenda across the plan – Trustwide & Core services
MD3 Essential skills	Mandatory training compliance levels below target Delivery of the essential skills programme
MD4 MCA & DoLs	Delivery of best practice – focus required on capacity assessments for patients with transient symptoms
MD5 Gillick competence	Delivery of best practice - outputs from reviews to be owned at Divisional level
MD7a Safeguarding training	Training levels remain below target across all services for both Adult and Children's safeguarding
MD8 Medicines management	Delivery of best practice - ownership and responsibility for medicines management to be progressed at Divisional level
MD11 Maternity patient experience	Significant work undertaken in maternity services, however maternity services remain under scrutiny in response to the national maternity picture
MD12 Second maternity theatre	
MD13 Third & fourth degree tears and PPH	
MD14 Critical care use of theatre recovery	Appropriate actions have taken place, risk to sustained delivery due to demands on the service
MD15 Critical care capacity and demand	
MD 16 CDU	Appropriate actions have taken place, remains as a concern in response to pressures on the emergency pathway
MD19 Paediatric assessment area SD6 Paediatric provision ED (HRI)	Awaiting final decision on paediatric pathway

4. Future inspections

A follow up inspection is anticipated from the end of Quarter 2 onwards. Whilst a formal notification of the format of this has not been received, confirmation of the previous expectation that it will involve a re-inspection of the core services rated as 'requires improvement', along with a 'well led' organisational review remains unclear.

It should be noted that there remains a possibility of the CQC returning at any time; they have access to local intelligence - information and performance reports, and issues raised by the Coroner. High profile media cases from across the country may also trigger a CQC line of enquiry, e.g. maternity care at the Shrewsbury and Telford Hospital NHS Trust following a cluster of baby deaths. A CQC re-inspection of this Trust was conducted Dec 16, report awaiting publication.

A number of activities have now commenced to enable the Trust to prepare for a re-inspection this is being overseen by the Risk and Compliance Group.

4.1 Local Mock Inspections and update reports

A series of mock inspections have been scheduled. These have been prioritised based on:

- core services receiving a rating of requires improvement
- elements of the plan that would benefit from independent scrutiny

Three core service mock inspections have been completed to date:

- Maternity
- Children and Young People
- Outpatients

Further inspections are scheduled for:

- Safeguarding
- Critical Care
- ED/CDU

4.1.1 Mock inspections – high level findings:

Maternity:

- Positive feedback from the inspection team re: The involvement of women and partners with their care and decision making and staff going the extra mile; noted the 'systematic and cultural approach to keeping women safe'; No infection control issues were noted; Good governance processes described including incident reporting and learning, clinical audit .
- Progress noted re the action plans to support the reduction in rates of PPH and 3rd and 4th degree tears and minimising theatre delays
- Arrangements for supporting newly qualified and existing staff reviewed and noted positive examples of preceptorship, training and appraisals

The report identified a small number of issues to be addressed including resuscitation trolley checks and the development of a Gillick and Frazer one sided briefing note. These are being addressed by the Womens Directorate management team

Children & Young People:

- Good practice noted across many areas, including: clinical reviews – daily consultant reviews, use of PAWS via nerve centre; High standard of record keeping, including drug charts; Clear concise handovers; Learning lessons and responding to feedback; Knowledge of FGM, CSE, Gillick / Faser competence
- There were some differing messages regarding pathways on the Paediatric assessment unit at HRI and different views re the lead clinician for some patients pathways
- Whilst there was good infection control practice noted and observed, there was also some areas recommended for improvement which included some environment / cleanliness issues
- Positive feedback was given by all parents and children, including good examples of communication

The report provided recommendations and points for further consideration – these are being addressed by the Children's Directorate management team

Outpatients:
Awaiting report

4.1.2 Board of Directors updates

Updates have been scheduled from the senior management team responsible for the three core services rated as 'requires improvement' at the Board of Director meetings between June and September 2017. These will provide an opportunity to describe the changes that have been introduced and how these have been embedded into existing governance arrangements. It will enable Board level decision making regarding any aspects of the plans that remain outstanding, that do not have a clear route for change and may impact on compliance with local or national guidance / policy.

4.2 Inspection intelligence

4.2.1 CQC documentation – as part of the 2016 CQC consultation – 'next phase of regulation' the key lines of enquiry have been revised and include additional prompts for inspectors:

http://www.cqc.org.uk/sites/default/files/20161219_Annex_A1_HealthcareservicesKLOEspromptsandcharacteristics_consultationannex.pdf

Examples of additional prompts (across all domains) include:

- A range of prompts re the 'proper and safe handling of medicines' - ***safe***
- Arrangements for responding to external safety alerts, inquiries, reviews etc – ***safe***
- Regard for MHA code of practice – ***effective***
- Pain assessment and management - ***effective***
- Volunteers – active recruitment, training and support - ***effective***
- A range of prompts re 'supporting people to live healthier lives' - ***effective***
- Involvement of carers, family members and friends as partners in care delivery – ***caring***
- Supporting end of life decisions – ***responsive***
- Use of technology to support timely access – ***responsive***
- Supporting staff development - via high quality appraisals and career development conversations – ***well-led***
- Interaction between governance and management functions – ***well-led***
- Effective processes for managing risks, issues and performance – ***well-led***
- A range of prompts re 'provision and use of information' – ***well-led***

See ***Appendix 3*** for the full listing of prompts

In addition to the new prompts, some of the existing prompts have changed / moved within the domain. There are also some existing prompts that have moved from one domain to another, this includes a series of prompts related to consent and mental capacity, previously part of effective, which have moved to responsive (this was a must do action for the Trust).

A significant change is expected to the 'well-led' domain moving from 5 key lines of enquiry to 8 - linking together the CQC's current assessment and Monitor's well-led framework

4.2.2 Liaison with Trust's inspected under the new CQC regime - In order to gain a better appreciation of how the new inspection regime works a 'go see' has been arranged to South West Yorkshire Partnership NHS Foundation Trust in June 2017, this Trust achieved a 'good' rating from their follow up inspection during January 2017, compared to a 'requires improvement' rating in March 2016. It is recognised that this will not be a like for like review, as this is a Mental Health Trust. Additional 'go sees' have also been arranged to University Hospitals of Morecambe Bay NHS Foundation Trust and Addenbrooke's Hospital (Cambridge University Hospitals NHS Foundation Trust).

4.2.3 Review of current CQC inspection reports **-** There have been recent inspection reports where Trusts have received a negative shift in ratings from requires improvement to inadequate. An initial review of the Northern Lincolnshire and Goole and the United Lincolnshire Hospitals CQC reports has identified the following potential issues for a corporate 'well-led' inspection:

- Items sitting on the BAF for a long time without being closed
- Service risk register reviews
- Rates of mandatory training and appraisal
- Capacity and capability of divisional management teams and poor leadership and management at divisional level
- Lack of clarity in how results of clinical audit have been used to improve practice
- Learning from incidents shared across the trust
- Medicines management – fridges / medication checks / missed doses
- Turnover and gaps in staffing despite escalation
- Sepsis six being used across the trust
- Clinical validation of follow-up and ITT back logs for incomplete pathways
- Staff satisfaction and FFT responses
- Emergency preparedness and business continuity plans
- Complaint response times not being as described by the Trust
- Restraint, tranquilisation, ligature assessments and cutters being available across the Trust
- Number of bed moves

5. Organisational readiness for the next inspection

5.1 Lessons learnt from previous preparatory work

- There was a long lead in time to the last inspection – the Trust was one of the last Trusts to be inspected and knew it would be by the end of the financial year 2015/16
- Go sees worked well – helped staff to understand what to expect
- Core services / Domains self-assessed and presented to the CQC steering group, which enabled oversight of potential issues
- Opportunities were created for management teams to reflect on key CQC questions, e.g. Capsticks workshop
- Minutes submitted as evidence were not always of a good quality - need to have clear conclusions and actions re agenda items; ensure items aren't frequently deferred / that meetings don't fail to reach the end of the agenda; that evidence logs are managed well and progressed in a timely way
- Risk registers are now more up to date than at the time of the inspection; however the narrative requires reviewing to ensure it is timely and describes 'current' mitigations and actions and also reflects compliance risks
- During the Trust's preparation there was a significant focus on areas for improvement and less about identifying good practice / innovations – staff need to be prepared to discuss these
- There is a need for attention to detail and ownership of data submission:
  - Requires a critical review of data submitted
  - Core service teams need to be engaged with data submission - Why is it being requested? What is it showing?

5.2 Other factors to consider as part of the next inspection

- It is likely that some core services won't be part of the inspection – these services will be asked to support those that are
- Clinical supervision is mentioned in a requirement notice, but wasn't described in a must / should do action – there is a need to ensure that the Supervision policy is up to date and that practice follows policy
- CQC commented on some of the 'data' that was provided – this wasn't an action for the Trust, but recognised it as a concern in the well-led narrative – *'Data provided by the trust was not always accurate with different information provided for the same time period. Mandatory training and appraisals data was unreliable with trust and divisional data differing from ward level records'*
- If the Trust is inspected separately for the core service re-inspection and the well led organisation inspection, it is likely that there will be two separate inspection teams and two Provider Information Requests; this will create additional demands across the Trust.

5.3 Next steps

Core services

- Complete mock inspections for services rated 'requires improvement'
- Undertake self-assessments based on revised prompts
- Confirm position regarding historic concerns
- Undertake a table top exercise with these services - complement the information from the mock inspections by reviewing incidents, complaints, risk registers, compliance register, meeting minutes etc and a data pack (to be produced by Health Informatics)
- Carve up 9 core service lines amongst the Executive Directors and the senior nursing team
- The assigned executive leads to work through core service self-assessment response with the triumvirate management team
- Hold focus groups with teams – what are the current concerns?
- Generate a comprehensive list of good practice, innovations
- Share key information with staff, key messages and improvements since the last inspection – infographics style – easy read

Trust wide

- Undertake a self-assessment of well led prompts at Board level
- Consider a mock inspection early in September 2017
- Early review of the environment – 'Dump the junk'; Refresh the big pictures
- Review and update the 'I need to know file'
- Promote the revised Trust strategy - refresh the plan on a page; keep the focus on compassionate care
- Recognise service user involvement
- Need particular support for middle managers (frequent changes in roles) and new Executive Directors

What did the CQC report say?

Key:

Box shading: **Amber = rating of requires improvement** **Green = rating of good**

Text: **Black bold = CQC must do** **Black Italics = CQC should do,**

White = identified reasons for core service receiving a rating of requires improvement(along with the must / should do actions)

	Safe	Effective	Caring	Responsive	Well led
ED	• **CDU** • **Consultant staffing levels (CEM standards** • **Nurse staffing** • **6 SIs (12 months)** • **Wait for initial assessment** • **9 black breaches** • **Mandatory training rates** • **Outliers on CDU** • *Provision for paediatric patients (including staffing)*	• **Appraisal**	•	• **CDU /flow** • *Provision for paediatric patients*	• **CDU – not escalating to Executive team**
Medical	• **Incident grading - governance** • **Incident backlog - governance** • **Falls and pressure ulcers** • **Duty of candour timescales** • **Learning variable - governance** • **Below target harm free care** • **Record keeping variable** • **Risk assessments partially completed** • **Mandatory training rates, including safeguarding** • **Nurse staffing** • **NIV staffing standards** • **Medicines management**	• **Appraisal**	•	• **Complaints**	•
Surgical	• **GI bleed rota** • **Storage of medicines (fridge temp)**	•	•	• **Complaints**	•
Critical care	• **Non-compliance with intensive care stds – all staff groups:** - **Including supernumerary co-ordinator 24/7** • *Handover – H@N & outreach*	• **Critical care post reg. award** • **Out of date paper guidelines** • **Physio resources (NICE CG 83)** • **No Dietician at weekends** • **Appraisal rates** • **Pharmacist staffing (CRH)**	•	• **Delayed discharges / out of hours – capacity and demand** • **Use of theatre recovery** • **Follow up including - *Psychological support***	• **Support from senior staff** • **Involvement of nurses in governance meetings** • **Historical cultural issues / staff morale** • **Cascade of info to junior nursing staff**
Maternity & gynaecology	• **FGM** • **2nd obstetric theatre** **CRH** • SI - Management of fetal growth • SI – Retained swab • **Management of controlled drugs** • **Mandatory training** • **Safeguarding training** • **Staffing levels – gynae ward** **HRI** • **Learning from incidents - governance** • **Emergency equipment out of date** • **Evidence of checking sepsis box** • **Fridge temperature** • **Safeguarding training** • **Management of deteriorating women** • **Birth centre criteria / initial assessments** • **Staffing levels**	• **Gillick competence** • **PPH, tears** • **MCA / DoLs** • **Nutritional needs – mums & babies** • **Laminate guidance & leaflets out of date** •	• **Not involved in decisions about care/ not supported** •	•	• **Response to PPH, tears, 2nd theatre** • **Sharing risks with staff** • **Learning not embedded** • **Directorate meetings – variable in structure** • **Appropriate use of birth centre (HRI) and articulation of birth centre protocols**

Children & Young people	• Safeguarding training • Safeguarding supervision • Peadiatric medical cover (HRI) • APNP staffing levels (HRI) • Infection control training • Mandatory training • NICU infection control risks	• Outcomes: diabetes, • Readmissions- asthma, epilepsy, surgical • Improvement plans (care planning) • Out of hours services limited	•	CRH • Paediatric model (HRI) • Care of deteriorating child • Paediatric medical cover	• Risk register – addressing risks • Incident action plan timescales • Actions to improve outcomes • Management oversight of safety issues • Low safeguarding training
End of life care	•	•	•	•	• *Strategy & vision*
OPD & diagnostics	• *Adult OPD staff –Paediatric training: safeguarding, paediatric life support* • Incident trends and themes – governance • Mandatory training	Not rated • *24 hour service (nephrostomy / stenting)*	•	• Appointment backlogs and waiting lists • Appointment delays and cancellations • Hospital cancellations • Clinics overbooked • Ophthalmology appts cancelled and re-booked • ***Signage HRI / Acre Mills*** • OPD long waits • Capacity & demand • Poor continuity of care – particularly ophthalmology • Surgical OPD & trauma / ortho cramped (HRI) • Ortho & phlebotomy cramped (CRH) • Radiology busy – lack of space • Car parking • High number of complaints, no trend analysis - governance	• *Seven day working – radiology* • Governance processes – audit management structure, escalation of risks
Community adults	• ***Equipment / medical devices***	• ***Comprehensive performance data*** • Documentation of consent • Clinical guidelines, reviewed / standardised - governance • Clinical supervision - inconsistent	•	• Interpreting services	•
Com. children	•	• ***Midwifery and health visiting pathway***	•	•	• ***Therapy service provision*** • ***Tendering arrangements***
Com. EoLC	•	•	•	•	•
Trustwide report / actions	• Staffing levels • Mandatory and Role specific training • Safeguarding training • Safe storage and administration of medicines • Falls and pressure ulcers – risk assessment and use of equipment • ***RCA training / comprehensive investigations***	• Patient outcomes • Plans in response to outcomes / audits • Appraisal rates • Clinical supervision • Consent and mental capacity • MCA/DoLS assessments and documentation • Mortality – higher than expected range	•	• Complaint responses	• Governance processes • Data provided not always accurate – mandatory training and appraisals

CQC Response Group

Year-end position on Must Do and Should Do actions April 2017

Must Dos	Director	Officer	CQC Action		As at 30.4.17	Summary of the Trust response	Ongoing management of the action / monitoring of impact
MD1	Director of Nursing Medical Director Chief Operating Officer	Divisional *Director of Operations* / Associate Director of Nursing	Staffing	The trust must continue to ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.	MD1	• Can demonstrate a proactive recruitment process re nursing and medical workforce • Workforce 'supply' continues to be a challenge for the Trust • Robust arrangements in place for the management of temporary workforce • Use electronic management tool – supports real-time requirements based on acuity and dependency levels	• Captured on high level risk register – 6345, with a detailed narrative of controls and further actions • Weekly reports to TE re flexible workforce - Nursing Workforce Strategy and Modernisation Group - Medical Workforce Portfolio Group
MD2	Director of Nursing	Assistant Director of Nursing and Quality	Governanc e Processes	The trust must continue to embed and strengthen governance processes within the clinical divisions and at ward level.	MD2	Lots of evidence to demonstrate a continued approach to strengthening governance , an area that can always be improved • Risk registers reviewed – grading, description, controls, actions • Developed learning framework • Ward assurance tools enhanced • Ward to Board assurance framework commenced • Band 7 development programme delivered • Well led governance plan complete • Internal audits supports local assurance • Governance structure clarified	• Risk and Compliance Group: review high level risk registers monthly and Divisional registers bi-monthly • Quarterly Divisional PSQB reports to Quality Committee • Governance sub-groups in place for safety, experience, effectiveness and clinical outcomes
MD3	Director of Workforce & OD	Divisional *Director of Operations*	Appraisals, Mandatory Training and Essential Skills	The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.	MD3	• Trust had a target for 100% for both appraisal and mandatory training – this was not achieved at year end. • However, performance management is now more robust: data has been validated, support is being provided via the HR managers and trajectories have been agreed. • The CQC Response Group remained committed to the requirement for all staff to have an annual appraisal and complete the required mandatory training, but recommended that the target is reviewed based on 2016 / 17 performance. This is being taken forward through the Well-led Committee • A comprehensive plan for the appraisal season and for mandatory training compliance is being prepared by the senior W&OD team. This will include a communication / campaign programme, compliance reporting and identification / resolution of issues that may get in the way of getting to target compliance rates • The Essential skills programme content has been agreed, target audience defined, database for capturing activity	• Well-led committee to progress further actions in line with the Workforce &OD strategy
MD4	Director of Nursing	Deputy Director of Nursing	MCA & DoLS	The trust must continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards	MD4	• Improved training material and approach – local training packages and multi-agency events • Bespoke paperwork & guidance introduced for DoLs – supporting staff to complete this • Positive audit results • A lot of good messages heard during 'go see'	• Safeguarding committee to continue to progress initiatives to support staff understanding and application

MD5	Director of Nursing	Deputy Director of Nursing	Gillick competence	The service must ensure staff have an understanding of Gillick competence.	MD5	• Improved training material – level 2 & 3 safeguarding • Detailed information shared with Maternity, Gynae and Paeds post inspection • Some mixed feedback from initial go see • More positive message from mock inspection (remains some confusion with 'Fraser' competency • A4 briefing re differences shared	• Safeguarding committee to continue to monitor the impact of briefings
MD6	Medical Director	Assistant Director of Nursing and Quality	Mortality Reviews	The trust must continue to identify and learn from avoidable deaths and disseminate information throughout the divisions and trust.	MD6	• Improved arrangements for mortality reviews • Examples of learning from mortality reviews shared at numerous clinical forums • Evidence of sharing learning via reports and meetings • Positive discussions re mortality plans with NHSI (Dec 16) • 3 ISRs and action plans in response to mortality alerts • Current mortality rates are within expected range	• Mortality surveillance group reporting to Clinical Outcomes Group
MD7a	Director of Nursing	Deputy Director of Nursing	Safeguarding Training	The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role.	MD7a	• All staff reviewed in line with the intercollegiate document • Improved monitoring arrangements • Additional training sessions • Level 3 training compliance still low, but improved by 30% for both adult and children in year: adults 13 – 40%, children 33 – 63% • Separate process in place for monitoring paediatric medical staff (consultants and juniors) by Named Doctor	• Safeguarding committee and Divisional PSQBs monitor uptake of training and address concerns
MD7b	Director of Nursing	Deputy Director of Nursing	FGM awareness	The service must also ensure all relevant staff are aware of Female genital mutilation (FGM) and the reporting processes for this.	MD7b	• Improved training material • Part of essential skills programme for specific staff groups • Some mixed feedback from initial go see • More positive message from mock inspection with all staff disciplines able to describe that they were aware of FGM and that it was reportable • CASH under 18s proforma now used in Gynae and Maternity	• Safeguarding committee to continue to monitor the impact of briefings
MD8	Director of Nursing	Clinical Director of Pharmacy	Medicines	The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.	MD8	• Cold storage: new calibrated thermometers rolled out across the Trust, included training and monitoring tool • Out of date medicines: awareness raising, 'not to be used after….' stickers, supported by ward based ATOs • Controlled drugs: CD checklists introduced, new stationary in place • Audits showing improvements but not to the required level	• Director of Nursing leading a task and finish group looking at alternative approached to achieving a consistent level of performance
MD9	Director of Nursing	Divisional *Director of Operations Community*	Interpreter and written information	The trust must ensure that interpreting services are used appropriately and written information is available in other languages across all its community services.	MD9	• Engaged with community teams to ensure message re not using family members is understood • Reminded teams re access to interpreting services, including the translation of leaflets	• Patient experience group to receive performance meeting reports
MD10	Director of Nursing	Deputy Director of Nursing	Falls and Pressure Ulcers	The trust must ensure that appropriate risk assessments are carried out in relation to mobility and pressure risk and ensure that	MD10	• Continued programme of quality improvement directed by learning from incidents – incorporates risk assessments and equipment usage • Champions for falls and Tissue Viability • New falls improvement plan for Acute Medical Directorate • Local plan as part of NHSI stop the	• Plans and performance monitored through Patient Safety Group

				suitable equipment is available and utilised to mitigate these risks.		pressure campaign	
MD11	Divisional Director FSS	Associate Director of Nursing FSS	Maternity Patient Experience	Within maternity services the service must focus on patient experience and ensure women feel supported and involved in their care.	MD11	• Further developed approach to reviewing and responding to feedback • Customer care training delivered • Worked with Healthwatch to further assess experience, responding to findings which includes a focus on hard to reach groups • Driver diagram demonstrates approaches used by the team to capture / respond to / report on user feedback	• Monitored via Maternity Clinical Performance and Improvement Group, reporting to Divisional PSQB and Patient Experience & Caring Group
MD12	Chief Operating Officer	Divisional *Director of Operations FSS*	Second Emergency Theatre	The trust must review the provision of a second emergency obstetric theatre to ensure patients receive appropriate care.	MD12	• Commissioned RCOG invited service review, supported proposal for 2nd middle grade doctor out of hours, funding secured and progressed to advert • Process in place to monitor delays to maternity theatres and ensure escalation occurs	• Continued monitoring of delays to accessing theatre via Maternity governance meeting, captured on local dashboard. Reports via Maternity Clinical Performance and Improvement Group to Divisional PSQB
MD13	Medical Director / Director of Nursing	Divisional Director / Associate Director of Nursing FSS	Third and Fourth degree tears and PPH	The trust must continue work to reduce the numbers of third and fourth degree tears following an assisted birth and the incidence of PPH greater than 1500mls following delivery.	MD13	• Comprehensive governance arrangements in place to monitor performance re PPH and 3rd / 4th degree tears and associated action plans • Improved position re PPH and 3rd/4th degree tears associated with normal birth • Progressing actions to support reduction relating to assisted births	• Continued monitoring via Maternity governance meeting, captured on local and regional (benchmarked) dashboard. Reports via Maternity Clinical Performance and Improvement Group to Divisional PSQB
MD14	Chief Operating Officer	Associate Director of Nursing Surgery	Critical Care use of theatre recovery	The trust must review the admission of critical care patients to theatre recovery when critical care beds are not available to ensure staff suitably skilled, qualified and experienced to care for these patients.	MD14	• Patients nursed in accordance with local guidance to ensure they are looked after safely • Critical care capacity discussed at daily theatre safety huddles to improve organisational management • Agreed investment in outreach will include support to ICU patients in theatre recovery	• Ongoing audit fed into DMT. Reports to Surgical PSQB
MD15	Chief Operating Officer	Divisional *Director of Operations Surgery*	Critical care capacity and demand	The trust must continue to review arrangements for capacity and demand in critical care.	MD15	• Improved principles for effective flow • Escalation arrangement in place • Longer term management plans being developed	• Delayed transfers and out of transfers included on Critical care dashboard – presented monthly to DMT. Reports to Surgical PSQB
MD16	Chief Operating Officer	Divisional *Director of Operations Medicine*	Clinical Decisions Unit (CDU)	The trust must ensure that patients on clinical decision unit meet the specifications for patients to be nursed on the unit and standard operating procedures are followed.	MD16	• Revised SOP for the unit • More structured management plans for patients on CDU pathway • Escalation process for patients not on a pathway • Reduced LOS noted	• Quarterly audits to ED Quality Improvement Forum. Reports to Medical PSQB

MD17	Director of Nursing	Assistant Director of Nursing and Quality / Divisional Associate Directors of Nursing	Complaints	The trust must ensure there are improvements to the timeliness of complaint responses.	MD17	• Much improved position with complaint backlog achieved • Weekly tracker to enable early identification of issues • Revised policy • Training programme for investigators	• Monthly IPR to WEB • Monthly review at Divisional performance meetings • Quarterly complaints report to Patient Experience & Caring Group
MD18	Divisional Director - Medicine	Divisional *Director of Operations Medicine*	GI Bleed rota	The trust must ensure there is formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant	MD18	• Revised GI bleed pathway introduced • New rota in place ensuring consultant cover in and out of hours	• GI bleed pathway compliance via Acute Directorate Board performance report • Rota management overseen by General Manger – Surgical Directorate
MD19	Chief Operating Officer	Divisional *Director of Operations FSS*	Paediatrics assessment unit	The trust must review the model of care for the services provided on the paediatric assessment unit at Huddersfield Royal Infirmary.	MD19	• Model of care reviewed through colleague engagement process • Proposal developed – will go to WEB April 17 • Interim arrangements in place to maintain safe care	• Awaiting Executive Board Decision
Should Dos	**Director**	**Officer**	**Recommendation**		**As at 30.4.17**	**Summary**	
SD1	Director of Estates & Facilities	Divisional *Director of Operations Community*	Medical Devices (Cty)	The trust should ensure that the equipment inventory is updated in community adult services and that all equipment in use is properly maintained and checked.	SD1	• Community register now in place linked to medical devices corporate database • Small number of items still to be identified • Regular updates on equipment that requires calibration	• Medical devices corporate database • KPIs reported via Estates & Facilities Board
SD2	Director of Nursing	Associate Director of Nursing Surgery	Psychological Support (Critical Care)	The trust should review the availability or referral processes for formal patient psychological and emotional support following a critical illness.	SD2	• Follow up clinics in place monthly which includes psychological therapist	• Critical care DMT
SD3	Medical Director	Associate Director of Nursing Surgery	Handover (Critical Care)	The trust should review the handover arrangements from the hospital at night team to the critical care team to ensure continuity of patient care across the hospital.	SD3	• Face to face handovers in place both morning and evening on both sites	• Critical care DMT
SD4	Director of Nursing	Assistant Director of Nursing and Quality	RCA training for investigations	The trust should ensure that relevant staff have received training in root cause analysis to enable them to provide comprehensive investigations into incidents.	SD4	• Continued programme of RCA training • All SIs have trained lead investigator • Information available on intranet	• Head of Governance and Risk, reporting to SI review group • Quality of reports via SI panels and CCG meetings
SD5	Director of Nursing	Deputy Director of Nursing	End of life strategy and vision	The trust should provide consultation opportunities and team collaboration	SD5	• End of life strategy refreshed and • Workshop held with external stakeholders and commissioners • End of Life scoping facilitator has a focus	• Implementation plan to be monitored via EoL steering group

				in the development and completion of its business strategy and vision for end of life care.		on delivery of the strategy	• Reports to Clinical Outcomes Group
SD6	Director of Nursing	Associate Director of Nursing FSS	Paediatric provision OPD	The trust should ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.	SD6a (OPD)	• Safeguarding training and paediatric life support training delivered for staff working in adult OPD areas, where children are seen	• Monthly confirm and challenge – Matron and General Manager • Reports to FSS Divisional Board
		Associate Director of Nursing Medicine	Paediatric provision ED		SD6b (ED)	• Improvements made to the ED environment at CRH • Increased training and education for staff through 5 day care of the child course • Recruitment plan in progress	• ED Quality Improvement Forum to oversee. Reports to Medical PSQB
SD7	Director of Estates & Facilities	Associate Director of Estates & Facilities	Signage – HRI and Acre Mill	The trust should ensure signage throughout the HRI main building and Acre Mills reflect the current configuration of clinics and services.	SD7	• Revised signage in place at both Acre Mill and HRI	• Estates PSQB
SD8	Chief Operating Officer	Divisional *Director of Operations FSS*	Seven day working in Radiology	The trust should ensure there is access to seven-day week working for radiology services.	SD8	• 7 day working across modalities, but limited working and reporting • Further understand the impact of gaps	• The Trust is currently working with NHS England to map existing capacity against national standards – this will form the basis of future service plans. The embedded deadline has been revised in line with the anticipated completion of this work - to establish the baseline and develop an associated plan ***Embedded deadline extended to 30.9.17*** • Reports to FSS Divisional Board
SD9	Chief Operating Officer	Divisional *Director of Operations Community*	Therapy Service Provision (Children Cty)	The trust should continue to escalate, take an action plan forward and meet with stakeholders about therapy service provision.	SD9	• Staffing levels have improved	• Community Divisional Board
SD10	Director of Nursing	Associate Directors of Nursing Community & FSS	Midwifery health visiting pathway	The trust should audit the effectiveness of the pathway between midwifery and the health visiting service.	SD10	• Regular monthly meetings now in place, with more structured content • 2x audit reports	• Health visitors moving to Locala, therefore not Trust workforce
SD11	Chief Operating Officer	Divisional *Director of Operations Community*	Tendering arrangements (Cty)	The trust should ensure that staff are informed about new tendering arrangements as they develop.	SD11	• Comprehensive comms plan delivered during health visitor tender process	• Community Divisional Board
SD12	Chief Operating Officer	Divisional *Director of Operations*	Performance Data (Cty)	The trust should ensure there are	SD12	• Much improved position with access to a number of service databases /	• Community Divisional Board

		Community		systems to measure effectiveness and responsiveness of the services within community adult services.		dashboards • Opportunities continue to enhance dashboards • Staff have access to information via the knowledge portal for patients on their case load who have been admitted into the hospital and also have access to their service dashboards	

Revised list of CQC prompts

Key to type of change	
	No change, or minor change for clarity or to align between sectors
Moved	Prompt moved within or between key lines of enquiry or key questions
Changed	Substantive change to wording
New	New key line of enquiry or prompt, including those that are new for some, but not all, sectors

Notes:

Where we refer to 'people', we include adults, young adults and children, where applicable.

Safe		
By safe, we mean people are protected from abuse* and avoidable harm. *Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.		
Code	**Key line of enquiry / prompt**	**Applicability**
S1	Are there reliable systems, processes and practices to keep people safe and safeguarded from abuse?	Core
S1.1	Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?	Core
S1.2	Is implementation of safety systems, processes and practices monitored (including through regular safety audits) and improved when required?	Core

Key lines of enquiry and prompts: SAFE

Code	Key line of enquiry / prompt	Applicability
S1.3 New	How is safety promoted in recruitment practices and through ongoing checks (for example Disclosure and Barring Service checks)?	Core
S1.4	Do staff receive effective safety training in the systems, processes and practices?	Core
S1.5 Changed	Are there arrangements to safeguard adults and children from abuse and neglect that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures, including working in partnership with other agencies?	Core
S1.6 New	Do staff identify adults and children at risk of, or suffering, significant harm? How do they work in partnership with other agencies to ensure they are helped, supported and protected?	Core
S1.7 New	How are people protected from discrimination that might amount to discriminatory abuse or cause psychological harm? This includes discrimination on any protected characteristics under the Equality Act.[1]	Core
S1.8	How are standards of cleanliness and hygiene maintained?	Does not apply to NHS 111
S1.9	Are there reliable systems in place to prevent and protect people from a healthcare-associated infection?	Does not apply to NHS 111
S1.10	Does the design, maintenance and use of facilities and premises keep people safe?	Core
S1.11	Does the maintenance and use of equipment keep people safe?	Does not apply to NHS 111

1. The following are protected characteristics under the Equality Act: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

Code	Key line of enquiry / prompt	Applicability
S1.12	Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	Does not apply to NHS 111
S2	**How are risks to people who use services assessed, and their safety monitored and maintained?**	Core
S2.1 Changed	How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times and staff do not work excessive hours?	Core
S2.2	How do actual staffing levels and skill mix compare with the planned levels? Is cover provided for staff absence?	Core
S2.3	Do arrangements for using bank, agency and locum staff keep people safe at all times?	Does not apply to GP practices, GP out-of-hours, NHS 111
S2.4	How do arrangements for handovers and shift changes ensure that people are safe?	Does not apply to ambulance services, GP practices, GP out-of-hours, NHS 111
S2.5	Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively?	Does not apply to GP practices, GP out-of-hours, NHS 111
S2.6	How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges? Are staff able to seek support from senior staff in these situations?	Core

Key lines of enquiry and prompts: SAFE

Code	Key line of enquiry / prompt	Applicability
S2.7 Moved within safe	How is the impact on safety assessed and monitored when carrying out changes to the service or the staff?	Core
S3 New	**Are there reliable systems, processes and practices to ensure proper and safe handling of medicines?**	Does not apply to NHS 111
S3.1 New	Are medicines ordered, transported and stored safely and securely (including medical gases and emergency medicines and equipment)?	Does not apply to NHS 111
S3.2 New	Are blank prescription forms stored safely and tracked in line with NHS Protect guidance?	Does not apply to NHS 111
S3.3 New	Is there a system in place for completing medicine reconciliation in line with NICE guidance?	Does not apply to NHS 111
S3.4 New	Are medicines administered safely and recorded in notes?	Does not apply to NHS 111
S3.5 New	Where indicated, is therapeutic drug monitoring and physical health monitoring completed and are appropriate interventions made?	Does not apply to NHS 111
S3.6 New	Are people's medicines regularly reviewed including the use of 'when required' medicines?	Does not apply to NHS 111
S3.7 New	Are patient group directions (PGDs) and guidelines for the use of medicines in date, properly authorised and legally operated?	Does not apply to NHS 111
S4 Moved from effective to safe	**Do staff have all the information they need to deliver safe care and treatment to people who use services?**	Core

Code	Key line of enquiry / prompt	Applicability
S4.1 Moved within safe	Are people's individual care records, including clinical data, written and managed in a way that keeps people safe? (This includes ensuring that people's records are accurate, complete, legible, up to date and stored securely.)	Core
S4.2 Moved from effective to safe	Is all the information needed to deliver safe care and treatment available to relevant staff in a timely and accessible way? (This may include test and imaging results, care and risk assessments, care plans and case notes.)	Core
S4.3 Moved from effective to safe	When people move between teams, services and organisations (which may include at referral, discharge, transfer and transition), is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols?	Core
S4.4 Moved from effective to safe	How well do the systems that manage information about people who use services support staff to deliver safe care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)	Core
S5	**What is the track record on safety?**	Core
S5.1	What is the safety performance over time?	Core
S5.2	How does safety performance compare with other similar services?	Does not apply to GP practices, GP out-of-hours, NHS 111
S5.3	How well is safety monitored using information from a range of sources (including performance against safety goals where appropriate)?	Core
S6	**Are lessons learned and improvements made when things go wrong?**	Core

Key lines of enquiry and prompts: SAFE

Code	Key line of enquiry / prompt	Applicability
S6.1	Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate?	Core
S6.2 Changed	When things go wrong, are thorough and robust reviews, investigations or significant event analyses carried out? Are all relevant staff, services, partner organisations and people who use services involved in the review or investigation? Do staff participate in learning led by other services or organisations?	Core
S6.3	How are lessons learned, and is action taken as a result of investigations when things go wrong?	Core
S6.4	How well is the learning from lessons shared to make sure that action is taken to improve safety beyond the affected team or service?	Core
S6.5 New	How effective are the arrangements to respond to relevant external safety alerts, recalls, inquiries, investigations or reviews? Are these audited?	Core

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Notes:

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Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Code	Key line of enquiry / prompt	Applicability
E1 Changed	**Are people's needs assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?**	Core
E1.1 Changed	Are people's physical, mental health and social needs holistically assessed and care, treatment and support delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes?	Core
E1.2	What processes are in place to ensure there is no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions?	Core

Key lines of enquiry and prompts: EFFECTIVE

Code	Key line of enquiry / prompt	Applicability
E1.3 New	How is technology and equipment used to enhance the delivery of effective care and treatment and to support people's independence?	Core
E1.4 New	Are the rights of people subject to the Mental Health Act 1983 (MHA) protected and do staff have regard to the MHA Code of Practice?	Core
E1.5 Changed	How are people's nutrition and hydration needs (including those related to culture and religion) identified, monitored and met? Where relevant, what access is there to dietary and nutritional specialists to assist in this?	Does not apply to GP practices, GP out-of-hours, NHS 111
E1.6 New	How is a person's pain assessed and managed, particularly for those people who cannot speak?	Does not apply to specialist mental health services, specialist substance misuse services, NHS 111
E1.7 New	Are people told when they need to seek further help and advised what to do if their condition deteriorates?	Core
E2	**How are people's care and treatment outcomes monitored and how do they compare with other similar services?**	Core
E2.1 Changed	Is information about the outcomes of people's care and treatment (both physical and mental where appropriate) routinely collected and monitored?	Core
E2.2	Does this information show that the intended outcomes for people are being achieved?	Core

Code	Key line of enquiry / prompt	Applicability
E2.3	How do outcomes for people in this service compare with other similar services and how have they changed over time?	Core
E2.4 Changed	Is there participation in relevant quality improvement initiatives, such as local and national clinical audits, benchmarking, (approved) accreditation schemes, peer review, research, trials and other quality improvement initiatives? Are all relevant staff involved in activities to monitor and use information to improve outcomes?	Core
E3	**Do all staff have the skills, knowledge and experience to deliver effective care and treatment?**	Core
E3.1 Changed	Do recruitment processes ensure that all staff have the right qualifications, skills, knowledge and experience to do their job when they start their role? How is this assessed on an ongoing basis, or when staff take on new responsibilities?	Core
E3.2	How are the learning needs of all staff identified?	Core
E3.3 Changed	Do all staff have appropriate training to meet their learning needs and to cover the scope of their work? Is there protected time for this training?	Core
E3.4	Are staff encouraged and given opportunities to develop?	Core
E3.5	What are the arrangements for supporting and managing staff to deliver effective care and treatment? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.)	Core
E3.6	How is poor or variable staff performance identified and managed? How are staff supported to improve?	Core
E3.7 New	Are volunteers actively recruited, and are they trained and supported for the role they undertake?	Does not apply to GP practices, GP out-of-hours, NHS 111

Key lines of enquiry and prompts: EFFECTIVE

Code	Key line of enquiry / prompt	Applicability
E4 Changed	**How well do staff, teams and services within and across organisations work together to deliver effective care and treatment?**	Core
E4.1 Changed	Are all necessary staff, including those in different teams, services and organisations, involved in assessing, planning and delivering care and treatment?	Core
E4.2 Changed	How is care delivered and reviewed in a coordinated way when different teams, services or organisations are involved?	Core
E4.3 Changed	Do staff work together to assess and plan ongoing care and treatment in a timely and coordinated way when people are due to move between teams, services or organisations, including referral, discharge and transition?	Does not apply to NHS 111
E4.4 Changed	Are all relevant teams, services and organisations informed when people are discharged from a service? Where relevant, is discharge undertaken at an appropriate time of day and only done when any necessary ongoing care is in place?	Does not apply to GP practices, GP out-of-hours, NHS 111
E4.5 New	How are high-quality services made available that support care to be delivered seven days a week and how is their effect on improving patient outcomes monitored?	Acute hospitals
E5 New	**How are people supported to live healthier lives and how does the service improve the health of its population?**	Core
E5.1 New	Are people identified who may need extra support? This includes: • people in the last 12 months of their lives • people at risk of developing a long-term condition • carers	Core
E5.2 New	How are people involved in regularly monitoring their health, including health assessments and checks, where appropriate?	Core

Key lines of enquiry and prompts: EFFECTIVE

Code	Key line of enquiry / prompt	Applicability
E5.3 Moved from caring to effective	Are people who use services empowered and supported to manage their own health, care and wellbeing and to maximise their independence?	Core
E5.4 New	Where abnormalities or risk factors are identified that may require additional support or intervention, are changes to people's care or treatment discussed and followed up?	Core
E5.5 New	How are national priorities to improve the population's health supported? For example, smoking cessation, obesity, drug and alcohol dependency, dementia and cancer.	Core

Notes:

Where we refer to 'people', we include adults, young adults and children, where applicable.

Caring

By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.

Code	Key line of enquiry / prompt	Applicability
C1 Changed	**Are people treated with kindness, respect, and compassion and given emotional support?**	Core
C1.1 Changed	Do staff understand and respect people's personal, cultural, social and religious needs and how these may relate to care needs, and do they take these into account in the way they deliver services? Is this information recorded and shared with other services or providers?	Core
C1.2	Do staff take the time to interact with people who use the service and those close to them in a respectful and considerate way?	Core

Key lines of enquiry and prompts: CARING

Code	Key line of enquiry / prompt	Applicability
C1.3	Do staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them?	Core
C1.4	Do staff raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes?	Core
C1.5 Moved within caring	Do staff understand the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially?	Core
C1.6 Moved within caring	Are people given appropriate and timely support and information to cope emotionally with their care, treatment or condition? Are they advised how to find other support services?	Core
C.2 Changed	**How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support?**	Core
C2.1	Do staff communicate with people so that they understand their care, treatment and condition and any advice given?	Core
C2.2 Changed	Do staff recognise when people who use services and those close to them need additional support to help them understand and be involved in their care and treatment and do they enable them to access this support? (This could include communicating clearly, use of augmentative and alternative (AAC) methods, accessible information, language interpreters, sign language interpreters, specialist advice or advocates.)	Core
C2.3 Changed	How do staff make sure that people who use services and those close to them are able to find further information, including community and advocacy services, or ask questions about their care and treatment? How are they supported to access these?	Core

Code	Key line of enquiry / prompt	Applicability
C2.4 Changed	Are people empowered and supported to use and link with support networks and advocacy where necessary, so that it will have a positive impact on their health, care and wellbeing?	Core
C2.5 Changed	Do staff routinely involve people who use services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment? Do they feel listened to, respected and have their views acted on?	Core
C2.6 New	Are people's carers, family members and friends identified, welcomed, and treated as important partners in the delivery of their care?	Core
C2.7	What emotional support and information is provided to those close to people who use services, including carers, family and dependants?	Core
C3 New	**How is people's privacy and dignity respected and promoted?**	Core
C3.1 Moved within caring	How do staff make sure that people's privacy and dignity is always respected, including during physical or intimate care and examinations?	Core
C3.2 New	When people experience physical pain, discomfort or emotional distress do staff respond in a compassionate, timely and appropriate way?	Core
C3.3 Moved within caring	Do staff respect confidentiality at all times?	Core

Responsive

By responsive, we mean that services meet people's needs.[2]

Code	Key line of enquiry / prompt	Applicability
R1 Changed	**Are services delivered to meet people's needs?**	Core
R1.1	Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care?	Core

2. The definition of responsive has changed from: "By responsive, we mean that services are organised so that they meet people's needs." Service planning for population needs (previously the first two prompts of R1) will now sit in well-led (W2.5 and W7.4).

Code	Key line of enquiry / prompt	Applicability
R1.2 Changed	Where people's needs are not being met, is this identified and used to inform how services are improved and developed?	Core
R1.3 Changed	Are the facilities and premises appropriate for the services that are delivered?	Core
R2	Do services take account of the needs of different people, including those in vulnerable circumstances?	Core
R2.1 Changed	How are services delivered and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act?	Core
R2.2 Changed	How are services delivered and coordinated to take account of people with complex needs?[3]	Core
R2.3 New	How are people supported during referral, transfer between services and discharge?	Core
R2.4	How are people who are in vulnerable circumstances supported to access services and what actions are taken to remove barriers when people find it hard to access or use services?	Core
R2.5	Are reasonable adjustments made so that people with a disability can access and use services on an equal basis to others?	Core
R2.6 New	Do key staff work across services to coordinate people's involvement with the sustained and supported involvement of families and carers, particularly for those with multiple long-term conditions?	Core

3. For example, people living with dementia or people with a learning disability or autism.

Key lines of enquiry and prompts: RESPONSIVE

Code	Key line of enquiry / prompt	Applicability
R2.7 Moved from caring to responsive	How are people enabled to have contact with those close to them and to link with their social networks or communities?	Community health services, specialist mental health services, specialist substance misuse services
R2.8 New	Where the service is responsible, how are people supported to follow their interests and take part in social activities and, where appropriate, education and work opportunities?	Community health services, specialist mental health services, specialist substance misuse services
R2.9 New	How are services delivered and coordinated to ensure that everyone who may be approaching the end of life is identified, including those with a protected equality characteristic and people whose circumstances may make them vulnerable, and that this information is shared?	Does not apply to NHS 111
R2.10 New	How are people who may be approaching the end of life supported to make informed choices about their care? Are people's decisions documented and delivered through a personalised care plan and shared with others who may need to be informed?	Does not apply to ambulance services, NHS 111
R2.11 New	If any treatment is changed or withdrawn, what are the processes to ensure that this is managed openly and sensitively so that people have a comfortable and dignified death?	Does not apply to NHS 111
R3	Can people access care and treatment in a timely way?	Core

Code	Key line of enquiry / prompt	Applicability
R3.1	Do people have timely access to initial assessment, test results, diagnosis, or treatment?	Core
R3.2	Can people access care and treatment at a time to suit them?	Does not apply to ambulance services, NHS 111
R3.3 New	What action is taken to minimise the length of time people have to wait for care, treatment, or advice?	Core
R3.4	Do people with the most urgent needs have their care and treatment prioritised?	Core
R3.5	Are appointment systems easy to use and do they support people to access appointments?	Does not apply to NHS 111
R3.6	Are appointments, care and treatment only cancelled or delayed when absolutely necessary? Are delays or cancellations explained to people, and are people supported to access care and treatment again as soon as possible?	Core
R3.7	Do services run on time, and are people kept informed about any disruption?	Does not apply to NHS 111
R3.8 New	Is technology used to support timely access? Is the technology (including telephone systems and online/digital services) easy to use and does it support people to access advice and treatment?	Does not apply to ambulance services
R4	How are people's concerns and complaints listened and responded to and used to improve the quality of care?	Core
R4.1	Do people who use the service know how to make a complaint or raise concerns and do they feel comfortable doing so in their own way? Are they encouraged to do so, and are they confident to speak up?	Core

Key lines of enquiry and prompts: RESPONSIVE

Code	Key line of enquiry / prompt	Applicability
R4.2	How easy is it for people to use the system to make a complaint or raise concerns? Are people treated compassionately and given the help and support they need to make a complaint?	Core
R4.3	Are complaints handled effectively and confidentially, with a regular update for the complainant and a formal record kept?	Core
R4.4	Is the outcome explained appropriately to the complainant? Is there openness and transparency about how complaints and concerns are dealt with?	Core
R4.5 Changed	How are lessons learned from concerns and complaints and is action taken as a result to improve the quality of care? Are lessons shared with others (internally and externally)?	Core
R5 Moved from effective to responsive	**Is consent to care and treatment always sought in line with legislation and guidance?**	Core
R5.1 Moved from effective to responsive	Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004?	Core
R5.2 Moved from effective to responsive	How are people supported to make decisions?	Core

Code	Key line of enquiry / prompt	Applicability
R5.3 Moved from effective to responsive	How and when is possible lack of mental capacity to make a particular decision assessed and recorded?	Core
R5.4 Moved from effective to responsive	How is the process for seeking consent monitored and reviewed to ensure it meets legal requirements and follows relevant national guidance?	Core
R5.5 Moved from effective to responsive	When people lack the mental capacity to make a decision, do staff ensure that best interests decisions are made in accordance with legislation?	Core
R5.6 Moved from effective to responsive	Is any restraint of people who lack mental capacity monitored for necessity and proportionality in line with legislation, and is action taken to minimise its use?	Does not apply to NHS 111
R5.7 Changed	Do staff recognise when people aged 16 and over and who lack mental capacity are being deprived of their liberty, and do they seek authorisation to do so when they consider it necessary and proportionate?	Does not apply to NHS 111

Well-led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Code	Key line of enquiry / prompt	Applicability
W1 Changed	**Is there the leadership capacity and capability to deliver high-quality, sustainable care?**	Core
W1.1	Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?	Core
W1.2 Changed	Do leaders understand the challenges to quality and sustainability, and can they identify the actions needed to address them?	Core

Code	Key line of enquiry / prompt	Applicability
W1.3	Are leaders visible and approachable?	Core
W1.4 Changed	Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?	Core
W2 Changed	**Is there a clear vision and credible strategy to deliver high-quality sustainable care to people who use services, and robust plans to deliver?**	Core
W2.1	Is there a clear vision and a set of values, with quality and sustainability as the top priorities?	Core
W2.2	Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care?	Core
W2.3 Changed	Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?	Core
W2.4 Changed	Do staff know and understand what the vision, values and strategy are, and their role in achieving them?	Core
W2.5 New	Is the strategy aligned to local plans in the wider health and social care economy, and have services been planned to meet the needs of the relevant population?	Core
W2.6 Changed	Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?	Core
W3 New	**Is there a culture of high-quality, sustainable care?**	Core
W3.1	Do staff feel supported, respected and valued?	Core
W3.2	Is the culture centred on the needs and experience of people who use services?	Core

Code	Key line of enquiry / prompt	Applicability
W3.3 New	Do staff feel positive and proud to work in the organisation?	Core
W3.4	Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?	Core
W3.5 Changed	Does the culture encourage candour, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?	Core
W3.6 New	Are there mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations?	Core
W3.7	Is there a strong emphasis on the safety and well-being of staff?	Core
W3.8 Changed	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?	Core
W3.9 Changed	Are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?	core
W4 New	**Are there clear responsibilities, roles and systems of accountability to support good governance and management?**	Core
W4.1 Changed	Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?	Core
W4.2 New	Do all levels of governance and management function effectively and interact with each other appropriately?	Core

Code	Key line of enquiry / prompt	Applicability
W4.3	Are staff at all levels clear about their roles and do they understand what they are accountable for, and to whom?	Core
W4.4 Changed	Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?	Core
W4.5	Are there robust arrangements to make sure that hospital managers discharge their specific powers and duties according to the provisions of the Mental Health Act 1983?	Specialist mental health services
W5 New	**Are there clear and effective processes for managing risks, issues and performance?**	Core
W5.1 Changed	Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?	Core
W5.2 New	Are there processes to manage current and future performance? Are these regularly reviewed and improved?	Core
W5.3	Is there a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken?	Core
W5.4 Changed	Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?	Core
W5.5 Moved from safe to well-led	Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?	Core

Code	Key line of enquiry / prompt	Applicability
W5.6 Changed	When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where the financial pressures have compromised care?	Core
W6 New	**Is robust and appropriate information being effectively processed and challenged?**	Core
W6.1 Changed	Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?	Core
W6.2 New	Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and do they challenge it appropriately?	Core
W6.3 New	Are there clear and robust service performance measures, which are reported and monitored?	Core
W6.4 Changed	Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?	Core
W6.5 New	Are information technology systems used effectively to monitor and improve the quality of care?	Core
W6.6 New	Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?	Core
W6.7 New	Are there robust arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?	Core

Code	Key line of enquiry / prompt	Applicability
W7 New	**Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?**	Core
W7.1	Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?	Core
W7.2 Changed	Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?	Core
W7.3 Changed	Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected characteristic?	Core
W7.4 New	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?	Core
W7.5 New	Is there transparency and openness with all stakeholders about performance?	Core
W8 Changed	**Are there robust systems and processes for learning, continuous improvement and innovation?**	Core
W8.1 Changed	In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?	Core
W8.2 Changed	Are there standardised improvement tools and methods, and do staff have the skills to use them?	Core
W8.3 New	How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a service user? Is learning shared effectively and used to make improvements?	Core

Code	Key line of enquiry / prompt	Applicability
W8.4 Changed	Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?	Core
W8.5 New	Are there systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?	Core

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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, 1st June 2017	**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 May 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Risk and Compliance Group in May was not held due to EPR implementation. All members have been consulted via email on new high level risks propsoed and discussion with key leads has taken place.	
Governance Requirements: Keeping The Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

To assure the Board of Directors that all risks are accurately identified and mitigated adequately through reviewing the risks identified on the 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 Trust and is a key part of the Trust's risk management system.

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

The Issue:

The attached paper includes:

i. A summary of the Trust risk profile as at May 2017 which identifies the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks.

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

During May the following changes have been made:

The 3 finance risks have been re-freshed for the financial year 2017/18, have new reference numbers and all have a risk score of 20:

- 6967 - non delivery of 2017/18 financial plan
- 6968 - cash flow risk
- 6969 - capital programme - the risk score has increased from 15 to 20.

One new risk has been added to the high level risk register during May relating to Endoscopy provision and capacity, risk 6971 scored at 15.

Risk 6903, scored at 20 relating to the intensive care unit at Huddersfield Royal Infirmary and environmental and estates risks which was added in March 2017 has been further extended to include risks relating to resuscitation at HRI.

One risk, risk 6503, delivery of the electronic patient record programme has been reduced from 20 to 15 due to completion of "go live".

Next Steps:

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

Recommendations:

Board members are requested to:

I. Consider, challenge and confirm that potential significant risks within the high level risk register are being appropriately managed
ii. Approve the current risks on the risk register.
iii. Advise on any further risk treatment required

Appendix

Attachment:

Risk Register as at 24051combined.pdf

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HIGH LEVEL RISK REGISTER REPORT

Risks as at 24th May 2017

TOP RISKS

2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Staffing risk, nursing and medical
6131 (20): Service reconfiguration
5806 (20): Urgent estates schemes not undertaken
6967 (20): Non delivery of 2017/18 financial plan
6968 (20): Cash flow risk
6903 (20): Estates/ ICU risk

RISKS WITH INCREASED SCORE

6969 (was 6723) (20): Capital programme risk, increased from 15 to 20

RISKS WITH REDUCED SCORE

6503 (15): Delivery of Electronic Patient Record Program. Following completion of “Go live” this risk has been reduced to 15

NEW RISKS

6957 (20): Collective Estates Resus/ ICU risk
6971 (15): Endoscopy provision risk

Finance risks:
6967 (20): replaces risk 6721 for 2017/18
6968 (20): replaces risk 6722 for 2017/18
6969 (20): replaces risk 6723 for 2017/18

CLOSED RISKS

None

May 2017 - Summary of High Level Risk Register by type of risk

Risk ref	Strategic Objective	Risk	Executive Lead	MONTH							
Strategic Risks				**Oct 16**	**Nov 16**	**Dec 16**	**Jan 16**	**Feb 17**	**Mar 17**	**Apr 17**	**May 17**
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme - transformation	Director of THIS (MG)	=20	=20	=20	=20	=20	=20	↓ 15	=15
Safety and Quality Risks											
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	=20	↓15	↑ 20	=20	=20	=20	=20	=20
6886	Transforming & Improving Patient Care	Non-compliance with 7 day services standards	Medical Director (DB)	-	!15	=15	=15	=15	=15	=15	**=15**
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=16	=16	=16	=16	=16	=16	=16	=16
2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20	=20	=20
6822	Keeping the Base Safe	Not meeting sepsis CQUIN	Medical Director (DB)	!16	=16	=16	=16	=16	=16	=16	=16
5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	!16	=16	=16	=16	=16	=16	=16	=16
6829	Keeping the Base Safe	Aseptic Pharmacy Unit production	Director of Nursing	!15	=15	=15	=15	=15	=15	=15	=15
6841	Keeping the Base Safe	Not being able to go live with the Electronic Patient Record – operational readiness	Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15	=15	=15
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	↑20	=20	=20	=20	=20	=20	=20	=20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD	=16	=16	=16	=16	=16	=16	=16	=16

Risk ref	Strategic Objective	Risk	Executive Lead	MONTH							
6903	Keeping the base safe	ICU/ resus estates joint risk	Director of Estates and Performance (LH)	-	-	-	-	-	**!16**	↑ 20	=20
6924	Keeping the base safe	Misplaced naso gastric tube for feeding	Director of Nursing (BB)	-	-	-	-	**!15**	**=15**	**=15**	**=15**
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15	=15	=15
6971	Keeping the base safe	Endoscopy provision	Divisional Director Surgical and Anaesthetics (JO'R)	-	-	-	-	-	-		!15
	Finance Risks										
6967	Financial sustainability	Non delivery of 2017/18 financial plan	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20
6968	Financial sustainability	Cash flow risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20
6969	Financial sustainability	Capital programme	Director of Finance (GB)	15 =	=15	=15	=15	=15	=15	=15	↑20
	Performance and Regulation Risks										
6658	Keeping the base safe	Inefficient patient flow investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Director of Workforce (IW)	=15	=15	=15	=15	=15	=15	=15	=15
	People Risks										
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce (IW	=20	=20	=20	=20	=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 24/05/2017

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 (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6693 Failure to comply with monitor staffing cap = 6715 Poor quality / incomplete documentation	= 6345 Staffing risk, nursing and medical	
Likely (4)				= 4783 Outlier on mortality levels = 6658 Inefficient patient flow = 6300 Clinical, operational and estates risks outcome = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 6694 Divisional governance arrangements = 6753 Inappropriate access to patient identifiable data = 5862 Falls risk = 6822 CQUIN sepsis	= 2827 Over reliance on locum middle grade doctors in A&E = 6967 Not delivering 2016/17 financial plan = 5806 Urgent estate work not completed = 6131 Service reconfiguration = 6968 Cash Flow risk ! 6903 ICU/Resus Estates risk
Possible (3)					= 6814 EPR operational readiness = 6829 Pharmacy Aseptic Unit = 6886 Non-compliance with 7 day services standards ↑ 6969 Capital programme = 6924 Misplaced naso gastric tube = 6878 Malware risk to IT systems ↓ 6503 Non-delivery of EPR programme ! 6971 Endoscopy provision
Unlikely (2)					
Rare (1)					

High level risk register 15+ I

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
2827	Medical	Apr-2011	Developing our workforce	There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints. Locum shifts not being filled by the Flexible Workforce team and gaps not being escalated to the clinical team in a timely manner. ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps	20 4 x 5	20 5 x 4	12 4 x 3	March 2017: Awaiting above changes. Notification from School of EM that CHFT have been allocated a further 2 Higher Trainees from September 2017. Awaiting notification if posts have been filled. April 2017: Impact of IR 3 has led to worsening of position in terms of filling vacant shifts and requests for increased pay rates from long term locums. Discussion being had with individuals. Trust decision to support the service by agreeing to pay increased rates through the agencies. May 2017: 3 long term, full time agency locums are in the process of converting to CHFT bank contracts. 2 additional MGs have been appointed.	Jun-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Caroline Smith
5806	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.	Each of the risks above has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	The lack of funding is the main gap in control. Also the time it takes to deliver some of the repairs required. In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.	16 4 x 4	20 5 x 4	6 3 x 2	March 17 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. Various projects have recommenced after a significant delay in the capital programme due to environmental cleaning. April 17 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so within the current budgetary constraints. The 17/18 Capital Plan is currently under review for approval while short term minor projects are being progressed to ensure continuity. May 17 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so within the current budgetary constraints. The 17/18 Capital Plan is currently under review for approval while short term minor projects are being progressed to ensure continuity.	Jun-2017	Mar-2018	RC	Lesley Hill / David McGarrigan	Paul Gilling / Chris Davies

6131	Corporate	Oct-2014	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	10 5 x 2	December 2016 Update: On the 16th November the Joint Scrutiny Committee decided that if the CCG's do not satisfactorily address their concerns the Committee will consider referral to the Secretary of State. The Committee will meet in February 2017 to assess progress of the development of the Full Business Case. March 2017 update - .JOSC met in February and agreed to meet in July and make a decision on referral to SoS once the full business case is completed	Jun-2017	Aug-2017	WEB	Anna Basford	Catherine Riley

6345	Corporate	Jul-2015	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas - 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 - lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to 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 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 Therapy Staffing - posts designed to be as flexible as possible - review of skill mix and development of Assistant Practitioners. - flexible working - aim to increase availability of flexible work force through additional resources / bank staff	Medical Staffing Lack of: - 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 Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	March 2017: Previous actions continue Nurse Staffing • Targeted recruitment for substantive Registered Nursing and Midwifery workforce ongoing. Focusing on local recruitment from graduate programmes and overseas recruitment • Liaise with staff who have recently left the Trust to ascertain reasons for leaving, and encourage return to the Trust • Specific recruitment to bank, night and weekend posts • Focus on retention of existing staff underway • Branded recruitment process under development, promoting CHFT as an exemplar employer • Development programmes for Ward Managers in progress • Standard Operating procedure for use and authorisation of temporary nursing staff launched • Workforce review of ward nursing establishments undertaken by Chief Nurse office January 2017 Targeted recruitment for substantive Registered Nursing and Midwifery workforce on going. Focusing on local recruitment from graduate programmes and overseas recruitment • Liaise with staff who have recently left the Trust to ascertain reasons for leaving, and encourage return to the Trust • Specific recruitment to bank, night and weekend posts • Focus on retention of existing staff underway • Branded recruitment process under development, promoting CHFT as an exemplar employer • Development programmes for Ward Managers in progress • Standard Operating procedure for use and authorisation of temporary nursing staff launched • Workforce review of ward nursing establishments undertaken by Chief Nurse office January 2017 Recruitment campaign in the Philippines completed - nurses to become compliant & start to arrive in Trust from July/Aug 2017 May 17 - Medical Staffing CESR working group established to explore opportunities to develop specialty doctors in to consultants across all specialties BMJ joint advert has generated interest in consultant vacancies - Histopathology, Breast Surgery, Vascular Surgery, Anaesthetics and Urology	Jun-2017	Jan-2018	WLG	David Birkenhead, Brendan Brown, Ian Warren	Rachael Pierce

6967	Corporate	Apr-2017	Financial sustainability	The Trust is planning to deliver a £15.9m deficit in 2017/18. There is a risk that the Trust fails to achieve its financial plans for 2017/18 due to: - £20m (4% efficiency) Cost Improvement Plan challenge is not fully delivered - Additional efficiency challenge of £3m (planning gap) is not delivered - loss of productivity during EPR implementation phase and unplanned revenue costs - inability to reduce costs should commissioner QIPP plans deliver as per their 1718 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	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach	Further work ongoing to tighten controls around use of agency staffing. For 2017/18 the Trust has been given a £16.86m ceiling level for agency expenditure by NHS Improvement. Agency spend must be reduced considerably from the level of expenditure seen in 16/17 if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding.	20	5 x 4	20	5 x 4	15	5 x 3	Whilst the Trust has 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 will have to be added to the £17m CIP target. At 5.3% efficiency this will be extremely challenging to deliver. Whilst the organisation has outline plans for the majority of the £17m CIP target, there is still a lot of work to do to get the full value through Gateway 2. Any revenue costs resulting from EPR implementation will also have to be absorbed within the Control Total, which may create additional challenges in achieving the planned deficit. Failure to achieve the Control Total would also impact on Sustainability & Transformation funding. There remains a gap between the Trust's activity plan and that of local Commissioners that is linked to QIPP plans. If commissioners are successful in delivering these plans, the Trust will need to ensure that costs are reduced to compensate any associated loss of income.	Jul-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell
6968	Corporate	Apr-2017	Financial	Risk that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as going concern.	* Agreed £8m capital loan from Independent Trust Financing Facility. * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from NHS Improvement * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers	The level of outstanding debt held by the Trust is being closely monitored but is not entirely within the Trust's ability to control. The majority of this is owed by other NHS organisations.	20	5 x 4	20	5 x 4	15	5 x 3	The Trust plan for 17/18 is reliant on cash support from Department of Heath of £28.80m. £8m of Capital funding has been previously approved as part of an existing Capital Loan facility, the remaining revenue support loan requirements will have to be applied for on a monthly basis and will be subject to a potentially variable interest rate.	Jul-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell
6969	Trustwide	Apr-2017	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2017/18 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. Following a mandate from NHS Improvement to reduce Capital expenditure for 2017/18 due to national funding pressures, the Trust's Capital Programme has been severely curtailed and a number of capital schemes have had to be removed. This has increased the risk to the development and sustainability of services and has the potential to impact on clinical, safety and performance issues.	Agreed £8m capital loan from Independent Trust Financing Facility (ITFF) to support capital programme, specifically the Electronic Patient Record (EPR) investment. Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Executive Directors are meeting on 18 April to re-prioritise the capital plan and agree a strategy to provide NHSI with the impact of reducing our capital levels in terms of safety, performance and quality of care.	.	20	5 x 4	20	5 x 4	12	4 x 3	The planned capital expenditure for 17/18 is £14.40m. From a cash perspective, all capital expenditure, including any slippage on the EPR programme, must be contained within available internally generated capital funding, supplemented in 17/18 by the remaining £8m of our pre-approved capital loan facility. Further meeting of Capital Management Group on 11th May to prioritise and Executive meeting planned for 22nd May.	Jul-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell

6903	Estates & Facilities	Dec-2016	Keeping the base safe	Collective ICU & Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to access for estates maintenance and capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.	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	March Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. April Update - Short term Business Continuity Plans discussed with surgery, contingencies and resilience. Medium / Long term plan to refurbish / move service. May Update - Short term Business Continuity Plans discussed with surgery, contingencies and resilience. Medium / Long term plan to refurbish / move service. RESUS collective risk added to ICU risk.	Jun-2017	Sep-2017	RC	Lesley Hill / David McGarrigan	Chris Davies
6822	Medical	Aug-2016	Keeping the base safe	CQUIN target at risk of not being met for 2016/17 based on current compliance for screening for sepsis, time to antibiotic and review after 72 hours and risk of non - compliance in line with new NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of joined up working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treated within the hour and all of the sepsis 6 requirements delivered impact and 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 Q2 -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign to be launched ASAP, introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards NICE guidelines - Cerner currently testing qSOFA and new NICE cut offs	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of joined up working between nursing and medical colleagues	15 5 x 3	16 4 x 4	12 4 x 3	March update Continue to focus on actions that are having an impact Preparation for 2017/18 CQUIN underway CQUIN target for 2016/17 not likely to be met April update Data for quarter not yet available therefore unable to identify whether the target has been met May update Still awaiting data for Q4. Actions continue in identifying patients at risk. Training session for teams planned for June.	Jun-2017	Jul-2017	PSQB	David Birkenhead	Juliette Cosgrove

6596	Corporate	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	March 2017 Capacity continues to be an issue. Further training course scheduled for April 2017 and priority given to areas where further investigators are needed. April 2017 The training course was delivered. Senior staff in corporate services will be asked to become investigators to increase the number of available investigators. Targeted effort during April to close down those with extended investigation periods. May 2017 Continued focus on closing investigations with 17 submitted during March and April. Information on corporate staff to support investigations being confirmed during May. Any staff requiring training to be offered training date of 28 June. Departure of senior investigations manager in May. Post revised and recruited to with start date of August 2017.	Jun-2017	Jul-2017	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove

6598	Corporate	Jan-2016	Keeping the base safe	There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation. Further essential skills subjects are been identified and added to the list with increasing frequency. This obviously not only extends the period of time the roll out project will take but also leads to a re-prioritisation exercise around establishing which are the key priority essential skills to focus on first.	There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject. Compliance measurement will be enabled as each target audience (TA) is set although this is a lengthy process within the confines of the current Learning Management System. A database is being completed showing departmental training completion dates. This is to be hosted on the intranet to allow access at department level for updates and will feed into ESR. This is anticipated to be live by June 2017. Brendan Brown / Lindsay Rudge are restricting additions to the list to keep it to a manageable number.	1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. 4/ There are issues with PC settings which leads to completed e-learning not been recorded as complete. 5/ Planned updates to system not due until April 2017 so limitations as above will remain until this time. 6/ There are frequent requests for new essential skills to be added with no clear process to approve such requests. 7/ Heavy focus on EPR training has an impact on staff being able to complete essential skills training due to time and resource implications.	16 4 x 4	16 4 x 4	12 4 x 3	March 2017 MCA/DoLS work in progress awaiting correspondence from safeguarding team to progress this. 11 maternity essential skills now completed. The lead person for OLM target audience setting has now gone on maternity leave. A replacement starts later in the month but there may be a short period where delays are experienced. May 2017 ESR Manager Nigel Collins has suggested alternate methodology within OLM to allow compliance reporting in a different way. Blood transfusion essential skills target audience have now been completed as a result of this.	May-2017	Oct-2017	NA	Jason Eddleston	Ruth Mason

6658	Medical	Mar-2016	Keeping the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20 4 x 5	16 4 x 4	9 3 x 3	Feb/ March 2017 Update Variability noted with delays in February, increasing number of patients with a 50 day LOS- fortnightly LOS meetings arranged with senior managers from partner organisations to expedite discharge. Accelerator Zone funding provided to support delivery of the 95% ECS and improve flow out of the departments now in place. Impact is being monitored closely. Buddy managers supporting the OOH's period. April 2017 Much improved situation with 97% ECS. Anticipation to reduce risk scoring over next month. May 2017 Performance in month has reduced significantly and longer waits have been experienced by patients this is a consequence of introducing the new EPR. Divisions are developing an action plan which identifies the key blockers, micromanagement in place until the end of the month.	Jun-2017	Jun-2017	BOD	COO Helen Barker	Bev Walker

6300	Trustwide	May-2015	Keeping the base safe	As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services.	-CQC Response Group monitors improvements and progress with actions System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being held to monitor progress with the action plans chaired by the Chief Nurse - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, has been conducted and an action plan developed. Nearly all actions have been delivered and assurance gained. The Risk and Compliance Group will now oversee any areas outstanding.	The inspection report has shown us to be in the "requires improvement" category	16	4 x 4	16	4 x 4	8	4 x 2	March 2017 Further progress made with the must do (MD) and should do (SD) recommendation on the CQC plan, 20 actions green – complete, 12 actions blue – complete and embedded. One action amber (on track to deliver) Extension to deadlines agreed for 2 embedded dates MD14: critical care – use of theatre recovery (31.12.16 to 31.3.17) to scope the possibility of providing a supernumerary co-ordinator post out of hours to support the care of critical care patients admitted to theatre recovery if required. SD 10: midwifery / health visitor pathway (31.1.17 to 17.3.17) to gather midwifery feedback on the monthly meetings that are now in place Future oversight of the plan (April 2017 onwards) will be via the risk and compliance group. April 2017 All actions are now green. An end of plan review will be now undertaken and the last actions to be embedded will be overseen by the Risk and Compliance Group. No dates have been issued for further inspection. May 2017 Year-end position: all of the actions in the plan are rated blue – embedded or green – action complete. There are 3 remaining green actions on the plan; embedded dates for these have been extended from 31.3.17 to Sept / Oct 2017. These are must do actions: Mandatory and Essential Skills Training and Appraisals; Medicines management and should do action: Seven day working in radiology. Progress with these actions will be reported to the Risk and Compliance Group.	Jun-2017	Jun-2017	WEB	Brendan Brown	Juliette Cosgrove
5862	Medical	Aug-2013	Keeping the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls.	Insufficient uptake of education and training of nursing staff, particularly in equipment. Staffing levels due to vacancies and sickness. Inconsistent clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12	4 x 3	16	4 x 4	9	3 x 3	March update Acute Directorate are developing falls prevention action plan with a focus on areas identified from incidents Review of NICE guidance Planning for national falls audit April update New falls action plan signed off. Targeted work in the acute medical directorate has commenced including a focus on falls at night. Implementation of a post falls checklist. A reduction in falls is being seen. May update MAU team at CRH are to commence working with NHS Quest to focussed improvement work. All other actions continue as per April update.	Jun-2017	Jun-2017	PSQB	Brendan Brown	Juliette Cosgrove

4783	Corporate	Aug-2011	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	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	March 2017 update Latest SHMI (Oct 15 to Sept 16) has fallen to 108 Consultants are joining the initial screening reviews. Mortality Surveillance Group recieves monthly mortality review reports and alert/outlier mortality review reports. CAIP plan on track April 2017 update HSMR is now 101.97 and SHMI 108 and both are in expected range. There are no alerts for the second month for specific conditions. All other actions within the CAIP plan are making progress. May 2017 update Mortality Surveillance Group continues to meet monthly. 3rd month with no alerts in SHMI and HSMR	May-2017	Sep-2017	COB	David Birkenhead	Juliette Cosgrove

6693	Corporate	Mar-2016	Keeping the base safe	Risk of financial penalties and reputational damage due to non compliance with NHSI cap rules resulting in tighter control and scrutiny by regulatory bodies (special measures) and negative media coverage (name and shame).	Weekly reporting of all off-cap breaches Assurance via Finance, Performance & Well-led Group Centralisation of agency bookings via FWD to ensure governance of SOP Prioritising bank cover over agency use Adhering to a Preferred Supplier List (PSL) of framework agencies Executive control of off-cap engagements Divisional action plans to replace all medium/long-term agency contracts with alternative cover Ongoing implementation of NHS-I agency spend toolkit recommendations and Workforce Modernisation Programme initiatives. As from 13 March Allocate Bank system now used for Medical staff, Allied Health Professionals and Non-Medical Non-Clinical and non-rostered nursing areas, roll out plan in place for nursing to transfer across to Allocate from RosterPro Central and all should be transferred across by end of July 2017. 13 March 2017 - now able to capture all wage cap breaches to NHSI Weekly report on bank and agency usage now submitted to the Deputy Director of Workforce & Organisational Development, data now being captured via two electronic booking systems and manipulated into one report. Once all nursing transferred onto Allocate, one system will be used for all data capture and reporting.	Evidence that some agency bookings are going outside of SOP, i.e. not going through FWD One agency not on PSL being engaged to meet short-term demand/pressures High cost agency workers being engaged to meet short-term demand/pressures No robust action plan yet to replace medium/long-term agency use Due to no prospective cover in A&E rota medical locums being engaged to cover annual leave in A&E Trust has not yet embedded internal agency cap levels recommended by Workforce Programme.	15	3 x 5	15	3 x 5	15	3 x 5	Awaiting ratification of Agency Control Panel from WEB/WWLC Regional Working Group of MD's to co-ordinate regional approach to determine regional bank solution Business case to be completed by 31/03/17 to implement Trust wide e-rostering to automate booking processes and embed rostering efficiencies NHS-I to provide peer review of Trust status against gency spend toolkit recommendations and to assist in further action identified where appropriate. Downgraded to current risk level 15 due to ability to provide data on demand and up to date no enforcement notice from NHSI or negative press cover.	May-2017	Jul-2017	WLG	Ian Warren/Jason Eddleston	Lisa Cooper

6715	Corporate	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication and multidisciplinary working.	A multi professional clinical documentation group meets bi monthly to ensure new documentation is ratified, standards on documentation are addressed. This group also receives reports and audits with regard to documentation and identifies to the divisions areas (teams, wards departments) of concern as well as any specific areas of concern within a specific standard. Clinical records group monitors performance, highlighting best and worst performing wards and action plans are developed and managed through the divisions, including specific areas for improvement. January Update Work is progressing to devise and implement a ward assurance tool that will audit nursing documentation. The CRAS audits remain suspended. There has been little progress in fluid balance documentation which has been noted by the Director of Nursing as a result he is revising the improvement methodology and leadership to support this. May 2017 The Trust has gone live with the EPR on the 1st May, Matrons are undertaking some audit to ensure compliance. Reports will be produced once the system is further embedded. The senior nurse team will commission reporting to ensure it is included in the ward assurance framework. A meeting regarding Quality is being chaired by the Chief Nurse to establish understanding and way forward on the 17th May. Professional standards of documentation will improve as the EPR system automatically registers, username, time date, legibility.	The number of audits undertaken can be low Unable to audit to allow and act on findings in real time The discharge documentation is under going review Fluid balance is being reviewed, the evidence base is being examined by the Deputy Director of Nursing Awaiting the ward accreditation review in order to recommence audit (which will not collect comparable information)	20 4 x 5	15 3 x 5	6 3 x 2	May 2017 The Trust has gone live with the EPR on the 1st May, Matrons are undertaking some audit to ensure compliance. A meeting regarding quality is being chaired by the Chief Nurse to establish understanding and way forward on the 17th May. Professional standards of documentation will improve as the EPR system automatically registers, username, time date, legibility. .	Mar-2017	Aug-2017	QC	Brendan Brown	Jackie Murphy

6503	Corporate	Dec-2015	Transforming and improving patient care	RISK of: non - delivery of Electronic Patient Record Programme due to failure to deliver the transformation associated with not achieving the key deliverables around timescales, engagement and financial targets causing CRB to not be realised, significant cost overruns which ultimately could make the programme unsustainable. The Trust along with its partners BTHFT (Bradford Teaching Hospitals Foundation Trust) and Cerner are implementing an EPR system that will enable service transformation whilst improving patient safety and patient and clinician experience. This is a summary risk, EPR risks escalated at Transformation Group will be brought to R&C by exception. This will impact on patient care, safety and patient experience and mean the expected financial benefits of EPR programme will not be realised.	A Well-developed Governance Structure in place underpinned by a contract between CHFT and Cerner and a partnership agreement between CHFT and BTHFT. Management of EPR programme risks using Best Practice MSP (Managing Successful Programmes) methodology and EPR specific risk register Executive sponsorship of the programme with CEO's chairing the Transformation Board Separate assurance process in place Clinical engagement from divisions Clearly identified and protected funding as identified in the Full Business Case. All Risk and issues are recorded on the programme risk and issue register and managed by the EPR Risk Review Board.	- Further divisional engagement required - A more in depth understanding of the transformational change is required within the clinical divisions. The impact on activity during go live will be significant and the changes in processes post go live will be equally significant. An understanding, acceptance and support will be essential to success. - Financial offsetting for 16/17 to mitigate against the reduction in activity during go live and short term post go live. - Additional 'Mop up' training is required to fill the gaps in differing roles - Benefits tracking needs dedicated time/resource to assist the division with benefits and transformation.	20 5 x 4	15 5 x 3	5 5 x 1	April Update: Technical / Operational readiness is still on plan for the cut-over being the 29th of April. - Resources identified / secured for Friends, floorwalkers, service desk, corporate friends etc. - There is a shortfall around Manual Data Migration of around 15 wte. - Progress of Operational Checklist / Work off list. - Training figures as at COP 03/0417: 3041 (51%) people trained 4889 (82%) staff booked on training 11% DNA rate 1% failure rate - Based on the above progress, the programme status report has moved from amber to yellow, the change in score on this risk reflects that. May Update (Post go-live, end of week 3): Position statement: The Trust cut-over to Cerner Millennium EPR successfully on the planned weekend. The cutover plan worked well from an operational perspective with minimal delay with inpatients up and running in most area's prior to Outpatients on the 2nd May. Initial issues were due to End User Access and Role functionality followed by 'How do I?' type questions. Cut-over Risk: Mitigation and controls were effective, clear plans and operational structure (silver command etc) worked well. Post Go-live Risk: The post go-live risks outlined under description still exist at this early stage although initial assessment of the mitigation/controls would suggest the likelihood will reduce post ELS. Additional gaps will be addressed including 'Mop up' training, additional CYMBIO support around DQ and Reporting and a Hardware assessment across both sites. Both the Impact and likelihood scores stay the same until ELS is complete and mitigation is proven.	Jun-2017	Sep-2017	RC	Mandy Griffin	Mandy Griffin

6886	Corporate	Nov-2016	Transforming and improving patient care	The seven day service compliance is a part of one of the five categories that the Single Oversight Framework is judged on. As the trust is an early adopter of the four priority standards (2, 4, 5 and 8) it is expected that full compliance will not be achieved by March 2017. At present the impact of not meeting this is not clear as NHS Improvement have not stated what (if) penalties are in place for un met targets. The panel discussed the likely outcomes of not meeting this deadline (financial? Monitoring? Greater oversight?). It was also mentioned that nationally the target is September 2020, and whether we would expect to be able to meet the standards by this date also. This is due to split site acute services, no additional investment for the extra consultants needed, consultant workforce vacancies and difficulties in recruiting. This will result in inconsistent service delivery over the 7-days and especially at weekends. In turn this may impact on clinical outcomes, patient flow and patient experience. Currently there is no contractual obligation or penalty in not achieving compliance with the four priority standards by March 2017. This may also impact on local and national reputational loss and be focus of future enquiry.	High level action plans are being reviewed with the aim of developing more detailed plans to review what can be achieved within current resources and current configuration of acute services. This will include details of workforce and skill mix, financial implications and full benefits such LOS and patient experience. This will need to take into account what can realistic be achieved with the scope of the 5-year plan. 7DS reports via the Safer Programme.	The main reasons for not achieving compliance include: • Lack of dedicated funding to recruit additional consultants to meet compliance • Existing difficulties in retaining and recruiting to consultant posts within certain specialties especially in Medicine and Radiology • Split-site configuration of hospital services. Whilst the completion of a more detailed action plan will help identify possible solutions towards achieving compliance it is doubtful that within current resources and current configuration of acute services that full compliance will be achieved. Note the national timeline for all trusts to achieve full compliance with the priority standards is 2020 which is before the likely 5-year timeline to reconfiguration of acute services. Also at present whilst there is no financial penalty in achieving compliance this may change in the future.	15 3 x 5	15 3 x 5	9 3 x 3	January 2017 CHFT remains non-compliant against the four priority standards in relation to 7DS. Cumulative 7 day services national surveys demonstrate near compliance with standards 2 and 6. Compliance with standards 5 and 8 remain a challenge. A detailed action plan is being developed to mitigate against this risk that is within current configuration of acute services and resources. It is likely that we will remain non-compliant against these standards by March 2017. The consequence of remaining non-compliant is still not known. March 2017 Update The benchmark for standard 2 has changed from 'time of arrival' to 'time of admission'. Our current compliance with this standard is approximately 80% and so this change should enable near compliance with this specific standard. The next 7DS national survey will be from patients admitted over a seven day period in March with results likely to be available in April 2017. Depending on these results this risk may improve. ANHSI has committed further resource to the trust to better understand what changes to services could be made to greater achieve compliance, although the timeline to complete this work is still being negotiated. April 2017 update No change to this current risk. We are awaiting the results of the latest national survey and the completion of an action plan (with the support of NHSE) on the priority standards. May 2017 update Again there is no change to this risk as yet. The date for this quarter's national survey has been extended to 24 May 2017. However early analysis suggests improved compliance with both standards 2 and 8. There is a possibility of reducing this risk in June 2017 once the results are known.	Jun-2017	Jun-2017	BOD	David Birkenhead	Sal Uka

6829	Family & Specialist Services	Aug-2016	Keeping the base safe	The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately 50,000 pa ready to administer injectable medicines with short expiry dates for direct patient care. Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service on behalf of NHSE. Critical findings would be reported to the MHRA who have statutory authority (under the Medicines Act 1968) to close the unit if it does not comply with the national standards. The 20 year old HRI unit is a maximum life-span up to the end of 2018.capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards. Resulting in the lack of availability of high risk critical injectable medicines for urgent patient care.Non-compliance with national standards with significant risk to patients if unresolved.	Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. Self-audits of the unit External Audits of the units undertaken by the Quality Control Service on behalf of NHSE every 18 months. Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance.	If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance' rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.	15 3 x 5	15 3 x 5	3 3 x 1	March 2017 Chased up feasibility costs with Engie. Expected within 14 days. HRI unit to be inspected by external auditors on 5 April 2017 3 April 2017 Initial Feasbility Study received from Engie but further clarification required on technical specification. Meeting to be arranged with Engie, Pharmacy and Technical expert.The external audit of the HRI Unit is to take place on 5 April and the outcome of this audit will inform risk ratings and timescales. 16.May.17 Costings of feasibility study still awaited. EL Audit of HRI unit took place on 5th April 17 but report has not yet been received due to need for it to be peer-reviewed (expected by 22nd May)	Jun-2017	Dec-2018	DB	Brendan Brown	Mike Culshaw
6841	Corporate	Sep-2016	Keeping the base safe	Risk of: Not being able to go live with the Electronic Patient Record POST GO LIVE Inability to use the system effectively once the extended support mechanisms start to reduce following Early Live Support. Lack of confidence of the system due to any quality and/or performance issues. Efficiency and productivity may reduce due to inexperience of using the system Inability to report against regulatory standards Resulting in: Reputational damage arising from inability to go live with the EPR , financial impact, impact at every point of patient care (appointments, patient flow, records, MDT s, payment) and continued use of paper records which can impact on safe, efficient and effective patient care.	Pre go-live - A robust governance structure is in place to support the implementation of the EPR, including EPR specific risk register reviewed at weekly EPR meeting. - Weekly EPR operational board with direct escalation to WEB (and sponsoring group) - 90/60/30 day plans will aid control - 1:1 consultant plan Cut over: - Strong cut over plan with a developed support structure for BAU post ELS. - Command and control arrangements for cut over (Gold, Silver, Bronze) Post go-live: - gap - CYMBIO Support - CHFT Support/BTHFT Programme resource gap covered (£320k capital)	1. Need to address requests for 'Mop up' Training in some areas 2. Address Hardware requirements (Walk around 23/24th May) 3. Further work from CYMBIO around DQ 4. Time to understand reporting position	15 5 x 3	15 5 x 3	10 5 x 2	April Update: Technical & Operational readiness is still on plan for the cut-over being the 29th of April. - Resources identified / secured for Friends, floorwalkers, service desk, corporate friends etc. - There is a shortfall around Manual Data Migration of around 15 wte. - Progress of Operational Checklist / Work off list. - Training figures as at COP 03/0417: 3041 (51%) people trained 4889 (82%) staff booked on training 11% DNA rate 1% failure rate - The successful completion of the above would mitigate the risk but not enough to lower the score at this point. May Update (Post go-live, end of week 3): Position statement: The Trust cut-over to Cerner Millennium EPR successfully on the planned weekend. The cutover plan worked well from an operational perspective with minimal delay with inpatients up and running in most area's prior to Outpatients on the 2nd May. Initial issues were due to End User Access and Role functionality followed by 'How do I?' type questions. Cut-over Risk: Mitigation and controls were effective, clear plans and operational structure (silver command etc) worked well. Post Go-live Risk: The post go-live risks outlined under description still exist at this early stage although initial assessment of the mitigation/controls would suggest the likelihood will reduce post ELS. Additional gaps will be addressed including 'Mop up' training, additional CYMBIO support around DQ and Reporting and a Hardware	Jun-2017	Sep-2017	RC	Helen Barker	Mandy Griffin

6971	Surgery & Anaesthetics	Apr-2017	Keeping the base safe	Business continuity risk relating to reduced endoscopy provision / capacity 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. This would adversely impact the Trust's ability to achieve all 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.	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 (maintenance contractor) technicians in place for all AER's across both sites 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) contracted to deliver up to 60 lists worth of activity concentrating on fast track patient cohort (23/04/17 - 06/08/2017.	Reliance on HRI AER's due to AER's failures in testing at CRH (review June 17)	20	5 x 4	15	5 x 3	5	5 x 1	To replace all AER's as part of the endoscopy decontamination replacement scheme, by expediting the scheme the risk will be mitigated. CRH decontamination to have replacement AER's in place and commissioned by mid July focus will be concentrated on recovering the flexible sigmoidoscopy patients by increasing lists from 5.5 this will take approx. 6 weeks. Early July invites will be sent out to out to patients on the bowel cancer screening programme to ensure continuity is maintained in service delivery following a lead time of weeks for invite to appointment. September, supporting decontamination unit to be built at HRI that will support the decontamination replacement on both sites.	Jun-2017	Aug-2017	DB	Julie O'Riordan	Jason Bushby

6924	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	5 x 3	15	5 x 3	8	4 x 2	NPSA self -assessment has been completed and action plan is in development High use areas identified and training plan in place to ensure all nursing staff are trained and assessed as competent by 1st April 2017 Training figures monitored weekly for compliance from these areas Task and finish group – next steps will be a focus on training of medical staff Draft nutrition policy has been developed – plan to sign off through task and finish group. Currently with medical staff for comments. Update 17.5.17 Response sent re NPSA alert Nutritional Policy has had medical review and is awaiting final sign off. NG training continues – slight delay in completion due to EPR training Dr Uka has joined the task and finish group to work through training requirements and plan for medical staff.	Jun-2017	Aug-2017	QC	Brendan Brown,	Jo Middleton

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st June 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - JUNE 2017 - This report brings together a number of governance items for review and approval by the Board	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Constitutional Changes - Membership Council - 5.4.17 Declaration of Interests - Audit and Risk Committee	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:-
- Board Workplan
- Declaration of Single Sex accommodation compliance
- Use of Trust Seal
- Constitutional Changes
- Board Meeting Dates 2018

Main Body

Purpose:

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

Background/Overview:

-

The Issue:

Board Workplan - Appendix 1
The Board work plan has been updated and is presented to the Board for review at appendix 1.

The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and APPROVE the work plan.

Declaration of Single Sex accommodation compliance
All providers of NHS funded care are required to confirm whether they are compliant with the national definition ‘to eliminate mixed sex accommodation except where it is in the overall best interests of the patient, or reflects their patient choice’. Trust Boards must approve the declaration and ensure that it is clearly visible on the Trust website. T

The Board is asked to approve the declaration included at appendix 2.

Use of Trust Seal - Appendix 3
One document has been sealed since the last report to the Board in December. This was in relation to the agreed overage deed with Locala for the sale of Princess Royal Community Health Centre which took place on 30.11.16

The Board is asked to NOTE the use of the Trust Seal.

Constitutional Changes - Appendix 4
The Trust's Constitution was reviewed and updated for review by the Membership Council in April 2017. The following key amendments were approved:
- The format of the Constitution has changed to match that of the model constitution provided by NHS Improvement.
- References to Monitor have been removed and amended to NHS Improvement.
- Commitments – the Constitution previously included a section on commitments. These did not match the ones in the Membership Charter and are not included in the model. They have therefore been removed and the ones in the Membership Charter retained.
- Paragraph 7.10 – Automatic membership by default for staff members. Staff become members of the Trust on employment unless they choose to opt out – there was previously no reference to this in the Constitution

so it has been added.
- Paragraph 10 – Annual Members' Meeting – the requirement to hold the meeting within 6 months of the financial year has been removed from the model and it is recommended that this is no longer included. In addition the provisions for the running of the meeting have been placed in an Annexe for ease of use.
- Paragraph 14.1 – Elected Council Members – clarification that a Membership Councillor may not hold office for more than six years or two terms excluding any time served on the reserve register.
- Paragraph 14.3 – The Trust holds a reserve register of membership councillors. Previously this made reference to the fact that this was to enable the working of the sub-committees of the Board. However Board sub-committees, while have attendance from membership councillors, do not have membership councillors as part of their quorum and therefore reference to this was removed. The Membership Council is asked to consider whether the reserve register should be maintained.
- Paragraph 20 – Membership Council – standing orders – the detail of how meetings will be run, quoracy, chairing, notice of meetings etc had been included but is set out in the Membership Council Standing Orders and there were some differences between the two. The references have been removed from the Constitution and a copy of the Standing Orders approved by the Membership Council in January 2017 included as an annexe.
- Paragraph 21 – Membership Council – referral to the Panel – following the Mid Staffs Inquiry, Membership Councils were given the power to refer a trust to a Panel appointed by NHS Improvement. This was not included in the previous constitution and so has been added.
- Paragraph 33 – Board of Directors – conflicts of interest of directors – wording has been strengthened in line with the model.

A further clarification has also been added in relation to expenses to bring the submission of expenses into line with the Trust policy - paragraph 23.
In addition the Membership Council agreed to changing their name to Council of Governors reflecting that the Trust is an outlier in that almost all other councils are called Councils of Governors. All of the documentation released from NHS Improvement refers to Council of Governors.

The Board is asked to APPROVE the Constitution

Board Meeting Dates 2018 - Appendix 5

The Board is asked to AGREE the meeting dates for 2018.

Next Steps:

-

Recommendations:

Please see recommendations against each item.

Appendix

Attachment:

COMBINED GOV REPORT.pdf

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DRAFT BOARD WORK PLAN 2017-2018 - WORKING DOCUMENT - SUBMITTED TO BOARD 1 JUNE 2017 – UPDATED 02.05.17 (v1)

Date of meeting	6 April 2017	MEETING CANCELLED ~~4 May 2017~~	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	4 Jan 2018	1 Feb 2018	1 March 2018
Date of agenda setting/Paper Review of drafts	28.3.17	24.4.17	22.5.17	26.6.17	24.7.17	28.8.17	25.9.17	23.10.17	27.11.17			
Date final reports required	29.3.17	26.4.17	24.5.17	28.6.17	26.7.17	30.8.17	27.9.17	25.10.17	29.11.17			
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework (Quarterly)	-	✓	-	-	✓	-	-	✓	-	-	✓	-
DIPC report	-	✓	-	Annual Report	✓	-	-	✓	-	-	✓	-
Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance report: to include such items as:												
- Standing Orders/SFIs/SOD review								✓				
- Non-Executive appointments (+ Nov - SINED & Deputy)								✓				
- Board workplan			✓			✓			✓			✓
- Board skills / competency									✓			

Date of meeting	6 April 2017	4 May 2017	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
- Code of Governance	✓											
- Board meeting dates			✓									
- Committee review and annual report												✓
- Annual review of NED roles								✓				
- Use of Trust Seal			✓			✓			✓			✓
- Quarterly Feedback from NHSI			✓			✓			✓			✓
- Declaration of Interests (annually)												✓
- Declaration of Interests Policy (Jan 2018)			TBC									
- Declaration of Interest – outcome from Consultation			TBC									
- Attendance Register (Apr+Oct 2017)	✓					✓						
- BOD TOR + Sub Committees												✓
- Constitutional changes (+as required)											✓	
- Compliance with Licence Conditions (April 2018)												
- Board to Ward Visits Feedback			✓			✓			✓			✓
Care of the acutely ill patient report	✓			✓		✓		✓		✓		✓
CQC Assessment Update on Action Plan		✓ Deepdrive	✓ Deepdrive	✓ Deepdrive						✓		
Patient Survey				✓								✓
Quarterly Quality Report (+ QA in Annual Report)	✓	Quality A/cs	✓			✓			✓			✓
Colleague Engagement /Staff Survey (NB - Gold Standard by 2018 and Platinum Standard by 2020 agreed at 25.2.16 BOD)	✓					✓						✓
Nursing and Midwifery Staffing – Hard Truths Requirement		✓						✓				

Date of meeting	6 April 2017	4 May 2017	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
Safeguarding update – Adults & Children		✓ Annual report						✓				
Review of progress against strategy (Qly)			✓					✓				
Plan on a Page Strategy Update			✓									
Quality Committee update & mins	✓	✓	✓	✓	✓			✓		✓	✓	
Audit and Risk Committee update & mins	✓	✓		✓	✓			✓		✓	✓	
F&P Committee update & mins	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Well Led Workforce Committee update & mins	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
Performance Management Framework – update on work from sub-committee workplans		✓										
ANNUAL ITEMS												
Annual Plan												✓
Annual Plan feedback from Monitor						✓						
Annual report and accounts (private)		✓ EO										
Annual Quality Accounts		✓ EO										
Annual Governance Statement		✓ EO										
Appointment of Deputy Chair / SINED						✓						
Board Development Plan											✓	
Emergency Planning annual report						✓						
HPS Annual Report		✓										
HPS Business Plan											✓	
Health and Safety annual report			✓					✓ (update)				
Capital Programme												✓
Equality & Inclusion				✓ (update)						✓(AR)		

Date of meeting	6 April 2017	4 May 2017	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
DIPC annual report (ALSO SEE REGULAR ITEMS)				✓								
Fire Safety annual report			✓									
Medical revalidation & appraisal				✓								
Whistleblowing Annual Report											✓	
Review of Board Sub Committee TOR								✓				
Risk Appetite Statement from Board (Nov 2017)								✓				
Winter Plan									✓			
ONE-OFF ITEMS												
Membership Council Elections				✓								✓
Single Oversight Framework (VP/GB)						✓						
Hospital Pharmacy Transformation Plan (AB/Mike Culshaw)												
Risk Management Strategy										✓		
Workforce Strategy											✓	

Date of meeting	6 April 2017	4 May 2017	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
STANDING PRIVATE AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Private minutes of sub-committees	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
ADDITIONAL PRIVATE ITEMS												
Contract update										✓	✓	✓
Board development plan	✓							✓				
Feedback from Board development workshop			✓	✓		✓		✓				
Urgent Care Board Minutes	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
System Resilience Group minutes	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Hospital Programme Board minutes						✓		✓	✓	✓	✓	✓
Property Partnership/St Luke's Hospital/PR (as required)	Spring 2017					✓						
Equality and Diversity		✓										
Sustainability and Transformation Plan						✓			✓ (update)			
Private Finance and Performance Committee Minutes		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Declaration of Single Sex accommodation compliance

Calderdale and Huddersfield NHS Foundation Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Critical Care/High Dependency) or when patients actively choose to share with all party agreement.

If our care should fall short of the required standard, we will report it.

We will also set up an audit mechanism to make sure that we do not misclassify any of our reports. We will publish the results of that audit on our website at: www.cht.nhs.uk

What does this mean for patients?

Other than in the circumstances set out above, patients admitted to Calderdale and Huddersfield NHS Foundation Trust can expect to find the following:-

Same sex-accommodation means:-

- The **room where your bed is** will only have patients of the same sex as you
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area.

It is possible that there will be both men and women patients on the ward, but they will not share your sleeping area. You may have to cross a ward or corridor to reach your bathroom, but you will not have to walk through opposite sex areas.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital. It is probable that visitors of the opposite gender will come in to the room where your bed is, and this may include patients visiting each other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed area. If you need help to use the toilet or take a bath (e.g. you need a hoist or special bath) then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time.

Further information

Published Mixed Sex Accommodation data can be found at:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/MixedSexAccommodation/index.htm

May 2017

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
251	29.11.16	29.11.16	Princess Royal Community Health Centre – completion on 30.11.16. Agreed sale figure £1.215m. Agreed overage deed should Locala dispose of land for alternative uses. Documents signed and sealed: • Contract for the sale of freehold land – Princess Royal • Overage Deed relating to the above sale • Land Registry Transfer of titles • Licence Agreement for CHFT's Childrens Therapy to remain in occupation at Princess Royal	NAME: GARY COOTE TITLE: EXECUTIVE DIRECTOR OF FINANCE NAME: VICTORIA PICKLES VPickles TITLE: COMPANY SECRETARY.

Latest review March 2017

CONSTITUTION OF THE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

TABLE OF CONTENTS

CONSTITUTION FOR THE CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

1. Definitions

1.1. Unless otherwise stated words or expressions contained in this constitution bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

1.2. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.3. Headings are for ease of reference only and are not to affect interpretation.

1.4. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.5. In this constitution:

The Accounting Officer	is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
The 2006 Act	means the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.
The 2012 Act	is the Health and Social Care Act 2012.
Annual Members' Meeting	is defined in paragraph 10 of the constitution.
Appointed Council Member	means those Council Members appointed by the Appointing Organisations;
Appointing Organisations	means those organisations named in this constitution who are entitled to appoint Council Members;
Areas of the Trust	the areas specified in Annexe 1;
Authorisation	means an authorisation given by Monitor
Board of Directors	means the Board of Directors as constituted in accordance with this constitution;
Director	means a member of the Board of Directors
Non-Executive Directors	means the Chairman and non-executives on the Board of Directors;

Elected Council Member"	means those Council Members elected by the public constituency and the staff constituency;
Financial year	means: (a) a period beginning with the date on which the Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;
Monitor	is the former name for the Trust's regulator, as provided by Section 61 of the 2012 Act;
Local Authority Council Member	means a Member of the Membership Council appointed by one or more Local Authorities whose area includes the whole or part of the area of the Trust;
Member	means a Member of the Trust;
Membership Council	means the Membership Council as constituted by this constitution and referred to as the Board of Governors/ Council of Governors in the 2006 Act;
The NHS Trust	means the NHS Trust which made the application to become the Trust;
Other Partnership Council Member	means a Member of the Membership Council appointed by a Partnership Organisation other than a Primary Care Trust or Local Authority;
Public Constituency	means those individuals who live in an area specified as an area for any public constituency;
Public Council Member	means a Member of the Membership Council elected by the Members of the public constituency;
Secretary	means the Board Secretary of the Trust or any other person appointed to perform the duties of the Secretary;
Staff Constituency	means those individuals who are eligible for Trust membership by reason of 8.5-8.9 of this Constitution are referred to collectively as the Staff Constituency;
Staff Council Member	means a Member of the Membership Council appointed by the Members of one of the classes of the constituency of the staff membership;
The Trust	means Calderdale & Huddersfield NHS Foundation Trust.

2. Name and status

2.1. The name of this Trust is “Calderdale and Huddersfield NHS Foundation Trust”.

3. Head Office and Website

3.1. The Trust’s head office for the purpose of this Constitution is at Trust Offices, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA, or any other address decided by the Membership Council.

3.2. The Trust will maintain a website, the address of which is www.cht.nhs.uk or any other address decided by the Membership Council.

~~The Trust will display its name and website on the outside of its head office and every other place at which it carries on business, and on its business letters, notices, advertisements, other publications~~

4. Purpose

4.1. The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

4.2. The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

4.3. The Trust may provide goods and services for any purposes related to:-

4.3.1. the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

4.3.2. the promotion and protection of public health.

4.4. The Trust may also carry out activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry out its principal purpose.

5. Powers

5.1. The powers of the Trust are set out in the 2006 Act.

5.2. All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

5.3. Any of these powers may be delegated to a committee of directors or to an executive director.

5.4. The Trust may do anything which appears to it to be necessary or desirable for the purposes of or in connection with its functions.

5.5. In particular it may:

5.5.1. acquire and dispose of property;

5.5.2. enter into contracts;
5.5.3. accept gifts of property (including property to be held on Trust for the purposes of the Trust or for any purposes relating to the health service);
5.5.4. employ staff.

5.6. Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing, or securing the provision of pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

5.7. The Trust may borrow money for the purposes of or in connection with its functions, subject to the limit published by NHS Improvement from time to time.

5.8. The Trust may invest money (other than money held by it as Trustee) for the purposes of or in connection with its functions. The investment may include investment by:
5.8.1. forming, or participating in forming bodies corporate;
5.8.2. otherwise acquiring membership of bodies corporate.

5.9. The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its function.

6. Membership and Constituencies

6.1. The Trust shall have members, each of whom shall be a member of one of the following constituencies:
6.1.1. A public constituency
6.1.2. A staff constituency

7. Members

7.1. The Members of the Trust are those individuals whose names are entered in the register of members. Every Member is either a Member of one of the public constituencies or a Member of the staff constituency.

7.2. Subject to this Constitution, Membership is open to any individual who:
7.2.1. is over 16 years of age;
7.2.2. is entitled under this Constitution to be a Member of the public constituencies, or staff constituency; and
7.2.3. completes or has completed a membership application form in whatever form the Membership Council approves or specifies.

Public Membership

7.3. There are eight public constituencies corresponding to the areas served by the Trust as set out in Annexe 1. Members of each constituency are to be individuals:
7.3.1. who live in the relevant area of the Trust;
7.3.2. who are not eligible to be Members of the staff constituency; and
7.3.3. who are not Members of another public constituency.

7.4. The minimum number of members of each of the public constituencies is to be 50.

Staff Membership

7.5. There is one staff constituency for staff membership. It is to divided into five classes as follows:
- 7.5.1. doctors or dentists;
- 7.5.2. Allied Health Professionals, Health Care Scientists and Pharmacists;
- 7.5.3. Management, administration and clerical;
- 7.5.4. Ancillary staff;
- 7.5.5. Nurses and midwives.

7.6. Members of the staff constituency are to be individuals:
- 7.6.1. who are employed under a contract of employment by the Trust and who either:
  - 7.6.1.1. are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or
  - 7.6.1.2. who have been continuously employed by the Trust for at least 12 months; or
- 7.6.2. who are not so employed but who nevertheless exercise functions for the purposes of the Trust, and have exercised the functions for the purposes of the Trust for at least 12 months.

7.7. Individuals entitled to be Members of the staff constituency are not eligible to be Members of the public constituency.

7.8. The Secretary is to decide to which class a staff member belongs.

7.9. The minimum number of members in each class of the staff membership is to be 20.

Automatic membership by default – Staff

7.10. An individual who is:
- 7.10.1. Eligible to become a member of the Staff Constituency, and
- 7.10.2. Invited by the Trust to become a member of the Staff Constituency,

Shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless he / she informs the Trust that he / she does not wish to do so.

8. Disqualification from membership

8.1. A person may not be a member of the Trust if, in the opinion of the Membership Council, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the Trust.

9. Termination of membership

9.1. A Member shall cease to be a Member if:

9.1.1. they resign by notice to the Company Secretary;
9.1.2. they die;
9.1.3. they are disqualified from Membership by paragraph 7;
9.1.4. they cease to be entitled under this Constitution to be a Member of any of the public constituencies or the staff constituency.

9.2. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annexe 3 – Further Provisions.

10. Annual Members' Meetings

10.1. The Trust is to hold an annual meeting of its members meeting ~~within six months of the end of each financial year.~~ The Annual Members Meeting shall be open to members of the public.

10.2. Further provisions about the Annual Members' Meeting are set out in Annexe 4 – Annual Members' Meeting.

11. Membership Council - composition

11.1. The Trust is to have a Membership Council which shall comprise both elected and appointed councillors.

11.2. The composition of the Membership Council is specified in Appendix 6 – Composition of the Membership Council.

11.3. The composition of the Membership Council, subject to the 2006 Act, shall seek to ensure that:
11.3.1. the interests of the community served by the Trust are appropriately represented;
11.3.2. the level of representation of the public constituencies, the staff constituency and the partnership organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs.;

12. Membership Council – elections of membership councillors

12.1. Public Council Members are to be elected by Members of the public constituencies, and Staff Council Members by Members of the staff constituency.
12.2. The Election procedures including the arrangements governing nominations, the advertisement of candidates, rules regarding canvassing voting, and the election of reserves to fill casual vacancies are to be determined by the election rules, set out in Annexe 2 – Election Rules.

13. Membership Council - appointed membership councillors

13.1. Local Authority Council Members
The Secretary, having consulted each Local Authority whose areas includes the whole or part of the area of the Trust is to adopt a process for agreeing the appointment of Local Authority Councils Member with those Local Authorities.

13.2. Partnership Council Members

The Secretary, having consulted each partnership organisation is to adopt a process for agreeing the appointment of partnership Council Members with those partnership organisations.

14. Membership Council - tenure for membership councillors

14.1. Elected Council Members:

14.1.1. shall hold office for a period of three years commencing immediately after the annual members meeting at which their election is announced;

14.1.2. subject to the next sub-paragraph are eligible for re-election after the end of that period;

14.1.3. may not hold office for more than six consecutive years or two terms excluding any period on the reserve register (see 14.3 below);

14.1.4. cease to hold office if they cease to be a Member of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution.

14.2. Appointed Council Members:

14.2.1. shall hold office for a period of 3 years commencing immediately after the annual members meeting at which their appointment is announced;

14.2.2. subject to the next sub-paragraph are eligible for re-appointment after the end of that period;

14.2.3. may not hold office for longer than 6 consecutive years;

14.2.4. shall cease to hold office if the Appointing Organisation terminates their appointment.

14.2.5. cease to hold office if they cease to be a Member of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution.

14.3. The Foundation Trust will retain a reserve register of Membership Councillors who have previously held and completed their elected terms of office with the Foundation Trust as per paragraph 14.1. Access to the Register will be exceptional and for a time limited period. No reserve Membership Councillor shall be retained on the reserve list for more than 2 years following completion of their elected terms of office. Membership Councillors can apply to be on the reserve register if they are not re-elected following the first term of their elected office. The normal rules of selection and exclusion for Membership Councillors will apply to reserve Membership Councillors. A majority of the Membership Council, who are present when the decision is taken, must agree the movement of a reserve Membership Councillor from the reserve list onto the Membership Council. The reserve Membership Councillor may only serve on the Membership Council for a 12 month period. No further terms on the register will be available. The reserve Membership Councillor may only cover a vacancy that exists following elections. This may be on the Constituency to which they were previously elected and hold terms of office or to a different vacant seat. The rules of good governance will apply at all times and the Board of Directors and Membership Council will have regard to the need to continually refresh their elected and appointed members, whilst ensuring that the business of the Membership Council can continue seamlessly using the best available knowledge and experience.

15. Membership Council - vacancies amongst membership councillors

15.1. Where a vacancy arises on the Membership Council for any reason other than expiry of term of office, the following provisions will apply.

15.2. Where the vacancy arises amongst the Appointed Council Members, the Secretary shall request that the Appointing Organisation appoints a replacement to hold office for the remainder of the term of office.

15.3. Where the vacancy arises amongst the elected Council Member, the Membership Council shall be at liberty either:

15.3.1. to call an election within three months to fill the seat for the remainder of that term of office, or

15.3.2. to invite any elected reserve Council Members or the next highest polling candidate for that seat at the most recent election, who is willing to take office to fill the seat until the next annual election, at which time the seat will become vacant and subject to election for any unexpired period of the term of office.

16. Membership Council – disqualification and removal

16.1. A person may not become a Council Member of the Trust, and if already holding such office will immediately cease to do so if:

16.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

16.1.2. they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

16.1.3. they have within the preceding five years, been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

16.1.4. they are a Director or Company Secretary of this Trust, a Director of another NHS Trust or a Council Member or Non-Executive Director of another NHS Foundation Trust;

16.1.5. they are under ~~18~~ 16 years of age;

~~16.1.6. being a Member of a public constituency, they were entitled to be a Member of the staff constituency until less than one year ago;~~

16.1.7. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

16.1.8. they are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

17. Membership Council - termination of office and removal of Membership Councillor

17.1. A person holding office as a Council Member shall immediately cease to do so if:

17.1.1. they resign by notice in writing to the Secretary;

17.1.2. they fail to attend two meetings in any 12 month period, unless the other membership councillors are satisfied that:
17.1.3. the absences were due to reasonable causes; and
17.1.4. they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.
17.1.5. in the case of an elected membership councillor, they cease to be a member of the constituency by whom they were elected;
17.1.6. in the case of an appointed membership councillor, the appointing organisation terminates the appointment;
17.1.7. they have failed to undertake any training which the Membership Council requires all membership councillors to undertake;
17.1.8. they have failed to sign and deliver to the Secretary a statement in the form required by the Membership Council confirming acceptance of the code of conduct for membership councillors;
17.1.9. they refuse to sign a declaration in the form specified by the Membership Council that they are a member of a specific public constituency and are not prevented from being a member of the Membership Council. This does not apply to staff members;
17.1.10. they are removed from the Membership Council under the following provisions.

17.2. A Council Member may be removed from the Membership Council by a resolution approved by not less than three-quarters of the remaining membership councillors Members present and voting at a general meeting of the Membership Council on the grounds that:
17.2.1. they have committed a serious breach of the code of conduct; or
17.2.2. they have acted in a manner detrimental to the interests of the Trust; and
17.2.3. the Membership Council consider that it is not in the best interests of the Trust for them to continue as a membership councillor.

18. Membership Council – duties of membership councillors

18.1. The general duties of the Membership Council are:
18.1.1. to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors;
18.1.2. to represent the interests of the members of the Trust as a whole and the interests of the public;

18.2. The Trust must take steps to secure that the membership councillors are equipped with the skills and knowledge they require in their capacity as such.

18.3. The Membership Council shall appoint at a general meeting one of its public members to be Lead Membership Councillor of the Membership Council.

18.4. The specific roles and responsibilities of the Membership Council are set out in Annexe 5 – Roles and Responsibilities.

19. Membership Council – meetings of the Membership Council

19.1. The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed with the provisions of paragraph 26 below) or, in his absence the Deputy Chair (appointed in accordance with the provisions of paragraph 26 below), shall preside at meetings of the Membership Council.

19.2. Meetings of the Membership Council shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

19.3. For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties, the Membership Council may require one or more of the directors to attend a meeting.

20. Membership Council – standing orders

20.1. The standing orders for the practice and procedure of the Membership Council and its meetings are included in a separate document which is attached at Annexe 8.

21. Membership Council – referral to the Panel

21.1. In this paragraph, the Panel means a panel of persons appointed by NHS Improvement to which a governor of an NHS foundation Trust may refer a question as to whether the Trust has failed or is failing:

21.1.1. to act in accordance with its constitution, or

21.1.2. to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

21.2. A membership councillor may refer a question to the Panel only if more than half of the members of the Membership Council voting approve the referral.

22. Membership Council – conflicts of interest

22.1. If a Membership Council has a pecuniary, personal or family interest, whether that interest is actual or potential, or whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Membership Council, the councillor shall disclose that interest to the members of the Membership Council as soon as they become aware of it.

22.2. The Standing Orders for the Membership Council shall make provision for the disclosure of interests and arrangements for the exclusion of a membership councillor declaring any interest from any discussion or the consideration of the matter in respect of which an interest has been disclosed. This should be in line with the NHS England guidance on Conflicts of Interest.

22.3. The Standing Orders for the Membership Council are attached at Annexe 7.

23. Membership Council - expenses

23.1. The Trust may pay travelling and other expenses to membership councillors at such rates as it decides. These are set out in the Standing Orders for the Membership Council at Annexe 7 and are to be disclosed in the annual report.

23.2. Membership councillors are not to receive remuneration.

24. Board of Directors – general duty

24.1. The business of the Trust is to be managed by the Board of Directors, who (subject to this Constitution) shall exercise all the powers of the Trust. The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust as to maximise the benefits for the members of the Trust as a whole and for the public.

24.2. A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Directors are appointed or any vacancy on the Board of Directors.

25. Board of Directors – composition

25.1. The Trust is to have a Board of Directors. It is to consist of executive and non-executive directors.

25.2. The Board of Directors is to comprise:
- 25.2.1. a non-executive Chair;
- 25.2.2. up to 7 other non-executive directors;
- 25.2.3. up to 7 executive directors.

25.3. One of the executive directors shall be the Chief Executive who shall be the Accounting Officer.

25.4. One of the executive directors shall be the finance director.

25.5. One of the executive directors is to be a registered medical practitioner.

25.6. One of the executive directors is to be a registered nurse or a registered midwife.

26. Board of Directors – appointment and removal of the Chairman, Deputy Chair and other non-executive directors

26.1. The Membership Council shall appoint a Chair of the Trust.

26.2. The Board of Directors will appoint one non-executive director to be Deputy Chair of the Trust. This individual may, through agreement with the Chair, take on the role of Senior Independent Non-Executive Director (SID).

26.3. The Chair and Deputy Chair will be the Chair and Deputy Chair of both the Membership Council and the Board of Directors.

26.4. To be eligible for appointment as a non-executive director of the Trust the candidate must live and/or work within the West Yorkshire and Harrogate area.

26.5. The Membership Council at a general meeting shall appoint or remove the Chairman of the Trust and the other non-executive directors.

26.6. Non-Executive Directors are to be appointed by the Membership Council using the following procedure:

26.6.1. The Board of Directors will work with the external organisations recognised as expert in non-executive appointments to identify the skills and experience required

26.6.2. Appropriate candidates will be identified by the Board of Directors who meet the skills and experience required

26.6.3. A sub-committee of the Membership Council (not exceeding four persons) including the Chair, will interview a short list of candidates and recommend a candidate for appointment by the Membership Council.

26.7. Removal of the Chairman or other non-executive director shall require the approval of three-quarters of the Membership Council.

26.8. The Board of Directors shall appoint one non-executive director to be the Deputy Chair of the Trust.

27. Board of Directors – Senior Independent Director

27.1. The Board of Directors will appoint one non-executive director to be the Senior Independent Director.

27.2. The Trust has a detailed job description for the SID. The main duties include:

27.2.1. Being available to members of the Foundation Trust and to the Membership Council if they have concerns that contact through the usual channels of Chair, Chief Executive, Finance Director and Company Secretary has failed to resolve or where it would be inappropriate to use such channels. In addition to the duties described here the SID has the same duties as the other Non-Executive Directors.

27.2.2. A key role in supporting the Chair in leading the Board of Directors and acting as a sounding board and source of advice for the Chair. The SID also has a role in supporting the Chair as Chair of the Membership Council.

27.2.3. While the Membership Council determines the process for the annual appraisal of the chair, the senior independent director is responsible for carrying out the appraisal of the chair on its behalf.

27.2.4. The SID should maintain regular contact with the membership councillors and attend meetings of the Membership Council to obtain a clear understanding of Membership Council views on the key strategic performance issues facing the Foundation Trust. The SID should also be available to membership councillors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example.

27.2.5. In rare cases where there are concerns about the performance of the chair the SID should provide support and guidance to the Membership

Council in seeking to resolve concerns or in the absence of a resolution in taking formal action. Where the foundation Trust has appointed a lead membership councillor the SID should liaise with the lead membership councillor in such circumstances.

27.2.6. In circumstances where the board is undergoing a period of stress the SID has a vital role in intervening to resolve issues of concern. These might include unresolved concerns on the part of the Membership Council regarding the chair's performance; where the relationship between the chair and the chief executive is either too close or not sufficiently harmonious, where the Foundation Trust's strategy is not supported by the whole Board or where key decisions are being made without reference to the Board or where succession planning is being ignored.

27.2.7. In the circumstances outlined above, the SID will work with the chair, other directors and/or membership councillors, to resolve significant issues.

28. Board of Directors – tenure of non-executive directors

28.1. The Chair and the Non-Executive Directors are to be appointed for a period of three years.

28.2. The Chair and the Non-Executive Directors will serve for a maximum of two terms.

28.3. In exceptional circumstances a Non-Executive Director (including the Chair) may serve longer than six years (two three-year terms). Any subsequent appointment will be subject to annual re-appointment. Reviews will take into account the need to progressively refresh the Board whilst ensuring its stability. Provisions regarding the independence of the Non-Executive Director will be strictly observed.

29. Board of Directors – appointment and removal of the Chief Executive and other executive directors

29.1. The non-executive directors shall appoint or remove the Chief Executive.

29.2. The appointment of the Chief Executive requires the approval of the Membership Council.

29.3. A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

30. Board of Directors – disqualification

30.1. A person may not become or continue as a Director of the Trust if:

30.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

30.1.2. they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

30.1.3. they have within the preceding five years been convicted in the British Islands of any offence, and a sentenced of imprisonment (whether

suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

30.1.4. they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

30.1.5. they are a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

30.1.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

30.1.7. in the case of a Non-Executive Director they have failed to fulfil any training requirement established by the Board of Directors; or

30.1.8. they have failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors and fit and proper persons test; or

31. Board of Directors - meetings

31.1. Meetings of the Board of Directors shall be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

31.2. Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Membership Council.

31.3. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Membership Council.

32. Board of Directors – standing orders

32.1. The standing orders for the practice and procedure of the Board of Directors are attached at Annexe 8.

33. Board of Directors – conflicts of interest of directors

33.1. The duties that a director of the Trust has by virtue of being a director include in particular –

33.1.1. A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

33.1.2. A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

33.2. The duty referred to in sub-paragraph 31.1.1 is not infringed if –

33.2.1. The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

33.2.2. The matter has been authorized in accordance with the constitution.

33.3. The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

33.4. In sub-paragraph 31.1.2, "third party" means a person other than –
33.4.1. The Trust, or
33.4.2. A person acting on its behalf.

33.5. If a director of the Trust has in any way a direct of indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

33.6. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

33.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

33.8. This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

33.9. A director need not declare an interest –
33.9.1. If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
33.9.2. If, or to the extent that, the directors are already aware of it;
33.9.3. If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –
33.9.3.1. By a meeting of the Board of Directors, or
33.9.3.2. By a committee of the directors appointed for the purpose under the constitution.

33.10. Any Director who has a material interest in a matter as defined below shall declare such interest to the Board of Directors and it shall be recorded in a register of interests and the Director in question:
33.10.1. shall not be present except with the permission of the Board of Directors in any discussion of the matter, and
33.10.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

33.11. Any Director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Directors.

33.12. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Director or their spouse or partner in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust, including private healthcare organisations and other foundation Trusts.

33.13. The exceptions which shall not be treated as material interests are as follows:

33.13.1. shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange.

34. Board of Directors – remuneration and expenses

34.1. The Board of Directors shall appoint an executive remuneration committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and Executive Directors.

34.2. The remuneration and allowances, and the other terms and conditions of office, of the Chairman and Non-Executive Directors shall be decided by the Membership Council at a general meeting. The Membership Council may take advice from independent pay advisors whose Terms of Reference will be established and ratified by the Board of Directors and the Membership Council.

34.3. The remuneration and allowances for Directors are to be disclosed in the annual report.

35. Secretary

35.1. The Trust shall have a Secretary who may be an employee. The Secretary may not be a Council Member, or the Chief Executive or the Finance Director. The Secretary shall be accountable to the Chief Executive and their functions shall include:

35.1.1. acting as Secretary to the Membership Council and the Board of Directors, and any committees;
35.1.2. summoning and attending all members meetings, meetings of the Membership Council and the Board of Directors, and keeping the minutes of those meetings;
35.1.3. keeping the register of members and other registers and books required by this Constitution to be kept;
35.1.4. having charge of the Trust's seal;
35.1.5. publishing to members in an appropriate form information which they should have about the Trust's affairs;
35.1.6. preparing and sending to NHS Improvement and any other statutory body all returns which are required to be made;
35.1.7. providing support to the Membership Council and the Non-Executive Directors;
35.1.8. overseeing elections conducted under this Constitution;
35.1.9. offering advice to the Membership Council and the Board of Directors on issues of governance and corporate responsibility.

35.2. Minutes of every members meeting, of every meeting of the Membership Council and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be included on the agenda of the next meeting.

36. Registers

36.1. The Trust is to have:

36.1.1. a Register of Members showing, in respect of each Member, the name of the member, the constituency to which they belong and, (where the

Membership Council has decided that the Membership of the Public, or Staff constituencies shall be sub-divided for election purposes) any sub-division of that constituency to which they belong;

36.1.2. a Register of Members of the Membership Council;
36.1.3. a Register of Directors;
36.1.4. a Register of Interests of Council Members
36.1.5. a Register of Interests of the Directors.

36.2. The Secretary shall add to the Register of Members any individual who becomes a Member of the Trust or remove from the Register of Members the name of any Member who ceases to be entitled to be a Member under the provisions of this Constitution.

37. Documents available for public inspection

37.1. The following documents of the Trust are to be available for inspection by members of the public. If the person requesting a copy or extract under this paragraph is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37.1.1. a copy of the current Constitution;
37.1.2. a copy of the current Authorisation;
37.1.3. a copy of the latest annual accounts and of any report of the auditor on them;
37.1.4. a copy of the report of any other auditor of the Trust's affairs appointed by the Membership Council;
37.1.5. a copy of the latest annual report;
37.1.6. a copy of the latest information as to its forward planning;
37.1.7. a copy of the Trust's Membership Strategy;
37.1.8. a copy of any notice given under section 52 of the 2006 Act (Monitor's notice to failing NHS Foundation Trust).
37.1.9. The register of Members shall be made available for inspection by members of the public. Article 2(b) of the Public Benefit Corporation (Register of Members) Regulations 2004 allows for members to request their details are not published as part of the Register of Members.

38. Auditors

38.1. The Trust is to have an auditor and is to provide the auditor.

38.2. The Membership Council at a general meeting shall appoint or remove the Trust's auditors.

38.3. The auditor is to carry out his duties in accordance with Schedule 7 to the 2006 Act and in accordance with any directions given by NHS Improvement standards, procedures and techniques to be adopted.

39. Audit and Risk Committee

39.1. The Trust shall establish a committee of non-executive directors as an Audit and Risk Committee to perform such monitoring, reviewing and other functions as are appropriate.

40. Accounts

40.1. The Trust must keep proper accounts and proper records in relation to the accounts.

40.2. NHS Improvement may with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts.

40.3. The accounts are to be audited by the Trust's auditor.

40.4. The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40.5. The following documents will be made available to the Auditor General for examination at their request:
- 40.5.1. the accounts;
- 40.5.2. any records relating to them; and
- 40.5.3. any report of the auditor on them.

40.6. The annual accounts, any report of the auditor on them, and the annual report are to be presented to the Membership council at a General Meeting.

40.7. The Trust shall:
- 40.7.1. lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and
- 40.7.2. once it has done so, send copies of those documents to NHS Improvement.

41. Annual report, forward plans and non-NHS work

41.1. The Trust is to prepare an Annual Report and send it to NHS Improvement.

41.2. The Trust is to give information as to its forward planning in respect of each financial year to NHS Improvement. The document containing this information is to be prepared by the Directors, and in preparing the document the Board of Directors shall have regard to the views of the Membership Council.

41.3. Each forward plan must include information about:-
- 41.3.1. the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and
- 41.3.2. the income it expects to receive from doing so.

41.4. Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 39.3.1 the Membership Council must:-
- 41.4.1. determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions and
- 41.4.2. notify the directors of the Trust of its determination.

41.5. A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Membership Council voting to approve its implementation.

42. Indemnity

42.1. Members of the Membership Council and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and the benefit of members of the Membership Council and Board of Directors and the Secretary.

43. Seal

43.1. The Trust shall have a seal.

43.2. The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

44. Dispute Resolution Procedures

44.1. Every unresolved dispute which arises out of this Constitution between the Trust and:

44.1.1. a Member; or
44.1.2. any person aggrieved who has ceased to be a Member within the six months prior to the date of the dispute; or
44.1.3. any person bringing a claim under this Constitution; or
44.1.4. an office-holder of the Trust;

is to be submitted to an arbitrator agreed by the parties. The arbitrator's decision will be binding and conclusive on all parties.

45. Amendment of the constitution

45.1. The Trust may make amendments of its Constitution only if:-

45.1.1. More than half of the members of the Membership Council of the Trust voting approve the amendments; and
45.1.2. More than half of the members of the Board of Directors of the Trust voting approve the amendments.

45.2. Amendments made under paragraph 43.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3. Where an amendment is made to the constitution in relation to the powers or duties of the Membership Council (or otherwise with respect to the role that the Membership Council has as part of the Trust)

45.3.1. At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

45.3.2. The Trust must give the members an opportunity to vote on whether they approve the amendment.

45.4. If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

45.5. Amendments by the Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and significant transactions

46.1. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Membership Council.

46.2. The Trust may enter into a significant transaction only if more than half of the members of the Membership Council of the Trust voting approve entering into the transaction.

46.3. The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

47. Dissolution of the Trust

47.1. The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2006 Act.

~~48. Notices~~

~~28.1 Any notice required by this Constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.~~

~~28.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.~~

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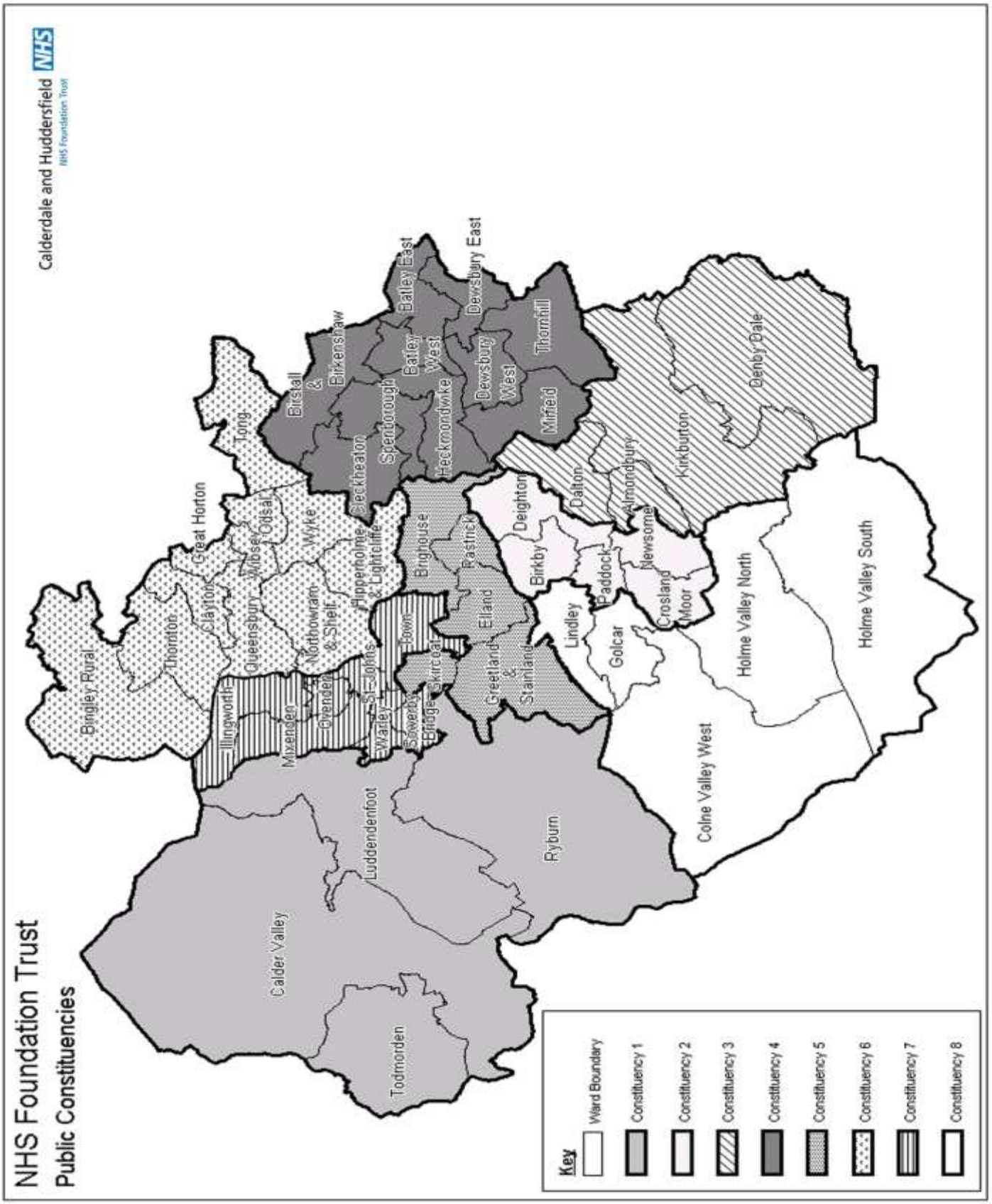
ANNEXE 1 – PUBLIC CONSTITUENCIES



Constituency	Wards	Population
1	Todmorden	37,487
	Calder Valley	
	Luddendenfoot	
	Ryburn	
2	Birkby	62,501
	Deighton	
	Paddock	
	Crosland Moor	
	Newsome	
3	Dalton	56,161
	Almondbury	
	Kirkburton	
	Denby-Dale	
4	Cleckheaton	144,794
	Birstall & Birkenshaw	
	Spenborough	
	Heckmondwike	
	Batley West	
	Batley East	
	Mirfield	
	Dewsbury West	
	Dewsbury East	
	Thornhill	
5	Skircoat	47,727
	Greetland & Stainland	
	Elland	
	Rastrick	
	Brighouse	
6	Northowram & Shelf	150,326
	Hipperholme & Lightcliffe	
	Bingley Rural	
	Thorton	
	Clayton	
	Queensbury	
	Great Horton	
	Wibsey	
	Oddsall	
	Wyke	
	Tong	
7	Illingworth & Mixenden	63,407
	Ovenden	
	Warley	
	Sowerby Bridge	
	St Johns	
	Town	
8	Lindley	73,412
	Golcar	

Constituency	Wards	Population
	Colne Valley West	
	Holme Valley North	
	Holme Valley South	

Note on Constituencies

Population data and indices of deprivation have been used to formulate the eight constituencies. Constituencies are as close as possible to one eighth of the population of Calderdale and Kirklees, though attempts to reflect Local Authority boundaries and areas of similar deprivation levels mean there is some variation. Constituencies 4 and 6 are noticeably larger because persons in these constituencies mostly use services provided by other NHS Trusts. Each Constituency comprises of several electoral areas for local government elections.

/KB/CONSTITUTION-MARCH 2006
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UPDATED 20.6.06
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UPDATED 12.11.07
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UPDATED 24.10.13
UPDATED 8.4.14 (map/constituencies)
UPDATED 20.1.15 (election rules – electronic voting)

ANNEX 2

MODEL ELECTION RULES 2014

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1. Interpretation

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2.Timetable
3. Computation of time

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4. Returning officer
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6. Expenditure
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Part 1 Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:
"corporation" means the public benefit corporation subject to this constitution;
"election" means an election by a constituency, or by a class within a constituency, to fill vacancy among one or more posts on the council of governors;
"the regulator" means the Independent Regulator for NHS foundation Trusts; and
"the 2006 Act" means the National Health Service Act 2006
"e-voting" means voting using either the internet, telephone or text message;
"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;
"method of polling" means voting either by post, internet, text message or telephone
"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;
"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;
"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting.

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	**Time**
Publication of notice of election	**Not later than the fortieth day before the day of the close of the poll.**
Final day for delivery of nomination papers to returning officer	**Not later than the twenty eighth day before the day of the close of the poll.**
Publication of statement of nominated candidates	**Not later than the twenty seventh day before the day of the close of the poll.**
Final day for delivery of notices of withdrawals by candidates from election	**Not later than twenty fifth day before the day of the close of the poll.**
Notice of the poll	**Not later than the fifteenth day before the day of the close of the poll.**
Close of the poll	**By 5.00pm on the final day of the election.**

Computation of time

3.1 In computing any period of time for the purposes of the timetable:
(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,
shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 Returning Officer

4.1 Subject to rule 66, the returning officer for an election is to be appointed by the corporation.
4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff
5.1 Subject to rule 66, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure
6.1 The corporation is to pay the returning officer:
(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation
7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 Stages

8. Notice of election
8.1 The returning officer is to publish a notice of the election stating:
(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the corporation,
(d) the address and times at which nomination papers may be obtained;
(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates
9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer:
(a) is to supply any member of the corporation with a nomination paper, and
(b) is to prepare a nomination paper for signature at the request of any member of the corporation,
but it is not necessary for a nomination to be on a form supplied by the returning officer and it can, subject to rule 13, be in an electronic format.

10. Candidate's particulars
10.1 The nomination paper must state the candidate's:
(a) full name,
(b) contact address in full, and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests
11.1 The nomination paper must state:
(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination paper must include a declaration made by the candidate:
(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination paper must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

14.1 Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:
(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination paper is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:
(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:
(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing,
as given in their nomination paper.
15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a person requests a copy or extract of the statement of candidates or their nomination papers, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 Contested elections

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide if eligible voters, within a constituency, or class within a constituency, may, subject to rule 19.4, cast their vote by any combination of the methods of polling.

19.4 The corporation may decide if eligible voters, within a constituency or class within a constituency, for whom an e-mail mailing address is included in the list of eligible voters may only cast their votes by, one or more, e-voting methods of polling.

19.5 If the corporation decides to use an e-voting method of polling then they and the returning officer must satisfy themselves that:

(a) if internet voting is being used, the internet voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the internet voting record of any voter who chooses to cast their vote using the internet voting system.

(b) if telephone voting is being used, the telephone voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the telephone voting record of any voter who choose to cast their vote using the telephone voting system.

(c) if text message voting is being used, the text message voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the text voting record of any voter who choose to cast their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voters and voter ID number if e-voting is a method of polling,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

Action to be taken before the poll

21. List of eligible voters

21.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

21.2 The list is to include, for each member, a postal mailing address and if available an e-mail address, where their voting information may be sent.

21.3 The corporation may decide if the voting information is to be sent only by e-mail to those members, in a particular constituency or class within a constituency, for whom an e-mail address is included in the list of eligible voters.

22. Notice of poll

22.1 The returning officer is to publish a notice of the poll stating:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) the methods of polling by which votes may be cast at the election by a constituency or class within a constituency as determined by the corporation in rule 19 (3).
(f) the address for return of the ballot papers, and the date and time of the close of the poll,
(g) the uniform resource locator (url) where, if internet voting is being used, the polling website is located.

(h) the telephone number where, if telephone voting is being used, the telephone voting facility is located,
(i) the telephone number or telephone short code where, if text message voting is being used, the text message voting facility is located,
(j) the address and final dates for applications for replacement voting information, and
(k) the contact details of the returning officer.

23. Issue of voting information by returning officer

23.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following voting information:
(a) by post to each member of the corporation named in the list of eligible voters and on the basis of rule 21 able to cast their vote by post:
(i) a ballot paper
(ii) information about each candidate standing for election, pursuant to rule 61 of these rules,
(iii) a covering envelope

(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19.4 able to cast their vote only by an e-voting method of polling:
(i) instructions on how to vote
(ii) the eligible voters voter ID number
(iii) information about each candidate standing for election, pursuant to rule 61 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate.
(iv) contact details of the returning officer.

23.2 The documents are to be sent to the mailing address or e-mail address for each member, as specified in the list of eligible voters.

24. The covering envelope

24.1 The covering envelope is to have:
(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25. E-voting systems

25.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

25.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

25.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

25.4 The provision of the polling website and internet voting system, will:
(a) require a voter, to be permitted to vote, to enter his voter ID number;

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(v) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the internet voting record") that is stored in the internet voting system in respect of each vote cast using the internet of-
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote, and

(e) if their vote has been cast and recorded, provide the voter with confirmation

(f) prevent any voter voting after the close of poll.

25.5 The provision of a telephone voting facility and telephone voting system, will:
(a) require a voter to be permitted to vote, to enter his voter ID number;

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the telephone voting record") that is stored in the telephone voting system in respect of each vote cast by telephone of-
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

25.6 The provision of a text message voting facility and text messaging voting system, will:
(a) require a voter to be permitted to vote, to provide his voter ID number;

(b) prevent a voter voting for more candidates than he is entitled to at the election;

d) create a record ("the text voting record") that is stored in the text messaging voting system in respect of each vote cast by text message of:
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

The poll

26. Eligibility to vote

26.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

27.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

27.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

28. Spoilt ballot papers

28.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

28.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

28.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless satisfied as to the voter's identity.

28.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):
(a) is satisfied as to the voter's identity, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement spoilt ballot paper.

29. Lost voting information

29.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

29.2 The returning officer may not issue replacement voting information for lost voting information unless they:
(a) are satisfied as to the voter's identity,
(b) have no reason to doubt that the voter did not receive the original voting information.

29.3 After issuing replacement voting information, the returning officer shall enter in a list ("the list of lost ballots"):
(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, and
(c) if applicable, the voter ID number of the voter.

30. Issue of replacement voting information

30.1 If a person applies for replacement voting information under rule 28 or 29, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 28.3 or 29.2, they are also satisfied that that person has not already voted in the election.

Polling by internet, telephone or text

31. Procedure for remote voting by internet

31.1 To cast their vote using the internet the voter must gain access to the polling website by keying in the url of the polling website provided in the voting information,

31.2 When prompted to do so, the voter must enter their voter ID number.

31.3 If the internet voting system authenticates the voter ID number the system must give the voter access to the polling website for the election in which the voter is eligible to vote.

31.4 To cast their vote the voter may then key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

31.5 The voter must not be able to access the internet voting facility for an election once their vote at that election has been cast.

32. Voting procedure for remote voting by telephone

32.1 To cast their vote by telephone the voter must gain access to the telephone voting facility by calling the designated telephone number provided on the voter information using a telephone with a touch-tone keypad.

32.2 When prompted to do so, the voter must enter their voter ID number using the keypad.

32.3 If the telephone voting facility authenticates the voter ID number, the voter must be prompted to vote in the election.

32.4 When prompted to do so the voter may then cast his vote by keying in the code of the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

32.5 The voter must not be able to access the telephone voting facility for an election once their vote at that election has been cast.

33. Voting procedure for remote voting by text message

33.1 To cast their vote by text the voter must gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided on the voter information.

33.2 The text message sent by the voter must contain their voter ID number and the code for the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

33.3 The text message sent by the voter must be structured in accordance with the instructions on how to vote contained in the voter information.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

34. Receipt of voting documents

34.1 Where the returning officer receives a:
(a) covering envelope, or
(b) any other envelope containing a ballot paper,
before the close of the poll, that officer is to open it as soon as is practicable; and rules 35 and 36 are to apply.

34.2 The returning officer may open any covering envelope for the purposes of rules 35 and 36, but must make arrangements to ensure that no person obtains or communicates information as to:
(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

34.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers.

35. Validity of votes

35.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll.

35.2 Where the returning officer is satisfied that rule 35.1 has been fulfilled, the ballot paper is to be put aside for counting after the close of the poll.

35.3 Where the returning officer is not satisfied that rule 35.1 has been fulfilled, they should:
(a) mark the ballot paper "disqualified",
(b) record the unique identifier on the ballot paper in a list (the "list of disqualified documents"); and
(c) place the document or documents in a separate packet.

35.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet, telephone or text voting record has been received by the returning officer before the close of the poll.

36. De-duplication of votes

36.1 Where a combination of the methods of polling are being used, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in an election.

36.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in an election they shall:
(a) only accept as duly returned the first vote received that contained the duplicated voter ID number
(b) mark as "disqualified" all other votes containing the duplicated voter ID number

36.3 Where a ballot paper is "disqualified" under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) record the unique identifier and voter id number on the ballot paper in a list (the "list of disqualified documents"); and
(c) place the ballot paper in a separate packet.

36.4 Where an internet, telephone or text voting record is "disqualified" under this rule the returning officer shall:
(a) mark the record as "disqualified",
(b) record the voter ID number on the record in a list (the "list of disqualified documents".
(c) disregard the record when counting the votes in accordance with these Rules.

37. Sealing of packets

37.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 35 and 36, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers,
(c) the list of lost ballots
(d) the list of eligible voters, and
(e) complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

Part 6 Counting the votes

Note: the following rules describe how the votes are to be counted manually but it is expected that appropriately audited vote counting software will be used to count votes where a combination of methods of polling is being used and votes are contained as electronic e-voting records and ballot papers.

STV38. Interpretation of Part 6

STV38.1In Part 6 of these rules:

"ballot" means a ballot paper, internet voting record, telephone voting record or text voting record.
"continuing candidate" means any candidate not deemed to be elected, and not excluded,
"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,
"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,
"mark" means a figure, an identifiable written word, or a mark such as "X",
"non-transferable vote" means a ballot:
(a) on which no second or subsequent preference is recorded for a continuing candidate,
or
(b) which is excluded by the returning officer under rule STV46,
"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,
"quota" means the number calculated in accordance with rule STV43,
"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballots from the candidate who has the surplus,
"stage of the count" means:
(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,
"transferred vote" means a vote derived from a ballot on which a second or subsequent preference is recorded for the candidate to whom that ballot has been transferred, and
"transfer value" means the value of a transferred vote calculated in accordance with rules STV44.4 or STV44.7.

39. Arrangements for counting of the votes

39.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

40. The count

40.1 The returning officer is to:
(a) count and record the number of votes that have been returned, and
(b) count the votes according to the provisions in this Part of the rules.

40.2 The returning officer, while counting and recording the number of votes and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or a voter's voter ID number.

40.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV41. Rejected ballot papers

STV41.1 Any ballot paper:
(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV41.2The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV41.3 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV41.1

FPP41. Rejected ballot papers

FPP41.1 Any ballot paper:
(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,
shall, subject to rules FPP41.2 and FPP41.3, be rejected and not counted.

FPP41.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP41.3 A ballot paper on which a vote is marked:
(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,
is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP41.4 The returning officer is to:
(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP41.2 and FPP 41.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP41.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:
(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,
and, where applicable, each heading must record the number of ballot papers rejected in part.

STV42. First stage
STV42.1 The returning officer is to sort the ballots into parcels according to the candidates for whom the first preference votes are given.

STV42.2 The returning officer is to then count the number of first preference votes given on ballots for each candidate, and is to record those numbers.

STV42.3 The returning officer is to also ascertain and record the number of valid ballots.

STV43. The quota
STV43.1 The returning officer is to divide the number of valid ballots by a number exceeding by one the number of members to be elected.

STV43.2 The result, increased by one, of the division under rule STV43.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV43.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV44.1 to STV44.3 has been complied with.

STV44. Transfer of votes
STV44.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballots on which first preference votes are given for that candidate into sub- parcels so that they are grouped:
(a) according to next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.2 The returning officer is to count the number of ballots in each parcel referred to in rule

STV44.3 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.1(a) to the candidate for whom the next available preference is given on those papers.

STV44.4 The vote on each ballot transferred under rule STV44.3 shall be at a value ("the transfer value") which:
(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballots on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV44.5 Where at the end of any stage of the count involving the transfer of ballots, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballots in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:
(a) according to the next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.6 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.5(a) to the candidate for whom the next available preference is given on those ballots.

STV44.7 The vote on each ballot transferred under rule STV44.6 shall be at:
(a) a transfer value calculated as set out in rule STV44.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

STV44.8 Each transfer of a surplus constitutes a stage in the count.

STV44.9 Subject to rule STV44.10, the returning officer shall proceed to transfer transferable ballots until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV44.10 Transferable ballots shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:
(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV44.11 This rule does not apply at an election where there is only one vacancy.

STV45. Supplementary provisions on transfer

STV45.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballots of the candidate with the highest surplus shall be transferred first, and if:
(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballots of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballots of the candidate on whom the lot falls shall be transferred first.

STV45.2 The returning officer shall, on each transfer of transferable ballots under rule STV44:
(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:
(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV45.3 All ballots transferred under rule STV44 or STV45 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot or, as the case may be, all the ballots in that sub-parcel.

STV45.4 Where a ballot is so marked that it is unclear to the returning officer at any stage of the count under rule STV44 or STV45 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot as a non-transferable vote; and votes on a ballot shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV46. Exclusion of candidates
STV46.1 If:
(a) all transferable ballots which under the provisions of rule STV44 (including that rule as applied by rule STV46.11 and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV47, one or more vacancies remain to be filled,
the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV46.12 applies, the candidates with the then lowest votes).

STV46.2 The returning officer shall sort all the ballots on which first preference votes are given for the candidate or candidates excluded under rule STV46.1 into two sub-parcels so that they are grouped as:
(a) ballots on which a next available preference is given, and
(b) ballots on which no such preference is given (thereby including ballots on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV46.3 The returning officer shall, in accordance with this rule and rule STV45, transfer each sub-parcel of ballots referred to in rule STV46.2 to the candidate for whom the next available preference is given on those ballots.

STV46.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV46.5 If, subject to rule STV47, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballots, if any, which had been transferred to any candidate excluded under rule STV46.1 into sub- parcels according to their transfer value.

STV46.6 The returning officer shall transfer those ballots in the sub-parcel of transferable ballots with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballots (thereby passing over candidates who are deemed to be elected or are excluded).

STV46.7 The vote on each transferable ballot transferred under rule STV46.6 shall be at the value at which that vote was received by the candidate excluded under rule STV46.1.

STV46.8 Any ballots on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV46.9 After the returning officer has completed the transfer of the ballots in the sub-parcel of ballots with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballots with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV46.1.

STV46.10 The returning officer shall after each stage of the count completed under this rule:
(a) record:
(i) the total value of votes, or
(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:
(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV46.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV44.5 to STV44.10 and rule STV45.

STV46.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV46.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:
(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV47. Filling of last vacancies
STV47.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV47.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV47.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV48. Order of election of candidates
STV48.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV44.10.

STV48.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV48.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV48.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP48. Equality of votes
FPP48.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 Final proceedings in contested and uncontested elections

FPP49. Declaration of result for contested elections
FPP49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who they have declared elected:
(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or
(ii) in any other case, to the chairman of the corporation; and
(c) give public notice of the name of each candidate whom they have declared elected.

FPP49.2 The returning officer is to make:
(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP41.5,
available on request.

STV49. Declaration of result for contested elections
STV49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:
(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
(b) give notice of the name of each candidate who they have declared elected –
(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or
(ii) in any other case, to the chairman of the corporation, and
(c) give public notice of the name of each candidate who they have declared elected.

STV49.2 The returning officer is to make:
(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV41.1,
available on request.

50. Declaration of result for uncontested elections
50.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:
(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who they have declared elected to the chairman of the corporation, and
(c) give public notice of the name of each candidate who they have declared elected.

Part 8 Disposal of documents

51. Sealing up of documents relating to the poll
51.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:
(a) the counted ballot papers,
(b) the ballot papers endorsed with “rejected in part”,
(c) the rejected ballot papers, and
(d) the statement of rejected ballot papers.
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.2 The returning officer must not open the sealed packets of:
(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers,
(c) the list of lost ballots,
(d) the list of eligible voters, and
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.3 The returning officer must endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

52. Delivery of documents

52.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 51, the returning officer is to forward them to the chair of the corporation.

53. Forwarding of documents received after close of the poll

53.1 Where:
(a) any voting documents are received by the returning officer after the close of the poll,
or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voter information is made too late to enable new ballot papers to be issued,
The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

54. Retention and public inspection of documents

54.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

54.2 With the exception of the documents listed in rule 55.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

54.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so

55. Application for inspection of certain documents relating to an election

55.1 The corporation may not allow the inspection of, or the opening of any sealed packet containing –
(a) any rejected ballot papers, including ballot papers rejected in part,
(b) any disqualified documents, or the list of disqualified documents,
(c) any counted ballot papers, or
(d) the list of eligible voters,
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage by any person without the consent of the Regulator.

55.2 A person may apply to the Regulator to inspect any of the documents listed in rule 55.1, and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

55.3 The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to –
(a) persons,

(b) time,
(c) place and mode of inspection,
(d) production or opening, and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

55.4 On an application to inspect any of the documents listed in rule 55.1:
(a) in giving its consent, the regulator, and
(b) making the documents available for inspection, the corporation, must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –
(i) that their vote was given, and
(ii) that the regulator has declared that the vote was invalid.

Part 9 Death of a candidate during a contested election

FPP56. Countermand or abandonment of poll on death of candidate
FPP56.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:
(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP56.2 Where a new election is ordered under rule FPP56.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP56.3 Where a poll is abandoned under rule FPP56.1(a), rules FPP56.4 to FPP56.7 are to apply.

FPP56.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 35 and 36, and is to make up separate sealed packets in accordance with rule 37.

FPP56.5 The returning officer is to:
(a) count and record the number of ballot papers that have been received, and
(b) seal up the ballot papers into packets, along with the records of the number of ballot papers.
(c) seal up the electronic copies of records that have been received referred to in rule 25 held in a device suitable for the purpose of storage.

FPP56.6 The returning officer is to endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP56.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP56.4 to FPP56.6, the returning officer is to deliver them to the chairman of the corporation, and rules 54 and 55 are to apply.

STV56. Countermand or abandonment of poll on death of candidate

STV56.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:
(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
(i) ballots which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
(ii) ballots which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV56.2 The ballots which have preferences recorded for the candidate who has died are to be sealed with the other counted ballots pursuant to rule 51.1(a).

Part 10 Election expenses and publicity

57. Election expenses

57.1 Any expenses incurred, or payments made, for the purposes of an election which to the regulator under Part 11 of these rules.

58. Expenses and payments by candidates

58.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:
(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

59. Election expenses incurred by other persons

59.1 No person may:
(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or their family any money or property (whether a a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

59.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 60 and 61.

Publicity

60. Publicity about election by the corporation

60.1 The corporation may:
(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

60.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 61, must be:
(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, the expense of the electoral prospects of one or more other candidates.

60.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

61. **Information about candidates for inclusion with voting information**

61.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 23 of these rules.

61.2 The information must consist of:
(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a polling method, the numerical voting code, allocated by the returning officer, to each candidate, for the purpose of recording votes on the telephone voting facility or the text message voting facility, and
(c) a photograph of the candidate.

62. Meaning of "for the purposes of an election"

62.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

62.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11Questioning elections and the consequence of irregularities

63. Application to question an election

63.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

63.2 An application may only be made once the outcome of the election has been declared by the returning officer.

63.3 An application may only be made to the Regulator by:
(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

63.4 The application must:
(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the Regulator may require.

63.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

63.6 If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

63.7 The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

63.8 The determination by the person or persons nominated in accordance with rule 63.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency including all the candidates for the election to which the application relates.

63.9 The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 Miscellaneous

64. Secrecy

64.1 The following persons:
(a) the returning officer,
(b) the returning officer's staff,
must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:
(i) the name of any member of the corporation who has or has not been given voter information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter
iv) the candidate(s) for whom any member has voted.

64.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter id number allocated to a voter.

64.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

65. Prohibition of disclosure of vote

65.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

66. Disqualification

66.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:
(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

67. Delay in postal service through industrial action or unforeseen event

67.1 If industrial action, or some other unforeseen event, results in a delay in:
(a) the delivery of the documents in rule 23, or
(b) the return of the ballot papers and declarations of identity,
the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

UPDATED 20.1.15 (electronic voting)

ANNEXE 3 – FURTHER PROVISIONS

(From paragraph 9.2)

Termination of Membership

1. A Member may be expelled by a resolution approved by not less than three quarters of the full Membership Council present and voting at a general meeting. The following procedure is to be adopted.

2. Any Member may complain to the Company Secretary that another Member has acted in a way detrimental to the interests of the Trust.

3. If a complaint is made, the Membership Council may itself consider the complaint having taken such steps as it considers appropriate to ensure that each Member's point of view is heard and may either:

   3.1. dismiss the complaint and take no further action; or
   3.2. arrange for a resolution to expel the Member complained of to be considered at the next general meeting of the Membership Council.

4. If a resolution to expel a Member is to be considered at a general meeting of the Membership Council, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

5. At the meeting the Membership Council will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

6. If the Member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

7. A person expelled from Membership will cease to be a Member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

8. No person who has been expelled from Membership is to be re-admitted except by a resolution carried by the votes of three quarters of the Membership Council present and voting at a general meeting.

ANNEXE 4 – ANNUAL MEMBERS' MEETING

(From paragraph 10.2)

1. All Members meetings, other than annual meetings, are called special members meetings.

2. Members' meetings are open to all members of the Trust, members of the Membership Council and the Board of Directors, representatives of the Trust's financial auditors, but not to members of the public. The Membership Council may invite representatives of the media, and any experts or advisors, whose attendance they consider to be in the best interests of the Trust to attend a members' meeting.

3. All Members meetings are to be convened by the Secretary by order of the Chair of the Membership Council or upon a resolution of the Board of Directors.

4. The Membership Council may decide where a members' meeting is to be held and may also for the benefit of Members:

   4.1. arrange for the annual members' meeting to be held in different venues each year;
   4.2. make provisions for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Membership Council shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

5. At the Annual Members' Meeting the Membership Council shall present to the Members:
   5.1. the annual accounts;
   5.2. any report of the auditor;
   5.3. any report of any other auditor of the Trust's affairs;
   5.4. forward planning information for the next financial year;
   5.5. a report on steps taken to secure that (taken as a whole) the actual membership of its constituencies is representative of those eligible for such membership;
   5.6. the progress of the Membership Strategy;
   5.7. any proposed changes to the policy for the composition of the Membership Council and of the Non-Executive Directors.
   5.8. the results of the election and appointment of Membership Council Members will be announced.

6. Notice of a Members' meeting is to be given:
   6.1. by notice on the Trust's website at least 14 clear days before the date of the meeting
   6.2. by notice emailed to all those members for whom we hold an email address
   6.3. included within the Trust's members newsletter
   6.4. be given to the Membership Council and the Board of Directors, and to the auditors;

7. The notice of the member's meeting must:
   7.1. state whether the meeting is an annual or special members' meeting;
   7.2. give the time, date and place of the meeting; and
   7.3. indicate the business to be dealt with at the meeting.

8. It is the responsibility of the Membership Council, the Company Chairman of the meeting and the Secretary to ensure that at any members meeting:
   8.1. the issues to be decided are clearly explained;
   8.2. sufficient information is provided to members to enable rational discussion to take place;
   8.3. where appropriate, experts in relevant fields or representatives of special interest groups are invited to address the meeting.

9. The Chair of the Trust or, in their absence, the Deputy-Chair or, in their absence, the Lead Membership Councillor is to chair members' meetings.

10. Subject to this Constitution, a resolution put to the vote at a members' meeting shall, except where a poll is demanded or directed, be decided upon by a show of hands.

11. On a show of hands or on a poll, every member present is to have one vote. On a poll, votes may be given either personally or by proxy under arrangements laid down by the Membership Council, and every member is to have one vote. In case of an equality of votes the Chairman shall decide the outcome.

12. Unless a poll is demanded, the result of any vote will be declared by the Chairman and recorded in the minutes. The minutes will be conclusive evidence of the result of the vote.

13. A poll may be directed by the Chair or demanded either before or immediately after a vote by show of hands by not less than one-tenth of the members present at the meeting. A poll shall be taken immediately.

ANNEXE 5 – ROLES AND RESPONSIBILITIES OF MEMBERSHIP COUNCILLORS

(from paragraph 11.3)

1. The roles and responsibilities of the Membership Councillors are:
   - 1.1. at a general meeting, to appoint or remove the Chair and the other Non-Executive Directors;
   - 1.2. at a general meeting, to approve an appointment (by the Non-Executive Directors) of the Chief Executive;
   - 1.3. at a general meeting, to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;
   - 1.4. at a general meeting, to appoint or remove the Trust's auditor;
   - 1.5. at a general meeting, to be presented with the annual accounts, any report of the auditor on them and the annual report;
   - 1.6. at a general meeting, to appoint or remove any auditor appointed to review and publish a report on any other aspect of the Trust's affairs;
   - 1.7. to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning in respect of each financial year;
   - 1.8. to respond as appropriate when consulted by the Board of Directors in accordance with this Constitution;
   - 1.9. to undertake such functions as the Board of Directors shall from time to time request;
   - 1.10. to prepare and from time to time to review the Trust's Membership Strategy, its policy for the composition of the Membership Council and of the Non-Executive Directors.

2. A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Members of the Membership Council are appointed or any vacancy on the Membership Council.

ANNEXE 6 – COMPOSITION OF THE MEMBERSHIP COUNCIL

(from paragraph 12.2)

1. The Membership Council of the Trust is to comprise:
   1.1. up to 16 Public Council Members from 8 public constituencies (2 members from each constituency) set out in Annexe 1

   1.2. up to six Staff Council Members from 1 Staff Constituency from the following classes:
      1.2.1. doctors and dentists (1 member);
      1.2.2. Allied Health Professionals, Health Care Scientists and Pharmacists (1 member);
      1.2.3. Management, Administration and Clerical (1 Member);
      1.2.4. Ancillary Staff (1 Member);
      1.2.5. Nurses and Midwives (up to 2 members);

   1.3. Two Local Authority Council Members, one to be appointed by each of: Calderdale Metropolitan Borough Council and Kirklees Metropolitan Council;

   1.4. Up to six Council Members appointed by partnership organisations. The partnership organisations shall appoint a Council Member to represent their organisation on the Membership Council. The partnership organisations are identified as:
      - Huddersfield University,
      - South West Yorkshire Partnership NHS Foundation Trust
      - Locala Community Interest Company
      - NHS Calderdale Clinical Commissioning Group
      - NHS Greater Huddersfield Clinical Commissioning Group

ANNEXE 7 – MEMBERSHIP COUNCIL – STANDING ORDERS

AS APPROVED AT MEMBERSHIP COUNCIL JANUARY 2017

ANNEXE 8 – BOARD OF DIRECTORS – STANDING ORDERS

Due to be presented to Audit and Risk Committee 18 April 2017

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETINGS – JANUARY TO DECEMBER 2018

Unless otherwise stated all meetings will commence from 9.00 am – 12.30 pm in the venues indicated below unless otherwise stated:

DATE OF BOD MEETING		VENUE
Thursday	4 January 2018	Large Training Room, CRH
Thursday	1 February 2018	Large Training Room, CRH
Thursday	1 March 2018	Hospital Boardroom, HRI
Thursday	5 April 2018	Hospital Boardroom, HRI
Thursday	3 May 2018	Large Training Room, CRH
Thursday or Friday	TO BE CONFIRMED EITHER: 24 May 2018 ? 2.00 PM OR 25 May 2018 ? 9.00 AM (Signing off ARA)	24.5.17 - TBC - Hospital Boardroom, HRI
Thursday	7 June 2018	Large Training Room, CRH
Thursday	5 July 2018	Large Training Room, CRH
Thursday	2 August 2018	Hospital Boardroom, HRI
Thursday	6 September 2018	Large Training Room, CRH
Thursday	4 October 2018	Hospital Boardroom, HRI
Thursday	1 November 2018	Large Training Room, CRH
Thursday	6 December 2018	Hospital Boardroom, HRI

CRH - Lge TR, LC = Calderdale Royal Hospital Large Training Room, Learning Centre, HX3 0PW
HRI – Boardroom = Huddersfield Royal Infirmary, Boardroom, HD3 3EA
HRI – DR1 = Huddersfield Royal Infirmary, Discussion Room 1, Learning Centre HD3 3EA

KB/BOD-MEETING DATES JAN – DEC 2018
April 2017

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 1st June 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Board Report: - The Board is asked to receive and approve the Integrated Board Report for April 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board (25/5/17) and Quality Committee (31/5/17)	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

April's Performance Score is 69% for the Trust. The SAFE domain has once again gone back to a Green rating following improvements in Harm Free Care, Category 4 Pressure Ulcers and % PPH. The RESPONSIVE domain has returned to an Amber rating due to missing the 62 day GP Referral to Treatment target for the first time in over 12 months and continuing to underperform in the Diagnostics 6 week target. CARING has deteriorated due to FFT Maternity and FFT A&E would recommend but remains Amber.

Methodology for scoring has changed for FINANCE and WORKFORCE to reflect emphasis on indicators considered more important and this methodology has been applied to previous months for comparison purposes. This formed part of a review of weighting of indicators across all domains where the weighting for Diagnostics and Readmission Rates has reduced but further debate is necessary for FFT (response rates) within the Caring Domain where a wider discussion around the need for additional indicators is also required.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the Integrated Board Report for April 2017

Appendix

Attachment:

IPR Report - April 2017.pdf

Board Report

April 2017

Performance Summary

April

RAG Movement

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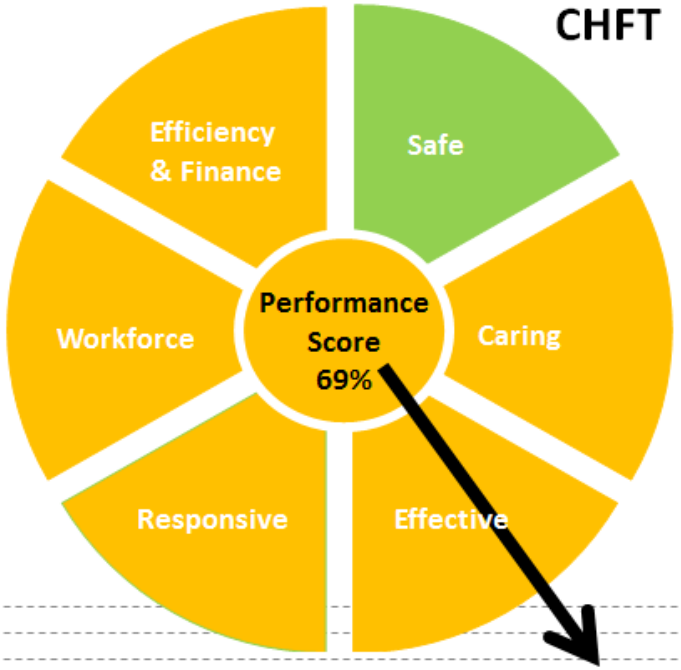
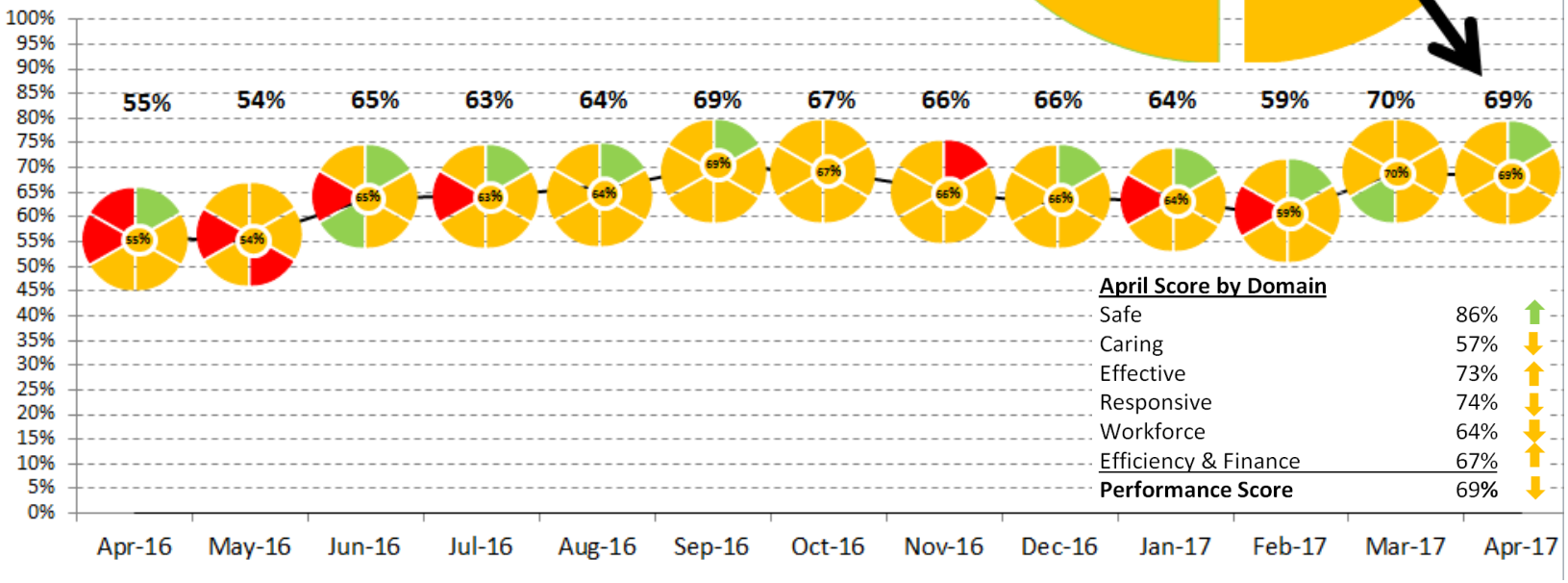


Total performance score



April Score by Domain

Safe	86%
Caring	57%
Effective	73%
Responsive	74%
Workforce	64%
Efficiency & Finance	67%
Performance Score	69%

SINGLE OVERSIGHT FRAMEWORK

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

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	98.2%	98.0%	↑	96.3%
	Inpatient Complaints per 1000 bed days	1.9	2.4	↑	TBC
EFFECTIVE	Average Length of Stay - Overall	5.12	4.99	↓	5.17
	Delayed Transfers of Care	2.28%	2.36%	↑	5%
	Green Cross Patients (Snapshot at month end)	114	129	↑	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	100.37	100.59	↑	100
	Theatre Utilisation (TT) - Trust	82.0%	85.4%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.52%	0.80%	↑	0.6%
	Emergency Care Standard 4 hours	95.09%	97.40%	↓	95%
	% Incomplete Pathways <18 Weeks	94.97%	95.14%	↓	92%
	62 Day GP Referral to Treatment	84.2%	90.4%	↓	85%
SAFE	% Harm Free Care	94.51%	92.71%	↑	95.0%
	Number of Outliers (Bed Days)	334	259	↓	495
	Number of Serious Incidents	2	8	↑	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: Sickness Absence rate (%) achieved 3.7% in March (target 4%) with long term sickness maintaining its target and short term just missing its target at 1.33% (1.3%).

Improved: Average co-morbidity score and Average Diagnosis per Coded Episode both peaked in April as a result of continued engagement with clinical teams around documentation quality. The roll-out of 3M has assisted quality especially for junior coders plus the coding team were at full establishment.

Improved: % Last Minute Cancellations to Elective Surgery to 0.52% in April. This was as a result of minimal bed pressures (cancellations usually due to physical lack of bed availability or late availability causing late starts and theatre over-runs) and realistic theatre scheduling.

MOST DETERIORATED

Deteriorated: The Trust's Diagnostic Waiting List position has reduced to 90.98% in month as a result of the increased waiting list in Non-Obstetric Ultrasound. Combinastion of a peak in referrals and removal of agency staff. The activity profile for this modality is high impacting significantly on the overall Trust performance.

Deteriorated: 62 Day GP Referral to Treatment reduction in month to 84.25%. First time 85% target has been missed for over 12 months but reflective of a deteriorating position through Q4. There were 19 breaches in all, 5 were full breaches with complex pathways. Due to Easter less patients were treated so there was a greater impact from these breaches.

Deteriorated: Mortality Reviews at 25.7% were at their lowest level for 2016/17 in March.

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

ACTIONS

Action: CHFT has an agreed trajectory in place for recovery and is monitoring on a daily basis. Extra Capacity has been opened at Beechwood (North Halifax) which has resulted in an extra 600 scans in month. There will be some recovery in May and expected return to green in June 2017.

Action: Conversations undertaken with the Radiology service to ensure tests and reports are completed within 14 days. Ongoing work with the clinical leads for each tumour site to ensure an efficient service.

Action: From a screening mortality review point of view, the completion rate will continue to fall; a decision has been made to focus on the Structured Judgement (2nd level) reviews rather than the roll out of screening reviews to consultants, largely as a result of EPR.

Arrow direction count ↔ 1 ↑ 10 ↓ 8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.9	7.7	↑	
Sickness Absence Rate	3.71%	4.03%	↑	4.0%
Turnover rate (%) (Rolling 12m)	11.83%	11.52%	↓	12.3%
Vacancy	434.53	305.58	↓	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q2	82%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q2	64%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£0.66	£3.93	🔴
Expenditure vs Plan var (£m)	£0.74	-£3.84	🟢
Liquidity (Days)	-27.28	-28.49	🟢
I&E: Surplus / (Deficit) var - Control Total basis (£m)	£0.03	£1.45	🟢
CIP var (£m)	-£0.07	£0.98	🔴
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	13.71%	15.22%	🟢

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care** - Performance has improved in month from 92.7%, however it remains below target at 94.51%. Harms in Falls, Ulcers and Catheter Associated UTIs were noted as contributing to this performance level. A deep dive review has now been completed and will be shared through divisional teams and improvement leads. • **Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)** - there were 5 reports sent to CCG in April – 1 of these were within 60 days, the remaining 4 were completed within agreed extended timescales. The Risk Management managers are continuing to work with investigators to deliver timely investigations. A collaborative approach to improve performance across the Divisions will be led by the AD for Quality.
	• **Complaints closed within timeframe** - 60 complaints were closed in April, 52% of these were closed within target timeframe which was consistent with the last 2 months. The number of overdue complaints was 18 at the end of April which was a significant improvement on March. • **Friends and Family Test A & E Survey - Response Rate** - was 8.5% in month. The ED team have reviewed this indicator and agreed an improvement plan for implementation in Quarter 1 and improved perfromance in quarter 2. • **Friends and Family Test A & E Survey - % would recommend the Service** - at 85.3%.
Caring	• **Friends and Family Test (Maternity Survey) - % would recommend the Service** - at 92% the reduction was specifically in the 2nd part of the Maternity FFT - Labour and Birth. The Division has completed an analysis of this reduction and found a number of responses of 'Don't know' on the Labour and Birth question. However in the vast majority, the mother completing the form has responded positively about the stay on the postnatal ward with either a likely/very likely to recommend response which has assured the service that the reduction is a data collection issue rather than a reduction in clinical care. • **Friends and Family Test Community Survey** - Community FFT reported 87% would recommend the service against a 96% national average. The division has agreed to fund a new server to support the web based system and this will be installed in late May, with an expected improvement in June and quarter 2.
Effective	• **Perinatal Deaths (0-7 days)** - All perinatal deaths were reviewed in order to identify any learning. • **Mortality Reviews** - The completion rate for Level 1 reviews reduced to 25.66% in March with 2016/17 at 40.06% compared to 2015/16 position which was 48.8%. From a screening mortality review point of view, the completion rate will continue to fall; a decision has been made to focus on the Structured Judgement (2nd level) reviews rather than the roll out of screening reviews to consultants, largely as a result of EPR. • **Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG** - Has missed target for last 2 months. Calderdale Community services continue to focus efforts on supporting people on discharge in order to prevent people being readmitted to hospital once discharged. The Virtual ward service contacts patients over 60 who have had an emergency medical admission and will provide advice, home visit and support where necessary. Community matrons and specialist matrons review any patient on their caseload that has been admitted or readmitted and review the reasons. A piece of work has been undertaken to fast track referrals by the community falls team if the matrons identify that their patients are at high risk of falling in order to reduce the risk of these patients being readmitted.

Background Context

A&E continues to be busy with activity 1.5% over plan in month. High attendances at the beginning of the week mixed with lower weekend discharge numbers continue to drive variation in performance. The month started well, supported by continuation of some of the Accelerator Zone schemes however this deteriorated in the last week of the month reflecting some out of hospital pressures and the final planning for EPR Go-Live.

Non-elective activity overall was 1.2% above the month 1 plan. This was mainly due to Emergency and Non-Elective Short Stay admissions. Long stay patient numbers reduced as a result of the continued work on the Safer programme.

One ward at CRH was closed for several days at CRH due to Norovirus, this was contained but required other capacity to be retained to support flow.

There was a bank holiday weekend during April which had an impact on flow both over the four days but in the days after this as backlogs needed to be cleared across the health and social care system; to respond to this additional capacity remained open within CHFT.

EPR preparation was a focus for all Divisions and their teams, additional capacity was deployed for cutover weekend however plans to increase discharges prior to the weekend were difficult to achieve.

Executive Summary

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

Area	Domain
Responsive	• **Stroke -** % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival has reduced to 76.2% in month. Although the team have not reached the target the improvement has been sustained. 40.5% Stroke patients were scanned within 1 hour of hospital arrival (where indicated) against 48% target. The 1 hour to scan is now being monitored on a daily basis and the numbers have improved. • **RTT pathways over 26 weeks** - numbers have increased to 174 which is the highest number since May 2016. Fluctuations in > 26 week open pathways is as a result of capacity constraints in some specialities. • **% Diagnostic Waiting List Within 6 Weeks** - The Trust's Diagnostic Waiting List position has reduced to 90.98% in month as a result of the increased waiting list in Non Obstetric Ultrasound between December and April which now has an extra 1,500 patients. Due to the response taken in April/May the position has improved with a forecast position of 138 breaches at the end of May compared to over 600 at the end of April. • **38 Day Referral to Tertiary** - at 27.78% this is a small improvement on last month's 20% although still some distance from 49.5% achieved in 2015/16. • **62 Day GP Referral to Treatment** - at 84.25% the Trust missed this target for the first time in over 12 months. The tumour sites and divisions are reviewing Consultant practice and pathways to see where improvements can be made. All patients that have cancer and take 104 days or more will be classed as an orange incident and investigated.
Workforce	• **Sickness Absence rate** - Sickness Absence rate (%) achieved 3.7% in March (target 4%) with long term sickness maintaining its target and short term just missing its target at 1.33% (1.3%). • **Return to work Interviews** fell slightly to 71%. 3 in 10 still not being completed.
Efficiency/ Finance	• **Finance:** Delivered a year to date Deficit position that shows a slight improvement compared to the agreed control total of £4.04m, • Capital expenditure is slightly below plan, • Cash position is slightly above the planned level at £2.04m. • Delivery of CIP is behind the planned level at £0.63m against a planned level of £0.69m. • A Use of Resources score of level 3, in line with the plan. The year to date financial position is a deficit of £4.01m as reported on a Control Total basis, a favourable variance of £0.03m from the planned £4.04m. The underlying deficit position is £4.02m, a favourable variance of £0.01m reflecting the following item that is excluded from the Control Total: • Impact of Donated Assets (£0.01m) However this financial position has only been achieved with the assistance of £0.20m of non-recurrent income and the release of £0.33m of Contingency Reserve, 1/6th of the total £2m Reserve available this year. The underlying operational position is a £0.53m unfavourable variance from plan linked mainly to loss of income from Non-Elective activity, Direct Access Radiology and Flexi Sigmoidoscopy screening impacted by the Endoscopy fire. With the exception of pass through costs, these income variances have not been matched by a reduction in expenditure. Total agency spend in month was £1.36m; lower than the planned value of £1.83m and the NHS Improvement Agency Ceiling. Whilst some of the reduction in Agency expenditure is linked to staff moving onto payroll and the filling of vacancies, a proportion is likely to be non recurrent as it was linked to IR35 negotiations and the Easter holiday period. Early indications are that Agency expenditure for Month 2 is likely to be much higher. Month 1 did see some additional non recurrent operating costs due to EPR implementation and training. A higher level of cost is likely to be seen over the next couple of months.
Activity	• In month activity is below planned levels mainly due to Other NHS Tariff and Other Non-NHS Tariff. Waiting lists are still high reflecting ongoing demand.

Background Context

IR35 came into force during April having a significant impact across several specialties and service areas including AED, Dermatology, Acute Medicine and Ophthalmology.

EPR preparation was in the last 4 weeks of delivery with high numbers of staff accessing training and lots of activity to ensure EPR coud be safely deployed. All other mandatory training was stopped for the month and all non-essential meetings were cancelled from the middle of the month.

The Trust PAS system was turned off at 6pm 28th April and all services moved to paper, turning on again during the evening of 30th April. This was a particularly challenging weekend for AED.

The E-referral system, in partnership with GPs, had been turned off from 21st April to allow all clinics to be migrated ready for EPR. This impacted on routine referrals in and ASIs, urgent and fasttrack referrals continued to be received by FAX.

A cohort of elective activity is performed at weekends however all but urgent activity was cancelled on 29th and 30th April taking out some routine capacity impacting particularly on Outpatients. This combined with the Easter break being in April for 17/18 reduced the number of working days and outpatient and elective activity is below plan as a consequence as no specific phasing has been applied to reflect the changes.

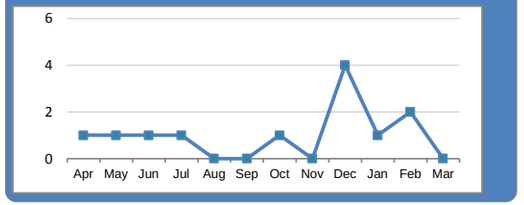
Safe, Effective, Caring, Responsive - Community Key messages

Area	Reality	Response	Result
Safe	**Pressure Ulcer Management** 2 grade 3 pressure ulcers were recorded in community services.	**Pressure Ulcer Management** The division is working with the TVN service to support the "React to Red" campaign.	**Pressure Ulcer Management** Reduced number of grade 3 pressure ulcers in Community settings in 2017/18. **By when: Review September 2017** **Accountable: ADN**
Effective	**Wound Management** Teams are working hard to ensure there are good processes in place to support the evidence required for the wound assessment CQUIN where all wounds that require complex dressings need a regular formal review and updated care plan.	**Wound Management** All wounds are reviewed by a senior nurse and the care plan updated.	**Wound Management** Low wound healing rates are achieved and maintained. **By when : September 2017** **Accountable: ADN**
Caring	**Friends and Family Test** Community services receive excellent feedback from patients and relatives, however FFT responses are consistently poor with 87% responses indicating that they would recommend. Division has undertaken a review of these and discovered that the majority of text and answerphone responses do not relate to community services but other services either acute or primary care. The division is therefore moving to a web based system from June 2017.	**Friends and Family Test** The division has agreed to fund a new server to support the web based system and this will be installed in late May. Web forms are ready to be used and the division has agreed that staff will ask patients on a certain day each week to feed back via the web based form.	**Friends and Family Test** A more accurate feedback mechanism will be in place enabling the Trust to accurately report FFT and to understand where to focus improvements. **By when: June 2017** **Accountable: Head of Therapies**
Responsiveness	**MSK responsiveness** There continues to be challenges to meet clinical demand in the MSK service and the administrative tasks once a person has been seen (letter typing and signing).	**MSK responsiveness** Additional Saturday clinics continue. Additional staff have been recruited. Significant amount of redesign is being undertaken in the service in preparation for the implementation of the single point of access.	**MSK responsiveness - Typing turnaround** Continued focus on reducing letter delay whilst undertaking significant service change through April and May. **By when: End May 2017** **Accountable: Head of Therapies**

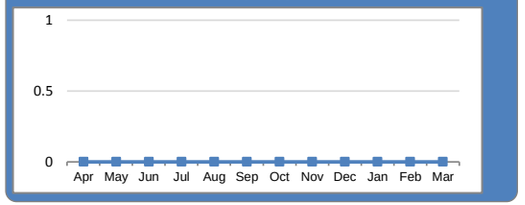
Dashboard - Community

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

Safe



One month in arrears



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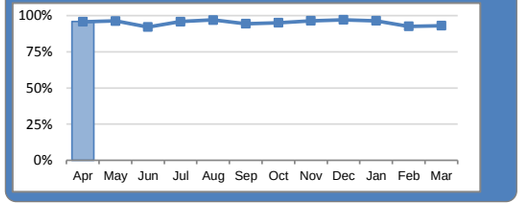
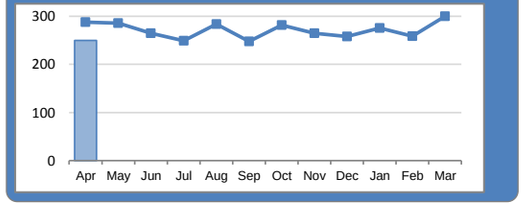
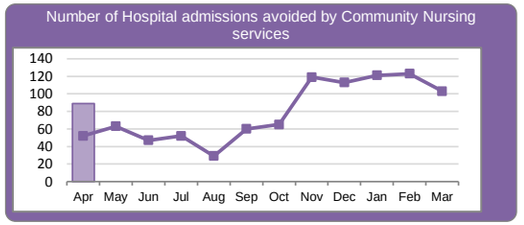
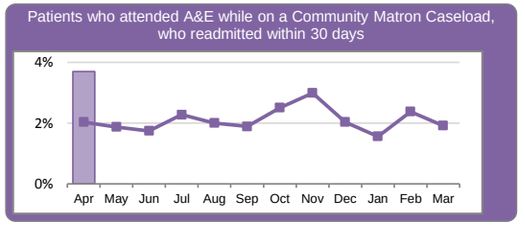
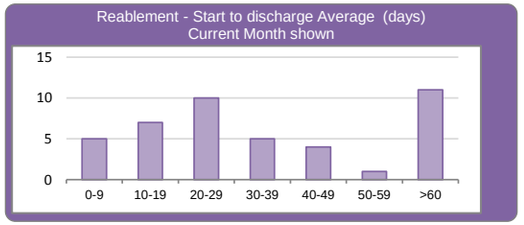


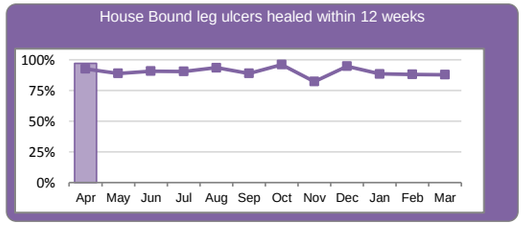


Effective

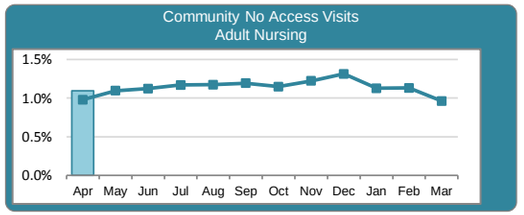


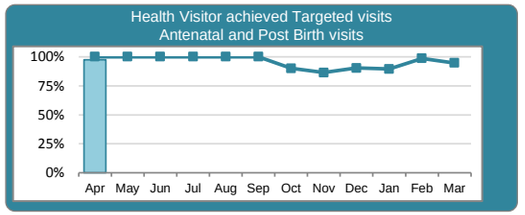


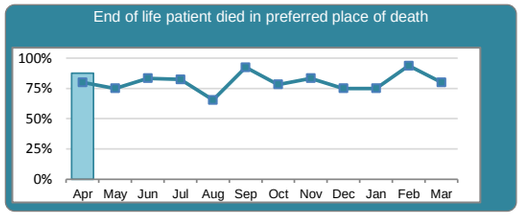


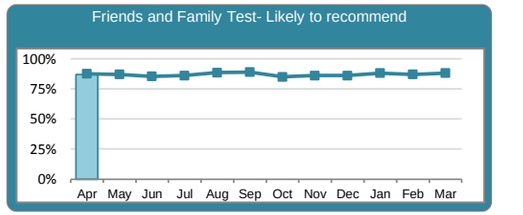


Caring

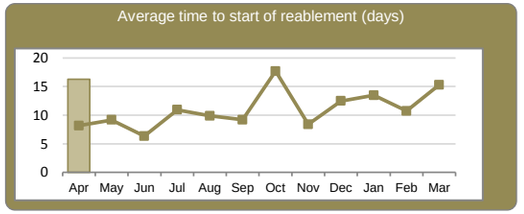


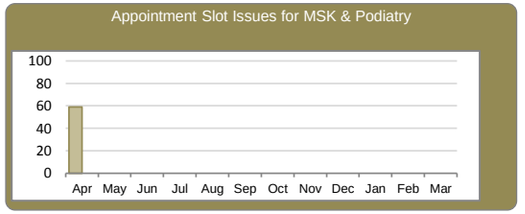


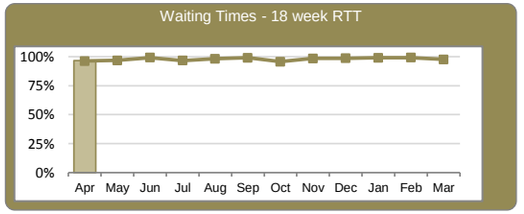


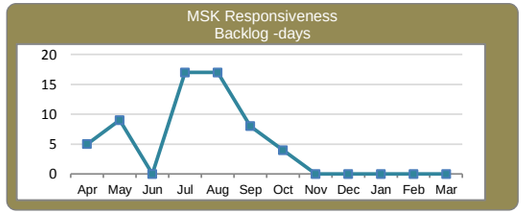


Responsive

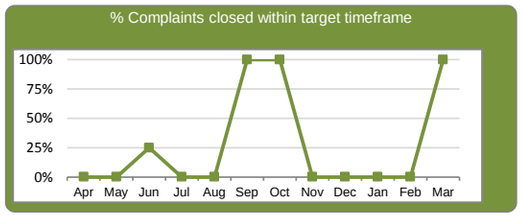


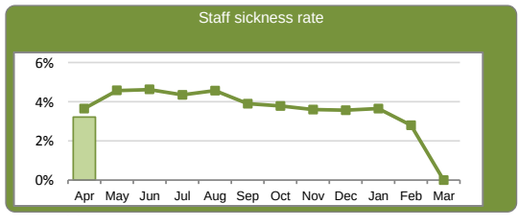




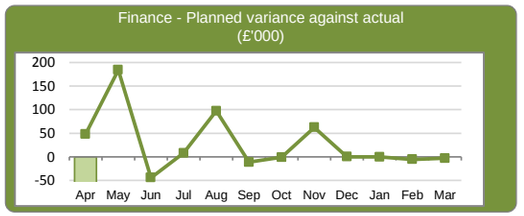


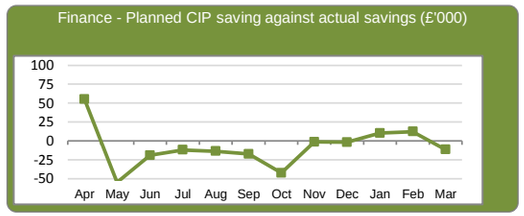
Well Led





One month in arrears





Hard Truths: Safe Staffing

Fill Rates

Average fill rates reported to Unify for Registered Nurse (RN) on both day and night shifts have improved. Table 1 indicates fill rates of less than 90%.

Average fill rates for care staff on both sides remain above 100%.

Table 1: Average Fill Rates Registered Nurses and Care Staff (Overall Summary)

Average Fill Rates:	Registered Nurses		Care Staff	
	Day	Night	Day	Night
April 2017 HRI	**86.51%**	**92.28%**	**113.62%**	**126.53%**
April 2017 CRH	**84.78%**	**93.55%**	**100.60%**	**105.38%**
March 2017 HRI	81.84%	88.77%	110.98%	141.29%
March 2017 CRH	82.65%	89.34%	104.74%	123.21%
February 2017 HRI	85.13%	91.14%	107.49%	135.87%
February 2017 CRH	84.54%	91.69%	103.64%	127.50%
January 2017 HRI	85.30%	89.50%	103.80%	132.00%
January 2017 CRH	85.00%	92.60%	102.90%	119.20%

The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds.

In April 2017 nine wards reported fill rates of less than 75% for registered nurses.
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 April 2017 are attributed to a level of vacancy and the teams not being able to achieve their WFM. Interim WFM have been developed within the divisions and going forward will be worked to.
There are good RN fill rates at HRI on the MAU and Wards 2a/b, 5B and 6B/C at CRH with high HCA coverage. This has been attributed to the transition into the new WFM and further impacted by additional 1-1 usage due to patient acuity and dependency.

Average fill rates for HCA's on night of < 75% have again been recorded within the FSS division during April 2017. This is due to long term sickness. The shortfall is being managed on a daily basis balanced against the acuity of the workload.
Low fill rates have been reported for both qualified and HCA staff on the Paediatric Unit at CRH. This is as the seasonal workforce model comes into effect.

Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; realisation of supervisory time for band 7 registered nurses and for care staff supporting reduced fill rate of registered nurse hours.

Hard Truths: Safe Staffing (2)

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

	Total CHPPD (Qualified and Unqualified)						Fill Rates Day (Qualified and Unqualified)			Fill Rates Night (Qualified and Unqualified)		
	Feb-17		Mar-17		Apr-17							
	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	Feb-17	Mar-17	Apr-17	Feb-17	Mar-17	Apr-17
CRH MAU	10.3	9.0	12.6	11.0	9.7	9.2	84.9%	84.1%	97.8%	94.9%	92.2%	90.5%
HRI MAU	7.5	8.5	8.7	9.6	9.2	10.2	104.2%	99.9%	102.1%	136.8%	125.4%	126.2%
WARD 2AB	6.2	6.1	6.5	6.5	6.1	6.3	90.6%	92.7%	104.2%	102.4%	109.6%	103.9%
HRI Ward 5 (previously ward 4)	6.3	6.6	6.2	6.6	6.0	6.9	89.3%	97.0%	110.9%	102.0%	124.1%	120.6%
HRI Ward 11 (previously Ward 5)	7.0	6.8	6.6	6.3	6.6	6.5	94.8%	92.1%	97.7%	98.4%	98.4%	100.4%
WARD 5AD	6.3	6.7	6.3	6.5	7.4	7.0	101.0%	103.6%	96.2%	112.0%	103.7%	93.3%
WARD 5C	6.2	6.0	6.4	6.1	6.3	6.2	91.6%	93.5%	97.5%	100.0%	100.0%	100.0%
WARD 6	6.7	6.2	6.2	5.7	7.0	6.8	95.9%	88.5%	90.2%	100.0%	98.6%	109.3%
WARD 6BC	5.5	5.1	5.7	5.4	5.2	5.5	91.8%	93.7%	104.8%	104.4%	99.5%	107.7%
WARD 5B	6.1	6.9	6.1	7.5	6.8	8.0	108.1%	111.1%	116.7%	143.0%	145.2%	120.8%
WARD 6A	5.3	6.5	5.4	5.9	6.6	6.2	112.0%	107.2%	84.9%	108.7%	109.8%	110.1%
WARD 8C	5.7	6.8	6.0	6.8	8.3	7.9	113.3%	109.3%	90.8%	127.2%	121.8%	104.0%
WARD CCU	11.5	9.0	12.2	9.4	10.1	9.4	81.0%	79.5%	86.8%	75.7%	74.2%	103.2%
WARD 6D	12.5	10.8	14.4	12.0	12.3	11.0	83.3%	78.4%	84.4%	95.5%	90.4%	96.5%
WARD 7AD	6.7	6.3	6.9	6.6	7.0	6.9	91.7%	93.0%	95.1%	100.0%	100.0%	105.6%
WARD 7BC	6.6	6.5	6.7	6.6	7.3	7.3	97.0%	97.4%	99.4%	99.5%	100.0%	100.6%
WARD 8	5.8	6.5	7.1	8.1	6.9	8.2	108.1%	111.7%	121.4%	104.1%	118.8%	112.8%
WARD 12	6.0	5.8	6.5	6.1	6.4	5.8	79.5%	82.9%	81.7%	106.7%	116.4%	109.2%
WARD 17	6.9	5.2	6.6	5.1	6.8	5.5	80.8%	75.7%	81.4%	103.8%	80.3%	80.0%
WARD 21	5.2	5.6	5.2	5.5	5.7	5.8	89.5%	93.7%	102.0%	114.4%	131.2%	99.3%
ICU CRH ICU HRI	31.7	26.9	35.2	28.0	36.1	29.5	84.0%	80.0%	82.6%	88.4%	79.0%	80.5%
WARD 3	6.1	7.5	6.1	6.5	6.8	7.1	111.6%	109.6%	108.3%	130.1%	100.0%	101.1%
WARD 8AB	6.7	6.7	7.4	6.8	9.6	7.7	86.2%	85.7%	73.8%	101.5%	100.9%	92.0%
WARD 8D	6.6	6.7	9.3	8.5	8.8	8.5	92.5%	86.6%	91.3%	101.6%	103.4%	109.1%
WARD 10	5.6	5.9	5.6	5.7	5.7	5.8	102.4%	101.1%	101.5%	101.5%	105.6%	99.6%
WARD 15	3.8	3.6	5.1	5.4	5.3	5.7	92.6%	98.1%	99.9%	103.2%	122.6%	122.5%
WARD 19	7.9	7.4	8.2	7.5	8.7	8.3	85.0%	84.0%	92.6%	96.1%	100.5%	101.1%
WARD 20	6.2	5.8	6.5	6.0	7.6	7.1	91.6%	87.9%	90.3%	110.2%	101.6%	98.9%
WARD 22	8.5	8.1	8.5	8.2	8.7	8.5	93.5%	94.8%	96.5%	100.0%	100.8%	100.0%
SAU HRI	9.0	8.5	9.8	9.1	11.3	10.6	90.2%	90.1%	90.3%	101.3%	99.3%	100.5%
WARD LDRP	28.9	25.9	30.3	25.8	25.6	21.1	87.0%	83.1%	80.7%	91.6%	87.1%	83.8%
WARD NICU	10.3	8.7	12.2	9.7	13.3	10.7	78.7%	75.2%	77.5%	90.4%	85.1%	83.8%
WARD 1D	8.9	7.9	8.5	7.9	4.3	4.2	82.3%	89.6%	97.0%	90.3%	100.0%	101.1%
WARD 3ABCD	15.8	14.2	13.8	12.5	16.2	13.1	87.8%	83.3%	69.8%	100.2%	102.7%	98.4%
WARD 4C	7.6	7.5	8.5	8.2	9.2	9.0	94.4%	93.2%	97.5%	98.9%	100.0%	98.9%
WARD 9	8.2	7.7	7.3	6.6	4.9	4.6	88.9%	81.7%	91.4%	98.9%	100.0%	97.8%
WARD 18	28.9	27.1	28.4	25.1	23.4	22.0	94.2%	86.6%	91.3%	93.5%	90.3%	97.0%
WARD 4	4.9	4.9	5.1	4.9	7.2	7.1	85.2%	99.9%	83.8%	100.0%	101.1%	72.3%
Trust	**7.8**	**7.5**	**8.1**	**7.7**	**8.3**	**7.9**	**91.7%**	**90.9%**	**92.8%**	**101.9%**	**100.9%**	**99.1%**

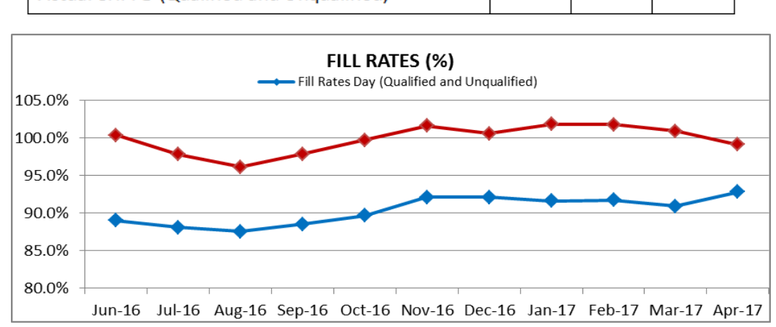
Care Hours Per Patient Day

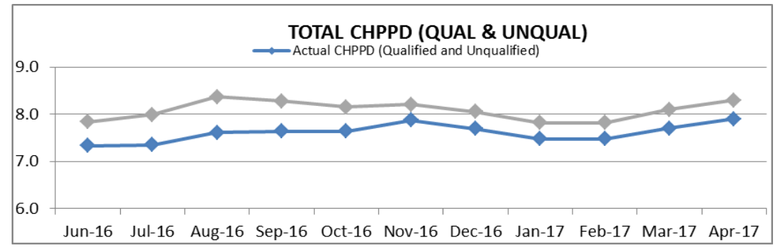
A review of April 2017 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 24 clinical areas of the 37 reviewed with CHPPD less than planned. 1 area reported CHPPD as planned. 12 areas reported CHPPD slightly in excess of those planned.

Areas with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.
Table 3 details fill rates and CHPPD data for the previous 3 months.

Table 3: STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Feb-17	Mar-17	Apr-17
Fill Rates Day (Qualified and Unqualified)	91.7%	90.9%	92.8%
Fill Rates Night (Qualified and Unqualified)	101.8%	100.9%	99.1%
Planned CHPPD (Qualified and Unqualified)	7.8	8.1	8.3
Actual CHPPD (Qualified and Unqualified)	7.5	7.7	7.9





Internal Never Events

No red flagged staffing incidents were reported in April 2017.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jean Robinson, Lead Infection Prevention and Control Nurse
Date: Thursday, 1st June 2017	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Quarterly DIPC report - Quarterly DIPC report - the Board is asked to receive the report on the position of Healthcare associated infections	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the report on the positive of Healthcare associated infections

Main Body

Purpose:

None

Background/Overview:

None

The Issue:

None

Next Steps:

None

Recommendations:

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

Appendix

Attachment:

Quarterly DIPC Report up to 30th April 2017 2.pdf

Report from the Director of Infection Prevention and Control to the Weekly Executive Board
January to April 2017

Performance targets

Indicator	End of year target	End of year performance 1st April 2016 – 31st march 2017	April 2017	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**2**	0	
C.difficile (trust assigned)	21	**32**	0	7 avoidable and 25 unavoidable cases
MSSA bacteraemia (post admission)	12	**13**	2	Local target – 15/16 outturn
E.coli bacteraemia (post admission)	29	**48**	0	Local target – 15/16 outturn
MRSA screening (electives)	95%	**95.2%**	95.1%	March validated
Central line associated blood stream infections (Rate per 1000 cvc days)	1	**0.43**	Awaiting data	Rolling 12 months
ANTT Competency assessments (doctors)	95%	**79%**	79%	Significant improvement
ANTT Competency assessments (nursing and AHP)	95%	**88%**	89%	Significant improvement
Hand hygiene	95%	**98.9%**	98.4%	

Quality Indicators

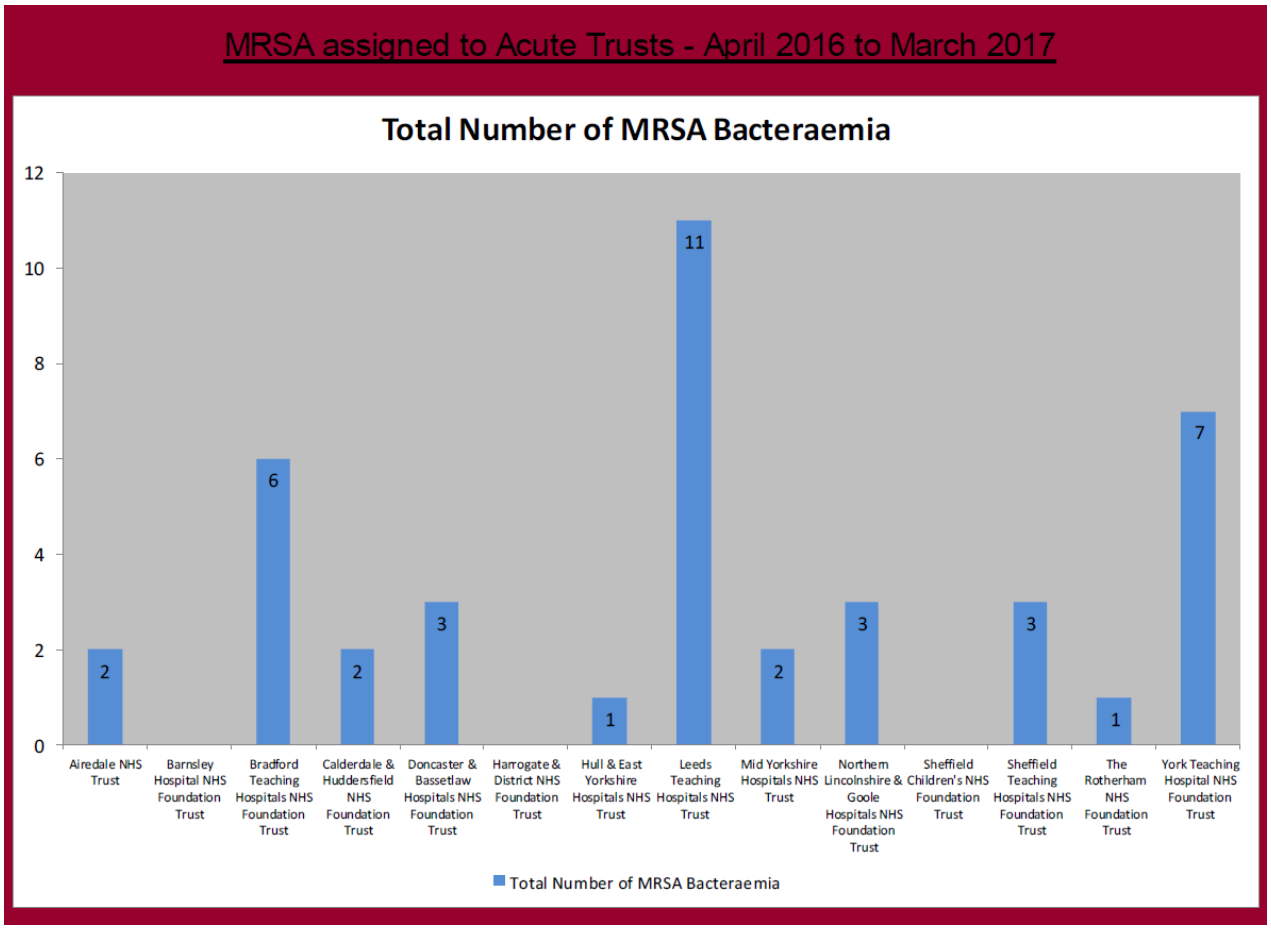
Indicator	Agreed target	End of year performance 1st April2016 – 31st march 2017	April 2016	Comments
MRSA screening (emergency)	**95%**	**89%**	89%	March validated data
Isolation breaches	**Non set**	**267**	18	49 fewer isolation breaches than previous year.
Cleanliness		**97%**	97%	

MRSA bacteraemia:

To the end of March 2017, there have been **2** post admission cases **MRSA bacteraemia**: both classified as avoidable. The Objective for 2017/18 is 0.

Case 1:- A 69yr old gentleman was admitted during November, having been found by his neighbour on the floor. He was in a very unkempt state on arrival to hospital and had declined medical and social care input for many years. He had numerous pressure sores and skin lesions which were inflamed; he also had moisture lesions to both groins and was doubly incontinent. The patient became unwell 2 weeks after admission with pyrexia. There was no MRSA screening completed neither on admission nor on the subsequent transfer. The patient made a full recovery and has been discharged home with social care support.

Case 2:- A 62yr old gentleman was admitted in December following a large left sided cerebral infarct. He was transferred to ward 7C where stroke HDU had relocated due to the usual ward affected by Norovirus. Patient had a previous history of MRSA from 2004 and was also on long term antibiotics due to having a splenectomy. MRSA screening swabs of nose and groin taken on the ward but the sample was rejected as not labelled and this was not repeated by the ward. Chronic sinus and stoma sites not screened as per policy. Swab from inflamed abdominal sinus subsequently taken 10 days later confirming MRSA. Infection treated appropriately and colonisation suppression prescribed and completed. PEG sited in endoscopy under antimicrobial cover on 12.1.17 with no post procedure issues. Pyrexia prompted blood cultures to be taken later in February which confirmed a MRSA bacteraemia considered associated with a LRTI. Key areas for learning from the case included admission screening procedures and the correct collection and documentation of blood cultures.



MSSA bacteraemias: there have been 13 post-admission MSSA bacteraemia cases during 2016/17 against the internal target of 9. The internal objective for 2017/18 will be 9.
Of the 13 cases:-

The range of days from admission to positive blood culture is 4-77 days, with an average of 23.2 days and a median of 19 days.

- 5 hospital acquired pneumonia (including one in a neonate)
- 1 line infection (should be subject to community RCA)
- 1 cannula site related
- 2 where the patient was severely neutropenic (1 iatrogenic, 1 due to disease)
- 2 where the cause was not known

Suggested actions

1	Investigate possibility of HAP prevention bundle. Mouth care work already ongoing
2	Enhanced surveillance / make better use of data already captured / prospective case note review

MRSA - Hospital-Acquired Infections (HAIs):
There have been 27 acquisitions this year compared to 23 for the same time period last year, which is disappointing as prior to that there had been a year on year reduction since 2006/7 when we had 207 acquisitions.
Wards are informed of any HAIs that occur within their area and are asked to carry out a ward-led investigation; these are presented to the PSQBs. If more than one case occurs in a short period of time, an outbreak meeting may be held to identify any issues / concerns and formulate an action plan in order to reduce the risk of further acquisitions.

MRSA emergency screening:- The target of 95% has not been achieved this year. The divisions have been tasked to ensure that all patients are screened as per policy, this is being monitored via the HAI performance board.

Clostridium *difficile:* - The target/ceiling for 2016/17 was 21.

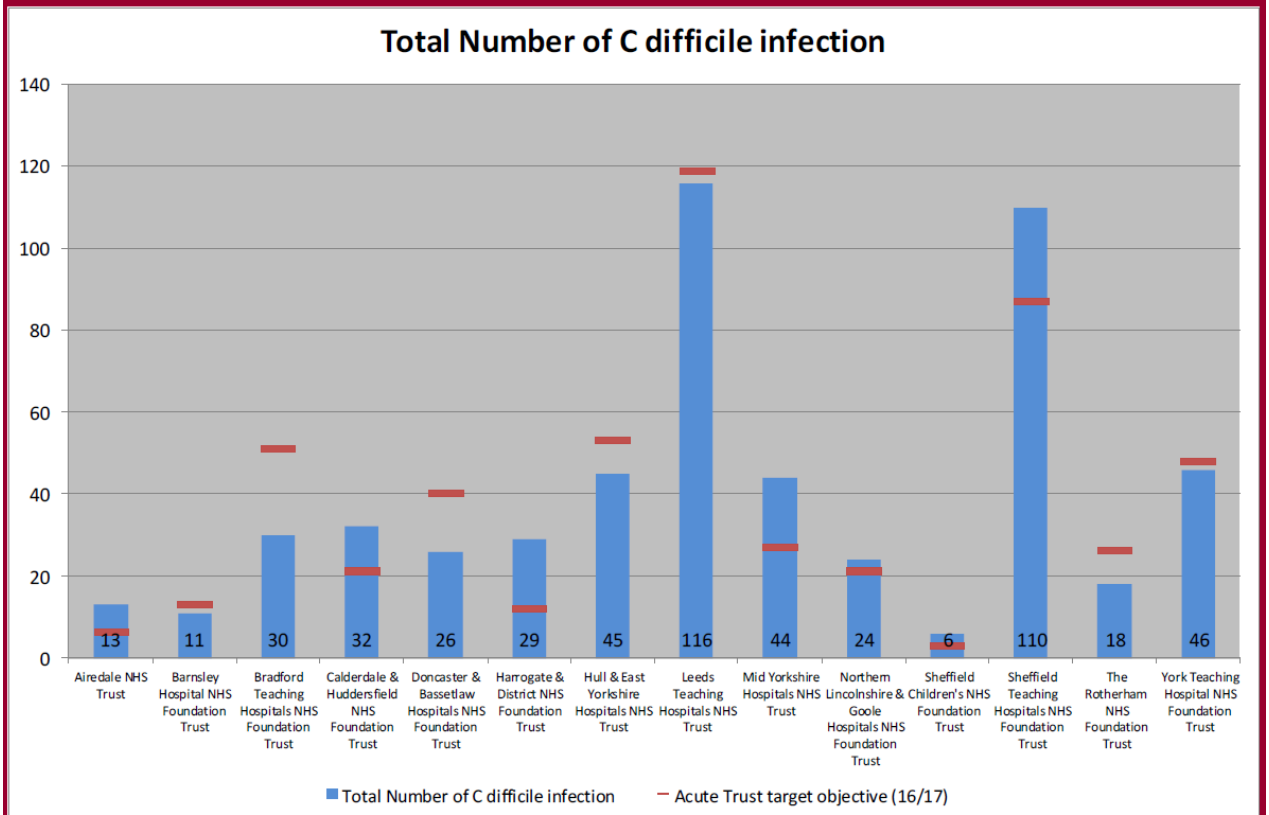
- There have been 32 post admission cases of *Clostridium difficile* to the end of March 2017.
- 7 have been agreed as **avoidable** and 25 have been agreed as **unavoidable**.

Key themes from the C-diff cases are:

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

Work is ongoing to improve compliance with the above issues with the development and roll out of the EPR.

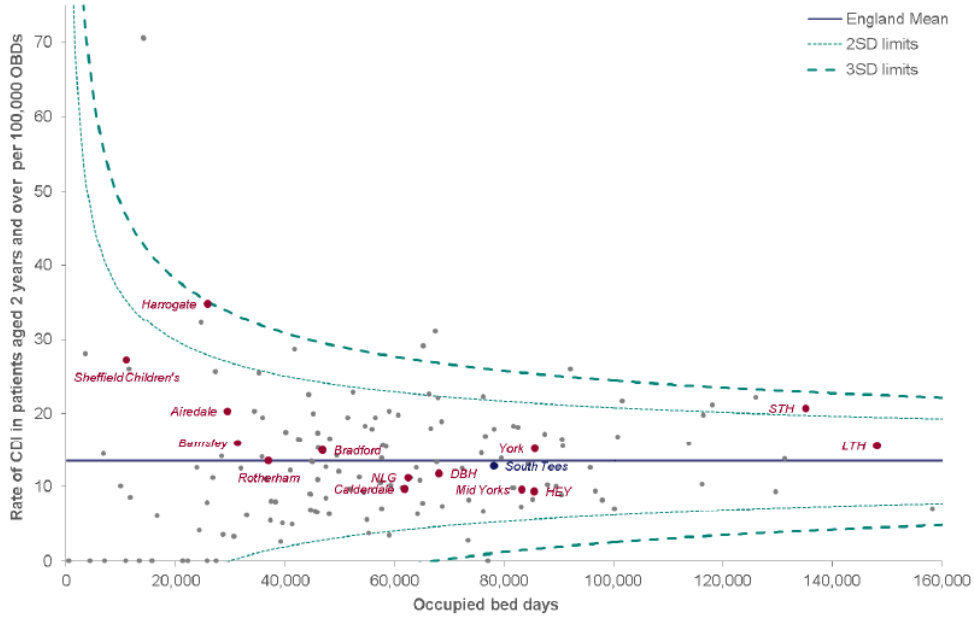
C Diff apportioned to Acute Trusts - April 2016 to March 2017



The most recent HCAI quarterly report shows that CHFT remains below the England average for the incidence of CDI:

Figure 2: Trust-apportioned CDI rates in patients over 2 years of age per 100,000 bed days for all England acute trusts from October to December 2016

Source: HCAI Mandatory Surveillance; Data points represent all acute NHS trusts in England. Trusts within Yorkshire and the Humber are highlighted in red; Dashed lines represent control limits at 2 and 3 standard deviations (SDs) around the national mean to allow identification of trusts with significantly outlying rates.



NLG = Northern Lincolnshire and Goole; DBH = Doncaster and Bassetlaw Hospitals; Mid Yorks = Mid Yorkshire Hospitals; HEY = Hull and East Yorkshire Hospitals; LTH = Leeds Teaching Hospitals; STH = Sheffield Teaching Hospitals

Escherichia-coli (E-coli) bacteraemias:
There have been 48 post-admission E-coli bacteraemia cases from April 2015 to March 2016 against the internal target of 25.
33 within Medical Division; 13 within Surgical Division; 2 within FSS Division.
The internal objective for 2017/18 will be 36.
Findings of a case note review of 25 cases showed: - The range of days from admission to positive blood culture is 2-117 days, with an average of 20.68 days and a median of 16 days. Of these:

- 5 CA-UTI
- 5 Cholangitis
- 1 UTI
- 5 Post-procedure
- 9 Other (liver abscess, endocarditis, mesenteric ischaemia, intra-abdominal abscess)

Suggestions for future potential work:

1	Enhanced prospective surveillance – retrospective case note reviews may miss more subtle nuances.
2	Investigate possibilities of EPR to identify patients with urinary catheters - ?targeted review of these patients
3	Establish complication rates of urological procedures and ERCP and compare to published complication rates.

Central Vascular Access Device related bacteraemias
The internally set target for CVAD related bacteraemias is 1 per 1000 CVAD line days. The end of year rate is 0.43 and below target.

Isolation Breaches:-
There have been 267 isolation breaches during the last 12 months compared to 316 breaches for the previous year.

- Isolation is included in the Action plan for 2016/17.
- Work is ongoing with the roll out of EPR to ensure all infection risk patients are identified on admission to prompt the need for isolating the patients.

Audits:
55 Quality improvement environmental audits have been carried out since the beginning of April 2016 to end of March 2017.
Compliance scores: <75% = red rating; 76% - 90% = amber rating; 91%+ = green rating.

- 26 of the areas achieved a green rating.
- 29 of the areas achieved an amber rating.

Action plans are produced by the Ward / Department following an audit in order to address any issues or concerns identified; a follow-up audit is completed for areas that only achieve a red rating.

Urinary catheter point prevalence audit:-
A total of 109 catheters were audited over a one week period in March 2017. At HRI, 65 catheters were audited, at CRH, 44 were audited and of these, 22 were within Surgery and Anaesthetics, 84 within Medicine and Elderly, and 3 within Family and Specialist Services (FSS) division. The figure for the total number of catheters is slightly higher than last year.

PVC prevalence audit:-
The audit covered all inpatient areas (41 wards) within Huddersfield Royal Infirmary and Calderdale Royal Hospital. The total number of cannulas audited was 251 compared to 237 in 2016, of these:

- 130 were within the medical division
- 101 were within the surgical division
- 20 were within the FSS division

Hand hygiene:-
Wards and departments continue to audit hand hygiene compliance and staff are encouraged to report actual practice so that any problems can be identified. A meeting has been held with GOJO our current alcohol gel supplier with the intention being that we pilot the use of an Observational APP which focuses on the WHO '5 moments' of hand hygiene and can we used on hand held devices. We aim to pilot this in the next few months on a couple of areas to ensure it meets the organisation's needs.

ANTT:-
Competency rate is now at 88% for nursing staff (previously 81.69%) and 79% (previously 73.35%) for Doctors; Trust overall 85.02% (previously 78.72%). Plans to improve performance includes:- ANTT competency matrix on all divisional PSQBs; additional support provided to ANTT assessors by the IPCNs; new assessors identified and trained on ward/departments are being supplied with their individual clinical area matrix so that they can target those staff who are not ANTT assess, this is proving to have a positive effect.

Outbreaks and Incidents

During January to March there have been several wards affected at CHFT with Norovirus as follows:-

WARDS CLOSED & BED DAYS LOST FIGURES					
MONTH	**HOSPITAL SITE**	**WARD**	**DAYS CLOSED**	**BAY/S CLOSED**	**BED DAYS LOST**
January	HRI	0	0	0	0
	CRH	0	0	0	0
February	HRI	11A	4	-	10
		11B	4	-	27
	CRH	6B	6	1	13
		6C	7	1	27
March	HRI	0	0	0	0
	CRH	C6B	2	-	7

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

Training: The IPCT continue to deliver both planned and ad hoc sessions to all levels of CHFT staff.
Newly introduce ‘beyond the basics’ training for Clinicians which is being evaluated positively.

IPCNs: The team have currently 1 WTE IPCNs vacant post as a result of one member of staff immigrating to Australia. Recruitment has been successful and the new recruit will join the team on the 3rd July. 2 members of the team successfully completed the Healthcare Associated Infection Prevention Control Course.

IPCNs continue to work both proactively and reactively, dealing with potential and actual outbreaks and situations as they arise; informing ward staff of results which require further action such as isolating the patient and maintaining enhanced precautions; carrying out planned training sessions and ad hoc sessions upon request; audit and surveillance; reviewing and updating IPC policies.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Vicky Thersby, Safeguarding Lead
Date: Thursday, 1st June 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: SAFEGUARDING ADULTS AND CHILDREN ANNUAL REPORT 2016/17 - his is Calderdale and Huddersfield Foundation Trusts (CHFT) Annual Safeguarding Adult and Children's Report. This reporting period covers April 2016 to March 2017. The report confirms the Trusts commitment and pledge to ensure the Safeguarding of Adults and Children remains a key organisational priority. The report has been written by the Head of Safeguarding in conjunction with the Named Nurses for Safeguarding Children and Adults, the Named Midwife, the Designated Nurse for Looked After Children (Calderdale) and the Domestic Abuse Lead.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Safeguarding Committee Meeting	
Governance Requirements: Governance, risk and compliance against statutory safeguarding responsibilities	
Sustainability Implications: None	

Executive Summary

Summary:

This is Calderdale and Huddersfield Foundation Trusts (CHFT) Annual Safeguarding Children and Adults Report. This reporting period covers April 2016 to March 2017.
The report will describe and inform CHFT Board of Directors of its commitment and pledge to ensure the Safeguarding of Children and Adults remains a key organisational priority.

The report provides an overview of activity within the organisation outlining key achievements and challenges and highlights on-going work and developments across the Trust, and provides assurance to the Trust Board that CHFT is fulfilling its statutory safeguarding responsibilities and working in partnership across both Calderdale and Kirklees.
The purpose of this report is to ensure that CHFT is informed of progress and developments both locally across the health and social care footprint, and nationally on issues relating to the children's and adults safeguarding agendas.
The report describes further plans and continued development for the forthcoming year, and highlights forthcoming legislation relating to the Deprivation of Liberty Safeguards (DOLS).
Safeguarding Children and Adults is an integral aspect of patient care within CHFT, and this requires services to work effectively together to prevent harm and intervene when harm, neglect, or abuse is suspected; and ensure systems and processes effectively support patients and staff.
The key element to safeguarding is partnership working and as such the safeguarding team continues to progress with CHFTs contribution to multi-agency working with its partners.

Main Body

Purpose:

Please see enclosed within body of report

Background/Overview:

Please see enclosed within body of report

The Issue:

Please see enclosed within body of report

Next Steps:

Please see enclosed within body of report

Recommendations:

The Board of Directors is asked to receive the annual report and to note the improvement plans for 2017/18

Appendix

Attachment:

Annual Safeguarding Report Trust Board June 2017 main report final version.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

ANNUAL SAFEGUARDING CHILDREN AND ADULTS REPORT 2016/17

1. FOREWORD

This is Calderdale and Huddersfield Foundation Trusts (CHFT) Annual Safeguarding Children and Adults Report. This reporting period covers April 2016 to March 2017.

The report will describe and inform CHFT Board of Directors and Non- Executive Directors of its commitment and pledge to ensure Safeguarding Children and Adults remains a key priority.

The report has been written by the Head of Safeguarding in conjunction with the Named Nurses for Safeguarding Children and Adults, the Named Midwife, the Designated Nurse for Children Looked After (Calderdale) and the Domestic Abuse Lead.

2. INTRODUCTION

The report provides an overview of activity within the organisation outlining key achievements and challenges and highlights on-going work and developments across the Trust, and provides assurance to the Trust Board that CHFT is fulfilling its statutory safeguarding responsibities and working in partnership across both Calderdale and Kirklees.

The purpose of this report is to ensure that CHFT is informed of progress and developments both locally across the health and social care footprint, and nationally on issues relating to the children's and adults safeguarding agendas.

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Safeguarding Children and Adults is an integral aspect of patient care within CHFT, and this requires services to work effectively together to prevent harm and intervene when harm, neglect, or abuse is suspected; and ensure systems and processes effectively support patients and staff.

The key element to safeguarding is partnership working and as such the safeguarding team continues to progress with CHFTs contribution to multi-agency working with its partners.

3. GOVERNANCE ARRANGEMENTS

The Executive Lead for Safeguarding Children and Adults is the Chief Nurse. The Chief Nurse is responsible for ensuring that there are robust and effective arrangements for safeguarding adults and children within CHFT.

The Head of Safeguarding is responsible for key safeguarding staff within the Trust and reports directly to the Deputy Chief Nurse. The Head of Safeguarding represents CHFT at Local Safeguarding Adults and Children's Boards, and provides strategic support and direction to the governance and safeguarding arrangements for CHFT.

Named and Designated Safeguarding Nurses attend the sub-groups of the local Safeguarding Boards and contribute to multi-agency collaboration and partnership working. The Safeguarding Team links closely with other key departments such as Risk and Governance, Human Resources, and also Patient Safety and Quality Boards within Divisions.

The Safeguarding Committee reports directly to the Quality Committee and provides quarterly updates for the meeting. This has raised the profile of safeguarding within the Trust and ensures lines of accountability are aligned directly with the Trust Board.

Operationally the Safeguarding Committee has in place 2 sub-groups, Learning and Audit and Training and Policy Subgroup. Safeguarding Subgroups provide a forum to bring together key senior professional and operational managers across all Divisions. The individual Groups report directly to the Safeguarding Committee and support the Chief Nurse in discharging their responsibilities in relation to safeguarding and strengthening accountability.

Working Together to Safeguard Children 2015 states that all health organisations providing services for children should identify a Named Doctor and a Named Nurse (and a Named Midwife if maternity services are provided) for Safeguarding. It also outlines the need for a person with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation to be a member of the Local Safeguarding Children's Boards. There are no vacant statutory posts within CHFT.

In addition CHFT hosts two Designated Doctors for Safeguarding Children, two Designated Doctors for Looked After Children and a Designated and Named Nurse for Looked After Children for Calderdale. The Designated Nurse for Kirklees is employed by Locala. These roles are directly commissioned through the Clinical Commissioning Group (CCG).

There is a Named Doctor and Named Nurses for Safeguarding Children, and a Named Nurse and Specialist Advisor for Safeguarding Adults. Both the Safeguarding and the Looked After Children Team are supported by administrative roles.

The safeguarding team play a pivotal role in supporting colleagues in carrying out their safeguarding responsibilities. Work has continued with other partner agencies across Kirklees and Calderdale to ensure CHFT is discharging its statutory responsibilities.

4. ADULT SAFEGUARDING

Adult Safeguarding has been a statutory requirement since April 2015 following the introduction of the Care Act 2014, putting Adult Safeguarding Boards on a statutory footing, making safeguarding enquiries a corporate duty for councils, and making Safeguarding Adult Reviews (SARS) mandatory when certain triggering situations arise. Safeguarding Adults governance arrangements continue to be strengthened.

Safeguarding concerns and referrals are encouraged to be recorded on Datix to ensure correct multi-agency responses and procedures are followed that link in with Trust Policies and Procedures for investigation and recording purposes.

The Trust reports and records the number of safeguarding concerns raised and the referrals made into the multi-agency safeguarding procedures for North, York and West Yorkshire. The logging of concerns (that do not meet the threshold for reporting into the safeguarding procedures) ensures a true picture is captured of incidents with a safeguarding dimension. The numbers of referrals made are the incidents that do meet the threshold for reporting.

All Trust Datix incidents have a mandatory field to be completed when reporting incidents for staff to consider whether the incident is either a safeguarding concern or is a safeguarding referral. The safeguarding referrals are further analysed and discussed at the Safeguarding Committee meeting and broken down further to review whether the incident relates to care and treatment within the Trust or not.

Further work is anticipated to strengthen reporting on outcomes and associated actions and lessons learnt both within and across divisions.

5. MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY SAFEGUARDS

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009).The legal framework provided by the MCA 2005 is supported by the MCA Code of Practice, which provides guidance and information about how the Act works in practice.

The Code has statutory force which means staff who work with and/or care for adults who may lack capacity to make particular decisions have a legal duty to have regard to relevant guidance in the Code.

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

The specific aims for the work are to:

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

A significant number of urgent authorisations lapse on a month on month basis, particularly in relation to one local authority. This occurs when the Local Authority do not complete all its assessments within 14 days of the urgent authorisation being applied, because greater priority is given to other applications. In these cases the Safeguarding Team continues to monitor the patient to ensure that the deprivation is still valid, the patient still lacks capacity, all restrictions in place remain least restrictive whilst ensuring the patient remains safe on the ward, and that there are no objections to the DoL.

5.1 Historical Data

Year	Number of Urgent DoLS	Number Standard DoLS	Number Declined	Average p/month
2014	11	5	0	0.9
2015	194	33	11	16
2016 – 2017	369	50	212	31

These figures suggest that there is a positive level of awareness and recognition. MCA and DoLS training has been approved as an essential skill for staff.

5.2 Further legal updates

The Law Commission's report on Deprivation of Liberty and a Draft Bill was published on the 13th March 2017. The report recommends that the DoLS should be replaced with a new scheme called the Liberty Protection Safeguards which would change the process for authorising a DoL in hospital.

Whilst this has been proposed any significant changes are not anticipated for at least another 2 years, and CHFT will continue as per the existing protocol and policy. The Board will be further updated as to progress through Parliament.

From the 3rd April 2017 the Policing and Crime Act has removed DOLS from being classed as state detention (as part of an amendment to Coroners and Justice Act 2009).

This removes the need for deaths (whilst a DOLS is in place) to be reported to the coroner; notwithstanding normal procedural requirements. However if someone has a DoLS which is not yet authorised, has not been applied for or it has lapsed it is still classed as a DoL.

Data around DoLS is now captured monthly and reports are shared at the Safeguarding Committee meeting. The CQC are notified of all DoLS authorisations and outcomes. This is in line with the requirements of the legislation. All patients who are subject to an urgent or standard authorisation are monitored by the Safeguarding Team.

6. SAFEGUARDING CHILDREN

Whilst historically Safeguarding Children policy and practice has been more established within all organisations following the introduction of the Children's Act in 1989/2004, child protection continues to have a high profile on a national basis and CHFT Safeguarding Team work closely with the Safeguarding Children's Boards, Children's Services and the Clinical Commissioning Groups Designated Professionals for Safeguarding Children to ensure that new processes are clearly implemented ensuring that staff are made aware of changes at the earliest opportunity.

The way data is now captured and presented has changed. All incidents that relate to children are during the year 2016-17 are now reported onto Datix (this data does not include the numbers of referrals made to Children's Social Care).

Further information is collected at the request of the Safeguarding Children Boards and shared on a quarterly basis. This information provided by CHFT informs the Safeguarding Children Boards and their subgroups of activity relating to attendances of children and young people in the Emergency Department. This data supports and informs partners and contributes to multi-agency working and safeguarding of vulnerable children and young people.

This data shows an increase in reporting of incidents. Further analysis regarding themes, patterns and trends will be reported on a quarterly basis to the Safeguarding Committee Meeting.

Reported on Datix	2016 - 2017
Child Safeguarding Concerns	55
Child Safeguarding Referrals	22
TOTAL	77

This data reflects a new data capture in relation to incidents.

6.1 Female Genital Mutilation

Female Genital Mutilation (FGM) encompasses “All procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs, for non-therapeutic reasons.” FGM can have far reaching consequences for the physical, psychological and sexual health of those women and girls affected. It is a violation of their human rights, a form of child abuse and is illegal in the UK. With increasing international migration, the UK has become host to a large number of women affected by FGM. Research suggest 279,500 women and girls in the UK have undergone FGM and a further 22,000 girls are at risk of the procedure.

CHFT has an FGM guideline developed in 2016 which includes a flow chart to support staff with enquiring and assessing the levels of risk in relation to FGM.

Statutory FGM reporting is carried out and the numbers of cases are also reported internally through the Safeguarding Committee Meeting. From January 2017 FGM training became an essential skill for staff working in FSS, the Emergency Department, the Safeguarding Team, Health Visitors and CASH services. This training is also delivered in the levels of Safeguarding training for Children and Adults.

6.2 Child Sexual Exploitation (CSE)

From February 2017 there is a revised statutory definition of CSE.

‘CSE is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.’

The Safeguarding Team has an ongoing CSE action plan and part of this is developing a CSE Risk assessment tool for the use in the Emergency Department. The Safeguarding Team contributes to the CSE Hub within Calderdale and CHFT’s Safeguarding Children Policy includes specific reference to CSE. Resources are shared through the Trust Safeguarding Champions Network. The Team have delivered bespoke CSE workshops and there are plans to deliver further workshops.

6.3 Ofsted Inspection - Kirklees Children’s Social Care

Ofsted inspected Kirklees Children’s Social Care in September and October 2016. They focused on local services for children in need of help and protection, looked after children and care leavers. The Independent Safeguarding Children Board was also inspected. An overall assessment of inadequate was made. Adoption performance and the experience and progress of care leavers were assessed as requiring improvement.

Kirklees Council are working towards remodelling the whole service, changing working practices, and management oversight. Some good work was highlighted (e.g.) strong support for adopted children, and a good response to CSE.

The report was sent to the Secretary of State as it had been categorised as showing Systemic Failure. A commissioner has been appointed (January -March 2017)the consideration of the Commissioners findings will be available in due course, however improvement work continues.

A monitoring visit took place in March where a number of positives and also confirmed pre-identified areas already known for improvement. The next monitoring visit from Ofsted will take place in June 2017.

The Child Protection Information Sharing System is planned for implementation in December 2017 along with the introduction of a new case management system for children's social care records.

All partner agencies are required to work with Kirklees Social Care and the Safeguarding Board to support in improving services for Children and Young People.

6.3.1 Key points and recommendations within the report that may specifically impact on CHFT

- Ensure that the responses to pre-birth assessments are timely and robust. Pre-birth tracking meetings are not yet demonstrating a sufficient impact.
- There were concerns relating to young people's risk taking behaviours that has not been recognised as indicators of CSE and referred to a dedicated team.
- Multi-agency partnership working is poor. Partner agencies have not been sufficiently involved in the Multi-agency Safeguarding Hub (MASH) information sharing and decision making, and that thresholds are not consistently applied
- The strategic response to CSE is good, although potential risk factors are not always recognised by social workers and other professionals
- The Safeguarding Board have not been aware of inadequacies or challenged the effectiveness of safeguarding in the local area
- Strategy meetings do not always have sufficient contributions from other agencies and fail to plan to take actions together

6.3.2 The Safeguarding Children's Board

The Board was judged to be inadequate and the key points are detailed below:

- The frequency and impact of its auditing activities have not responded sufficiently to its widespread issues in children's services.
- The Board has not progressed SCR's and actions in a timely manner to improve practice
- The CDOP has also been delayed in analysing all child deaths
- Performance data the Board receives is poor and significant delays in receiving partners' data. There has been a lack of tracked and analysed data that can identify emerging themes and trends over time.

- There is inconsistent membership and attendance in work streams which has impacted on progress
- There is insufficient multi-agency trainers
- There are issues about all professionals in agencies recognising indicators and risk factors relating to CSE

The following recommendations were made to the board:

- Ensuring all agencies participate in the workings of the Board
- Secure timely meaningful multi-agency data with analysis to ensure effective oversight of safeguarding practice and service effectiveness
- Ensure all agencies recognise the indicators and risk factors relating to child sexual exploitation
- Ensuring a full programme of audit activity
- Effective implementation of the revised continuum of need

CHFT continues to support and attend the Safeguarding Children's Board and provides representation and membership to all of its subgroups to support in delivering the Safeguarding Children's Boards action plan. CHFT is and has been committed in its partnership working to:

- Provide timely feedback of action plans and reports to KSCB ensuring all actions and plans are SMART
- Ensure data requests are feedback to KSCB. Provide meaningful data and challenge to the work stream where data is not significant or robust for the Board
- Provide support to the Safeguarding Board in participating in multi-agency audits
- Ensuring the revised CSE strategy is fully implemented within CHFT and continue to raise awareness for frontline professionals
- Ensure all children who are recognised at risk of CSE are flagged on the new EPR system
- Ensure the section 11 audit completed in 2015 is reviewed and updated as requested by the Safeguarding Children's Board

7. DOMESTIC ABUSE

CHFT has hosted a Domestic Abuse Lead and a Domestic Abuse Practitioner. This service is commissioned by Calderdale Clinical Commissioning Group for one year only; based out of the Domestic Abuse Hub (DA Hub) in Calderdale. It has been operational since January 2016 and the DA Health Service has been part of CHFT since May 2016. Commissioning of this service in 2017/18 is at risk, discussions with CCG and local authority are in place to agree next steps.

The service provides health information from all multi-agency partners in order to manage high and medium risk incidents in cases of Domestic Abuse. The health information is on behalf of all health agencies in Calderdale and actions are then shared out to the

appropriate health professionals involved in order to reduce duplication, allow a more coordinated approach and early identification of any unmet health needs.

The DA Health service in the last twelve months has developed:

- A DA pathway implementation across all of CHFT and other health agencies
- A Domestic Abuse Policy that includes the recommendations from Domestic Homicide Reviews and introduced new procedures for employees and up to date legislation changes.
- A service to ensure seamless response to Domestic Abuse across both authorities and all health agencies ensuring clear and relevant information sharing in order to manage risk.
- Training review and strategy to ensure trust wide adherence to NICE guidelines.

Number of CHFT Referrals	2015 -2016	2016 - 2017
To MARAC	27	37 (Kirklees) 60 (Calderdale)
TOTAL	27	97

By Department	2015 -2016	2016 - 2017
Emergency Department	19	48
Maternity	8	9
Community		3

This data is for CHFT referrals only and does not include referrals made by GP's, SWYFT or LOCALA. Huddersfield Royal Infirmary referrals data has only been collected since May 2016.

There is a dedicated worker from Pennine Domestic Violence Group who works into HRI Emergency Department providing twice weekly drop in sessions to collect referrals, support staff and raise the awareness of CHFT DA pathway and referral system.

The data evidences that as awareness is raised there is an increase in the identification of DA and referrals that are made. It is anticipated these figures will continue to increase as awareness improves across all health providers.

Number of Datix Alerts	2014-2015	2015-2016	2016-2017
Domestic Abuse/violence	4	6	22

8. PREVENT

CONTEST, is the UK national counter-terrorism strategy, and one of the elements of it is PREVENT, which aims to stop people becoming terrorists or supporting terrorism. The NHS is a key strategic partner in the PREVENT work stream, as it is recognised that healthcare professionals may meet and treat people who are vulnerable to radicalisation. This duty is incorporated into the NHS contract.

CHFT's PREVENT Policy describes how the PREVENT Strategy is implemented in CHFT. PREVENT has 3 national objectives:

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

Representation is provided by the Trust at appropriate external meetings including the regional PREVENT leads meeting and district level CHANNEL meetings, by the Resilience Manager.

CHANNEL is a multi-agency group, which meets on an as required basis, with the purpose of undertaking risk assessments of PREVENT referrals and then developing support programs to divert those identified away from potential radicalisation where appropriate.

CHFT has made significant progress in working towards its responsibilities towards the PREVENT agenda. CHFT is considered an exemplar site in relation to the number of staff trained. This has been confirmed by the NHS Regional Prevent Coordinator.

Further work has been carried out this year in line with the Prevent Competencies Framework. There are now 2 levels of training.

- Level 1Prevent training is part of the Level 1 Adult Safeguarding Training package
- Level 2 is the Health wrap training.

All staff are required to either complete this or attend a one off face to face Health Wrap training session.

The Trust has currently trained 4,284 to date and there are 1,601 people left to train.

PREVENT figures are monitored monthly at the safeguarding committee meeting and quarterly updates are submitted to the Regional Prevent Coordinator for Health (NHS England).

9. TRAINING

A significant piece of work has taken place to review all staff groups within CHFT this year that require mandatory safeguarding children and adults training. This was completed in Q1 and re-reviewed in Q3. This involved ensuring that all staff groups were reviewed in line with the Intercollegiate Document for Safeguarding Children and the Draft Intercollegiate Document for Safeguarding Adults.

These new figures and compliance reflect the increased numbers of staff that are required to complete a higher level of training.

MCA and DoLS is currently delivered as part of levels 2 and 3 Safeguarding Adults training however this is now planned as an essential skills framework and will be reported separately from Quarter 1 (2017-2018).

Female Genital Mutilation (FGM) is now an essential skill for FFS, Accident and Emergency, Safeguarding Team, Health Visiting and CASH services. This commenced in January 2017.

9.1 Training compliance 2016/17

Calderdale and Huddersfield NHS — Safeguarding Compliance — compassionate care

		Target	Trust	Compliance: Surgical	Medical	Families and Specialist Services	Community	Estates	Corporate	THIS
Training	% of Staff Trained - Level 1 (Only)	100%	87.37%	84.67%	71.72%	90.51%	89.23%	87.73%	89.35%	95.43%
	% of Staff Trained - Level 2 (Adults)	100%	74.54%	75.49%	72.23%	75.26%	80.28%	90.00%	50.00%	100.00%
	% of Staff Trained - Level 2 (Children)	100%	75.39%	75.90%	72.06%	78.85%	80.69%	90.00%	50.00%	100.00%
	% of Staff Trained - Level 3 (Adults)	100%	39.42%	20.62%	30.88%	16.67%	64.60%	-	50.00%	-
	% of Staff Trained - Level 3 (Children)	100%	61.72%	55.56%	19.57%	61.15%	78.83%	-	42.86%	-
	% of Staff Trained - FGM	100%	48.82%	-	32.31%	54.27%	46.85%	-	33.33%	-
	% of Staff Trained - Prevent	100%	72.82%	70.28%	60.64%	84.77%	83.85%	49.62%	79.88%	87.74%

Level 1 training figures have increased from 81% to 87% this year; an increase of 6%. This is delivered by an eLearning package.

Level 2 has increased from 60% to 74% (adults) and from 63 % to 75% (children), an increase of 14% and 12% respectively. This is now delivered by a new eLearning package launched in February 2016.

Level 3 Adults – was a new data capture since the allocation of Level 3 to particular staff groups, and continues to increase from 13% to 39% (26% increase). This training is delivered face to face.

Level 3 Children has increased by 28% from 33% to 61%. This training is delivered face to face.

Prevent compliance figures have increased by 10% from 62% to 72%. This training has been delivered face to face this past year.

FGM is now at 48%. The eLearning package became available in January 2017

10. SERIOUS CASE REVIEWS (SCR), SERIOUS ADULT REVIEWS (SAR) AND DOMESTIC HOMICIDE REVIEWS (DHR)

Under Regulation 5 of The Children Act (2004), The Care Act (2014), and under Section 9 of the Domestic Violence and Victims Act (2004), statutory duties apply in cases of Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews.

The purposes of reviews enable Local Safeguarding Boards and Community Partnerships to fulfil their obligations under each of these Acts and for us as a partner agency to contribute to the carrying out of a review, identify any lessons to be learned and apply these lessons to future practice.

Each Act defines a slightly different obligation and review of a case in relation to adults, children and domestic homicides.

Key themes in each review enable services to look at establishing what lessons to be learned about how professionals/ agencies (individually and together), work to safeguard children and/or adults at risk; review the effectiveness of local safeguarding procedures (multi-agency and single agency) and inform and improve local inter-agency practice.

The Safeguarding Team have fulfilled partnership requests for information and contributed to a number of reviews that have been published and are ongoing.

Review	**2016-17**
Serious Case / Learning Lessons Reviews	6
Serious Adult Review	1
Domestic Homicide Review	2

The safeguarding committee is developing its outcome and lessons learned dashboards to ensure shared learning is integral to divisional PSQBs.

11. AUDIT

A number of audits have taken place this last year. These are presented to the Safeguarding Committee for discussion and action.

- Section 11 (Children's Act 2004) audits are a statutory requirement for CHFT to undertake. CHFT has completed its Section 11 audit for Calderdale Safeguarding Children's Board and contributed and been involved in the Section 11 Challenge event.
- The Trust wide MCA and DoLS audit provides the Board with assurance that there is a marked improvement in Trust wide awareness with an increase in the number of applications year on year.
- A comprehensive audit schedule is presented at the Safeguarding Committee on a monthly basis and audits presented at the training and audit subgroup

- CHFT completed the CCG Annual Safeguarding Adults Standards self-assessment audit tool, which is a newly introduced audit too from the CCG, this will be monitored by the Safeguarding Committee

12. CQC INSPECTIONS

The Care Quality Commission (CQC) Trust wide inspection in March 2016 resulted in 4 must do actions for the safeguarding team to lead on. All these actions are rated completed and sustained with ongoing recognition and requirement for continued development and embedding.

a) The Trust must strengthen its knowledge and training in relation to the MCA and DoLS.
b) The service must ensure staff have an understanding of Gillick Competence.
c) The Trust must ensure that staff have undertaken safeguarding training at the appropriate level for their role.
d) The service must ensure all relevant staff are aware of Female Genital Mutilation (FGM) and the reporting processes for this.

12.1 Children's and Children Looked After CQC Inspection Calderdale.

The review took place on 25 - 29 April 2016 and was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.
The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

Individual action plans are monitored by the CCG through the Safeguarding Committee meeting attended by the CCG Designated Nurse for Safeguarding Children. Assurance and progress on action plans through clinical audit, review of training needs analysis and the impact of the effectiveness of training

Action plans are being monitored and reviewed at the monthly Safeguarding Committee Meeting and have been reviewed at the Quality Committee

A review of Kirklees Children and Children Looked After CQC Inspection has not been completed.

13. KEY ACHIEVEMENTS FROM LAST YEAR'S REPORT

Considerable progress has been made since the last annual report to continue embedding safeguarding collectively across the partnership, and internally.

a) The Safeguarding Children Policy and the Domestic Abuse Policy has been reviewed and updated
b) The Managing Allegations of Abuse against Staff Policy has been updated to strengthens systems and structures of reporting
c) Further work regarding data collection and capturing incidents has been ongoing throughout the year with the team having Datix training. This has included reporting outcomes of safeguarding investigations onto the Datix system in relation to Adult concerns and referrals.
d) Sharing key Safeguarding messages with staff is though the Safeguarding Newsletter. The team have now developed a monthly notice board to send out with key messages.
e) The Safeguarding Team are now co-located with Adult Social Care and the Discharge Team to promote collaborative working and an open and transparent culture.
f) The team has worked with the Volunteers department to ensure Volunteers are compliant with Safeguarding Training every 3 years.
g) A Trust Wide Audit relating to DoLS has identified improved picture from 2015-2016 audit.
h) Completion of MCA DoLS as part of essential skills training; currently MCA DoLS training is within level 2 and level 3 safeguarding adults.
i) Attendance of Matrons at Multi-agency MCA DoLS training in January 2017
j) Completion of the staff review in line with the Prevent Competencies Framework and utilising eLearning. Historically all Prevent training was face to face. This will now be recorded in line with the Prevent Competencies Framework.
k) CHFT Safeguarding Team has contributed to Safeguarding Week in 2016 for Calderdale by delivering training on 'The Impact of Domestic Abuse' and 'Coercive and Controlling Behaviour' jointly with the Police; 'Safeguarding and Human Rights Awareness Raising' – focus on safeguarding and human rights'; Neglect – a day in the life of a child,' and 'Patient Stories – improving the journey between services.'
l) FGM eLearning is now an essential skill for targeted groups of staff.
m) The Safeguarding Team have supported CASH services in developing an under 18 safeguarding proforma. This proforma has been utilised in other areas of the Trust
n) Appraisal documentation has been amended so staff can include the number of hours safeguarding training undertaken
o) A Local data sharing protocol has been developed with partners for sharing information with Calderdale safeguarding Children Board
p) FSS staff now have mandatory Athena Safeguarding Training from the 24th March
q) CQC improvement plans progressed in line with trust inspection and CCG inspection.

14 IMPROVEMENT PLANS FOR 2017/18

a) Priorities for 2017 will include continued compliance with The Mental Health Act (1983). This includes: securing honorary contracts to enable Mental Health Liaison Psychiatrists to act as Responsible Clinicians for CHFT detained patients, implementing the Mental Health Act Joint Protocol for CHFT/SWYFT and developing systems and processes to capture patients who have been sectioned under the MHA 1983 on a centralised database with the support of SWYFT and Mental Health teams.
b) To re-launch the training for Duty Matrons and Site Commanders on the receipt and scrutiny of Mental Health Act papers, and understanding the role of security and use of restrictive interventions to enable appropriate detention of patients under the Act.
c) To continue work embedding knowledge and skills in all areas regarding MCA and DoLS
d) Ensuring scrutiny of all referrals made by CHFT staff to Children's Social Care
e) Continued work and challenge to ensure robust Children and Adults data collection
f) Development and implementation of a CSE risk assessment in the Emergency Department and work towards roll out throughout the trust.
g) Further work and embedding of monitoring of training for junior medical staff
h) Further work is ongoing to embed Safeguarding Supervision Trust wide. This work is planned for completion in Q1 (2017-18) to coincide with an updated Supervision Policy. The safeguarding Team working alongside the safeguarding champions who will take an active part in ensuring wards & departments are developing processes to enable safeguarding supervision to take place.
i) To continue increasing the capture of adult safeguarding referrals and concerns via the Datix reporting system when these relate to other providers
j) To achieve more timely outcomes relating to referrals through closer collaboration with Social Services colleagues, both referrals relating to CHFT care to ensure that learning is shared as widely as possible and development needs can be followed up through the safeguarding subgroups and referrals relating to the care of other providers to obtain feedback on the appropriateness of our referrals
k) To clarify the interface and associated local agreement between CHFT internal processes for orange / red incidents and formal adult safeguarding processes as led by Calderdale and Kirklees Social Care.
l) Safeguarding Champions have been identified throughout the organisation and part of this role will require them to be trained to facilitate safeguarding supervision in line with their staff requirements to help improve compliance. Training has been delivered in January and March and 42 Champions are trained to date with a further date arranged for 23.5.17.
m) Update of the Adult Safeguarding Policy in Quarter 1 and development of a separate MCA DoLS Policy
n) Development of a Safeguarding Dashboard that is aligned to the Safeguarding Strategy
o) Further audits planned are the Adult Safeguarding Policy audit and another MCA DoLS Trust wide audit in relation to Adults.
p) Further planned involvement in Safeguarding Week in October 2017
q) The FGM guideline is being reviewed and updated to include Department of Health recommendations regarding risk assessments.

r) Development of a CSE Risk Assessment for the Emergency Department and completion of the CSE action plan
s) Active support to Kirklees children's services improvement plan
t) To ensure that following go live with EPR the system continues to support statutory and regulatory compliance.
u) To review the risk associated if the DV Hub funding is not continued.

15 CONCLUSION

This Annual Report provides an insight into CHFT progress and future developments and plans for 2017-2018. It provides assurance and overview to the Trust Board that Safeguarding remains a key priority and continued work is ongoing to ensure it is embedded in all aspects of patient care.

16 RECOMMENDATIONS

The board is asked to approve the report and the specific improvement plans for 2017/18

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st June 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: HOSPITAL PHARMACY SPECIALS (HPS) ANNUAL REPORT - The Board is asked to receive and approve the HPS Annual Report	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Financial sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and approve the HPS Annual Report

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the HPS Annual Report

Appendix

Attachment:

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Annual Report FY2017
Huddersfield Pharmacy Specials

1. Introduction

Huddersfield Pharmacy Specials (HPS), also referred to as the Pharmacy Manufacturing Unit (PMU), is a division of Calderdale & Huddersfield NHS Foundation Trust. HPS is a manufacturer of unlicensed sterile and non-sterile products known as Specials. Additionally, HPS provides a medicines over-labelling and pre-packing service to hospitals and private providers, both contract manufacturing and research and development and clinical trial supplies for third party organisations. We present below key achievements and the divisions operation and financial performance during the financial year FY17 (1st April 2016 to 31st March 2017).

2. Structure, Governance and Management

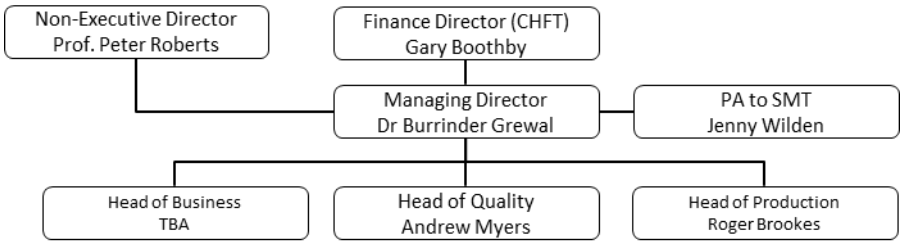
HPS trades from purpose built facilities located at Acre Mill (School Street West), Huddersfield. The unit operates under the authority and licences issued by The Medicines and Healthcare Products Regulatory Agency (MHRA), the UK medicines regulator. The licenses the unit have which permit it to operate, manufacture and provide services are listed below:

Table 1: HPS licenses and certifications

Licence/Certificate	Licence/certificate no.	Issue Date	Expiry Date
Manufacturers "Specials" Licence	MS 19055 version 15	29 November 2001	Ongoing
Wholesaler Distribution Licence WDA(H)	19055	21 July 2014	Ongoing
Investigational Medicinal Products MIA(IMP)	MIA(IMP) 19055, version 16	12 December 2005	Ongoing
United Kingdom Controlled Drug Licence	345102	14 March 2017	13 March 2018
Authorisation to receive duty free spirits	DFS/020537	23 December 2016	Ongoing
Industrial denatured alcohol (IDA)	DNA/138430	11 July 2016	Ongoing
GDP Compliance of a Wholesale Distributor	UK WDA (H) 19055 Insp GDP 19055/431097-0008	27 June 2016	Ongoing
Certificate of GMP Compliance of a Manufacturer UK MIA (IMP)	UK MIA (IMP) 19055 Insp GMP/IMP 19055/431097-0007	28 June 2016	Ongoing

On a day to day basis, HPS is run by a Senior Management team headed by a Managing Director who in turn reports into the Trust's Finance Director; the Senior Management Team meets at least once a week. The board of HPS consists of the Senior Management Team, the Trust Finance Director (also the board chair) and a Trust Non-Executive Director. Board meetings are held every two months although management and financial reports are produced on a monthly basis and the Managing Director and Trust Finance Director meet monthly. The current board governance structure is given below and the names of those in post (as at 31st March 2017).

Figure 1: HPS Governance structure



3. Workforce

Prior to FY17, HPS appointed Dr Burrinder Grewal as its new Managing Director (start date 21st March 2016) and during the year appointed Roger Brookes (start date 1st November 2016) as the units new Head of Production. Andrew Myers continued to be Head of Quality and at the time of writing the unit was looking to recruit to the position of Head of Sales and Customer Services; together these four positions form the Senior Management team at commencement of FY18.

Of significant note, HPS during FY17 completed the staffing of its New Product Development team, which currently consists of 3.6 permanent WTE's and 1 WTE on a fixed term contract (recruited to help deliver a significant contract won for research and development activities).

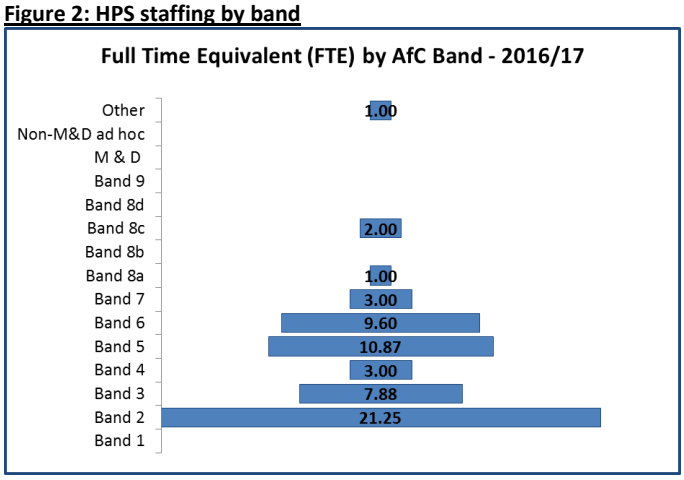
Staff in post at the commencement and end of FY17 numbered 56 and 64 respectively. On a whole time equivalent basis, HPS employed 59.60 WTE at the beginning of FY18 (an increase of 8.15 WTE's during FY17).

Table2: HPS staff numbers

	End of	
	FY16	FY17
No. staff in post (SIP)	56	64
No. WTE	51.45	59.60
Annual staff turnover rate	4.16%	5.38%

Overall, the staffing structure remained largely unchanged from previous years with manufacturing and production being delivered through teams working in the distinct operational areas of Sterile, Non-Sterile and Tablet Packing; staff in these areas were supported by teams from Quality (including new product development), Customer Services, warehousing and cleaning.

Figure 2: HPS staffing by band



Appraisals and mandatory training: At the commencement of FY18, HPS reported 100% completion of staff appraisals covering FY17. Mandatory training completion rates ranged from 75.41% to 93.44% across the 10 training requirements.

Staff feedback: During January 2017, the Senior Management Team held a series of workshops involving all staff to solicit their feedback and opinion in a number of areas given that the overall strategy for HPS is one of growth. Detailed outputs and analyses were generated in a number of areas;

i) staff developed a series of values they felt were important to them
ii) provided feedback as to why they enjoy working at HPS
iii) discussed the purpose and strategy of HPS and
iv) verified why HPS is required to grow going forward and the changes/opportunities that will create

The sessions were welcomed, with outcomes being presented back to all staff; there is a good appreciation amongst all staff in relation to the strategy HPS is seeking to pursue in-order to grow further.

4. Quality

Inspectors from the MHRA audited HPS from June 28th to 30th 2016. The outcome and feedback in brief was as follows:

i) HPS had no critical or major observations/incidences to rectify and the inspection had no impact on our normal operations (this is the first time the unit has **not** had any major incidences to rectify)

ii) Advice given centred around other deficiencies that HPS was required to correct in areas such as cleaning, product recalls and archiving etc.

Subsequently, a plan to address the above issues was approved by the MHRA and the unit is making good progress against this plan.

Further feedback/comments received from the MHRA in relation to the audit are given below:

"HPS is a well-run facility, one of the better ones they have come across"
"Your deviation investigations are of a very high standard especially compared to other NHS units"
"You are progressing well to commercial standards"
"You should invite other NHS units to show them best practice"

HPS will next be audited by the MHRA during FY20 (at the earliest).

Turning to management of quality on a day to day basis, the table below references some key quality metrics routinely collated and reviewed by the Senior Management Team. Outcomes from quality metrics against business performance was generally in-line with expectations. Production and other business activities significantly increased during FY17 and hence increases in deviations and quality investigation reports would be expected particularly as new products and processes start to be developed.

Table3: Measurement of Quality

	FY16	FY17	% change
Deviations (DEV)	1803	2474	↑37%
Quality Investigation Reports (Major DEV)	26	29	↑12%
Change Controls (CC)	72	68	↓6%
Customer Complaints (CR)	140	118	↓16%
Out of Specifications (OOS)	15	21	↑40%
Supplier Complaints (SC)	50	36	↓28%
Corrective and Preventative Actions (CAPA)	1269	1354	↑7%

However, given the brisk nature of trading during FY17 it was particularly pleasing to note that the number of customer complaints received significantly decreased compared to FY16. Going forward the senior management team remain committed to drive and monitor the delivery of quality throughout HPS with specific emphasis on improving CAPA close out rates which continues to be challenging for all staff.

5. Finance

During FY17 HPS delivered income of £7.8m and returned to the trust contribution of £2.3m. As is shown below, HPS demonstrated significant actual year on year growth; revenue increased by 10% and contribution by 4.5%.

Table 4: HPS financial results FY17

	FY15	FY16	FY17
Income	£6.8m	£7.1m	£7.8m
Contribution	£3.1m	£2.2m	£2.3m

The results presented are particularly pleasing (growth in both revenue and net profit) as the unit saw planned pay expenditure increase by 17% (from £1.66m (FY16) to £1.94m (FY17)) mainly due to the recruitment of a new product development team and an increase in non-pay expenditure (increased by 14% compared to FY16) which was, inter alia, largely due to expenses incurred arising from new product development initiatives (i.e. investing for the future) and the maintenance of the units Water For Injection system; such technical problems resulted in a significant number of production work days being lost during FY17 and hence had a negative impact on revenue and profit for HPS.

Agency spend: There was no agency spend at close of FY17 and there is no planned agency spend for FY18.

Capital Expenditure: During FY17, HPS spent £39K on the purchase of a new HPLC machine to be used in Quality Control and for new product development activities and £13K on its Water for Injection system.

Aged debt: The aged debt position for the unit deteriorated by £81K from period opening and closing values of £919K and £1m respectively. However, given that 61% of debt is current and trading during the year increased significantly the figures do not represent a material or trend worsening of the aged debt position. That said, the senior team monitor aged debt on a monthly basis and during the year have introduced measures such as requesting card payment at the point of customer order and a formal process of debt "chasing" where customers have had accounts put on stop until monies owed have been paid.

6. Business activity and strategy

Historically, HPS has supplied product to every NHS Trust in the UK. During period, HPS traded with 244 NHS organisations and approximately 460 private companies (mainly corporate/independent pharmacies). Some 75% of revenue was derived from NHS organisations. Based on our underlying strategy, we anticipate that over the coming years the share of revenue from the private sector will increase due to HPS diversifying into contract research and manufacturing (where the customer typically will be pharmaceutical companies), licensing of products, wholesaling of pharmaceutical products and exporting etc.

HPS throughout FY17 pursued and delivered a business strategy that sought to enhance or develop sales in the following areas;

i) Maximise sales of existing products (across sterile, non-sterile and tablet packing)
ii) Obtain Licenses (marketing authorisations) for existing products
iii) Manufacture new products where competitors can no longer service the market (opportunity lead sales)
iv) Introduce new products where demand and a business case have been proved
v) Contract manufacturing for third parties
vi) Contract Research for third parties
vii) Clinical Trial supplies
viii) Wholesaling of medicinal products

Overall, the strategy has proved successful with the unit commencing the process of taking its first product through regulatory licensing/approval and signing its first Contract Research Agreement in June 2016. Furthermore, the unit significantly increased its visibility and interactions with clinical colleagues based at CHFT and the wider region, which has resulted in a number of new products currently being developed that will be launched in FY18. Such activity forms a sound basis for the future growth of HPS. Accordingly, HPS will continue business activity in the above areas and commences FY18 with a strong sales pipeline.

7. Forward plan and strategy for FY18

Looking forward HPS has embarked upon FY18 with a similar strategy as that set out above for FY17 and we expect to report significant progress against each strategic aim during the course of the coming year.

During FY18, HPS will invest through capital expenditure to update its water for injection system; such capex is imperative in-order to mitigate ongoing pressures arising from lost production days that impact HPS revenue and profitability and increasing equipment maintenance costs and to ensure continuity of medicine supply is maintained to our NHS customers.

Further expenditure is planned in-order to manufacture products into flexible (i.e. plastic bags) rather than rigid (i.e. glass bottles) containers (bringing total planned spend to approximately £400K). We also anticipate making an addition to the senior management team through the recruitment of a Head of Sales and Customer Services.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st June 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: TREASURY MANAGEMENT POLICY - The Board is asked to approve the Treasury Management Policy	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Audit and Risk Committee	
Governance Requirements: Financial sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Treasury Management Policy

Main Body

Purpose:

The Board is asked to approve the Treasury Management Policy

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Treasury Management Policy

Appendix

Attachment:

Treasury management policy - Update 310317.pdf

UNIQUE IDENTIFIER NO: G-87-2012 v 5
Review Date:
Review Lead: Director of Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Treasury Management

Policy Version 5

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

UNIQUE IDENTIFIER NO: G-87-2012 v 5

Review Date:

Review Lead: Director of Finance

Document Summary Table		
Unique Identifier Number	G-87-2012	
Status		
Version	V5	
Implementation Date	October 2006	
Current/Last Review Dates	December 2007, December 2008, December 2009, December 2011, December 2012, April 2015, April 2017	
Next Formal Review		
Sponsor	Director of Finance	
Author	Deputy Director of Finance	
Where available	Intranet	
Target audience	Finance staff	
Ratifying Committees		
Committee Name	**Executive Board**	
	Board of Directors	
	Audit & Risk Committee	**19th April 2017**
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Other Stakeholders Consulted		
Internal Audit		

Does this document map to other Regulator requirements?	
Monitor	*Managing Operating Cash in NHS Foundation Trusts*

Document Version Control	
1	Removal of Prudential Borrowing Limit

Contents

1. Introduction

Foundation Trusts have wide discretion to invest and borrow money for the purposes of or in connection with their functions. This Treasury Management Policy sets out a governance framework for the management of operating cash within an acceptable risk profile and in accordance with their duty to safeguard and properly account for the use of public money.

Treasury Management includes:

- cash-flow monitoring and forecasting
- working capital management
- banking
- money market transactions
- optimising returns through investment
- planning and managing borrowing
- reducing financial transaction and borrowing costs
- minimising financial and corporate risk

Treasury management does not distinguish between 'revenue' and 'capital' cash; both are classed as cash resources and form part of the treasury management system.

The policy deals primarily with the short term management of the Trust's operating cash, i.e., cash that is required to support the Trust's ongoing operations. Any short term investments will have a maximum maturity date of three months, in line with Monitor's guidance.

This policy is written in conjunction with the guidance contained within 'Managing Operating Cash in NHS Foundation Trusts' (December 2005) issued by Monitor. (In 2016 NHS Improvement became the operating name for the combined body replacing Monitor and NHS Trust Development Authority. Within this document Monitor is referred to as NHS Improvement unless it relates to a document published by Monitor pre 2016. [This document describes guidelines that are intended to ensure adequate safety (i.e. manageable risk profile) and liquidity (i.e. accessibility of funds at short notice), of such investments, while generating a competitive return].

2. Purpose

It is the Board's duty to safeguard and properly account for the use of public money. The Treasury Management Policy aims and objectives are:

- to support the delivery of the Trust's objectives by ensuring the availability of short and long term liquidity;

- to maximise returns on the investment from surplus cash balances, from investment in safe harbour deposits within an acceptable risk profile and adequate liquidity;

- to identify, manage and where possible eliminate the financial risks arising from operational and treasury management activities, including interest rate and foreign exchange rate risks;

- to ensure that competitively priced funding is available at all times;

- to ensure compliance with all banking and/or loan covenants; and

- to maintain productive relationships with banks and/or central government funding bodies who may meet current and future banking and funding needs.

3. Duties (roles and responsibilities)

3.1 Board of Directors

The key responsibilities of the Board of Directors in respect of operating cash management include:

- approving the Trust's Treasury Management Policy;

- approving all external credit and borrowing arrangements, including finance leases.

3.2 Audit and Risk Committee

The Audit and Risk Committee are responsible for recommending the Trust's Treasury Management Policy to the Board of Directors for approval.

3.3 Director of Finance

The Trust's Standing Financial Instructions state that any application for a loan or overdraft will only be made by the Director of Finance or by an employee so delegated by him.

The Scheme of Delegation states that the responsibility for the Investment of Funds has been delegated to the Director of Finance.

The Director of Finance assumes responsibility for treasury operations.

3.4 Day-to-Day Treasury Management Function

Day-to-day treasury management function is managed and overseen by the Assistant Director of Finance - Financial Control. Specific aspects of treasury management include:

- reporting on treasury activities on an accurate and timely basis;
- managing relationships with banks and central government funding bodies;
- managing treasury activities in accordance with agreed policy and procedures; and
- ensuring completeness of appropriate documentation

3.5 Cash Flow Forecasting

An annual cash flow is prepared in summary form based on the Trust's business plan and in addition a rolling cash flow forecast is maintained (for 12 months)

At the end of each month the forecast is updated for actual movements and changed forecasts and reviewed by the Assistant Director of Finance – Financial control.

A daily cash flow forecast is prepared covering a minimum of 13 weeks. The daily forecast is updated with actual movements and changes to forecasts cash flows are recorded daily basis.

The annual cash flow is used to facilitate all other reports from the Trust to support borrowing requirements.

The Cash Flow Forecast is included in the monthly finance report to a sub-committee of Trust Board.

4. Attitude to risk

4.1 Objective

The principal objective of treasury management is to maintain liquidity, to mitigate and manage risk and to ensure a competitive return within an acceptable risk profile. The Trust will adopt a risk-averse approach to its treasury management activities.

4.2 Investment of surplus cash

Surplus operating cash will be invested in instruments which ensure adequate safety (the risk to invested capital is minimised) and liquidity (investments can be released quickly).

Investments should be realisable and have a maturity date not exceeding three months. In order to meet this requirement, cash should only be invested in 'safe harbour' investments.

These investments represent the lowest risk ratings, reflecting the Board of Directors' prudent approach to investment risk. Under no circumstances will the treasury function be authorised to enter into trading positions or to undertake trading for purely speculative reasons.

Monitor have confirmed that deposits in 'safe harbour' investments qualify to be accounted for as cash in terms of their Trust risk assessment process, and do not require reporting under the Monitor's Compliance Framework. 'Safe harbour' investments are defined in more detail at Appendix A.

The Trust aims to achieve value for money from its investments whilst having regard to the following priority order of risk-averse investments:

(i) Security – minimise the risk of loss of investments
(ii) Liquidity – investments are flexible enough to allow cash to be accessed easily.
(iii) Return – having regard to the above factors, the return on these investments is value for money.

The Trust will have due regard when considering making investments to any other adverse impact to achieving best value, for example impact on the calculation of Public Dividend Capital payments.

4.3 Permitted Institutions

The Trust will place investments with institutions that:

- have been granted permission, or any European institution that has been granted a passport, by the Financial Services Agency to do business with UK institutions provide it has an investment grade credit rating of A1/A+ issued by a recognised rating agency; and

- the UK Government (or executive agency) that is legally and constitutionally part of any department of the UK Government (including the UK Debt Management Agency Deposit Facility).

The list of institutions being used for treasury deposits will be continuously reviewed to assess whether market conditions or intelligence suggest the need to ensure:

- that each one still qualifies as 'safe harbour' under the definitions in Appendix A, specifically that the institutions short term ratings meet the requirements with at least two of the three recognised ratings agencies* and also

- to establish whether it is appropriate to add (or delete) any new institutions from the list of active deposit takers.

If the credit ratings for any of these institutions alter to the extent that they no longer meet the definition of a safe harbour investment, any investments made with these institutions will be withdrawn with immediate effect and no further investments will be placed with them until their credit ratings recover. In addition, if any institution is put on credit watch by a recognised rating agency then the decision to invest with them will be reviewed.

4.4 Preferred Concentration Limit

The Trust applies no limit to the following:

- Government Banking Service

All other institutions have a limit of £6m of deposits. Cash investments will only be placed with permitted institutions in line with these deposit limits. Surpluses above £500k will be invested with more than one institution in order to spread the investment risk, as summarised in line with the table below.

Minimum	Maximum	No. of institutions (excluding GBS)
<£0.5m		One
£0.5m	£8.0m	At least two (no more than £4m in each)
£8.0m	£12.0m	At least three (no more than £4m in each)
£12.0m	£16.0m	At least four (no more than £4m in each)
£16.0m	£30.0m	At least four (with limit of £6m in each)

* Whilst the Monitor guidance specifies that the long term credit ratings are also at minimum levels, the Trust does not invest in long-term investments. There fore only the short-term credit ratings are assessed when determining which institutions can be invested in.

4.5 Sourcing of competitively priced working capital facility

In consistency with the Trust board's prudent approach to investment risk, the funding of working capital should also take a prudent approach to risk.

The Trust will ensure that all funding, whether short tem or long term financing, offers the most appropriate value for money.

4.6 Foreign exchange management

The Trust's foreign currency transactions are currently not material. Investing operating cash in foreign exchange risk represents investment outside of the Safe Harbour. To the extent the Trust deems it necessary to do so, it will only be for the management of operational risk only and not for speculative reasons.

4.7 Relationships with banks

The Trust will seek to build efficient and cooperative working relationships with a core number of banking institutions, but will also consider the negotiation of specific services from other banks. In working with banks the Trust will ensure compliance with any bank covenants.

4.8 Foreign Exchange Management

The Trust is not exposed to significant foreign exchange transactions and therefore this policy does not provide for particular risk management procedures in relation to this. Should the position with regard to foreign exchange transactions change then this clause in the Policy will be reviewed.

5. Funding

The Trust will maintain a risk-averse approach to borrowing, recognising the ongoing requirement to have sufficient funds in place to cover both existing business cash flows and capital expenditure programmes, maintaining sufficient headroom in accordance with the latest NHSI regulatory framework and guidance.

The Director of Finance will review the Trust's requirement for working capital on a regular basis and will ensure the Trust has sufficient liquidity to meet its operational commitments. The Trust will operate its main bank account with the Government Banking Service. Other bank accounts will be run only to support operational activities such as the banking of receipts and petty cash reimbursements.

The Trust will seek to secure working capital facilities and or loans at the lowest possible cost.

Options to be considered for borrowing are

- Public Dividend Capital (PDC) will be taken if made available by the Department of Health.
- Loan Agreements with Department of Health
- Revolving Working Capital Facility
- Any other funding sources made available to the Trust
- Any debt funding proposals will require the approval of the Board of Directors.

6. Controls

The following controls will apply:

- The Director of Finance will ensure appropriate documentation, policies and procedures are in place.
- Clearly defined roles and responsibilities will be established.
- Regular reporting protocols.
- Treasury management will be routinely covered as part of the Internal Audit cycle.

7. External professional advice

The Director of Finance will ensure that his senior staff, members of the Board and members of the Audit and Risk Committee have access, as appropriate, to external professional advisers on matters affecting investment and borrowing.

8. Training and Implementation

The Director of Finance is responsible for ensuring that there are adequate, robust and up-to-date Treasury Management Procedures document and in operation. These will cover the day-to-day operation of investment activity.

The Director of Finance will ensure that members of staff who are involved in Treasury Management have the appropriate levels of skills and training.

9. Equality Impact Statement

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

10. Monitoring Compliance with this Procedural Document

The regular reporting of treasury activities is crucial in allowing all relevant parties to appreciate the Trusts financial position and assess the ongoing appropriateness of Treasury objectives.

10.1 Daily/Weekly Movement Reports

Daily and weekly reports are completed by the Treasury Management function for review by the Assistant Director of Finance – Financial Control. This details all payments to / receipts from the operational accounts (Paymaster General and the Trust nominated clearing bank) against the forecasted position.

This is used by the Assistant Director of Finance – Financial Control to assess if any actions are required to ensure the Trust cash balance remains at an appropriate level.

If the Trust has surplus cash it will also be used to decide on proposed appropriate levels of investments or debt repayment to ensure a competitive rate of return by not carrying excess funds in operational accounts.

10.2 Monthly Report

As part monthly report for Finance and Performance committee, which is a subcommittee of the Trust Board, information is included on the Trust's cash balances for the current financial year, together with the Balance Sheet which incorporates: the month's closing cash balance; cash flow variances from plan; details on the Trust current borrowings position.

Treasury Management activity is reviewed as part of the Internal Audit programme to ensure compliance against Policy and controls.

11. Associated Documents/Further Reading

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

- Standing Financial Instructions
- Standing Orders – Board of Directors
- Reservation of Powers to the Board/Scheme of Delegation

Appendix 1

Safe Harbour Investments

The following is an extract from the Monitor guidance "Managing Operating Cash in NHS Foundation Trusts"[†]:

"Securities that are considered sufficiently safe and liquid to be in the safe harbour meet all of the following criteria:

- meet permitted rating requirement issued by a recognised rating agency;
- are held at a permitted institution;
- have a defined maximum maturity date;
- are denominated in sterling, with any payments or repayments for the investment payable in sterling;
- pay interest at a fixed, floating, or discount rate; and
- are within the preferred concentration limit.

The following definitions elaborate further on these criteria:

1. Recognised rating agency

Only the following are recognised rating agencies:

- Standard and Poor's;
- Moody's Investors Service Ltd; and
- Fitch Ratings

2. Permitted rating requirement

The short-term rating should be at least:

- A-1 Standard & Poor's rating; or
- P-1 Moody's rating; or
- F1 Fitch Ratings.

[†] http://www.monitor-nhsft.gov.uk/sites/default/files/publications/Managing_cash_final.pdf

The long-term rating should be at least:

- A1 (Moody's); or
- A+ (Standard & Poor's/Fitch Ratings).

3. Permitted institutions

Permitted institutions include:

- Institutions that have been granted permission, or any European institution that has been granted a passport, by the Financial Services Authority to do business with UK institutions provided it has an investment grade credit rating of A1/A+ issued by a recognised rating agency; and

- The UK Government, or an executive agency of the UK Government, that is legally and constitutionally part of any department of the UK Government, including the UK Debt Management Agency Deposit Facility.

4. Maximum maturity date

- The maximum maturity date for all investments should be 3 months.

- The maturity date for any investment should be before or on the date when the invested funds will be needed.

5. Preferred concentration limit

- Surpluses below £500k may be invested with one institution.

- Surplus above £500k should be invested across a number of permitted institutions to spread the investment risk.

- Investment limits should be set for permitted institutions based on their credit rating and net worth. These limits should be reviewed annually and reset if there is a change in either the credit rating or the net worth of the financial institution. If an institution is either downgraded or put on credit watch by a recognised rating agency, the decision to invest with them should be reviewed.

- Investments with permitted institutions should not exceed the set limit at any time.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st June 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: BUDGET BOOK 2017-2018 WORKINGS - The Board is asked to receive and approve the Budget Book 2017-2018 Workings	
Action required: Approve	
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:

The Board is asked to receive and approve the Budget Book 2017-2018 Workings

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the Budget Book 2017-2018 Workings

Appendix

Attachment:

Budget Book 1718 workings as per March submission v2.pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

BUDGET BOOK
2017-18
Revised

compassionate care

2017/18 Financial Plan - Overview

I&E Summary
The Trust submitted its business plans for 2017/18 and 2018/19 in line with the deadlines in draft in November 2016 and subsequently final plans in December 2016. At this stage the Trust accepted the control total for 2017/18 of £15.9m which drove the need for a challenging £17m Cost Improvement Programme (CIP).

However, at this stage, the Trust had not agreed the two year 2017 – 2019 contract with its main commissioners. The contracting round presented a number of material challenges for the local health economy. Following lengthy discussions with NHSI, contracts were ultimately agreed with commissioners without the need to progress to arbitration. 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. NHSI were advised of this impact prior to agreeing the contract position. Other elements contributing include the bid for and subsequent loss of the Public Health Early Years tender which had delivered a contribution to overheads.

The stated assumption made at the point of the December 2016 planning submission was that the costs directly associated with EPR 'go live', these being training, dual running and impact on productivity, would be capitalised against the overall investment to bring the asset into operation. It was acknowledged that this treatment was subject to the approval of the Trust's external auditors in 2016/17 and 2017/18 and it is now clear, with the further detail on costs that has developed, that there will be a level of residual set up costs that will be correctly reflected within the revenue position.

As such the £15.9m control total was appealed in January 2017 on the basis of the income driven challenge and also the risk surrounding the exceptional costs of EPR implementation in 2016/17. NHSI have not offered any flexibility to the control total in response to this appeal and as such the Trust faces a significant challenge to deliver a £15.9m deficit which drives a £20m efficiency savings requirement and containment of the financial risks associated with EPR implementation.

After due consideration, the final planning submission to NHSI in March 2017 was made to best align the Trust's latest plans within the control total and to mark the ambition held. The Trust has requested that NHSI acknowledge the scale of this challenge and note our continued commitment to deliver to the best of our ability. The plan assumes receipt of £10.1m Strategic Transformation Funding (STF) which is both intrinsic to and contingent upon delivery of the planned deficit. The underlying planned deficit therefore stands at £26m.

Capital Summary
The Trust developed capital plans as part of the annual planning process for the 2017/18 and 2018/19 plan. The original planning identified a capital requirement of £29m for 2017/18 and a further £19m for 2018/19 (excluding reconfiguration costs). The Trust received feedback from NHSI that the Trust was unable to incur capital expenditure in excess of the money it has available to it, and to do so would be ultra vires. The Trust was mandated to submit a revised reduced plan. In recognition of this the capital plan has been further scaled back. This is part of a national requirement to minimise the capital expenditure within the NHS to within the national budget (Capital Departmental Expenditure Limit (CDEL)).

The attached 'Budget Book' for 2017/18 lays out the detail of the Trust's financial plan for 2017/18. This content of this document has been shared with the Finance and Performance Committee in advance of 31 March 2017.

Strategic Plan
Work continues on the development of the Full Business Case in support of the Right Care, Right Time, Right Place service model. The 2017/18 and 2018/19 financial plans form a baseline for this work. Regulatory support for this case will be reliant upon the ultimate delivery of an annual breakeven position, moving from the current underlying deficit of £26m. It is also clear, from the latest position on national capital funding that alternative routes for investment will be required in support of reconfiguration.

The 2017/18 financial plans do not include any capital funds in support of either the preferred or do nothing option. Additionally no revenue has been identified to support the development of the FBC.

17/18 Plan: Income & Expenditure

Income & Expenditure	16/17 Budget	16/17 Actual	17/18 Business Plan (Excl. CIP)	17/18 CIP	17/18 Total Business Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income	331.62	332.76	334.27	0.42	334.68
Other Income	39.70	42.49	39.42	0.63	40.05
TOTAL INCOME	371.32	375.25	373.69	1.05	374.74
Medical	(69.77)	(69.16)	(71.43)	3.47	(67.97)
Nursing	(72.84)	(75.24)	(76.81)	2.00	(74.81)
Sci Tech & Ther	(26.42)	(27.33)	(28.88)	0.10	(28.78)
Support to clinical staff	(25.53)	(29.63)	(27.24)	2.62	(24.62)
Any Other Spend	(2.25)	(0.04)	(3.61)	0.00	(3.61)
Managers and infrastructure support	(40.31)	(39.67)	(43.00)	1.70	(41.31)
PAY EXPENDITURE	(237.12)	(241.07)	(250.98)	9.88	(241.10)
Drugs	(35.59)	(32.92)	(35.71)	0.38	(35.34)
Clinical Supplies & Services	(30.16)	(32.66)	(34.59)	1.83	(32.76)
Other Costs	(59.10)	(59.32)	(63.32)	6.86	(56.46)
NON PAY EXPENDITURE	(124.84)	(124.90)	(133.62)	9.07	(124.55)
TOTAL EXPENSES	(361.96)	(365.97)	(384.60)	18.95	(365.65)
EBITDA	**9.36**	**9.28**	**(10.91)**	**20.00**	**9.09**
Non Operating Expenditure	(25.46)	(23.07)	(38.93)	0.00	(38.93)
TOTAL SURPLUS/(DEFICIT)	**(16.10)**	**(13.79)**	**(49.84)**	**20.00**	**(29.84)**
Less: Incentive / Bonus STF funding		(1.35)			
Less: Items excluded from Control Total	(0.05)	(0.91)	13.90	0.00	13.90
TOTAL SURPLUS/(DEFICIT) on a Control Total Basis	**(16.15)**	**(16.05)**	**(35.94)**	**20.00**	**(15.94)**

Overview:
This budget is aligned to the planning submission made to NHS Improvement as at 30 March 2016. It represents year one of the longer term financial and operational plan under the 'Right Care, Right Time, Right Place' programme.

Key Assumptions:
- £15.94m Control Total accepted with reservations expressed to NHS Improvement.
- Efficiency challenge is £20m CIP, £16.7m already allocated to Divisions plus a further £3.3m planning gap (held as negative reserve)
- Income calculated using HRG4+ Planning Tariff.
- CIP updated from December planning submission to reflect development of schemes up to 28 March 17.
- Total Surplus / (Deficit) includes £14m Impairment of IT assets (EPR) assumed from Quarter 2 following completion of implementation, excluded from Control Total as shown above.
- EPR implementation costs are assumed in plan to be capitalised subject to External Audit approval of this treatment.
- Assumes full receipt of Sustainability & Transformation Funding of £10.1m.
- Against payment of £1m Apprentice Levy, £0.9m assumed to be recoverable.
- Contingency Reserves of £2m held as per 16/17.
- Revenue loans assumed at 1.5% interest rate, Capital loans at 2.4%.
- Incremental drift and pay awards applied to pay budgets at national guidance levels.
- Non Pay inflation only applied in target areas.

17/18 Plan: Statement of Financial Position

Statement of Financial Position	16/17 Budget As at 31 Mar 17 £'m	16/17 Actual As at 31 Mar 17 £'m	17/18 Business Plan As at 31 Mar 18 £'m
Non Current Assets			
Property, Plant & Equipment	166.11	163.55	150.39
On B/S PFI assets	69.47	72.59	71.63
Investment in Joint Venture	2.67	2.89	2.87
Other	2.68	3.13	2.68
	240.92	242.16	227.56
Current Assets			
Inventories	7.26	6.72	6.62
Receivables	14.38	17.04	13.38
Other	7.54	6.47	6.47
Cash	1.95	1.94	1.91
	31.12	32.18	28.37
Current Liabilities			
Loans	(2.21)	(2.57)	(2.79)
Deferred Income	(1.24)	(1.55)	(0.68)
Payables	(38.55)	(41.54)	(35.11)
Provisions	(2.31)	(1.88)	(1.58)
PFI Leases	(1.40)	(1.48)	(1.48)
	(45.71)	(49.03)	(41.64)
Non Current Liabilities			
Loans	(65.65)	(59.21)	(84.84)
PFI Leases	(76.09)	(76.01)	(74.53)
Provisions	(2.44)	(2.31)	(2.44)
Other	(1.41)	(1.50)	(1.33)
	(145.59)	(139.02)	(163.14)
TOTAL ASSETS EMPLOYED	**80.74**	**86.29**	**51.15**
Taxpayers Equity			
Public Dividend Capital	115.72	116.19	116.19
Income & Exp Reserve	(70.50)	(67.37)	(99.78)
Revaluation Reserve	35.52	37.46	34.74
TOTAL TAXPAYERS EQUITY	**80.74**	**86.29**	**51.15**

Key Assumptions:

- £14m Impairment of IT Assets is assumed following completion of EPR implementation.
- No other asset valuation adjustments are assumed.
- Cash is assumed to be balanced to £1.9m at the end of each month in line with Department of Health borrowing requirements.

17/18 Plan: Statement of Cash Flow

Statement of Cash Flow	16/17 Budget £'m	16/17 Actual £'m	17/18 Business Plan £'m
Surplus/(deficit) from Operations	**(16.10)**	**(13.79)**	**(29.84)**
non-cash flows in operating surplus/(deficit)			
Non-cash donations/grants credited to income	(0.20)	(0.66)	(0.20)
Depreciation and amortisation	10.99	10.07	10.76
Other operating non-cash (income)/ expenses	14.40	14.76	14.10
Impairments	0.00	(1.20)	14.00
	25.19	**22.97**	**38.66**
Operating Cash flows before movements in working capital	**9.09**	**9.18**	**8.82**
Increase/(Decrease) in working capital	**(1.36)**	**(6.48)**	**0.32**
Net cash inflow/(outflow) from operating activities	7.73	2.71	9.14
Net cash inflow/(outflow() from investing activities			
Capital Expenditure	(28.22)	(24.03)	(14.39)
Proceeds on disposal of property, plant and equipment	0.42	1.33	0.00
Increase/(decrease) in Capital Creditors	(0.02)	5.90	(4.94)
Other cash flows from investing activities	0.04	0.03	0.04
	(27.77)	**(16.76)**	**(19.29)**
Net cash inflow/(outflow) before financing	**(20.04)**	**(14.06)**	**(10.15)**
Net cash inflow/(outflow) from financing activities			
Public Dividend Capital Received		0.47	0.00
Drawdown of Loans	37.63	31.90	28.76
PDC Dividends paid	(2.69)	(2.35)	(1.78)
Repayment of Loan	(1.71)	(2.07)	(2.92)
Financing	(13.09)	(13.20)	(13.82)
Non-Current Movements	(0.09)	(0.68)	(0.09)
	20.05	**14.06**	**10.15**
Net increase/(decrease) in cash	**0.01**	**0.00**	**0.01**
Opening cash	1.94	1.94	1.90
Closing cash	**1.95**	**1.94**	**1.91**

Key Assumptions:

- Surplus / (Deficit) from Operations includes £14m Impairment of IT assets (EPR) assumed following completion of implementation.
- Borrowing requirement has been reduced from December planning submission and for 17/18 is assessed to be £28.76m: £8.00m for Capital Financing and £20.76m for Revenue support.
- Capital loan is £8m existing approved Capital loan facility. All other capital expenditure to be managed within internally generated funds.
- Revenue borrowing requirements in 17/18 are in excess of the Deficit and reflect additional working capital requirements of £4.93m. This cash will be required in the first few months of the year to pay EPR related Capital Creditors where Capital expenditure was accounted for in 16/17.
- Planned Capital expenditure has been significantly reduced due to lack of available Department of Health funding. The Trust is unable to commit to any Capital expenditure that cannot be funded internally or through existing approved loan facilities.

17/18 Plan: Activity & Income

Activity	16/17 Budget	16/17 Actual	17/18 Business Plan (Excl. CIP)	17/18 CIP	17/18 Total Business Plan
	Spells	Spells	Spells	Spells	Spells
NHS Clinical Income					
Elective	8,787	7,850	7,958		7,958
Non Elective	51,619	51,440	50,873		50,873
Daycase	36,895	38,688	38,132		38,132
Outpatients	338,922	352,534	359,602		359,602
A & E	148,571	151,349	155,414		155,414
Other-NHS Clinical	1,671,325	1,757,791	1,755,434		1,755,434
TOTAL INCOME	2,256,117.43	2,359,651.97	2,367,413.56	0.00	2,367,413.56

Income	16/17 Budget	16/17 Actual	17/18 Business Plan (Excl. CIP)	17/18 CIP	17/18 Total Business Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income					
Elective	22.48	21.56	22.36	0.00	22.36
Non Elective	87.09	89.72	95.53	0.00	95.53
Daycase	26.37	27.63	26.51	0.00	26.51
Outpatients	43.43	45.92	41.84	0.00	41.84
A & E	16.43	16.81	19.24	0.00	19.24
Other-NHS Clinical	129.03	124.12	121.80	0.42	122.22
CQUIN	6.79	6.99	6.99	0.00	6.99
Other Income	39.70	42.49	39.42	0.63	40.05
TOTAL INCOME	371.32	375.25	373.69	1.05	374.74

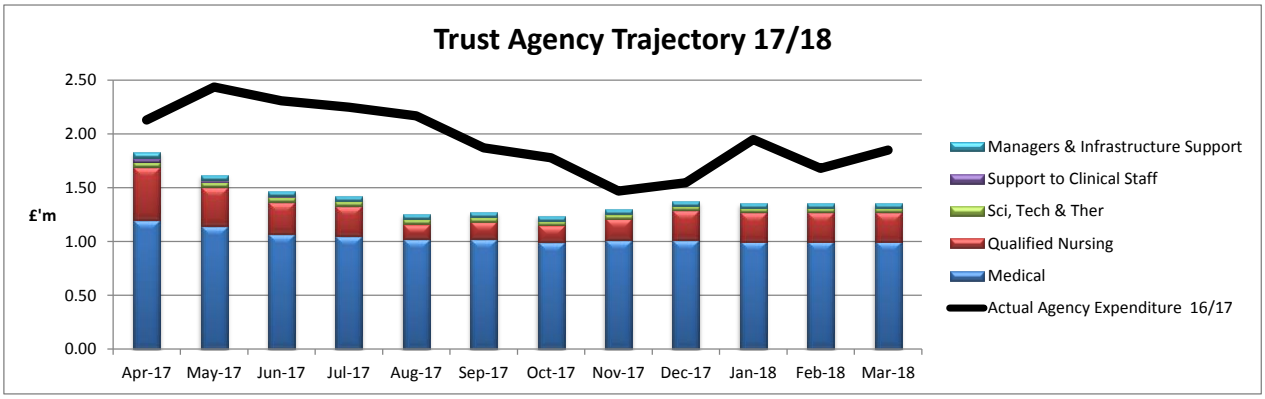
Key Assumptions:

- Income calculated using HRG4+ Planning Tariff.
- Planned activity levels differ from Commissioner contracts due to a different assessment of QIPP. If commissioners are successful in delivering these plans, the Trust will need to ensure that costs are reduced to compensate any associated loss of income.
- Some QIPP plans would also require enabling investment by Commissioners.
- Planned Income Generation (CIP) is driven by commercial activity rather than Commissioner Contract Income.

17/18 Plan: Agency Trajectory

Agency Trajectory 17/18	Apr-17 £'m	May-17 £'m	Jun-17 £'m	Jul-17 £'m	Aug-17 £'m	Sep-17 £'m	Oct-17 £'m	Nov-17 £'m	Dec-17 £'m	Jan-18 £'m	Feb-18 £'m	Mar-18 £'m	Total £'m
Medical	1.20	1.15	1.07	1.05	1.03	1.03	0.99	1.02	1.02	1.00	1.00	1.00	12.56
Qualified Nursing	0.50	0.36	0.29	0.28	0.14	0.16	0.16	0.20	0.27	0.27	0.27	0.27	3.18
Sci, Tech & Ther	0.05	0.05	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.50
Support to Clinical Staff	0.03	0.02	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.08
Managers & Infrastructure Support	0.06	0.05	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.55
Total	1.83	1.62	1.46	1.43	1.25	1.28	1.24	1.30	1.38	1.36	1.36	1.36	16.86

Actual Agency Expenditure 16/17	2.13	2.44	2.31	2.25	2.17	1.87	1.78	1.47	1.55	1.95	1.68	1.85	23.44



Key Assumptions:

- Assumes Agency expenditure will be kept within NHS Improvement cap at £16.86m.
- This represents a significant reduction from Agency expenditure in 16/17 at £23.44m.
- Income & Expenditure plan includes £2.4m funding to support agency premium.
- Use of Resources metric does include measurement of performance against the cap.

17/18 Plan: Reserves

Reserves Summary	17/18 Business Plan £'m	Notes
Uncommitted General Reserve		
Contingency Reserve	2.00	Assumed as Pay in Business Plan
	2.00	
Planning Gap		
Stretch CIP Target - unallocated to Divisions	(3.30)	
	(3.30)	
Committed Reserves		
Innovation Fund	0.70	To be transferred to Divisions once costs are incurred
	0.70	
TOTAL RESERVES	**(0.60)**	

Key Assumptions:

- EPR implementation costs are planned as Capital expenditure within the plan. However, there may be challenges on the accounting treatment which could lead to the need to treat as revenue expenditure. This would increase the deficit.

17/18 Plan: Capital

Scheme Category	Capital Schemes	17/18 Business Plan £'m
IT	Electronic Patient Record (EPR)	3.36
	Clinical & IM&T systems	0.10
	CRH computer room, core & clinical infrastructure	1.51
	Laptop/PC Equipment refresh & Anti-virus software	0.00
		4.97
Plant and machinery/equipment/transport/fittings	Families & Specialist Services Equipment Inc. MRI	0.70
	Medicine Equipment	0.15
	Surgical Equipment	2.14
	Community Equipment	0.04
	HPS Equipment	0.39
		3.41
Routine Maintenance (non-backlog) - Land, buildings and dwellings	A&E refurbishment	0.00
	Endoscopy refurbishment	0.60
	Ward move - patient flow	0.00
	Estate maintenance & compliance	0.72
		1.32
Backlog Maintenance - Land, buildings and dwellings	6 Facet survey - Estate physical condition	1.50
	6 Facet survey - Estate physical condition	1.16
		2.66
Other	PFI Lifecycle costs	1.51
	Estate maintenance & compliance resource	0.20
	Clinical & IM&T systems resource	0.33
		2.04
TOTAL CAPITAL EXPENDITURE		**14.39**

Key Assumptions:

- The Capital plan has been significantly reduced compared with the plan submitted in December following feedback from NHS Improvement. The Trust has been advised that it is unable to commit to any Capital expenditure that cannot be funded internally or through existing approved loan facilities.
- Internally generated funds from Depreciation (£10.8m), are also required to cover the cost of repayments on the PFI (£1.5m) and Capital Loans (£2.9m), leaving only £6.4m available for Capital Expenditure.
- In addition £8.0m remains on existing approved Capital loan facility and will be drawn down in 17/18.
- Assumes capitalisation of EPR implementation costs, subject to External Audit approval.

17/18 Plan: Investments

Category	Description	17/18 Business Plan £'m
Existing Pressures	Community Division: Pressures	261.00
	Expansion of Recruitment Team	115.00
	New Occupational Health Consultant	28.00
	Medical Director's Office: Additional PAs for coding	45.00
	Guardian of Safe Working	20.00
	Tissue Viability Funding	24.00
	Safeguarding Staffing	38.00
	Corporate Operations Manager	36.00
	Pharmacy ATOs x 4	80.00
	Radiation Protection Services	60.00
	PMU: Pressures	217.47
	Single use eye drops	100.00
	Surgical Division: CT1 Post	59.46
	Surgical Division: Consultant Contract	38.46
		1,122.39
New Pressures	Apprentice Levy	1,000.00
	Reduction in STF Funding	1,200.00
	PDC Dividend	(1,100.00)
	Depreciation	1,225.00
	Interest Payable (loans)	1,200.00
	Interest Payable (PFI)	103.00
	Education & Training Tariff	50.00
	CNST Inflation	1,524.35
	Property Rental for Children's services vacating PRCHC	70.00
	NHS Property Services market rent service charge	200.00
	PFI contract inflation at RPI	120.00
	Junior Doctor contract	643.96
	Lease pressure from renewal of Isotope imager	34.00
	THIS Contracts	200.00
	Capitalised Salaries EPR	721.11
	Nerve centre costs	80.00
		7,271.42
Developments	Education & Training Tariff	(227.00)
	New E-Rostering system - Allocate	271.40
	Staffing to support expansion of Apprenticeship programme	140.00
	Apprentice Levy - planned clawback of levy	(920.00)
	Divisional HR support	165.00
	Overseas recruitment costs	550.00
	FSS: CQC response to RCOG recommendation	265.00
	FSS: Staffing to support 3rd MRI scanner	64.49
	Innovation reserve	700.00
		1,008.89
TOTAL INVESTMENTS		**9,402.70**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Michelle Bamforth, Assistant to DON - Workforce Assurance Manager
Date: Thursday, 1st June 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: : CHFT NURSING AND MIDWIFERY HARD TRUTHS REPORT - Hard Truths Board Report	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Through the Hard Truths process - panel reviews	
Governance Requirements: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

EXECUTIVE SUMMARY:
This paper follows on from the detailed safe staffing report provided to the Trust Board in May 2016, and the follow up report from November 2016.

It will provide assurance to the Trust Board that nursing and midwifery staffing capacity and capability are monitored, reviewed and established in line with the recommendations of the Hard Truths (2014) document; Updated National Quality Board guidance (2016) and NICE Guidance for Safe Staffing of Adult Inpatient Wards (2014) and Maternity (2015).

This paper sets out the evidence base underpinning the staffing reviews completed in January 2017 as well as an analysis of the review findings.

This paper provides an overview of the size and shape of the nursing and midwifery workforce. Current and potential workforce risks are highlighted and recommendations made for investment, disinvestment or change to the workforce models.

This 6 monthly review provides assurances to the Board that the trust continues to develop the Nursing & Midwifery workforce and that workforce models have been reviewed, scrutinised and challenged. There remains significant risk to the workforce due to the national shortage of qualified staff & recent level of vacancies, therefore sustainable recruitment & retention to the nursing workforce is a priority alongside workforce modernisation.

The Board of Directors can be reassured that the Trust is reviewing the capabilities of the newly introduced Erostering and Safe Care systems and how these can be utilised to support our work in achieving the recommendations set out in Lord Carter's report.

The trust will continue to embed the NQB guidance to inform strategic workforce planning for the Nursing and Midwifery Workforce to ensure the right staff with the right skills are available at the right time and place to provide compassionate care to people who access our services.

Main Body

Purpose:

To assure the Board of Directors that staffing levels have been scrutinised & reviewed

Background/Overview:

See Report

The Issue:

See Report

Next Steps:

The Board of Directors can be reassured that the Trust is reviewing the capabilities of the newly introduced Erostering and Safe Care systems and how these can be utilised to support our work in achieving the recommendations set out in Lord Carter's report.

The Trust will continue to embed the NQB guidance to inform strategic workforce planning for the Nursing and Midwifery Workforce to ensure the right staff with the right skills are available at the right time and place to provide compassionate care to people who access our services

Recommendations:

The Board of Directors are asked to support the changes approved to the nursing workforce models detailed within this report.

Appendix

Attachment:

Final.pdf

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HARD TRUTHS REPORT

NURSING AND MIDWIFERY STAFFING

BOARD OF DIRECTORS – JUNE 2017

CONTENTS

1.0 INTRODUCTION

This paper follows on from the detailed safe staffing report provided to the Trust Board in May 2016, and the follow up report from November 2016.

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2.0 THE NURSING AND MIDWIFERY WORKFORCE

2.1 Vacancies

Vacancies for Registered Nurses / Midwives are currently 179 WTE (data sourced from ESR 1-3-17) .The vacancy level on individual areas is managed divisionally with substantive staff deployed flexibly for periods of time to ensure stability in all areas to meet patient's needs.

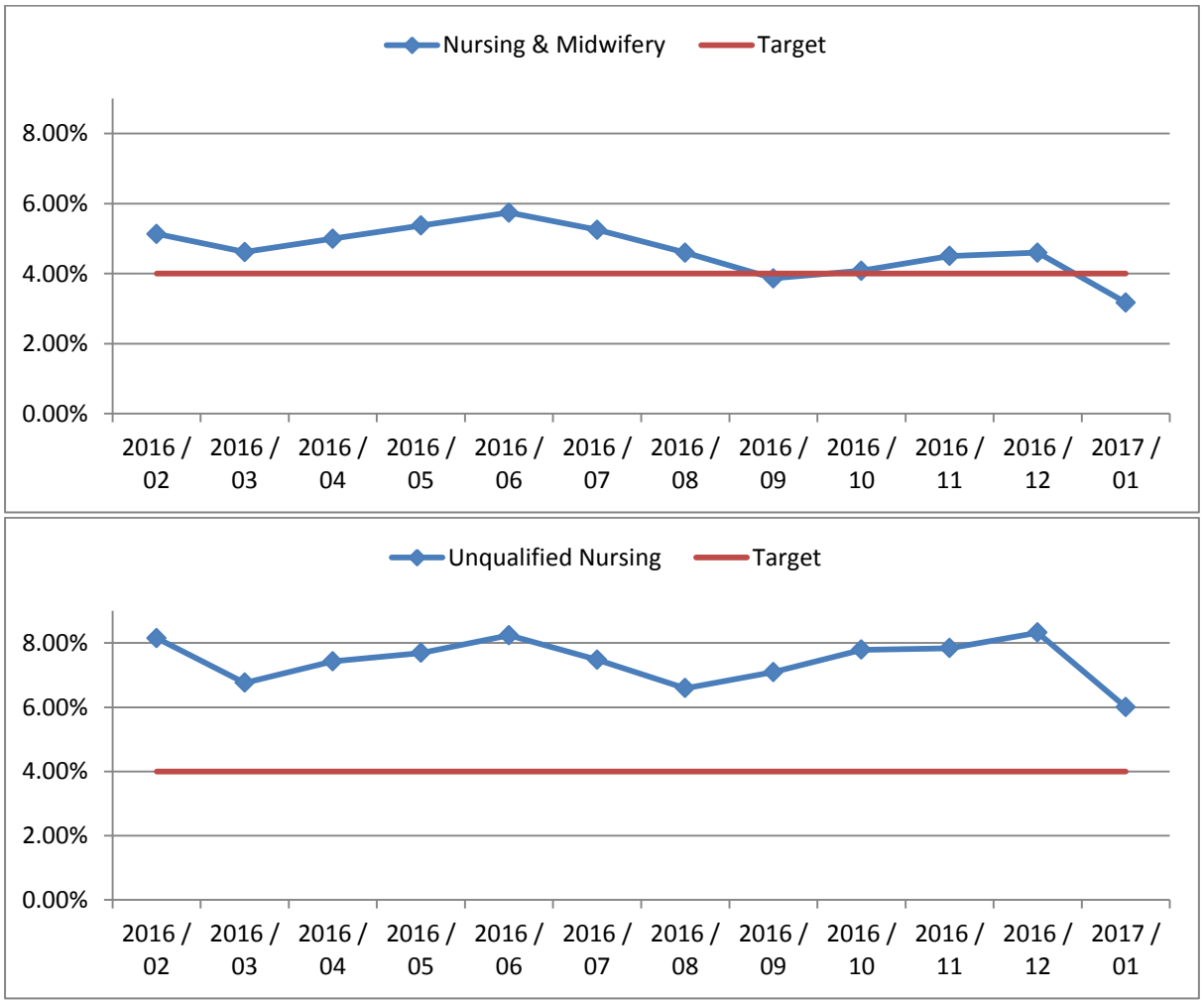
Table 1: Turnover Nursing and Midwifery Workforce

Month	December 2016	January 2017	February 2017	March 2017	April 2017
Turnover % RN / RM	1.22%	0.44%	0.86%	0.64%	1.41%
Turnover % Non Registered	0.77%	0.61%	0.90%	0.31%	1.14%

2.2 Absence

Despite focused attendance management, absence rates had begun to climb for both the registered & non-registered nursing workforce, but a slight improvement was noted in January 2017.

Table 2: Absence Rates Nursing and Midwifery Workforce



2.3 Average Fill Rates

On-going attention and analysis of the nursing workforce continues to take place at a national level, with particular focus maintained on safe staffing and the use of temporary and agency workforce. Calderdale & Huddersfield Foundation Trust (CHFT) continues to deliver within this agenda, and manage the complexity of nurse staffing issues with a pro-active and considered approach. Average fill rates are monitored by the Nursing Workforce Strategy Group and by the Associate Directors of Nursing for each division monthly. Average fill rates have maintained over the last three months supported by a level of both agency & flexible workforce support. (See appendix 2 for a summary of fill rates per area).

3.0 RECRUITMENT AND RETENTION OF THE NURSING WORKFORCE

Recruitment to the Nursing and Midwifery Workforce in 2016/17 is comparable to the level of recruitment achieved in 2015/16 .Retention of the registered workforce has slightly improved.

As part of the strategy to increase stability in the nursing workforce and reduce the use of temporary workforce the Trust have carried out an overseas recruitment project in March 2017. This has resulted in offers being made to 119 Pilipino nurses – which will ensure we meet our brief to recruit 75.

On-going work is underway with the recruitment agent, HEE and the Trust to ensure the recruitment process is as efficient as possible. It is envisaged that the overseas nurses will begin to join the organisation from Quarter 3 onwards.

Recruitment within the EEA has become increasingly challenging due to the demand for nurses and the introduction of the IELTs requirement to obtain NMC registration. CHFT planned levels of Registered Nurse recruitment from the EEA have been lower than expected between June 2016 and April 2017.

The continued focus and attention has been further enhanced to the domestic recruitment of registered nurses which remains a priority to the Trust. Two successful recruitment fairs have been hosted on site resulting in the overall recruitment of 50 Registered Nurses.

Monthly recruitment/assessment events continue to be hosted and the generic band 5 NHS jobs account is managed on a 48hr period, thus expediting the processing of all RN applications to the organisation.

The clinical education team continue to work closely with all local HEI's to support the recruitment of the local, graduating nursing workforce.

Retention:

To improve retention rates within the nursing workforce the clinical education team have developed a new preceptorship policy & document.

This is in line with national frameworks and approved by Health Education England. The package is supported by an on-going year-long development programme offered to all new registrants & staff new to the organisation.

The nursing workforce has recruited 2.0 WTE corporate clinical educators to work within this agenda.

Table 3: 2015/16 Nursing workforce recruitment and retention

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

Table 4: 2016/17 Nursing workforce recruitment and retention

Month	Qualified Hires	Qualified Leavers	Unqualified Hires	Unqualified Leavers
January	22	21	22	5
February	27	19	15	6
March	15	36	4	12
April	28	26	0	3
May	11	24	5	6
June	15	15	10	4
July	13	27	12	7
August	19	24	8	6
September	49	20	8	12
October	42	16	4	3
November	15	16	5	4
December	18	21	9	7
Grand Total	**274**	**265**	**102**	**75**

Modernisation :

The trust has been successful in its bid to be a pilot site for the Nursing Associate Role and are progressing this as lead partner for a multi- site model.

Aligned to the emerging national profile on the delivery of enhanced care models the trust will be introducing a peripatetic Enhanced Care Team from July to support care

delivery to patients who require 1 to 1 supervision and to further enhance the care models.

4.0 ALLOCATE AND SAFE CARE IMPLEMENTATION

At the Executive Board in October 2016 the Trust committed to the procurement of a replacement e-rostering system with Allocate.

The objectives of the implementation at CHFT for purchasing Health Roster, Bank Staff and Safe Care include:

- Improved service delivery and clinical safety - right people, right place, right time
- Improved productivity and utilisation of substantive and temporary staff - significant financial saving on Bank and Agency spend
- Reduction in avoidable costs - the drive to control expenditure
- Improved payroll accuracy - reduction in unnecessary overtime payments and enhancement errors
- Improved leave management
- Reduced sickness levels
- Improved rostering practice and access to rosters - increased roster efficiency
- Reduction in administration tasks and functions
- Improved leave management
- Improved reporting
- Improved workforce planning.

The Trust alongside procurement of health roster has purchased Health Roster Safe Care. This functionality will allow CHFT to understand in detail ward staffing levels in relation to patient numbers and patient acuity & dependency.

The implementation team is now operational and the role out to the new system is underway.

It is expected that all current rostered areas will be switched over by July 2017. The Trust will then start to review data from Safe Care in order to better understand trends in patient acuity, dependency and staffing level data.

5.0 UPDATED NATIONAL QUALITY BOARD GUIDANCE (NQB) AND CARE HOURS PER PATIENT DAY (CHPPD)

The 2013 NQB guidance set out 10 expectations and a framework within which organisations and staff should make decisions about safer staffing.

The updated NQB guidance has been brought together with the Carter report finding, to set out the key principles & tools that provider Boards should use to measure and improve their use of staffing recourse to ensure safe, sustainable and productive services.

A summary of CHPPD actual & planned for areas in scope at CHFT is detailed in Appendix 2.

Appendix 4 evidences CHFT response to the updated guidance.

6.0 NURSING WORKFORCE REVIEW PANELS

In January 2017 all nursing workforce models (WFMs) were reviewed using the nursing workforce model review panel which was introduced in October 2015. This ensured a consistent approach was utilised across each division to complete the reviews using standardised guidance and templates. This report will detail the recommendations/proposals from the reviews:

7.0 MEDICAL DIVISION

Interim work force models have been developed and implemented from March 2017 within the Medical division. The interim WFM has been developed to support care delivery whilst maintaining a focus on recruitment into vacant RN posts across the division. Once recruitment into the band 5 posts are realised the interim models will discontinue. The changes are detailed within Appendix 3 on those areas where interim models have been approved.

The new WFMs recognise areas of pressure from activity and are supported by current acuity & dependency studies (see Appendix 1).

The model will improve overall CHPPD levels and stability within the division. The proposal is supported by the development of divisional clinical educators (x4) who will operate in specific localities. They will focus on training support for the nursing workforce within the division and provide clinical support to new registrants and overseas nurses upon commencement into post across the clinical areas.

Further review of the specific WFMs where a longer term increase is proposed will be reviewed in the 18/19 workforce review aligned to strategic workforce and business planning.

8.0 SURGICAL DIVISION

Critical Care

The panel supported the recommendation for an additional 3.37wte band 5 at a cost of £118.470 to meet D16 guidance and CQC recommendations for 24 hour supernumerary co-ordination on the HRI site. This was taken through the divisional PRM structure for approval and governance.

The additional band 5's alongside working with the HOOP team will release a band 7 co-ordinator to be supervisory on the unit at weekends & nights. Week day cover will be provided by the Band 7 supervisory unit manager and senior clinical educator.

Surgical Specialities including Ward's 3, 10, 15, 19 & 20

Wards 19 and 20 were noted to be working across the floor supporting each other well to provide care and maintain safe staffing levels.

A proposal was made to increase the provision of long days for both the registered and support nursing workforce on ward 19. This would not reduce nurse to patient ratios and as the team cross covers with ward 20, would make ratio of long: short days more equitable across the floor.

The nursing workforce panel supported the introduction of an additional 1.22 WTE Band 2 to support a "Twilight Shift" on Wards 3,10 & 15, This was due to the realisation of increased demand and activity at this point during the day, caused by theatre returns and transfers from other areas.

Theatres:

Pre – Assessment:
No proposed changes made to the workforce model at present. However, divisionally further work is being carried out to identify how to release anaesthetic time back to anaesthetics by upskilling nursing staff to extend their roles.

Surgical Investment proposal:

Investment Recommended	£5,233
Disinvestment Recommended	£0
Difference between Investment and Disinvestment	**£5,233**

9.0 COMMUNITY DIVISION, DISTRICT NURSING

Significant work that had been completed by the division within the last 12 months which has allowed the district nursing team to establish activity led workforce models. No acuity studies have been completed recently within the community setting and there is minimal evidence of studies nationally. However the team are running local capacity & demand studies.

Initial recommendations reviewed by the panel required investment for an additional 2.33 WTE band 5 RN's to bring the establishment in line with the planned WFM. Following budgetary alignment additional investment was no longer required. The team were to look at reviewing the current WFM to introduce a long day shift – which would offset the outstanding difference and achieve the additional 2.33 WTE within existing establishment/budget.

There is currently 1.0 B7 WTE vacancy within District Nursing Team. However, leadership across the localities is currently under review as the locality model is implemented. The division are also implementing a Band 6 development programme to increase skill mix to meet caseload demand.

Community Investment proposal:

Investment Recommended	£0
Disinvestment Recommended	£0
Difference between Investment and Disinvestment	**£0**

10.0 FAMILIES AND SPECIALIST SERVICES DIVISION

Maternity Services

Midwifery staffing levels have been reviewed utilising the birth rate plus tool and the midwife to birth ratio

Ward 9 CRH

The panel were asked to consider the realignment of maternity inpatient services and note the realisation of different skill mix requirements within the department. The realignment scheme will place women undergoing induction of labour on Ward 9 (5 women cared for by 1 midwife 24/7) and women with babies who require additional care or who are on the NICU (8 women cared for by 1 midwife and 1 band 3 Family Support Worker)

This change in WFM would result in the disestablishment of a Band 6 midwife & Band 2 MSW and the investment of a Band 3 Nursery nurse MSW. The current ratio of Midwives to MSW 90:10 .This scheme will reduce the number of midwives to 191.88wte and with no increase the number of MSW (20.41wte) giving a ratio of 89:11.Disinvestment will be managed through vacancy £80.934.

Huddersfield Birth Centre

No proposed changes are made to the Birth Centre WFMs

Labour Ward & MAC

From 1 April 2017, changes will be made to the focus of the Band 7 Coordinators role, but not to the numbers of midwives working on LDRP. This will be to mitigate the impact of the disestablishment of the statutory supervision of midwives role.

Neonatal ICU

The division propose to disinvest in 2wte Band 5, £66 000.00. These posts are in the cost centre but not required to maintain Badger shift fill based on occupancy levels. These posts are not part of the derrogation plan - posts were not released last year due to double running costs associated with qualified in speciality (QIS) training to bring workforce up to required level of QIS which has now been achieved

Ward 3 Paediatrics

No changes recommended to nursing workforce as in the final phase of the 3 model scheme. The Division are currently evaluating the effectiveness of this initiative in terms of safe staffing and quality metrics.

A proposal to disinvest in 1 wte Band 1 Housekeeper £22 877 was supported by the panel. There are 2.6wte housekeeper posts across ward 18 and ward 3. One of these posts has been vacant for the last 6 months. During this time there have been no concerns about standards of hygiene or cleanliness. The two new ward managers actively participate in local audit and FLO and Exemplar Ward scores have been consistently high. This change is supported by the Matron and Clinical Managers

Ward 4, Gynaecology

The current WFM is established for a 16 bedded unit. The bed reduction scheme has resulted in the reduction of 4 beds.

The proposed new workforce model reflects this and would result in a disinvestment of 2.71wte Band 5 with a saving of £87,678.

Work is currently being done within the division to evaluate the opportunity for a nurse colposcopies and nurse hysteroscopist to increase their clinical activity to release consultant PA's. This would require 0.71wte from the revised WFM 0.71wte.

Gynaecology Assessment Unit CRH

A proposal was made to alter the workforce model in GAU during the week to compensate for the increased capacity & activity that the department are seeing following the closure of the HRI EPAU.

The panel advised to re-configure budgets to align this increase within establishment.

Out Patients Department

The division have presented their proposed OPD workforce model for Orthopaedics, ENT, and Medicine & Surgery. Previously no work force model was in place for this staffing group. This is a modernisation piece of work which complements work being undertaken within the division to develop a bespoke Clinical Prep Admin Team. The cost of this model is within current identified budget. The panel reviewed the proposal & supported it. The panel recommended that the development & ongoing governance of the extended band 3 workforce be monitored closely.

	Current	**Proposed**	**Variance**
Band 6	4.71	4.73	+0.02
Band 5	31.41	24.90	-6.51
Band 3	**-**	**9.56**	**+9.56**
Band 2 HCA - Admin	21.3	These posts will move into centralised Clinic Prep Admin Team – see GW2 Workbook	
Band 2 HCA – Clinical	32.28	34.55	+2.27

FSS Investment proposal:

Investment Recommended	£0
Disinvestment Recommended	£257,489
Difference between Investment and Disinvestment	**£257,489**

11.0 NON WARD BASED STAFFING REVIEWS

A Non-Ward Based and Specialist Nurse staffing review has been undertaken to record our baseline level from which we intend to benchmark and have identified any recommendations for improved service delivery. Some areas have been addressed in further detail such as the community nursing and specialist nursing teams and the community midwifery team. The findings of which are recorded within this paper.

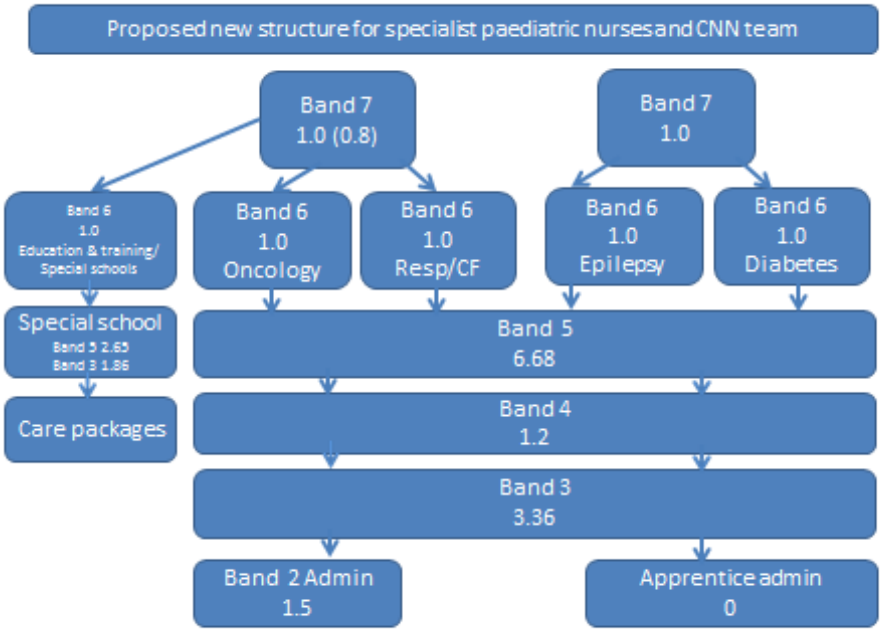
Medicine, Surgery and Community divisions have all commissioned further in depth reviews in to their Non-Ward based nursing teams, the process has begun through the Hard Truths review process and will be fully reported on in the subsequent Board report.

FSS: Community Children's Nursing services & Specialist Nursing teams

The division have reviewed their Community Children's nursing and Specialist nursing Teams services (CCNT & SNT). The review has focus on their current staffing structures, caseload sizes, referral numbers and current nationally recommended good practice guidance.

This has included a review of the skill mix of the teams which has been benchmarked against other local providers, a review of the contribution of practitioners to ensure no duplication of roles & review of working patterns against contracted hours.

The proposed new structure for the services is illustrated below and incorporated the amalgamation of services and develops a one team approach to service delivery. This proposed change will facilitate the extended hours of service for the CCNT which will improve service delivery & efficiency. The proposed new model would result in a £13.557 saving.



Community Midwifery services

The division has also carried out an in depth review of Calderdale and Huddersfield NHS Foundation Trust (CHFT) community midwifery services.
The objectives of the review were to:

1. Review qualified and unqualified community staffing levels and benchmark against current recommendations;
2. Review working patterns for qualified and unqualified community staff – this should include a review of on call arrangements, with benchmarking against other local providers and the extent and cost of call out for both hospital services and community services (Period April 16 – September 16);
3. Review antenatal clinic activity and determine whether there are any opportunities for efficiency;

Summary

- Community midwifery staffing levels benchmark higher than any others in the region with a caseload of 1:93, compared to 1:100/11). This is better than Royal College of Midwives recommended caseload size;
- Ratio of qualified to non-qualified staff is 88:12. This is in line with the recommendations of Birth Rate Plus
- The team are supported by a team of Band 7 midwives with broad areas of specialism and a Consultant Midwife. The complexity of the caseload is in line with the England average;
- Limited assurance available for Band 3 maternity support workers as there is no formal programme of assessment of competence;

Recommendations for Community Midwifery services

a) A formal Band 3 training and development programme for maternity support workers should be developed, with assessment of competence against standard criteria
b) Opportunities to extend the Band 3 role in line with the job description and nationally accepted criteria should be explored and a framework for training and assessment of competence established. Consideration should be given to using the Calderdale Framework
c) Service leads should review workforce against current and projected births for 2016-2017 to determine whether additional staff are required. There has been a reduction in bookings and births during 2016-2017 and this needs to be taken into consideration in workforce planning
d) A review of the administrative function should be undertaken to establish opportunities to provide a centralised 7 day service in line with the Trust strategic direction for administrative services

12.0 CONCLUSION

This 6 monthly review provides assurances to the Board that the trust continues to develop the Nursing & Midwifery workforce and that workforce models have been reviewed, scrutinised and challenged. There remains significant risk to the workforce due to the national shortage of qualified staff & recent level of vacancies, therefore sustainable recruitment & retention to the nursing workforce is a priority alongside workforce modernisation.

The Board can be reassured that the Trust is reviewing the capabilities of the newly introduced erostering and Safe Care systems and how these can be utilised to support our work in achieving the recommendations set out in Lord Carter's report.

The trust will need continue to embed the NQB guidance to inform strategic workforce planning for the Nursing and Midwifery Workforce to ensure the right staff with the right skills are available at the right time and place to provide compassionate care to people who access our services.

Appendix 1:

Acuity and Dependency Audit Results - November 2016

SURGERY												
Ward	Beds	AUKUH Nov 13	AUKUH Jan 14	SNCT Nov 14	SNCT June 15	SNCT Nov 15	SNCT May 16	SNCT Nov 16	Current N:B	Direct Patient Care % June 2015	Indirect Patient Care % June 2015	Comments
3	15	1.10	1.20	1.65	1.61	1.14	1.18	-	1.37	71.2 Q 85.8 Un Q	28.8 Q 14.2 Un Q	
10	20	1.10	1.50	1.30	1.41	1.39	1.55	-	1.25	59.9 Q 71.8 Un Q	40.1 Q 28.2 Un Q	
15	27	1.20	1.50	1.32	1.22	1.47	1.33	-	1.02	55.2 Q 78.6 Un Q	44.8 Q 21.4 Un Q	
19	22	1.30	1.60	1.42	1.62	1.53	1.41	-	1.75	54.7 Q 73.6 Un Q	45.3 Q 26.4 Un Q	
20	30	1.30	1.50	1.15	1.26	1.28	1.44	-	1.37	52.2 Q 69.4 Un Q	47.8 Q 30.6 Un Q	
22	23	1.10	1.20	1.18	1.18	1.19	1.05	-	1.23	60.2 Q 66.1 Un Q	39.8 Q 33.9 Un Q	
SAU	25	1.00	0.92	1.30	1.15	1.22	1.17	-	1.31	64.7 Q 49 un Q	35.3 Q 51.0 Un Q	
SAU AMB			-	-	-	0.83	0.75	-				
ICU HRI	8	-	-	3.03	2.30	3.02	3.39	-	4.95	40.7 Q 58.2 Un Q	59.3 Q 41.8 Un Q	
8AB	26	0.80	-	0.68	0.97	0.84	0.71	-	1.22	50.7 Q 66.1 Un Q	49.3 Q 33.9 UnQ	
8D	14	-	-	-	0.91	0.89	0.92	-	1.29	59.9 Q 71.2 Un Q	40.1 Q 28.2 Un Q	
ICU CRH	5	-	-	-	2.45	1.68	1.60	-		61.6	38.4	No unqualified hours for contact time.

MEDICINE												
Ward	Beds	AUKUH Nov 13	AUKUH Jan 14	SNCT Nov 14	SNCT June 15	SNCT Nov 15	SNCT May 16	SNCT Nov 16	Current N:B	Direct Patient Care % June 2015	Indirect Patient Care % June 2015	Comments
6D	15	1.38	1.13	1.33	-	1.18	1.30	1.11	2.10	70.3 Q 62.1 Un Q	29.7 Q 37.9 Un Q	
7AD	26	1.59	-	1.54	1.55	1.60	1.64	1.63	1.50	59.7 Q 67.2 Un Q	40.3 Q 32.8 Un Q	
7BC	26	1.54	1.22	1.48	1.55	7B – 1.62 7C – 1.62	7B – 1.63 7C – 1.58	7B – 1.65 7C – 1.53	1.50	73.1 Q 71.1 Un Q	26.9 Q 28.9 Un Q	
21	18	1.43	1.29	1.25	1.44	1.06	1.28	1.46	1.34	54.7 Q 71.9 Un Q	45.3 Q 28.1 Un Q	
HRI MAU	24	-	1.18	1.12	1.23	1.41	1.23	1.48	1.91	43.8 Q XXXX	56.2 Q XXXX	
HRI MAU AMB		-	-	-	-	0.30	0.58	-				
CRH MAU	24	1.24	1.15	1.22	1.46	1.47	1.52	1.45	1.91	60.5 Q 81.3 Un Q	39.5 Q 18.7 Un Q	
CRH MAU AMB		-	-	-	-	0.40	0.53	-				
6	23	-	1.35	1.26	0.98	1.37	1.34	1.50	1.46	43.5 Q 57.0 un Q	56.5 Q 43.0 Un Q	
2AB	31	1.28	1.24	1.24	1.14	1.26	1.24	2A – 1.02 2B – 1.11	1.31	54.7 Q 65.2 Un Q	45.3 Q 34.8 Un Q	
8	21	-	1.43	1.66	1.75	1.65	1.36	1.56	1.31	46.9 Q 61.7 Un Q	53.1 Q 38.3 Un Q	
4	15	1.70	1.54	1.31	1.36	1.44	-	-	1.7	71.2 Q 67.7 Un Q	28.8 Q 32.3 Un Q	
5AD	31	1.44	-	1.50	1.66	1.69	-	1.62	1.53	64.4 Q XXXX	35.6 Q XXXX	
17	24	1.21	-	-	1.21	2.43	-	1.51	1.32	62.5 Q 80.9 Un Q	37.5 Q 19.1 Un Q	
5C	16	1.42	1.42	1.59	1.59	1.57	1.58	1.67	1.42	62.8 Q 85.0 Un Q	38.7 Q 15.0 Un Q	

6BC / CCU		1.13	1.32	1.48	1.80	6BC 1.29 CCU 1.10	6BC 1.12 CCU 1.23	1.17	1.49	6B– 54.8% Q 6C – 51.5% 6B–66.7 Un Q 6C–81.1 Un Q	6B – 45.2% Q 6C – 48.5% 6B–33.3 Un Q 6C–18.9 Un Q	
12	20	1.23	1.45	1.31	1.43	1.28	1.36	1.31	1.38	55.1 Q 65.9 Un Q	44.9 Q 34.1 Un Q	
5	19	0.82	1.38	1.26	1.46	1.20	1.44	1.30	1.36	55.2 Q 66.0 Un Q	44.8 Q 34.0 Un Q	
CRH CDU		-	-	-	-	1.13	-	-				
HRI CDU		-	-	-	-	-	1.33	-				

FSS												
Ward	**Beds**	**AUKUH Nov 13**	**AUKUH Jan 14**	**SNCT Nov 14**	**SNCT June 15**	**SNCT Nov 15**	**SNCT May 16**	**SNCT Nov 16**	**Current N:B**	**Direct Patient Care % June 2015**	**Indirect Patient Care % June 2015**	**Comments**
3	25 + 10 assess beds							-	2.22	53.2 Q 55.7 Un Q	46.8 Q 44.3 Un Q	
18	8							-	2.42	49 Q	51 Q	No Unqualified for contact time
4C	16	-	-	-	1.02	0.97	1.13	-	1.50	55.4 Q 71.8 Un Q	44.6 Q 28.2 Un Q	
HBC / CBC	14							-	2.28	14 Q 47.5 un Q	86 Q 52.5 Un Q	
NICU	24							-	2.35	35.9 Q 0 Un Q	64.1 Q 100 Un Q	
1D	13							-	1.32	50.5 Q 57.5 Un Q	49.5 Q 42.5 Un Q	

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

Appendix 2

	Total CHPPD (Qualified and Unqualified)						Fill Rates Day (Qualified and Unqualified)			Fill Rates Night (Qualified and Unqualified)		
	Jan-17		Feb-17		Mar-17							
	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17
CRH MAU	9.5	8.5	10.3	9.0	12.6	11.0	84.9%	84.9%	84.1%	94.9%	94.9%	92.2%
HRI MAU	7.4	8.6	7.5	8.5	8.7	9.6	104.2 %	104.2 %	99.9%	136.8%	136.8%	125.4%
WARD 2AB	6.1	5.8	6.2	6.1	6.5	6.5	90.6%	90.6%	92.7%	102.4%	102.4%	109.6%
HRI Ward 5 (previously ward 4)	6.6	6.2	6.3	6.6	6.2	6.6	89.3%	89.3%	97.0%	102.0%	102.0%	124.1%
HRI Ward 11 (previously Ward 5)	6.5	6.3	7.0	6.8	6.6	6.3	94.8%	94.8%	92.1%	98.4%	98.4%	98.4%
WARD 5AD	6.3	6.6	6.3	6.7	6.3	6.5	101.0 %	101.0 %	103.6 %	112.0%	112.0%	103.7%
WARD 5C	6.1	5.8	6.2	6.0	6.4	6.1	91.6%	91.6%	93.5%	100.0%	100.0%	100.0%
WARD 6	6.7	6.5	6.7	6.2	6.2	5.7	95.9%	95.9%	88.5%	100.0%	100.0%	98.6%
WARD 6BC	5.2	5.1	5.5	5.1	5.7	5.4	91.8%	91.8%	93.7%	104.4%	104.4%	99.5%
WARD 5B	6.0	7.2	6.1	6.9	6.1	7.5	108.1 %	108.1 %	111.1 %	143.0%	143.0%	145.2%
WARD 6A	5.3	5.8	5.3	6.5	5.4	5.9	112.0 %	112.0 %	107.2 %	108.7%	108.7%	109.8%
WARD 8C	5.6	6.7	5.7	6.8	6.0	6.8	113.3 %	113.3 %	109.3 %	127.2%	127.2%	121.8%
WARD CCU	11.0	8.7	11.5	9.0	12.2	9.4	81.0%	81.0%	79.5%	75.7%	75.7%	74.2%
WARD 6D	11.4	10.1	12.5	10.8	14.4	12.0	83.3%	83.3%	78.4%	95.5%	95.5%	90.4%
WARD 7AD	6.8	6.5	6.7	6.3	6.9	6.6	91.7%	91.7%	93.0%	100.0%	100.0%	100.0%
WARD 7BC	6.5	6.4	6.6	6.5	6.7	6.6	97.0%	97.0%	97.4%	99.5%	99.5%	100.0%
WARD 8	7.1	7.5	5.8	6.5	7.1	8.1	108.1 %	108.1 %	111.7 %	104.1%	104.1%	118.8%
WARD 12	6.2	5.5	6.0	5.8	6.5	6.1	79.5%	79.5%	82.9%	106.7%	106.7%	116.4%
WARD 17	5.6	4.9	6.9	5.2	6.6	5.1	80.8%	80.8%	75.7%	103.8%	103.8%	80.3%

WARD 21	5.7	5.6		5.2	5.6		5.2	5.5	89.5%	89.5%	93.7%	114.4%	114.4%	131.2%
ICU CRH ICU HRI	42.6	36.6		31.7	26.9		35.2	28.0	84.0%	84.0%	80.0%	88.4%	88.4%	79.0%
WARD 3	6.1	7.3		6.1	7.5		6.1	6.5	111.6 %	111.6 %	109.6 %	130.1%	130.1%	100.0%
WARD 8AB	7.7	7.1		6.7	6.7		7.4	6.8	86.2%	86.2%	85.7%	101.5%	101.5%	100.9%
WARD 8D	7.0	6.7		6.6	6.7		9.3	8.5	92.5%	92.5%	86.6%	101.6%	101.6%	103.4%
WARD 10	5.5	5.6		5.6	5.9		5.6	5.7	102.4 %	102.4 %	101.1 %	101.5%	101.5%	105.6%
WARD 15	5.0	4.8		3.8	3.6		5.1	5.4	92.6%	92.6%	98.1%	103.2%	103.2%	122.6%
WARD 19	8.0	7.1		7.9	7.4		8.2	7.5	85.0%	85.0%	84.0%	96.1%	96.1%	100.5%
WARD 20	6.4	6.4		6.2	5.8		6.5	6.0	91.6%	91.6%	87.9%	110.2%	110.2%	101.6%
WARD 22	6.7	6.4		8.5	8.1		8.5	8.2	93.5%	93.5%	94.8%	100.0%	100.0%	100.8%
SAU HRI	8.4	7.9		9.0	8.5		9.8	9.1	90.2%	90.2%	90.1%	101.3%	101.3%	99.3%
WARD LDRP	34.7	31.0		28.9	25.9		30.3	25.8	87.0%	87.0%	83.1%	91.6%	91.6%	87.1%
WARD NICU	11.7	9.9		10.3	8.7		12.2	9.7	78.7%	78.7%	75.2%	90.4%	90.4%	85.1%
WARD 1D	9.6	8.2		8.9	7.9		8.5	7.9	82.3%	82.3%	89.6%	90.3%	90.3%	100.0%
WARD 3ABCD	15.5	14.4		15.8	14.2		13.8	12.5	87.8%	87.8%	83.3%	100.2%	100.2%	102.7%
WARD 4C	7.1	6.8		7.6	7.5		8.5	8.2	94.4%	94.4%	93.2%	98.9%	98.9%	100.0%
WARD 9	8.3	7.7		8.2	7.7		7.3	6.6	88.9%	88.9%	81.7%	98.9%	98.9%	100.0%
WARD 18	21.2	19.9		28.9	27.1		28.4	25.1	94.2%	94.2%	86.6%	93.5%	93.5%	90.3%
WARD 4	5.1	4.9		4.9	4.9		5.1	4.9	85.2%	85.2%	99.9%	100.0%	100.0%	101.1%
Trust	**7.8**	**7.5**		**7.8**	**7.5**		**8.1**	**7.7**	**91.6%**	**91.7%**	**90.9%**	**101.8%**	**101.9%**	**100.9%**

Appendix 3

Medical Division Interim Workforce Models 17/18 (only wards where interim models in place).

Ward 2c/d Medical Assessment Unit

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Current WFM					
	Qualified	Unqualified	RN to patient ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	2	1:4.8	72.28	1:6
Late	5	2	1:4.8		
Night	5	2	1:4.8		

New WFM					
	Qualified	Unqualified	RN to patient ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	3	1:4.8	61.39	1.74
Late	5	3	1:4.8		
Night	4	3	1:6.0		

Ward 2a/b Short Stay Unit

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	3	1:6.2	65:35	1.29
Late	5	3	1:6.2		
Night	4	2	1:7.5		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	3	1:6.2	64:36	1.23
Late	4	3	1:7.5		
Night	4	2	1:7.5		

Ward 5AD Acute Elderly Medicine

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	6	3	1:5.1	63:37	1.45
Late	5	3	1:6.2		
Night	4	3	1:7.5		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	4	1:6.2	55:45	1.53
Late	5	4	1:6.2		
Night	4	4	1:7.5		

Ward 5b Acute Elderly Medicine

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	3	2	1:5.3	65.35	1.52
Late	3	2	1:5.3		
Night	2	1	1:8		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	3	2	1:5.3	57:43	1.47
Late	3	3	1:5.3		
Night	2	2	1:8		

Ward 6a General Medical

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	3	2	1:5	65:35	1.52
Late	3	2	1:5		
Night	2	1	1:7.5		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	3	2	1.5	55:45	1.4.7
Late	2	3	1:7.5		
Night	2	1	1:7.5		

Ward 6bc Cardiology

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	2	1:6.4	70:30	1.16
Late	5	2	1:6.4		
Night	4	2	1:8		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	4	3	1:8	62:38	1.14
Late	4	3	1:8		
Night	4	2	1:8		

Ward 7BC and 7AD Stroke Rehabilitation Services

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	4	4	1:6.5	60:40	1.50
Late	4	3	1:6.5		
Night	4	2	1:6.5		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	4	4	1:6.5	51.49	1.51
Late	4	4	1:6.5		
Night	3	3	1:8.5		

Ward 1 Medical Assessment Unit

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	2	1:4.8	72:28	1.66
Late	5	2	1:4.8		
Night	5	2	1:6		

New WFM (increase in 6 beds)					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	5	1:6	54:46	1.57
Late	5	5	1:6		
Night	5	4	1:6		

Ward 5 Acute Elderly Medicine

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	3	1:5	57:43	1.53
Late	4	3	1:6.1		
Night	3	3	1:8.3		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	4	3	1:6.2	55:45	1.46
Late	4	3	1:6.2		
Night	3	3	1:8.3		

Ward 6 Short Stay Unit

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	2	1:4.6	68:32	1.51
Late	5	2	1:4.6		
Night	3	2	1:7.6		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	4	3	1:5.7	59:41	1.47
Late	4	3	1:5.7		
Night	3	2	1:7.6		

Ward 17 Gastroenterology

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	3	1:4.8	69:31	1.56
Late	5	3	1:4.8		
Night	4	1	1:6		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	5	3	1:4.8	62:38	1.53
Late	5	3	1:4.8		
Night	3	2	1:6		

Ward 21 General Rehabilitation

Current WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	3	3	1:6	61:39	1.37
Late	3	2	1:6		
Night	2	1	1:9		

New WFM					
	Qualified	Unqualified	Nurse to bed ratio	% Qualitied to unqualified	Nurse WTE per bed
Early	3	3	1:6	54:46	1.46
Late	3	2	1:6		
Night	2	2	1:9		

Ambulatory care HRI

Current WFM		
	Qualified	Unqualified
Early	1	1
Late	1	1

New WFM		
	Qualified	Unqualified
Early	1	1
Late	2	1

Appendix 4

NQB Guidance, update & CHFT's response

NQB RECOMMENDATIONS	What does this mean in practice	CHFT's Position –December 2016
1. **Boards take full responsibility for the quality of care provided to Patients, and as a key determinant to quality, take full collective responsibility for nursing, midwifery and care staffing capacity and capability.**	Includes all aspects of board reporting and monitoring of establishments, actual and day to day staffing levels Emphasis on hours monitoring included as part of the NICE guidance and the requirements for uploading information to NHS Choices	**In place** – Monthly Board report. Visible on Trust Website and 6 monthly strategic staffing establishment reports presented to Trust Board each year. 6 monthly Acuity & Dependency study's carried out on all in-patient area's
2. **Processes are in place to enable staffing establishments to be met on a Shift to Shift basis.**	Executive team should ensure that policies and systems are in place, such as eRostering and escalation policies.	**In place** – • Daily monitoring of staffing levels. • eRostering in place for all in patient areas. Safe Care live Module to be embedded in inpatient area's **by August 2017** • Safe staffing incorporated in the nursing & midwifery induction • CHPPD data reviewed & scrutinised • SOP in place for use of temporary staffing solutions with Head of Nursing sign off for Framework agency and
3. **Evidence based tools are used to inform nursing, midwifery and care staffing capacity and capability.**	Use of proven methodologies and triangulation with professional judgement for setting staff levels	**In place** – Benchmarking, Safer Nursing Care Tool, NICE guidance and professional judgement utilised as part of the 6 monthly staffing reviews.
4. **Clinical and managerial leaders foster a**	Encourages working in well-functioning	**In place** –

culture of professionalism and responsiveness where staff feel able to raise concerns	teams supported by appropriate infrastructure and support model. Requires an open culture to report shortfall.	incidents received, monitored and themed monthly.

Expectation	What does this mean in practice	CHFT's Position - December 2016
5. **A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments**	Directors of Nursing lead the process of reviewing staffing requirements and ensure that: There is a process in place actively involves sisters, charge nurses, or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR) and Operations. Recognising interdependencies between staffing and other aspects of the organisation's functions.	**In place** – Director of Nursing and Finance undertake staffing review panel. Heads of Nursing present to panel, along with General Manager, HR and Finance Business Partners and are key attendees at Monthly Nursing and Midwifery Workforce group.
6. **Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their**	Recommendation on adequate Headroom (no percentages stipulated) Recommendations on supervisory time for ward leaders (no time stipulated)	**In place** – Headroom included in all budgeted staffing levels for wards at 22% exclusive of Maternity Leave. Supervisory ward leader model is in place trust wide for 100% of time, however due to current vacancies this is not always achieved at 100%
7. **Boards receive monthly updates on workforce information, staffing capacity and capability is discussed at Public Board meeting at least every 6 months on the basis of full nursing and midwifery establishment review.**	Monthly workforce reports go to board detailing actual staffing levels against establishment for the Previous month – highlighting hotspot areas. 6 monthly establishment reviews to go to open board for discussion and debate	**In place** – Quality Board report presented monthly. Hotspot areas listed with actions when fill rates less than 75%. 6 monthly establishment review
8. **NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting,** **Department or service on each shift.**	Display information of staff present by shifts clearly and visibly for patients.	**In Place** – wards display staffing levels

Expectation	What does this mean in practice	CHFT's Position - December 2016
9. **Providers of NHS services take an active role in securing staff in line with their workforce requirements**	Robust recruitment and retention plans need to be in place within the organisation Organisations to work with LETB and others to inform commissioning intensions and future workforce planning.	**In place** – CHFT fully engaged with workforce planning cycle at both local and regional level. Funding reforms will allow CHFT to have greater influence with the local HEI to train more nurses, CHFT preparing for increased placement of students. Also…. - Recruitment & retention strategy in place - Robust preceptorship package – and ongoing educational programme embedded for new recruits - Band 5 development/competency package in place - Band 7 development programme
10. Commissioners should seek assurance that providers have sufficient nursing and care staffing capacity and capability to deliver the outcomes and quality standards.	Transparent communication and review with Commissioners about any issues relating to safety and staffing levels. Impact Assessments.	**In place** – CHFT maintain constant assessment and review with Commissioners about any issues relating to safety and staffing levels. Processes are in place to ensure the Medical / Nurse Director review of any Cost Improvement Programmes, ensuring that they are robustly assessed for impact on quality via Quality Impact Assessments.

Updated NQB Guidance:

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

NQB Expectation	CHFT's position
Exception 1 : Right Staff	- Evidenced based workforce planning: Strategic staffing establishment reviews & reports to board yearly. - 6 monthly acuity & decency studies. Safe care tool to be in place by August 2017 - Head room calculation built into staffing establishments - Professional judgment built into staffing establishment levels ensuring a triangulated approach to staffing reviews - CHPPD data collected, scrutinised & used to benchmark staff levels internally, locally & nationally
Expectation 2 : Right skills	- Robust mandatory training records - Clinical nurse educators in post providing skills mapping & assessment in clinical practice for new recruits to CHFT - Comprehensive preceptorship policy & programme mapped to national frameworks. Ongoing preceptorship/educational programme of study for new recruits - Robust induction package for all new nursing & midwifery recruits to CHFT - Modernisation plans to support the nursing workforce: Introduction of the Nursing Associate role, Band 4 Assistant Practitioners & ACP'S - Values based recruitment & retention to nursing & midwifery roles
Expectation 3: Right place & time	- Clear escalation process in place for staff to report staffing levels - Staffing incidents reported weekly & reviewed monthly at workforce meetings. - Staff deployed to cover unanticipated staffing shortages - eRostering system in place – rostering policy mapped to Best practice guidance (Updated December 2016) - Re-designed ward based roles – ward based pharmacist/AHP's - Flexible working opportunities - Monthly vacancy & pipeline reports to the senior nursing workforce team

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st June 2017	**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.

Main Body

Purpose:

The Board is asked to receive the updates and minutes from the sub-committees:-
Quality Committee - verbal update from meeting 31.5.17
Finance and Performance Committee - minutes of 4.4.17, 2.5.17 and verbal update from meeting 30.5.17
Audit and Risk Committee - minutes of 19.4.17 and verbal update from meeting 25.5.17

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.

Appendix

Attachment:

COMBINED SUB CTTEE MINS ETC..pdf

APP A

Minutes of the Finance & Performance Committee held on Tuesday 4 April 2017 at 9.00am in Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary

PRESENT

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

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance
Mandy Griffin	Director of Health Informatics (In part)
Andrew Haigh	Chair
Andrea McCourt	Head of Governance & Risk – (for item 066/17 only)
Victoria Pickles	Company Secretary – (for item 059/17 only)
Betty Sewell	PA (Minutes)

ITEM

WELCOME AND INTRODUCTIONS

055/17 The Chair welcomed attendees to the meeting.

056/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
David Birkenhead – Medical Director
Brendan Brown – Director of Nursing
Brian Moore – Membership Councillor
Owen Williams – Chief Executive
Ian Warren - Director of Workforce & Organisational Development

057/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

058/17 MINUTES OF THE MEETING HELD 28 FEBRUARY 2017

The minutes of the last meeting were reviewed and subject to an amendment to Minute **046/17 – Budget Book**, they were approved as an accurate record.

059/17 MATTERS ARISING AND ACTION LOG

The Company Secretary presented a paper which asked the Committee to review and approve the amendment to the Risk on the Board Assurance Framework in relation to the NHSI compliance which was requested to be reviewed at this Committee by the Board. Discussions took place and it was noted that in light of the Trust's year end position it was agreed to reduce the risk to the target score of 10. With regard to the wording of the Risk for 2017/18, it was agreed that discussions will take place to agree the phrasing/re-fresh of the Risk noting that we will still have

the same challenges as 2016 with the additional risks of the Control Total and one or two elements of regulatory risk due to the change in the rules.

The Committee approved the amendment to the Board Assurance Framework risk.

Helen Barker and Jan Wilson joined the meeting.

156/16: Review the Commissioner Requested Services (CRS) – The Director of Transformation and Partnerships presented a follow-up paper from the previous meeting which provided further analysis to show the service line position when benchmarked against the national reference cost index, the paper also identified potential opportunities to improve the services financial sustainability and viability going forward. The key areas were highlighted along with some detail of the work which is being carried out in mitigation.

Discussions took place with regard to how the Trust is addressing these large deficits through our Operational Plan and our CIP programme. It was noted that there are sizeable values associated with CIP schemes which relate to some areas highlighted and examples were provided. It was suggested that it would be interesting to see the likely financial impact and realistic financial targets to reduce the deficits.

Following further discussions the following actions were agreed:

ACTIONS:

- It was agreed that this information should be monitored over time to assess the impact and it will be reviewed again at this forum in 6 months – **AB 31/10/17**
- The SLR 'bubble charts' are included in the Finance Report and these are tracked within the Divisional PRMs, it was agreed that a focus of these charts would take place at a future Committee meeting – **GB 5/9/17**

It was noted that conversations with Commissioners are taking place through the Transformational Board and a Workshop is also being arranged. It was agreed that the Trust should find a way to work with the Commissioners looking at the whole health economy.

Community Services – The Director of Transformation & Partnerships reported to the Committee that dialogue continues with the local authority, it was agreed that the Committee would review again in 3 months – **AB 01/08/17**

042/17: Acuity Proxy – The Chief Operating Officer provided a paper for information following the last meeting which had also been shared with the CCGs.

The Committee noted the paper for information.

FINANCE AND PERFORMANCE

060/17 MONTH 11 FINANCE REPORT

The Deputy Director of Finance, reported the following headlines for Month 11:

- Favourable position retained at Month 11.
- Capital is below plan but we have a significant portion of expenditure committed in Month 12 which will take a cash requirement into 2017/18, EPR being one example.
- Cash is slightly better than planned due to early receipts and lower capital spend. Our overall borrowing is at a lower planned level and we are managing this position with delays in the STF payment which was expected to be paid in Month 11 and will now be received in Month 12 at the earliest.
- We maintain the year-end forecast position to deliver the planned Control Total and there is greater confidence that this can be delivered without the reliance of the Soft FM benefit due mainly to the prudence with the Divisional forecasts.
- Debtors – £5m outstanding at the end of February, it was confirmed that this is part of the Bad Debt Provision. It was noted that as part of the Cash Committee's new way of working, a deep-dive into clearing outstanding debt was very successful.

The Chief Operating Officer informed the Committee that a further meeting will be taking place with regard to the Accelerator Zone and the position for next year was clarified. Helen Barker also informed the Committee that the implementation of IR35 has completely destabilised the A&E department and it was noted that this would be further discussed within the Private Session of the Board.

061/17 2017/18 OPERATIONAL PLAN

The Director of Finance reported that conversations have taken place in different forums recently but to ensure everyone was up to speed explained the timeline with regard to developments. The paper provided an update on the Operational Plan for 2017/18 and 2018/19 that was submitted to NHSI on 29 March 2017. It was noted that the re-submission of our Capital plan was very uncomfortable with high risk capital schemes being removed to achieve the funds available to the Trust. As a result it was agreed to forward a formal letter with the revised plan which highlighted all the risks and the request to have further discussions with NHSI regarding capital in year.

ACTION: It was agreed that the letter to NHSI would be circulated – **GB Completed 6/4/17**

It was also noted that even though a Capital Plan had to be submitted it may require re-prioritisation and agreement on which schemes are escalated to NHSI.

The Committee noted the position and the approach to manage the capital plan.

STRATEGIC ITEMS

062/17 CIP UPDATE

The Director Transformation and Partnerships tabled a paper which updated the Committee with the very latest position. The key headline noted was that £14.5m

CIP has been identified against a target of £17m, this excludes the non-recurrent Soft FM provision. Of the £14.5m schemes 70% sit at Gateway 2 or 2 Ready which leaves 30% at Gateway 1 or still within scoping. The schemes at Gateway 1 will be discussed at Turnaround Executive later today and the possibility of holding Star Chambers will also be discussed. In terms of closing the gap, FSS, Estates and Surgery have the largest gaps, however, it was noted that 2 large schemes including Pharmacy and Outpatients sit with FSS but the benefits will be seen elsewhere.

063/17 EPR

The Associate Director of Finance reported that the forecast remains consistent with previous reports. Challenges still remain with our external auditors regarding capital and revenue costs, as an update, VAT has been included within the year to date costs and forecast reported due to a change in guidance from the Trust's VAT advisors.

The Chief Operating Officer provided an operational update and confirmed a meeting had taken place with each Division to review their operational plans which are now being reviewed. The challenge is the delivery and recovery of costs between a 6 week period to be managed through capital.

Discussions took place with regard to the assumptions which had been made for colleagues to learn the system, it was noted that there is a nervousness coming out of the training which is being managed. It was also noted that there is a significant issue with regard to the Digital Dictation connection and interface which is being quantified.

ACTION: It was agreed that 'hot-spots' would be shared with Executives for the implementation weekend to enable these areas to be closely monitored - **HB**

The following headlines were noted from a programme perspective:

- Operational and technical planning is now combined
- Training is progressing well with high volumes of staff completing training
- The Full Dress Rehearsal was signed off by Chief Execs last week
- The GE assurance report has rated Amber/Green with some issues being addressed
- 23 days to Go-live
- Feedback from Cerner is very positive

066/17 CNST CONTRIBUTIONS

The Head of Governance & Risk introduced a joint paper which had been prepared between Governance & Risk and Finance, the paper will also go to WEB.

The Deputy Director of Finance went on to explain that the basis for CNST contributions has not changed and our contribution for 17/18 has increased by 10%, which is the lowest banding increase. Queries are being pursued with NHSLA with regard to the data being used to calculate the claim but it is unlikely that there will be a reduction to our contribution following clarification. National and local benchmarking has been carried out, nationally we are above average and locally Maternity is a specific area which is higher than our local comparator also, Cardio

and Gastro. It was noted that anything we do to successfully change in the short term will not have an instant impact, as the premium calculated is based on paid claims over the last 5 years.

The Head of Governance & Risk reported that the Trust is now focussed on reducing claims, information on settled claims is shared on a quarterly basis with Divisions requesting them to identify learning from the claim. The paper explained the detailed work which has taken place with the FSS Division to understand the claims profile for Maternity and how we can learn lessons from this to improve safety for patients. The Chair of the Trust suggested that the consultant clinical psychologist working in Oncology should be linked into the psychological care work.

It was also noted that as from April 2017 the NHS Litigation Authority will be known as NHS Resolution bringing together the NHSLA and the National Clinical Assessment Service.

The Committee noted the contents of the paper.

064/17 EPR BUSINESS CASE REVIEW

The Director of Health Informatics introduced the paper re-setting the original business case with where we are now, questions and comments were opened to the Committee.

In depth discussions took place with regard to the benefits associated with the project and the need to carry out further investigation into additional benefits, this will be covered in the review post go live. It was noted that additional resource was required to work on the benefits realisation piece. It was agreed that the focus at this point in time should be on the delivery of the implementation and once the project is stabilised benefits can be identified.

Taking the learning forward and looking at the conclusions within the report, the original 13 month timeline was deemed unrealistic the key reasons for this was the dual implementation, which should have been better resourced, and the delays with data migration.

ACTION: It was agreed that a review of the treatment of EPR within the CIP programme needs to be planned – **HB/MG/AB/GB(Meeting scheduled for 18/4/17)**

GOVERNANCE

065/17 INTEGRATED PERFORMANCE REPORT – QUARTERLY DEEP-DIVE

The Chief Operating Officer reported that there had been an overall dip in performance relating to 'one-off' issues. The following points were highlighted:

- Last minute cancelled ops – there is a challenge to the team to review whether pre-assessment is robust as we are seeing a high number of cancelled ops for clinical reasons. In terms of non-clinical bed issues in March have not been the reason and a review of what is driving this position will be carried out. Findings will be shared with the Committee.

ACTION: To share the outcomes of the deep-dive into Cancelled Ops with the Committee – **HB 04/07/17**

- Diagnostics is another area of risk, whilst Endoscopy have managed well with the potential risk due to the fire, capacity in Bowel Screening has been affected. Ultrasound has also taken a significant hit, they have been reliant on agency but work is on-going with the team to reconfigure ways of working to get capacity back up.
- A significant positive improvement with #NoF has been seen and new clinical leadership and key actions are being implemented following a 'go-see' to Boston Hospital.

Referring to the action from the last meeting, it was noted that with regard to Length of Stay/Green Cross patients a paper will be discussed at WEB, the paper will be circulated and Helen Barker will take any questions off-line, this will be discussed at the meeting on the 30 May 2017.

The Committee noted the contents of the report and the overall performance score for February.

067/17 MONTH 11 COMMENTARY TO NHS IMPROVEMENT

The Committee received the paper for information which provides the Management Commentary on the financial position of the Trust at the end of February 2017 which has been submitted to NHSI.

The Committee noted the contents.

068/17 MINUTES FROM SUB-COMMITTEES:

Capital Management Group – Draft Minutes of meeting held 9 March 2017

ACTION: To include values against schemes in future Minutes would be helpful - **SB**

The Committee received the Minutes and noted the contents.

069/17 WORK PLAN

The Work Plan was received and noted by the Committee.

070/17 MATTERS FOR THE BOARD AND OTHER COMMITTEES

The Chair of the Committee noted the following items which had been discussed during the meeting:-

- EPR Update to the Private Board
- IR35 to be highlighted as part of the Private Board

071/17 ANY OTHER BUSINESS

There were no items raised.

DATE AND TIME OF NEXT MEETING
Tuesday 2 May 2017, 9.00am – 12.00noon, Gary Boothby's office, AMO – Revised attendance

As a reminder the next meeting, Tuesday, 2nd May will include Phil Oldfield, Chair, Richard Hopkin and Jan Wilson, Non-Executive Directors, Gary Boothby, Director of Finance, Kirsty Archer, Deputy Director of Finance and Stuart Baron, ; everyone else can stand down.

The next full Committee meeting will take place **Tuesday 30 May, 9.00am – 12.00noon**, Room 4 Acre Mill Outpatients building and the Work Plan would be amended accordingly.

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Tuesday 2 May 2017 at 9.00am in Acre Mills Outpatients

PRESENT

Gary Boothby	Director of Finance
Phil Oldfield	Non-Executive Director (Chair)
Richard Hopkins	Non-Executive Director
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance

ITEM

WELCOME AND INTRODUCTIONS

055/17 Attendees were welcomed to the meeting.

Due to EPR go-live, it had been agreed at the previous meeting that the meeting scheduled for Tuesday, 2nd May would include Non-Executive Directors; Gary Boothby, Director of Finance and Finance representatives only; everyone else was stood down.

056/17 APOLOGIES FOR ABSENCE

No apologies for absence, limited attendance agreed in advance.

057/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

058/17 MINUTES OF THE MEETING HELD 28 FEBRUARY 2017

It was agreed that the minutes of the last meeting will be ratified at the next formal Finance and Performance Committee on 30 May 2017.

059/17 <u>2016/17 YEAR END FINANCIAL POSITION</u>

HEADLINES

The full financial reporting pack and management commentary to accompany the Month 12 submission to NHSI had previously been circulated by e-mail to all members of the committee. The committee reviewed the headline year-end financial position reported for 2016/17.

- It was noted that all of the key financial metrics for the financial year have been met including delivery of the control total deficit and lower than planned capital expenditure, in line with the latest forecast committed to the regulator
- Cash holding is in line with the expectations laid down as a condition of the Trust's borrowing
- Loan funding was lower than planned, primarily due to the lower capital expenditure although capital creditors at the end of the year are high, linked to EPR and will take an additional cash requirement into 2017/18.

- CIP delivery exceeded plan but elements of this have been achieved non recurrently. In 2017/18 more emphasis would be placed on the full year recurrent impact of CIP delivery alongside the in-year position.
- The Use of Resources rating was discussed and sensitivities of the various metrics described to the committee.

YEAR END REVENUE POSITION

- The key differences between the control total deficit position and the year-end revenue position as presented in the Trust's submitted year end accounts was described.
- Aside from technical accounting adjustments the key difference is made up of Strategic Transformation Funding (STF), combining £0.26m STF incentive and £1.09m STF bonus as notified by NHS Improvement (NHSI).
- The methodology by which NHSI have derived the value of the STF bonus is not clear against regional comparators and this is to be raised as a query with the regulator.
- It was explained that the additional STF will bring a cash benefit only to 2017/18, easing some of the burden posed by 2016/17 capital creditors.
- The year-end provisions were reviewed and the rationale for the calculation of the provision for irrecoverable debts was discussed.
- The level of routine information provision to the committee was discussed and the improvements made to the reporting pack in year were welcomed, in overall terms the information was thought to be comprehensive and understandable. A specific request to include the value of the provision for irrecoverable debts will be picked up in future reporting (Action – KA).
- The underlying deficit was highlighted at circa £27m, this being the reported £16m deficit excluding £11m STF.

YEAR END AUDIT FOCUS

- The treatment of costs concerned with the implementation of the Electronic Patient Record have previously been discussed with the external auditors, KPMG and these may be of particular note due to their one off and significant nature.
- The level of prudence in the Trust's provisions was noted last year and may therefore be under review. The overall level of provisions held has reduced.
- The 'Going Concern' statement was discussed in the context of the Trust's financial position. It was explained that the Trust in in the same position as last year and indeed as many other organisations. The going concern note will be supported by the Trust's agreed loan funding, ongoing cash backed contracts with commissioners and future sustainability plans.

060/17 2017/18 FINANCIAL RISKS & OPPORTUNITIES

The key risks inherent within the 2017/18 financial plan which have been discussed at previous meetings of the committee were summarised as follows:

- EPR implementation costs / productivity impact
- CIP £17m, plus £3m additional efficiency requirement
- Commissioner QIPP & service reviews
- Agency costs

- Capital expenditure constraints – prioritisation
- Achievement of Strategic Transformation Fund criteria
- Full business case development funding
- Cash availability and interest

These will continue to form part of discussions with NHSI with the next opportunity for this being at the Quarterly Review Meeting scheduled for 9 May 2017. Opportunities and mitigations were also discussed and will continue to be pursued.

061/17 ANY OTHER BUSINESS

The appreciation of the committee for the continued hard work of the Finance team in submitting the year end accounts and financial plans, in accordance with tight national deadlines, was noted.

DATE AND TIME OF NEXT MEETING

Tuesday 30 May 2017, 9.00am – 12.00noon,
Room 4, Acre Mills Outpatients

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Audit and Risk Committee Meeting held on Wednesday 19 April 2017 in the Chief Executive's Office, Trust Headquarters, HRI commencing at 10.45 am

MEMBERS

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

IN ATTENDANCE

Gary Boothby	Executive Director of Finance
Kathy Bray	Board Secretary (minutes
Michael George	Internal Audit Manager
Adele Jowett	Local Counter Fraud Specialist
Helen Kemp-Taylor,	Head of Internal Audit
Peter Middleton	Membership Councillor
Alistair Newall	External Auditor
Clare Partridge,	External Auditor (for part of meeting)
Victoria Pickles	Company Secretary
Andrew Haigh	CHFT Chairman as Observer
Ian Warren	Executive Director of Workforce and OD (for agenda item 4)
Steve Billingham	Payroll Team Leader (for agenda item 4)
Pete Wellock	Payroll Team Leader (for agenda item 5)

Item

16/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Brendan Brown, Non-Executive Director
Andrea McCourt, Head of Governance and Risk

17/17 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

18/17 MINUTES OF THE MEETING HELD ON 18 JANUARY 2017

The minutes of the meeting held on 18 January 2017 were agreed as a correct record.

19/17 ACTION LOG AND MATTERS ARISING

b. 46/16 - Payroll Internal Audit

As agreed at the previous meeting Ian Warren, Executive Director of Workforce and OD, introduced Steve Billingham and Pete Wellock who were working with the Trust from Leeds Teaching Hospital initially for a 6 month period. Discussion took place regarding changes in the Payroll Department and it was noted that the current management arrangements in the department would be addressed as the Leeds arrangements were reviewed.

The team had been invited to update on the progress made to address the issues identified in the Audit of the payroll function which had been on the agenda for some time. To date most items on the Action Plan had been rated green and completed. Discussion took place regarding the changes which had been made bringing the Leeds model to CHFT which had reduced risks and was being embedded in the organisation to provide a more robust system. Work outstanding and on-going included double payment checks, move towards electronic timesheets and expenses checks, bank staff records and tax allowances and review of the Electronic Staff Record system, once the Electronic Patient Record system has been embedded in the organisation.

Discussion took place regarding the management of the department and it was noted that this would be addressed once the position with Leeds was reviewed.

It was agreed that a further report should be brought back to the meeting in July to update on the arrangements.

ACTION: IW – AGENDA ITEM 19.7.17

OUTCOME: The Committee noted the work undertaken to date and agreed to receive a further update at the meeting on 19 July 2017**.**

20/17 COMPANY SECRETARY'S BUSINESS

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

1. REPORT ON CURRENT REGULATORY COMPLIANCE ISSUES/CORPORATE COMPLIANCE REGISTER

The Audit and Risk Committee were asked to receive the updated Regulatory Compliance Register/Corporate Compliance Register. It was noted that this format was slightly different as work had been undertaken to strengthen the governance arrangements around compliance and risk. It was noted that at present this was a working document. Work was on going with Divisions to standardise the reporting and include visits and accreditations in the future.

OUTCOME: The Audit and Risk Committee **RECEIVED** the Corporate Compliance register and **NOTED** the revised format.

2. ARC SELF-ASSESSMENT OF COMMITTEE'S EFFECTIVENESS

The Audit and Risk Committee members and Board of Directors were asked to complete a self-assessment of the Audit and Risk Committee's Effectiveness in 2016 and an action plan had been developed to respond to the findings. A total of nine responses were received. The action plan attached to the papers had been developed to address these responses and would be brought back to the future ARC meetings to review progress.

OUTCOME: The Committee **APPROVED** the Action plan to address the feedback and agreed that it should be reviewed at future ARC Meetings.

ACTION: ARC AGENDA ITEM

3. ARC ATTENDANCE REGISTER

It was noted that the information in the Register will be used within the Annual Report and Accounts.

OUTCOME: The Committee **RECEIVED and APPROVED** the ARC Attendance Record

4. REVIEW OF ANNUAL GOVERNANCE STATEMENT

It was noted that the draft Annual Governance Statement had been circulated and further work would be undertaken to address the three outstanding issues before it is included in the Annual Report. It was agreed that the significant matters in-year would be:- CQC, Performance metrics, recruitment and retention and impacts of winter. Prof Peter Roberts suggested that sustainability should also be included as the Trust had done significant work setting up the Sustainability Group.

ACTION: COMPANY SECRETARY

OUTCOME: The Committee **APPROVED** the Draft Annual Governance Statement

5. REVIEW OF CODE OF GOVERNANCE

The Company Secretary reminded the Committee that as part of our annual reporting process we are required to provide a report stating compliance against the Code of Governance on a comply or explain basis. A draft assessment of compliance had been

circulated with the papers. It was agreed that outstanding work will include work with WYAAT and Local STP arrangements.
OUTCOME: The Audit and Risk Committee were asked to forward the Company Secretary any additional comments on the draft assessment of compliance with the Code of Governance.

6. REVIEW OF STANDING ORDERS
The Company Secretary advised that the Standing Orders had been reviewed in line with WYAAT Committee in Common. It was noted that this would come back to the Audit and Risk Committee in July for approval of changes in relation to Conflicts of Interest.
ACTION: COMPANY SECRETARY – ARC JULY AGENDA

OUTCOME: The Committee **APPROVED** the changes subject to amendments regarding Conflicts in Interest.

7. MANAGING CONFLICTS OF INTERESTS IN THE NHS
The guidance for Managing Conflicts of Interest in the NHS had been circulated and the template had been received earlier that week. It was noted that the new arrangements would come into force on the 1 June 2017. The Company Secretary briefly outlined the differences to the current Trust policy.

The key issue was the Trust deciding on the level of decision making within the organisation. The guidance had suggested that all staff 8d banding and above (or equivalent) must make an annual declaration as a minimum, although it was not clear whether this should be lower for CHFT.

The Company Secretary advised that an electronic system was available and once a decision on the banding had been made further would be undertaken to procure this.

Prof Peter Roberts expressed concern regarding the low number of declarations received from clinical practitioners and the risks for the Trust.

It was noted that discussions on the banding for declarations would be made at the Executive Board meeting on the 11 May.

OUTCOME: The Committee **NOTED** that this would be developed further following a decision on the level of decision making in the organisation had been made by the Executive Board.

8. REVIEW RISK AND COMPLIANCE GROUP TERMS OF REFERENCE
The Committee noted that the meetings of this group had been split to focus on risk and compliance at alternate meetings. The Terms of Reference had been amended to reflect this. It was noted that the minutes from this group would continue to feed into the Audit and Risk Committee.
OUTCOME: The Committee **APPROVED** the amended Terms of Reference for the Risk and Compliance Group

9. AUDIT AND RISK COMMITTEE ANNUAL REPORT
The Company Secretary presented a draft report from the Audit and Risk Committee which would be incorporated into the Trust Annual Report. It was noted that further work would be undertaken and subject to these amendments the Committee approved the document.
OUTCOME: The Committee **APPROVED** the draft Annual Report from the ARC

EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS
1. Review Waiving of Standing Orders
The Deputy Director of Finance presented a report detailing the waving of Standing

Orders during the fourth financial quarter of 2016/2017. During this quarter, 10 were placed as a result of standing orders being waived, at a total cost of £336,135.85. No amendments to earlier single sources were made this quarter.
OUTCOME: The Committee **RECEIVED** and **APPROVED** the report.

2. Review of Losses and Special Payments
In accordance with the Standing Financial Instructions, the Deputy Director of Finance presented the losses and special payments for the quarter ending 31 March 2017.

The key issues were:-

- **Loss of Personal Effects** £1k relates to six claims which ranged from lost glasses, lost trainers to lost dentures. It was agreed that this was a minor cost bearing in mind the activity within the Trust and the personal impact on patients.

- **Damage and loss to buildings, equipment and stores** of £16.2k consisted of Pharmacy expired stock. The Trust holds approximately £1.2m over 11,000 lines which are closely monitored. It was noted that work was underway with WYAAT to review an estates collaborative approach and the pharmacy position was overseen by the Pharmacy Management Board each month.

- **Public/Employer's liability claims** of £2.7k was made up of three repayments to NHS Litigation Authority for damages or costs.

- **Bad Debts** are entered onto the losses register when it has been determined that the loss is irrecoverable or it is uneconomical to pursue the debt further. Bad debts that are written off exclude any inter NHS balances. Bad debt for overseas visitors related to 5 invoices and other related to 7 invoices. These invoices are old debts dating back to 2014 and 2015 which had been pursued to exhaustion.

  Peter Middleton asked for assurance that staff dealing with overseas patient debts had received training and were supported in this role. It was confirmed that this was the case and a system was in place in the Trust.

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

3. TREASURY MANAGEMENT POLICY
The Executive Director of Finance presented the updated Treasury Management Policy. It was noted that the main changes related to 'investing' changes and the emphasis from investment to borrowing.

OUTCOME: The Committee **APPROVED** the Treasury Management Policy for inclusion on the Policies intranet system following submission to the next Board Meeting.

ACTION: BOD AGENDA – 1.6.17

22/17 INTERNAL AUDIT

1. Review of Internal Audit Follow-up Report
The Internal Audit Manager presented the report and the highlighted the progress made around the recommendations which had improved due to the intervention of Trust input in pursuing follow-ups on behalf of Internal Audit. The three audits reviewed were:- Community Midwives, Car Parking and Safe Guarding.

It was agreed that the high risk issues with limited assurance should be focussed on and the Company Secretary confirmed that she would pursue the 'Storage and Transport of Medicines Audit' before the next meeting.

ACTION: COMPANY SECRETARY

Discussion took place regarding the 'Action Overdue but some progress' column and it was agreed that this did not provide sufficient assurance and therefore suggested that risks with limited assurance should be focused on and either an extra column or symbol should identify the risk rating severency.

ACTION: INTERNAL AUDIT

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

2. Review of Internal Audit Progress Report

The Internal Audit Manager reported that since the last report to the Committee in January 2017 the following reports had been issued to and discussed with management:

Report No	Report	Opinion
CH/13/2017	Nervecentre	Significant
CH/14/2017	IG Toolkit	Limited
CH/15/2017	Payroll	Limited
CH/16/2017	Carter Efficiencies	Limited
CH/17/2017	ISO Compliance, Third Audit	Full
CH/18/2017	Medical Devices	Significant
CH/19/2017	Budget Monitoring	Significant
CH/20/2017	Transport	Significant
CH/21/2017	Theatre Stores	Limited
CH/22/2017	Complaints Handling	Limited
CH/23/2017	Radiology Reporting	Limited
CH/24/2017	Follow Up, Community Midwives, Car Parking, Safeguarding	Significant
CH/25/2017	Financial Transactions	Significant
CH/26/2017	Agency & Bank Staff	Limited
CH/27/2017	Controlled Drugs	Limited
CH/28/2017	Health & Safety	Significant

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

a. CH/14/2017 - IG Toolkit - Each year prior to the Trust confirming adherence to the Information Governance Toolkit, Internal Audit assesses the Trust's self-assessment and the evidence supporting it. This year the audit identified that the self-assessment was adequately supported in only 2 out of the 8 requirements reviewed. This compared to a similar assessment in 2015/16. The majority of the evidence that was inadequate was because it was not up to date.

Concern was expressed that there was insufficient evidence and compliance had not improved over the year and that further work was required. It was suggested that the timeline needed to be reviewed and Michael George, Internal Auditor agreed to investigate the 31 March 2017 position and report back to the Audit and Risk Committee outside the meeting.

ACTION: MG - INTERNAL AUDIT

b. CH/15/2017 - Payroll - The opinion of limited assurance related to an overpayment of

£700,000 that was paid to a locum doctor for one month's work. The payment was made despite three levels of checking being in place and following the failure of the exception reporting process, as the payment was larger than it could deal with. The rest of the audit work identified that transactions were being processed appropriately.

Concern was expressed regarding the system failure of the payroll system and it was noted that the software company responsible for the system had been approached to make adjustments to the system. Internally a further check system had been introduced and progress with this should be reported to the next meeting of Audit and Risk Committee.

ACTION: ARC AGENDA ITEM

CH/16/2017 - Carter Review Efficiencies - The audit considered how the Trust is using the Model Hospital data, to identify where variances in the cost of treatment between the Trust and its peers, may mean that there is the opportunity to deliver health care at a lower cost. Whilst the Trust has undertaken a considerable amount of work under the CIP banner to reduce cost, which will be reflected in future iterations of the comparative Model Hospital data, it had generally not adopted a systematic approach to understanding and explaining the Carter data itself and so only limited assurance could be given that any benefits obtainable through these comparisons have been identified.

The Committee agreed that data was being collated but may not be in the Carter format.

CH/21/2017 - Theatre Stores - The Bluespier system was used to record the holding and use of items by the Surgery Division. The audit reported that the stock levels were not accurate; in half the sample examined the levels present were different to those on Bluespier. Stock appeared to be used without being booked out. In addition the analysis to identify efficient re-order levels had not been undertaken for all stock and existing stock levels at the point Bluespier was adopted have been used. It is likely that more stock than is necessary is being held.

It was noted that an action plan was in place to address this issue. The Director of Finance reported that a go-and-see of a good tracking system had been undertaken and it was acknowledged that there were clinical variations in practice. Prof Roberts expressed concern regarding the lack of accuracy on materials used from a Never Event perspective.

CH/22/2017 - Complaints Handling - Internal Audit were asked to review how complaints were handled by Division. There were pre-existing concerns that Divisions were not following procedure. The audit identified that complaints handlers in Division did not maintain the level of contact with the complainant that they should have, insufficient records were kept of the investigation of the complaint, with formal statements from staff not always being obtained. The informal approach exposed the Trust to particular risk, should it be asked to justify its findings.

It was noted that this audit had been discussed at the Risk and Compliance Group and a proposed Action Plan to address the recommendations was in place.

CH/23/2017 Radiology Reporting - Internal Audit had been invited to review the process in Radiology to award additional payments for MRI and CT scans. It appeared that there was a small number of cases where consultants were being paid for work undertaken during their NHS paid hours and duplicate reports were being claimed for. Radiology lacked the systems to adequately control the risk of fraud.

The Committee acknowledged the challenges in Radiology outstripped the capacity

available. This report had been shared with staff and an Action Plan was being developed to introduce adequate controls.

CH/26/2017 Agency & Bank Staff - Internal Audit was asked to review new controls that had been put in place. The Internal Audit was undertaken at an early point in the adoption of the new system and at that time the Flexible Workforce Team was starting to take on their wider responsibilities. The audit found that there were still agency workers being engaged without sufficient regard for the cost, reporting and invoice checking were not at the right level, there were legacy issues to address with agency staff engaged on unfavourable terms and conditions. The need for agency staff stemmed in part, from poor workforce planning, which was now being addressed.

It was noted that authorisation controls were now in place and although there was still high usage of agency and bank staff, patient safety could not be compromised.

CH/27/2017 - Controlled Drugs Stationery - Internal Audit had been asked to review the adherence to basic controlled drugs recording procedures following findings of the CQC visit. The daily stock checks were generally being carried out, however not on a timely basis. The monthly Ward Manager checks were not being undertaken on most of the 38 wards and theatres visited. The daily check would pick up whether any controlled drugs were not present. The monthly check reviews the work done on a daily basis as well as some additional checks on issues such as the proper disposal of controlled drugs.

Concern was expressed whether the Trust was breaching legal requirements with regard to controlled drugs and the Company Secretary agreed to investigate this further.

ACTION: COMPANY SECRETARY

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

3. DRAFT INTERNAL AUDIT PLAN 2017/18

The Executive Director of Finance presented the Internal Audit Plan. The contents of the plan were noted which had been discussed at the Executive Board. The Committee discussed the fact that the timescale had been reduced by 30 days compared with 2016/17 and this was partly due to the slippage on the reconfiguration of services. It was noted that the Full Business Case was in the plan for 2017/18 and discussion took place regarding whether the Estates Audit was still required. It was noted that a paper would be presented to the next Board of Directors Meeting on Estates and Facilities and if necessary this would be referred to Internal Audit.

OUTCOME: The Committee **APPROVED** the Internal Audit Plan.

23/17 LOCAL COUNTER FRAUD

1. Local Counter Fraud Specialist Progress Report

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

The key areas of progress made towards the delivery of the work plan were noted:-

- Regular talk at Nurse and Health care assistant induction
- Liaison with the Director of WOD
- Checking of NFI matching service data
- Implementation of new NHS Protect guidance regarding Agency Fraud.

In addition she updated the Committee on three live investigations being undertaken and progress being made with each case.

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

24/17 EXTERNAL AUDIT

1. TECHNICAL UPDATE

The Senior Manager for KPMG explained that the Technical Update was for information and highlighted areas of particular interest particularly around IR35 and the impact on the Trust. It was noted that some Trusts had increased the rate of pay to compensate for the tax implications. The risk to patient safety was of utmost importance to the Trust.

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

ACTION: KB

OUTCOME: The Committee **RECEIVED AND NOTED** the Technical Update.

25/17 INFORMATION TO RECEIVE

The Committee **RECEIVED** the following minutes:

1. Quality Committee Minutes – 3.1.17, 30.1.17 and 27.2.17
2. Risk & Compliance Group Minutes – 17.1.17, 14.2.17 and 14.3.17
3. THIS Executive Meeting Summary Notes – 18.1.17 and 22.2.17
4. Information Governance & Records Strategy Committee Minutes 9.1.17 and 8.3.17
5. Nomination and Remuneration Committee (MC) Minutes – 8.3.17
6. Nomination and Remuneration Committee (BOD) Minutes – 2.2.17
7. Reporting Arrangements for Compliance for 2017-2018

26/17 ANY OTHER BUSINESS

There was no other business raised.

27/17 MATTERS TO ESCALATE TO BOARD

The Committee noted the following items to be brought to the attention of the Board at its meeting on 1 June 2017:

- Payroll Progress Report
- Company Secretary Report
- Treasury Management Policy
- Internal Audits – 8 Limited Assurance
- Local Counter Fraud Work

28/17 DATE AND TIME OF NEXT MEETING

It was noted that the meeting scheduled for Tuesday 23 May 2017 had been rearranged and the next meeting would now take place on Thursday 25 May 2017 commencing at 11.00 am in the Boardroom, Calderdale Royal Hospital (Trust Offices). Apologies were received from Clare Partridge, Helen Kemp-Taylor, Peter Middleton.

29/17 REVIEW OF MEETING

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