Board of Directors Public Meeting - 5.10.17

Schedule	Thursday 05 October 2017, 09:00 AM — 12:30 PM BST
Venue	Todmorden Health Centre
Organiser	Kathy Bray

Agenda

1. Welcome, Introductions - Stephen Baines & Annette Bell, CoGs

To Note

Presented by Andrew Haigh

2. Apologies for Absence - LH/BB/MG

To Note

Presented by Andrew Haigh

3. Declarations of Interests

For Comment

Presented by Andrew Haigh

4. Patient Story/Quality Report - 'Multidisciplinary Client Base Study' - Bethan Wallis and Sarah Jenkins presenting

For Comment

Presented by Andrew Haigh

5. Minutes of the meeting held 7.9.17

To Approve

Presented by Andrew Haigh

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th October 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 7.9.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 7 September 2017.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 7 September 2017.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 7 September 2017.

Appendix

Attachment:

draft BOD MINS - PUBLIC - 7.9.17(2).pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 7 September 2017 in the Boardroom, Huddersfield Royal Infirmary.

PRESENT

Andrew Haigh	Chairman
Owen Williams	Chief Executive (part of meeting)
Helen Barker	Chief Operating Officer
Brendan Brown	Executive Director of Nursing and Deputy Chief Executive
Dr David Anderson	Non-Executive Director
Gary Boothby	Executive Director of Finance
Dr David Birkenhead	Medical Director
Lesley Hill	Executive Director of Planning, Estates and Facilities
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Kathy Bray	Board Secretary (minute taker)
Mandy Griffin	Director of The Health Informatics Service (part of meeting)
Victoria Pickles	Company Secretary
Amanda McKie	Matron – Complex Care Needs Co-ordinator (item 4)

OBSERVER

Peter Middleton	Publicly Elected Governor
Nasim Esmail	Publicly Elected Governor
Karen Vella	Leadership Academy Shadow Board

133/17 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

134/17 APOLOGIES FOR ABSENCE

Apologies were received from:
Jason Eddleston, Executive Director of Workforce & OD
Karen Heaton, Non-Executive Director
Richard Hopkin, Non-Executive Director
Anna Basford, Director of Transformation and Partnerships

135/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

136/17 PATIENT STORY/QUALITY REPORT: LEARNING DISABILITIES

Amanda McKie, Matron – Complex Care Needs Co-ordinator attended the meeting to give a presentation entitled 'Dennis' Story' which highlighted the awareness of caring for patients with a learning disability, Do Not Attempt Cardiac Pulmonary Resuscitation (DNA CPR) and the Mental Health Capacity Act.

Amanda gave a brief background to the work undertaken in recent years to raise the profile on people with learning disabilities and the national strategy changes which had been put in place to acknowledge the different needs of these patients. Nationally this was a big agenda which had led to changes in practice including an external review of all deaths to

identify any cases/actions which could have been avoided and a review of the DNA CPR process for these patients. It was noted that the Trust is a trail blazers with Amanda being the only Matron in post nationally.

The video which had been made by the Trust and was used in training, told the story of Dennis, a very independent man who had learning disabilities and cerebral palsy who was being cared for in a home. He had been admitted to the Trust through A/E Department and responded well to treatment. On his return to the home, the staff and family were upset to find that Dennis had been put on a DNA CRP plan without their knowledge. It was noted that this was a medical decision but best practice states that this is communicated with the patient and their family so they have a better understanding of what this means. Legislation and guidance around the Mental Health Capacity Act strengthened the rights of people with learning disabilities.
The Board discussed the difficulties some medical staff face in raising the issue of DNA CPR and that this was understandable.

Linda Patterson asked whether carers were invited to stay in hospital with patients to help with their care and Amanda reported that this varied and depended on the funding package available.

The Chief Executive asked if there was anything that the Board to could do to support this work such as visibility out of hours. Amanda highlighted the need to raise awareness of the issues with the new junior doctors in A/E. She expressed her thanksto all the Trust for their help and support given to her in risk assessing individual patients.

Amanda circulated the Learning Disability Awareness leaflet to the Board

The Board thanked Amanda for the informative presentation.

OUTCOME: The Board RECEIVED and NOTED the work of Amanda caring for patients with learning disabilities.

137/17 MINUTES OF THE MEETING HELD ON 3 AUGUST 2017

The minutes of the previous meeting were approved.

OUTCOME: The minutes of the meeting were APPROVED as a correct record.

138/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG

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

139/17 CHAIRMAN'S REPORT

Nomination and Remuneration Committee (CoG) Update on NED Appointments

The Chairman reported that the Nomination and Remuneration Committee (COG) had met on the 4 September 2017 and interviewed 6 candidates for the Non-Executive Director vacancies. Two provisional offers had been made and accepted – one appointment to commence on the 1 October and the other on the 12 December 2017.

OUTCOME: The Board **NOTED** the Chairman's report

140/17 CHIEF EXECUTIVE'S REPORT

Full Business Case - Update

The Chief Executive updated the Board regarding a meeting which had taken place with representatives of the Trust, NHS Improvement and NHS England regarding the Full Business Case for the reconfiguration of hospital services. There was a need for the Trust

and Clinical Commissioning Groups to continue to drive this agenda. It was noted that the FBC had been discussed informally at the Chief Executives West Yorkshire Association of Acute Trusts (WYAAT) where there had been recognition of the clinical model.
The Chief Executive explained that there would be ongoing clinical engagement in the plans to start to develop how the services would be configured in more detail.
The Executive Director of Finance reported that NHS Improvement were expected to submit clarification questions on the Full Business Case to the Trust by mid-September.
The Company Secretary updated the Board on the discussions which had taken place with one of the two campaign groups. The Trust was committed to working equally and fairly, continuing open discussions and keeping in contact with both groups.

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

141/17 HIGH LEVEL RISK REGISTER

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

These were:-
6967 (25): Non delivery of 2017/18 financial plan
6968 (20): Cash flow risk
6969 (20): Capital programme
6903 (20): Estates/ ICU risk, HRI
7049 (20): EPR financial risk
5806 (20): Urgent estates schemes not undertaken
2827 (20): Over-reliance on locum middle grade doctors in A&E
6131 (20): Service reconfiguration
6345 (20): Staffing risk, nursing and medical

Risks with increased score
There are no risks with increased scores.

Risks with reduced scores
93 (12): NHS Improvement Agency Cap risk.
Following discussions at the Risk and Compliance Group on 22 August 2017, this risk is to be reduced from a risk score of 15 to 12, as the risk of action from NHS Improvement and the risk of reputational damage had decreased. This will now be managed from within the Workforce and Organisational Development risk register.

New risks
The following new risks were accepted to the high level risk register:

- 5747 (15): Service delivery risk re: vascular / interventional radiology (FSS)
- 6011 (15): Wrong blood in tube (FSS)

Following a meeting involving the EPR key leads, Chief Operating Officer, Medical Director and Chief Nurse, on 24 August 2017 the following new risks were added to the high level risk register resulting from the implementation of EPR:

- 7049 (20): financial risk due to increased costs and decreased income

- 7046 (16): quality and safety risks
- 7047 (16): performance risk of failed regulatory standards, contractual key performance indicators or other patients/staff focused performance

It was noted that further discussion would take regarding these risks with the EPR Stabilisation Plan later on the agenda.

Closed risks
No risks have been closed during August 2017.

Phil Oldfield pointed out that capital had been discussed at the last Finance and Performance Committee and the need to prepare a Capital Plan for 2018 along with a cashflow projection. The Executive Director of Nursing reported that this had been discussed with the Divisions at the performance review meetings the previous week.

David Anderson requested an update on the Interventional Radiology services risks. The Medical Director reported that a substantive appointment had been made and network discussions were underway to develop services across a number of sites in Yorkshire.

The Chairman raised the question around a solution for serious incidents and the Executive Director of Nursing reported that work was on going to broaden the number of investigators available to undertake SI investigations. It was agreed that a deep-dive report would be brought to the November 2017 BOD Meeting.

ACTION: Director of Nursing – BOD Agenda Item November 2017

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

141/17 GOVERNANCE REPORT

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

a. Board Workplan

The Board work plan had been updated and was presented to the Board for review. The Board was asked to consider whether there are any other items they would like to add for the forthcoming year. It was agreed that the following areas should be included:

- Private WYAAT updates
- Annual update on embedded performance management arrangements
- Work on the Compassionate Leadership In Practice programme

It was agreed that any other items should be forwarded to the Board Secretary for inclusion.

OUTCOME: The Board **APPROVED** the work plan.

142/17 CARE OF THE ACUTELY ILL PATIENT

The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report and reminded the Board of 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 Medical Director highlighted the key points from the report:

- Improved performance on SHMI - reduced to 104.7
- Improved position on HSMR reduced to98.71
- Concerns around data quality following implementation of EPR – remedial actions being

undertaken
- Alerting conditions – Acute Kidney Injury – 4 cases were being investigated to ensure learning within organization
- Learning from deaths – new protocol had been agreed at the Executive Board.
- Deteriorating Patient Group – tools available to be used to improve data and practice.
- End of Life Care –work continues to improve the end of care experiences for both patients and families.
- Caring for frail patients – work continues by the multi-disciplinary team
- Coding – work continued on meeting the clinical coding KPI targets.

OUTCOME: The Board **APPROVED** the Care of the Acutely Ill Patient Update.

143/17 CHFT ANNUAL FIRE SAFETY REPORT 1.4.16 – 31.3.17

The Executive Director of Planning, Estates and Facilities presented the Annual Fire Safety Report for the Trust.

It was noted that this paper gave board members the opportunity to have an overview of where the Trust was in terms of Fire Compliance for the year 2016 -2017 in relation to compliance with our legal duties. (Regulatory Reform {Fire Safety} Order 2005)

The paper reported on this year's issues and followed on from the previous year's annual fire safety report.

The key issues which had been addressed over the year and areas for further work included:
- Training statistics and areas of weakness, Fire Wardens and lack of trained staff across the Trust
- Fire Alarm actuations and improvements made
- The two recent fires at CRH within the endoscopy unit and a ventilation duct
- The need to have a budget that allows for safe premises, including compartmentation

Discussion took place regarding the Board's responsibilities vs capital challenges. Reference was made to the discussions with NHS Improvement around the capital challenges. It was agreed in view of the recent Grenfell Tower fire there should be an amendment to the wording of the risk mitigation statement: "Following the fire at Grenfell Tower the Trust will continue to monitor and apply the lessons from the post-incident inquiry process. It is also important for the Trust to assess capital and proposed building works to exacting standards in the light of inquiry findings."

ACTION: Executive Director of Planning, Estates & Facilities

OUTCOME: The Board **APPROVED** the Annual Fire Safety Report with the above amendment.

144/17 WINTER PLAN 2017

The Chief Operating Officer updated the Board on the development of the Winter Plan 2017 which had been approved by the Executive Board and A&E Delivery Board.

It was noted that the Winter Plan described the structure within which operational pressures during the winter period, will be anticipated and managed. It provided the framework for Managers and Clinicians in the Trust to work together, and with other organisations. This was a robust but flexible plan and would be changed as circumstances dictate. It was noted that this document, along with partner Winter Plans would be going to the A/E Delivery Board the following week.

Discussion took place regarding the fact that the capacity was dependent on length of stay and delayed transfers of care impacting on the flow of patients along with concerns about the fragility within the whole healthcare system.

OUTCOME: The Board **APPROVED** the Winter Plan 2017

145/17 INTEGRATED PERFORMANCE REPORT

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

- July's Performance Score stands at 54% for the Trust.
- The RESPONSIVE domain is now RED due to failing to meet the Emergency Care Standard, Diagnostic 6 weeks waits, both Cancer 2 week wait targets and both Cancer 62 day targets.
- Finance domain is now also RED due to deterioration in income and expenditure: Surplus / (Deficit) Control Total Basis and Agency expenditure.

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

146/17 EPR STABILISATION PLAN

The Chief Operating Officer asked that the Board consider the performance within the Integrated Performance Report alongside the EPR Stabilisation Plan.
She updated the Board on the developments since the implementation of the Cerner Millennium Electronic Patient Record on 1 May 2017. This was a joint programme with Bradford Teaching Hospitals Foundation Trust (BTHFT) who were scheduled to go live on 22 September 2017. It was noted that this implementation had been the largest and broadest deployment for Cerner across any Trust in England to date and the first in a joint programme. Whilst much of the system was working well, and feedback on the chosen approach for the deployment had been positive from external partners, there remained a number of key issues requiring resolution and, at 17 weeks post go-live, there was a need to increase the speed of resolution. The paper covered the areas concerned and the key themes were discussed:

- Clinical risk
- Engagement internally and externally
- Operational Performance
- Finance
- Bradford Go-live

Within these the outstanding issues previously discussed by the Board included:

- Hardware & Interface
- Appointments & Booking
- Correspondence
- TCI issues/Elective admission pathways
- Diagnostic and Pre-assessment
- Capacity Management
- Training
- Pharmacy & Medicines Management
- Outpatient clinics
- Access (to the system)
- Validation & data Quality

The Board discussed and agreed the issues highlighted in the report and:

- Noted this was not a review of deployment but specifically focused on areas yet to stabilise
- Noted the stabilisation issues as identified in the paper and associated appendices
- Discussed and agreed the actions proposed
- Agreed to defer the investigation of further benefits until all clinical, operational and existing financial risks have been mitigated to an acceptable level.

- Supported further escalation to Cerner to expedite resolution and agree actions should Cerner response be insufficient to mitigate existing risks
- Noted that all issues highlighted had been formally communicated with BTHFT as part of the lessons learned process to support a successful deployment there.
- It was agreed that consideration would be given to further escalation reflecting the outstanding perceived clinical risks highlighted by CHFT Clinicians.

OUTCOME: The Board **APPROVED** the EPR Stabilisation Plan as above.

147/17 MONTH 4 – 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance presented the Month 4 Financial Narrative which had been submitted to NHS Improvement and discussed in detail at the last Finance and Performance Committee.

Key Issues:

The Month 4 position is a deficit of £8.72m on a control total basis as planned, including year to date Sustainability and Transformation funding (STF) of £2.20m. The final planning submission made to NHSI on 30 March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had a number of concerns regarding the scale of this challenge. Whilst appreciating the overall NHS Provider sector position, it was hoped that a revised control total could be considered. The key risks to delivery were outlined as the abnormal costs of implementation or short term loss of income as a result of EPR implementation and the scale of the CIP challenge at £20m, 5.3%. The impact of EPR was assessed to be up to £5m, whilst only £17m of the required £20m CIP was believed to be achievable, leaving the Trust with a total risk of £8m plus any subsequent loss of STF funding.

The Board were informed that, as at Month 4, these concerns have not abated. Whilst the Trust is able to report delivery of the financial plan, there are a number of assumptions of a material value that have been made in order to deliver this position. The implementation of EPR continues to have a significant impact on both productivity and the capture of activity data and is driving a material clinical income variance year to date. In addition the year to date position is reliant upon a number of non-recurrent income and expenditure benefits which cannot be replicated going forwards plus the use of two thirds of the total contingency reserve available for this financial year.

There is now a significant risk that the Trust will not be able to achieve the 17/18 control total due to a combination of slower than expected recovery of clinical activity levels and therefore income following EPR implementation and remaining unidentified CIP of £3m. A recovery action plan has been implemented which aims to tackle: the recovery of clinical income at risk due to issues with capture and coding in EPR, the development of Divisional financial recovery plans, a Trust wide establishment review and further tightening of budgetary controls. Every effort will be made to deliver the financial plan, but a continuation of the current situation may make full recovery impossible. Delivery of the financial plan is now the highest risk on the Trust risk register scoring the maximum of 25.

Month 4 - Assumptions:

The forecast assumes:

- That the Trust is able to recover the £0.75m of estimated income in the year to date position.
- That EPR data capture issues are resolved quickly and that clinical activity returns to the planned level from Month 5 or income is recovered by the year end.
- Full achievement of the £20m Cost Improvement Programme including the £3.0m currently unidentified and a further £3.1m that is very high risk.
- Divisional recovery plans can be put in place to maintain the position in line with control total from month 5 to month 12.

- Full receipt of CQUIN funding.
- Securing STF income in full for both the finance (70%) and A/E performance (30%) elements of the target.
- That any further costs relating to EPR implementation, including those committed to address data capture and booking issues, can be either capitalised or offset by additional savings.
- That a programme of additional budgetary grip and control is successfully implemented as planned.

OUTCOME: The Board NOTED the contents of the report.

148/17 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

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

a. Quality Committee

Dr Linda Patterson, Chair of the Quality Committee reported on the items discussed at the meeting held on 4 September 2017 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- Quarterly reports from Divisions received – now standardized
- The Divisional reports now include a CQC update
- Staff retention concerns
- Complaints response times – delays in Divisional responses being addressed
- Cancer delays – as discussed previously
- Infection Control – the need to remain vigilant and ensure compliance with hand hygiene and other infection control measures

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 31 July 17 and the verbal update of the meeting held on 4 September17 meeting.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 5 September 17 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- Key lines of enquiry around EPR received
- Reforecast and trajectory narrative discussed
- Risk and financial performance challenges discussed

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 1 August 17 and verbal update from 5 September 17 meeting.

c. Workforce Well-Led Committee

The minutes from the meeting held on the 13 July and 10 August were received.

OUTCOME: The Board **RECEIVED** the minutes from the 13 July.17 and 10 August17 meetings.

a. Audit and Risk Committee

The minutes from the meeting held on 19 July 17 which had been discussed at the August Board meeting were received.

OUTCOME: The Board **RECEIVED** the minutes from 19 July 17 meeting.

b. Draft Minutes – Council of Governors Meeting Minutes – 6 July 17

The Chairman presented the draft minutes from the Council of Governors (CoG) Meeting held on 6 July 17. It was noted that the next CoG meeting was scheduled for 26 October17.

OUTCOME: The Board **RECEIVED** the draft minutes from the 6 July 17 meeting.

149/17 DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 5 October 2017 commencing at 9.00 am at Todmorden Health Centre.

Before the Chairman closed the meeting he wished to thank Peter Middleton, Governor for his involvement as Lead Governor for the past year and Governor for the past 6 years. It was noted that he had worked hard to ensure continuous improvement by the Trust and had made a difference during his tenure.

Also, it was noted that Prof. Peter Roberts' Non-Executive tenure was due to complete later in the month and the Board thanked him for his work on the Board and as Chair of the Audit and Risk Committee. It was noted that arrangements were being made for him to support the Estates agenda for the next 6 months.

The Chair closed the public meeting at 11:45pm.

6. Action Log and Matters Arising

For Comment

Presented by Andrew Haigh

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th October 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 October 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 October 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 Action Log for the Public Board of Directors Meeting as at 1 October 2017

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 October 2017/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
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 It was noted that the BAF would be brought to the July BOD Meeting. **6.7.17** Director of Finance to review description of Capital Risk within BAF to be reviewed and document returned to Finance and Performance Committee prior to Board	Nov.17		
175/16 3.11.16	**UPDATE FROM SUB-COMMITTEES** **Audit and Risk Committee – DECLARATIONS OF INTEREST** The Company Secretary explained that there	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	TBC		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	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.		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** New guidance to be discussed at WEB in ?June and taken to the Oct ARC. It was agreed that the revised policy would be brought to the BOD.			
1.6.17 83/17g	**BOARD TO WARD VISITS** The Company Secretary advised that reports were being obtained from the Executive Team following the visits undertaken during March-May and a formal report would be brought back to the Board.	VP	**3.8.17** Importance that visibility is evidenced stressed. A small number of reports had been received to date and these would be collated for the Board **7.9.17** Going forward it was agreed that key themes from each visit would be collated for discussion at a Board workshop and reported to Board every six months.	7.9.17		Added to Workplan
1.6.17 87/17	**HOSPITAL PHARMACY SPECIALS (HPS) ANNUAL REPORT** The Annual Report was received and production development noted. The DoF reported that in order for the service to undertake large scale products, significant investment was required and a Business Strategy would be brought to the Board later in the summer.	GB		TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 October 2017/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
1.6.17 90/17	**HARD TRUTHS – DISCHARGE PROCESS** As part of the Hard Truths paper, discussion took place regarding the new discharge processes which had recently being introduced with the help of Age Concern. It was agreed that once the service had been evaluated. The COO would report to the October CoG Meeting and give an update.	HB		26.10.17 CoG Meeting		
6.7.17 106/17	**GUARDIAN OF SAFE WORKING** It was noted that there was still a significant problem with some supervisors not addressing exception reports despite reminders and offers of additional training There was no admin support provided to the Guardian of Safe Working Hours with regard to managing the flow of exception reports. It was agreed that the Executive Medical Director and Tamsyn Grey would discuss this outside the meeting and bring an update to the Board.			Oct 2017		
7.9.17 141/17	**HIGH LEVEL RISK REGISTER** The Executive Director of Nursing reported that work was on going to broaden the number of investigators available to undertake SI investigations. It was agreed that a deep-dive			Nov 2017		

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
	report would be brought to the November 2017 BOD Meeting.					

7. CHAIRMAN'S REPORT

Presented by Andrew Haigh

a. NHS Providers and NHS Improvement Updates

b. Update from Nomination and Remuneration Committee - 22.9.17

c. Senior Team Changes

8. CHIEF EXECUTIVE'S REPORT

Presented by Owen Williams

a. Update on Bradford EPR Go-Live

9. High Level Risk Register

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 5th October 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 25 September 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Group 19 September 2017	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The high level risk register is presented on a monthly basis to ensure that the Board of Directors 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 25 September 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 September two new risks have been added to the high level risk register. These are:
Risk .

1. Risk 6441 – a financial risk relating to 2017/18 income within the Surgery and Anaesthetics division has been added to the risk register following discussion at the Risk and Compliance Group on 19 September 2017.

2. Risk 7062, risk score of 20, relating to the capital programme for 2018/19, has been added following agreement at the Board meeting of 4 September 2017

Following a review of the risks on both the Board Assurance Framework (BAF) and the high level risk register the Risk and Compliance Group supported the removal of the risk relating ot service reconfiguration, 6131, as this is a strategic risk and is reflected in two existing risks on the BAF. The risks will be removed from the high level risk register in October, pending Board agreement.

Next Steps:

To ensure that the high level risk register is dynamic and reflects all sigiificant risks to Trust objectives, a review of the high level risk register , the BAF and the 5 year strategy and one year plan has been undertaken.

This highlighted three areas for new risks to be developed for consideration on the high level risk register (leadership, health and safety action plan and development of bank and workforce models) as these are not currently reflected.

Two areas of new risks were identified for the BAF (strategic partnership work and patient and public involvement).

The proposals were discussed and supported at the Risk and Compliance Group meeting on 19 September

2017. Once developed the risks will be considered at the Risk and Compliance Group, with any risks scoring over 15 for the high level risk register being presented to the Board.

Recommendations:

Board members are requested to:

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

Appendix

Attachment:

High Level Risk Register Report - September 2017.pdf

HIGH LEVEL RISK REGISTER REPORT – SUMMARY OF CHANGES

Risks as at 25 September 2017

TOP RISKS

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

6967 (25): Non delivery of 2017/18 financial plan
7062 (20): Capital programme
6903 (20): Estates/ ICU risk, HRI
7049 (20): EPR financial risk
5806 (20): Urgent estates schemes not undertaken
2827 (20): Over-reliance on locum middle grade doctors in A&E
6131 (20): Service reconfiguration
6345 (20): Staffing risk, nursing and medical
6658 (20): Patient flow

The Trust risk appetite is included at Appendix 2.

RISKS WITH INCREASED SCORE

Risk 6658, patient flow, has increased from a risk score of 16 to 20 due to an Emergency Department (ED) 12 hour breach and exit block in ED due to slower processes on wards from EPR affecting discharge.

RISKS WITH REDUCED SCORE

Following discussion at the Finance and Performance Committee on 1 September 2017 and Board on 4 September 2017:

6969 (9): The finance risk score relating to the 2017/18 capital programme has been reduced from a risk score of 20 to 9 (see new risks below).

6968 (12) Cash flow 2017/18 – this risk has reduced from 20 to 12.

These risks will now be managed within the Finance risk register.

NEW RISKS

Risk 6441 – a financial risk relating to 2017/18 income within the Surgery and Anaesthetics division has been added to the risk register following discussion at the Risk and Compliance Group on 19 September 2017.

Risk 7062, risk score of 20, relating to the capital programme for 2018/19, has been added following agreement at the Board meeting of 4 September 2017.

CLOSED RISKS

It was agreed at the Risk and Compliance Group that EPR risk 6841 EPR post go live – previously scored at 15 – be closed as a stabilisation plan has been agreed in order to tackle the remaining issues (which have continued to reduce) following ELS. This plan includes some additions to the EPR back office team, Tactical secondments (inc medical secretaries and correspondence) and clarifying the governance board, which includes operational leadership. Unresolved issues logged by the end user are now sub 400.

This progress and mitigation reduces the original risk outlined and therefore met the target score.

Proposed risk removals

At its meeting on 19 September 2017 the Risk and Compliance Group considered a paper on the review and alignment of risks on the Board Assurance Framework (BAF) and high level risk register, including identifying areas of duplication. The following changes were proposed and supported relating to the high level risk register and will be reflected in October:

- 6131 service reconfiguration risk to be removed from the high level risk register as a strategic risk which is covered on the BAF within risks 002, internal focus on reconfiguration and 003, system-wide reconfiguration.

The removal of two risks from the BAF were also supported as these are already covered within the high level risk register:

- BAF ref 019 cash flow, captured as risk 6968 on the high level risk register, scored at 12
- BAF ref 001 mortality, captured as risk 4783 on the high level risk register, scored at 20.

APPENDIX 2 - September 2017 – Board - Summary of High Level Risk Register by type of risk as at 25.9.17

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead					
	Strategic Risks				**Apr 17**	**May 17**	**Jun 17**	**July 17**	**Aug 17**	**Sep 17**
002	6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	=20	=20	=20	=20	=20	= 20
007	4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=16	=16	=16	=16	=16	=16
012	2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
007	6990	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/18	Medical Director (DB)	=16	=16	=16	=16	=16	=16
007	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	=16	=16	=16	=15	=15	=15
007	6829	Keeping the Base Safe	Aseptic Pharmacy Unit production	Director of Nursing	=15	=15	=15	=15	=15	=15
011	5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
014	6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD (JE)	=16	=16	=16	=16	=16	=16
014	6977	Keeping the base safe	Mandatory training 2017/18	Director of Workforce and OD (JE)	-	-	! 16	=16	=16	=16
011	6903	Keeping the base safe	ICU/Estates joint risk	Director of Estates and Performance (LH)	!16	↑ 20	=20	=20	=20	=20
007	6924	Keeping the base safe	Misplaced naso gastric tube for feeding	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
007	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
007	6971	Keeping the base safe	Endoscopy provision	Divisional Director of Surgery and Anaesthetics (J O'R)		!15	= 15	=15	=15	=15
020	7046	Keeping the base safe	EPR Quality and safety risks	Exec Medical Director (DB)					!16	=16
007	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (MdB)					!15	=15
007	6011	Keeping the base safe	Blood transfusion process	Divisional Director of FSS (MdB)					!15	=15
021	6967	Financial sustainability	Non delivery of 2017/18 financial plan	Director of Finance (GB)	=20	=20	=20	↑25	=25	=25
021 & 022	7049	Financial sustainability	EPR financial risk due to increased costs and decreased income	Director of Finance (GB)					!20	=20
022	**7062**	**Financial sustainability**	**Capital programme 2018/19**	**Director of Finance (GB)**						**!20**
021	**6441**	**2017/18 income**	**Divisional income surgery and anaesthetics**	**Divisional Director of Surgery and Anaesthetics (JO)**						**! 16**
007	6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (BB)	=16	=16	=16	=16	=16	↑20
007	6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
009	7047	Keeping the base safe	EPR Performance – failed regulatory standards, contractual KPIs, patient / staff performance	Chief Operating Officer (HB)					!16	=16
012	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	=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

APPENDIX 3 - Trust Risk Profile as at 25/09/2017

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	**Minor**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Highly Likely (5)			= 6715 Poor quality / incomplete documentation	= 6345 Staffing risk, nursing and medical = 7049 fnancial risk arising from EPR **! 7062 Capital programme 2018/19** ↑ 6658 Inefficient patient flow	= 6967 Not delivering 2017/18 financial plan
Likely (4)				= 4783 Outlier on mortality levels = 6300 CQC improvement actions = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 5862 Falls risk = 6990 CQUIN sepsis = 6977 mandatory training = 7046 EPR quality and safety risks **!6441 Divisional income 2017/18 surgery and anaesthetics** = 7047 EPR Performance /regulatory/KPI risk arisisng from EPR	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6131 Service reconfiguration = 6903 ICU/ resus estates risk
Possible (3)					= 6829 Pharmacy Aseptic Unit = 6924 Misplaced naso gastric tube = 6971 Endoscopy provision = 6011 Blood transfusion process =! 5747 Vascular /interventional radiology service
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE November 2016 **Appendix 3**

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

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

High Level Risk Register
September 2017

Risks Scoring 15 or more

Risk No	Dep	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6967 (Baf REF021)	All Departments/Wards	Apr-2017	Financial sustainability	The Trust is planning to deliver a £15.9m deficit in 2017/18. There is a high risk that the Trust fails to achieve its financial plans for 2017/18 due to: - £20m (5.3% efficiency) Cost Improvement Plan challenge is not fully delivered - loss of productivity during EPR implementation phase and unplanned revenue costs - inability to reduce costs should commissioner QIPP plans deliver as per their 17/18 plans - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level - Risk overlaps that referred to in Ref. 6441 (Surgical Division).	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach Financial recovery actions were agreed by Turnaround Executive on 13th June. Controls around use of agency staffing have been strengthened. For 2017/18 the Trust has been given a £16.86m ceiling level for agency expenditure by NHS Improvement. Agency spend is planned to reduce considerably from the level of expenditure seen in 16/17 if the Trust is to deliver the financial plan, and not exceed the ceiling. Year to date this planned reduction in expenditure has been achieved.		20 5 x 4	25 5 x 5	15 5 x 3	**September 2017** 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 has been added to the £17m CIP target. At 5.3% efficiency this will be extremely challenging to deliver. The organisation currently has plans for £17m of the £17m CIP target, but only £13.6m is currently forecast to deliver without further remedial action. The year to date position is extremely precarious, with activity and income below the planned level. EPR implementation has had a significant impact on the capture and coding of activity and £1.2m of the assumed income year to date is estimated. There is a risk that this income will not be recovered and that the reduced activity and changes to case mix seen year to date will persist into future months. The corresponding underlying expenditure is not below plan and achieving Control Total in the year to date has relied on the release of five sixths of our Contingency Reserve and a number of non recurrent benefits that are one off in nature and cannot be repeated. Failure to achieve the Control Total in future months 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 in partnership with the Trust, the risk of ensuring that costs are reduced to compensate any associated loss of income sits with the Trust.	Oct-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell

7049 (Baf ref 021, 022)	All Departments/Wards	Aug-2017	Financial sustainability	EPR financial risk with increased costs and decreased income. Due to: Reduction in activity arising from increased time per patient in outpatients leading to reduced templates, errors with booking process related to migration and build leading to DNAs etc, pre-assessment build impacting on elective activity & mapping issues impacting on overall income capture. Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff Increased costs to ensure timely and appropriate response to clinical & operational risks.	Developing financial recovery plans. Weekly activity and income meeting chaired by Director of Transformation and partnership, weekly Theatre scheduling now attended by an Executive. systems to capture activity. Weekly performance monitoring. Targeted improvement for those in greatest need. Activity coding issues being addressed. Continuing to shadow monitor activity using existing systems. Cymbio dashboard deployed from Day 1 of EPR, weekly Data Quality Board, validation expertise deployed and extended, retaining senior analytical support until post Bradford Go-live, increased Booking staff to maximise appointment booking. Stabilisation plan developed.	Adequate system build BAU Team capacity. Staff training..	20 4 x 5	20 4 x 5	0 0 x 0	Identification of staff training needs. Specialty delivery of recovery plans. System build changes identified and prioritised, BAU team capacity review. Education and training for clinical staff. Placing Coders in clinical areas **September Update** EPR risk panel established during September, any new risks identified through this panel to be presented to Risk and Compliance Group 17.10.17.	Oct-2017	Mar-17	FC	Gary Boothby	Kirsty Archer
7062 (Baf ref 022)	All Departments/Wards	Sep-2017	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2018/19 due to having insufficient cash to meet ongoing commitments resulting in a failure to maintain infrastructure for the organisation. Based on the two year plan submitted to NHS Improvement in March 2017, the Trust will only have access to internally generated capital funds of £7.1m in 2018/19 to cover all capital requirements Whilst the capital risk for 2017/18 has been reduced to a current assessment of 9, the risk in 2018/19 is likely to be much higher as internal generated funds will only support Capital expenditure of £7.1m, less than half the amount committed for 2017/18. This value is constrained by the fact that the remainder (£8m) of the Trust's pre-approved capital loan of £30m is to be spent in 2017/18. Therefore, the Trust can only call on internally generated capital funding to the level of annual depreciation charges, against which PFI charges and capital loan repayments are pre-committed, leaving the £7.1m balance. In the context of the Trust's ageing and ailing HRI estate; medical equipment requirements including MRI investment; and with a number of schemes being pushed back from 2017/18, the risk in 2018/19 is heightened.	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances.		20 5 x 4	20 5 x 4	12 4 x 3	Added September 2017	Oct-17	Jun-2018	FPC	Gary Boothby	Philippa Russell

6903 (Baf ref 011)	Estate	Dec-2[illegible]5	Keeping the base safe	Collective ICU and Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to inadequate [illegible] capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff. ICU - Air Handling Unit (AHU) RESUS - Ventilation - RESUS – Electrical Resilience ICU & RESUS - Flooring ICU & RESUS - Electrical Infrastructure ICU & RESUS - Plumbing infrastructure - ICU & RESUS - Life Support Beams/Pendant - ICU - Building Fabric ICU - Nurse Call System RESUS - Medical Engineering Risk RESUS - Operational Safety RESUS – Compliance / Statute Law	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	July Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Our current risks are rising as our CAPEX continues to be reduced. August Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Our current risks are rising as our CAPEX continues to be reduced. **September Update** - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. Resus is currently undergoing a small works refresh i.e. removal of X-Ray equipment and installation of additional curtains.	Oct-2017	Dec-2017	RC	Lesley [illegible] / David McGarrigan	Chris D[illegible]es
2827 (Baf ref 012)	Accident & Emergency	Apr-2011	Developing our workforce	The inability to recruit sufficient middle grade and consultant emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Development of CESR programme ACP development Continued recruitment drive for Consultant and Middle Grade doctors Weekly meeting attended by flexible workforce department, finance, CD for ED and GM	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level CESR training will extended time to reach Consultant level with no guarantee of retention	20 4 x 5	20 5 x 4	12 4 x 3	July 2017: Start dates of Consultants confirmed. CESR candidate has withdrawn offer however interviewing again on 13 July 2017. Junior doctor posts out for bank recruitment and 2 applicants being pursued. ACP recruitment has been successful August 2017: Interviewing for CESR post 25th August From Sept there will be: 2 x 1st yr tACP in post, 3 x 2nd yr and 2 x recent qualified in yr 2 post working to achieve Trust competencies (will go to rota in March 2018) **September 2017** No change from last month. CESR interview did not occur due to IT problems. Further interview being arranged	Oct-2017	Aug-2018	WEB	David Birkenhead	Dr Mark Davies/Mrs Caroline Smith

5806 (CRR ref 011)	Capital Team	May-25	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 this relates to has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.	16 4 x 4	20 5 x 4	6 3 x 2	July Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Our current risks are rising as our CAPEX continues to be reduced. August Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Our current risks are rising as our CAPEX continues to be reduced. **September Update** Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. Resus is currently undergoing a small works refresh i.e. removal of X-Ray equipment and installation of additional curtains. The Capital Plan continues to progress on this financial years projects within budget.	Oct-2017	Mar-2018	RC	Lesley / David McGarrigan	Paul Gi g / Chris Davies
6131	Commissioning & Partnerships	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	June 2017 update - JOSC will meet in July to consider the Trust and CCG responses to the 19 recommendations and will then make a decision on referral to SoS. FBC due to be completed by the end of June and considered through formal governance processes in July before submission to NHS Improvement August 2017 - JOSC has referred the proposed reconfiguration of the hospital sites to the Secretary of State. The Full business Case is complete and has been published with Board papers. The FBC will be discussed in public at the August Board. **September 2017** - the full business case has been approved by The Board and submitted to NHSI. CHFT awaits the response.	Oct-2017	Oct-2017	WEB	Anna Basford	Catherine Riley

6345 (Locf ref: 012)	Resou ng / Recruitment	Jul-20	Keepi the base safe	Staffing Risk Risk of not being able to deliver safe, effective and high quality care with a positive [illegible] 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	August 17 Nurse Staffing - Previous actions continue. - Applicants from International recruitment trip to the Philippines are progressing. 120 offers were made in country, since March 2017; 5 candidates have withdrawn, 87 are completing their training for the International English Language Test System (IELTS), 25 have their IELTS exam booked with 14 due to take their IELTS exam before the end of August. We have 9 candidates have passed their IELTS and are progressing with their NMC application, 1 of which has been successful with their NMC application. - From September 2017 there will be 2 generic adverts being managed centrally by the Head Nurse for Professional & Workforce Development, to support all future band 5 in patient nurse jobs (ward/departments) come through the generic process. Specialist adverts can be advertising and managed within departments as required. Medical Staffing - Work has been undertaken to promote the role of Physician Associates (PAs) within the Trust, and 13 offers were made on the 10 June for posts within Medicine and Surgery. 10 are due to start on the 2 October 2017, 1 has withdrawn and 2 are still going through pre-employment checks. **September Update:** Nurse Staffing - Previous actions continue. - Applicants from International recruitment trip to the Philippines are progressing. 120 offers were made in country, since March 2017; 5 candidates have withdrawn, 87 are completing their training for the International English Language Test System (IELTS), 11 have their IELTS exam booked with 3 due to take their IELTS exam before the end of September. We have 11 candidates have passed their IELTS and are progressing with their NMC application, 3 of which has been successful with their NMC application and we are in the process of applying for visas. - We are now using 2 generic adverts, 1 for Medical division and the other 1 for Surgical division being managed centrally by the Head	Oct-2017	Jan-2018	WF	David E enhead, Brendan Brown, Jason Eddleston	Rachael ierce

6658 (Baf ref 007)	Accide & Emergency	Mar-2(	Keepir the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and [illegible] harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20 4 x 5	20 4 x 5	9 3 x 3	August 2017 Continued focus on preventing 'exit block' in the ED's. CHFT working with partners on reducing the number of medically stable patients remaining in hospital. These include the introduction of NHSE 8 High Impact changes. Introduction of trackers in ED will aid good flow in and out of each department. SAFER bed efficiency work revitalising 'bed before 11' and wards have discharge targets now. **September 2017** All initiatives introduced continue to be embedded. Trackers start in post in ED from 11th September 2017 Extending cubicle space in the ED at HRI should be complete by the end of September which will aid time to initial assessment.	Oct-17	Oct-2017	BOD	COO H n Barker	Bev We r
6441 (Baf ref 021)	All Departments/Wards S&A	May-2017	Financial sustainability	Risk of income being below planned levels for Division due to failure to delivery income CIP plans, inability to recover lost activity during EPR go live or planned level of activity in an appropriate case mix and inability to remove the equivalent total cost base to recognise this non delivery Resulting in non achievement of the Divisional planned contribution impacting on the Trusts ability to deliver its 17/18 I & E plan and remain a viable sustainable organisation	* Division Weekly activity / scheduling meeting " Theatre Productivity Work stream weekly review * Star Chamber approach if of plan "Weekly Operational Performance meeting with Director of Operations * Monthly Business Meeting incorporating performance management	Not all specialties job plans linked to activity volumes * individual surgeon performance management to activity plans	12 4 x 3	16	12 4 x 3	Attendance of Executive Director at weekly scheduling meeting. Division focus on Daycase & Elective. Trust wide including Division on Outpatient utilisation post EPR. EPR Stabilisation paper being prepared by COO. Directorate specific focus on aspects of planned care. Review of all surgery workforce against speciality in which activity captured. Recognition that income being captured at trust level but may be now within other Divisions with no change to control totals to recognise this	Nov-2017	Mar-2018	DB	Julie O'Riordan	Joanne Hardcastle

6596 (Ref 007)	All Departments/Wards Corporate	Jan-20	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - 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	16	8	July 2017 Progress with sharing learning - bitesize chunks of learning on screen savers weekly and highlighted in staff brief. First themed learning bulletin on falls - issued.in July, Sharing Learning-Improving Care. Investigations Training course held on 28 June 2017 - 14 staff trained, mainly nursing staff from medical division and Family and Specialist Services staff, of which 1 registrar, 1 corporate member of staff. Senior Risk Manager commences mid August 2017, exploring alternatives to cover expected risk vacancy in team. August 2017 Difficulties identifying investigators continue. Lack of trained investigators from Surgical and Anaesthetics division (all disciplines) and medical staff from Medical Division. Pressure ulcer serious incidents now being managed within SI process rather than separate panel to improve timeliness of reports. **September 2017** New Senior Risk Manager in post, tighter monitoring of investigations timescales, greater scrutiny of reports as drafted and support for investigators to increase the likelihood of reports and action plans being agreed at SI panel.	Oct-2017	Dec-2017	QC	Director Nursing, Brendan Brown	Juliette Isgrove

6598 (Ref 007)	Workforce Development	Jan-2017	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. Database capture tool delayed but now ready for use. This will help capture the completion dates not currently held within the system.	1/ 2 Essential skills training data held and target audiencess setting to allow compliance monitoring is inconsistent and patchy. 3/ Functionality of the OLM system limited. cannot facilitate disaggregated target audience setting. 4/ Issues with PC settings, leading 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/ Frequent requests for new essential skills to be added, no clear process to approve such requests. 7/ Heavy focus on EPR training and implementation has an impact on staff being able to complete essential skills training due to time and resource implications. 8/ Now all clinical staff have been issued a bank contract there are some discrepancies with competencies assigned to bank position but not their substantive post.	16	16	12	July 2017 Falls now underway - planned completion date 31.08.17 MCA/DoLS L1,2 & 3 awaiting action from the safeguarding team - due for completion 11.08.17 Data capture tool live from 24.07.17. Info to managers planned to coincide with go live date. August 2017 Two more essential skills added this month (naso-gastric tube feeding and fire warden training), bringing the total of essential skills training subjects to 32. Due to concerns on data capture the business intelligence team have created a bespoke data capture tool and will be able to produce full reports from mid- September. **September 2017** data-capture tool now live and colleagues notified of the need to populate with data. deadline of 30.09.17 given. MCA/DoLS level 1 now complete and uploaded to the e-learning platform. TA to be assigned the competence on 11.09.17 then this will appear in compliance matrix for staff to complete. Safeguarding level 2 inc MCA/DoLS - package ready but technical difficulties are preventing successful upload to the e-learning platform. Problem escalated for solving. Once this is resolved the revised package will replace the original safeguarding L2 for colleagues renewing with immediate effect. Falls prevention - package ready, final analysis on TA required, planned completion and roll out date 15.09.17 PREVENT WRAP - Complete and set up on ESR Driver essential skills - discrepancies with position codes identified. Unable to clarify due to staff sickness. Escalated for progress with a deadline date for completion of 29.09.17.	Oct-17	Oct-2017	WF	Jason Preston	Ruth Mann

6300 (Ref 007)	All Departments/Wards	May-25	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 the inspection we will be judged as inadequate in some services.	System for regular assessment of Divisional and Corporate compliance Routine policies and procedures Quality Governance Assurance structure CQC compliance reported in 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 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 has oversight of areas outstanding. A mock PIR for the Well Led domain is taking place to identify further areas for improvement Each division is restarting CQC groups to oversee pre inspection activity A Trust wide CQC Group will start meeting in September	The inspection report has shown us to be in the "requires improvement" category. We do not know the date of the next inspection We do not yet have the Insight Report from the CQC which details the data that they hold regarding our services	16	4 x 4	16	4 x 4	8	4 x 2	July 2017 No date for any inspection known as yet. Plans are being developed to do a review of the data that will be requested as part of the Well Led inspection. Other acute providers have started to have unannounced inspections, these are based upon intelligence the CQC hold on services. August 2017 Continue to prepare for re-inspection and the well-led Trust inspection, have commenced a self-assessment based on the well-led PIR which will be used to inform local intelligence. **September 2017** Divisions are setting up groups to prepare for the next inspection phase. Work continues on the Well Led PIR	Oct-2017	Dec-2017	WEB	Brenda rown	Juliette sgrove

5862 (Ref 007)	All Departments/Wards Medical	Aug-2013	Keeping the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls. Butterfly scheme. Delirium assessment	Insufficient uptake of education and training of nursing staff, particularly in equipment. Staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12 4 x 3	16 4 x 4	9 3 x 3	July update Actions as per plan, a sustained improvement has been noted. Achievements in areas of reduced falls incidents achieved through focused work driven by safety huddles. Enhanced support workers in post for high risk patients. August update To continue with safety huddle daily. All staff to be trained in the falls prevention equipment, including training about the falls bundle. **September update** Slips ,trips and falls policy redrafted for update at Falls Collaborative EPR falls awareness training being finalised. Equipment training on-going with ward based trainers. Falls awareness boards now being initiated on each ward. Falls incident numbers remain static for the previous 3 months (N=152) Reviiewed data and metrics on risk, focussed work on MAU and ward 5 ad, with risks on local risk register.	Nov-2017	Jan-2018	PSQB	Brenda rown	Janette ockroft

4783 (Ref 007)	All Departments/Wards Corporate	Aug-2017	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that 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	July update HSMR is 100.85 and SHMI is 104.73 and both remain in the expected range. Learning from death policy has been drafted and we are on target to implement the requirements of the national programme by September. There is a CUSUM alert on AKI and these cases are being reviewed. August 2017 update HSMR and SHMI remain in expected range. Learning from Death policy ready for approval at COG and WEB this month. Online initial screening review tool has gone live and includes automated escalation for cases assessed as poor or very poor care. **September 2017** Learning from death policy approved at WEB in August. Learning from death newsletter published to share the learning from mortality reviews. In the process of appointing an additional 2 PAs to perform the Structured Judgement Reviews. Currently there is a backlog of SJR to be performed due to 2 of the 3 medical staff have given notice to the role. HSMR and SHMI remain in the expected range	Oct-17	Oct-17	COB	David Greenhead	Juliette Isgrove

6977 (Baf ref 014)	Workforce Development	May-2017	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period. It was agreed at WED (June 2017) that the target compliance would be set at 95%. This risk is exacerbated by the requirement to complete EPR training in the same timeframe and there was a temporary issue concerning the National IG e-learning package which was withdrawn over the months of March - April 2017. This has now been resolved and is available under the refreshed title of Data Control. Impact: - Colleagues practice without the necessary understanding of how their role contributes to the achievement of strategic direction/objectives and without the knowledge/competence to deliver compassionate care. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised.	All electronic mandatory training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	Computer settings across the Trust have proved inconsistent. This can inhibit access to mandatory training and cause delays in compliance. This issue has been prioritised and a solution has been sourced.	16 4 x 4	16 4 x 4	4 4 x 1	A pay progression policy approach including mandatory training compliance is now in place. August 17 **September 2017** A mandatory training lead has been identified in Workforce & OD who is providing additional overview and scrutiny.	Oct-17	Mar-2018	WF	Jason Preston	Ruth Mann
6990 (Baf ref 021)	All Departments/Wards Corporate	Jun-2017	Transforming and improving patient care	CQUIN target at risk of not being met for 2017/18 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non - compliance with NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also financial penalties.	Awareness and new controls for ward areas Divisional plan, medical leads identified in all divisions -improvement action plan in place, improvements seen in data for 2016/17 -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign was launched introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards -sepsis prompt in EPR	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of communication and joined up working between nursing and medical colleagues Information on patients not receiving the sepsis bundle in a timely manner.	16 4 x 4	16 4 x 4	4 4 x 1	Assess impact of EPR sepsis prompt Improve safety huddles to include sespis Coordinate activity with the Deteriorating Patient Group Strengthen divisional leadership August update Detailed analysis work underway including a focus group with staff to understand barriers Areas for improvement identified Planning underway within each of those areas throughout August and September **September update** Analysis work continues focused on admission areas at both acute sites Weekly performance data shared with directorate teams Continued engament with staff as to barriers to detecting and responding to deteriorating patients	Oct-2017	Dec-2017	SC	David Birkenhead	Juliette Cosgrove

7046 (Ref 020)	All Departments/Wards	Aug-2017	Keeping the base safe	EPR Clinical risk of patients receiving delayed access to care. Due to: Migration issues which placed incorrect location codes to activity. Access issues for several members of staff resulting in delays. RTT build issue which does not place patients correctly onto the pathway. Electronic Discharge summary process not adhered to resulting in delayed information to GP. Lack of understanding on use of 'Encounters' leading to activity being connected with the incorrect episode. A 45day purge of all activity within the Message Centre including correspondence unknown to users resulting in delayed distribution of correspondence. Reductions in outpatient activity & issues with appointment correspondence delaying access to review. Lack of familiarity with the system leading to an increased potential for clinical risk	Remedy on Demand for escalation of all system related issues for resolution. Issues log populated by specialties, clinical and non-clinical staff to ensure all issues, risk, concerns were known and prioritised. All Divisions have own risk register and included in PSQB & Digital Modernisation Boards; high risks and risk changes reviewed at PRMs. Two weekly Operations Board with clear process for escalation. Datix reporting encouraged and all Red Datix received by Medical Director, Chief Nurse & Chief Operating Officer. Clinical Risk Panel established and Stabilisation plan developed. SWAT team deployed to undertake Deep Dives/RCAs. MDT meeting undertaken as required Visible leadership and feedback. Manual workarounds. Targeted support and training. On going training requirements identified and developed. Additional expert support deployed for Junior Doctor Change. Training & Access process for new and agency staff agreed. Access rights provided for all staff to undertake role as delivered pre-EPR	Response of external partner slow leading to delayed resolution. BAU team capacity & focus on BTHFT readiness Thematic review of incidents complaints, PALs etc. Adequate system build Training Review of access right. Robust audit of end to end pathways and documentation.	16 4 x 4	16 4 x 4	0 0 x 0	Stablisation plan developed. Each specilaty to meet with EPR Team and a Director to ensure all concerns identified and plans agreed. Quality Directorate to attend each Digitial Modernisation Board for assurance of appropriate escalation and mitigations. BAU team capacity and operational capability being reviewed. Change Board TORs reviewed to ensure operational/clinical led prioritisation. Further formal escalation to EPR partner regarding speed of resolution. Introduce thematic review of incidents, complaints, PALS etc. Submit change requests for system build. Formal review of roles and development of these on EPR to refine access rights. Identify training needs. Work with clinical leads to develop information and support tools. **September Update** EPR risk panel established in September 2017, will report on risks routinely to Risk and Compliance Group	Nov-2017	Mar-18	QC	David Greenhead	Alistair Morris

7047 (Ref 009)	All Depts/Wards	Aug-17	Keeping the base safe	EPR Performance risk of failed regulatory standards, contractual key performance indicators or other patient/staff focussed performance due to: Issues with data migration impacting on RTT pathways. Build/Configuration impacting on reporting data and pathway tracking. Delayed access for patient as a result of migration, build and staff familiarity. Patient satisfaction and reputational issues due to the percieved impact of the system as staff familiarise themslves. Staff satisfaction as they learn the new system or there are delays in resolving issues pertaining to patient care, flow and efficiency. Data Quality issues, duplications, incorrect pathways, coding all impacting on ablity to report . Management capacity & capability to resolve issues with the new system and maintain sufficient focus on all KPIs. Management reports inaccurate and requiring additinal validation before deployed delaying responsiveness. Management reports timeliness to comply with local and national reporting deadlines	Weekly Performance meetings, Weekly Data Quality Board, Additional Data Quality expertise and capacity, weekly activity review. Modelling of data to identify potential performance risks. Recruitment of additional staff into AED & Booking office. Shadow monitoring of activity using existing systems. Task and finish groups to address activity dips. Investigating areas of most concern. Manual recovery where poor recording is identified. Micromanagement of pathways. Working with IT to design appropriate reports. Use of Cymbio reports. Manual recording and collection of data. Stabilisation plan developed. Management capacity increases prioritised. All regulatory bodies kept informed proactively	Adequate system build. Availability of additional management capacity with correct skill set. Vacancies remain across all staff groups BAU capacity to support resolution of outstanding issues. Partner responsiveness & ability to find solutions. Several very large scale priorities to be managed. Communication and engagement	16 4 x 4	16 4 x 4	0 0 x 0	Stabilisation plan Outpatient transformation/productivity work. Retention of Cymbio expertise and formal process for knowledge transfer. Establishment of centre validation team. Continue work with Health Informatics to develop enhanced performance reports. Production of clear, annotated improvement trajectories. Clarity of EPR versus non EPR issues to ensure recovery plans response to root cause..	Octoer 2017	Mar-18	QC	Helen Baker	Division Directors

6971 (Ref ref 11)	Endoscopy HRI	Apr-20	Keeping the base safe	Business continuity risk relating to reduced endoscopy provision / capacity and hysteroscopy capacity (risk 6993) due to increased demand on the Adelaide 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 (HRI) Cantel (CRH) (maintenance contractor) technicians in place for all AER's A full downtime 36 hour period for maintenance schedules to be completed and all relevant tests to ensure all compliance is met. In sourced provider (medinet) is continuing to support service delivery through 2 CRH theatres on Saturdays, meetings with providers with a view to out source patient back log have commenced (Living Care/Yorkshire Clinic) these providers have offered capacity that will clear the back log by November. CRH decontamination - replacement AER's in place, commissioned and operational Additional hysteroscopy sessions to reduce the waiting list. Explore use of private sector - equipment, facilities and nursing staff with them if we're unable to progress either of the 2 options to its fullest extent.		20	5 x 4	15	5 x 3	4	4 x 1	To replace all AER's as part of the endoscopy decontamination replacement scheme, by expediting the scheme the risk will be mitigated. **September 2017** Supporting decontamination unit to be built at HRI that will support the decontamination replacement on both sites. In front of plan Reintroduction of BCSP	Oct-17	Oct-17	DB	Julie Ordan	Jason Ebby

6829 (Ref 007)	Pharmacy	Aug-2015	Keeping the base safe	The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately [illegible] pa ready to administer injectable medicines with short expiry dates for direct patient care. Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service(SPS) on behalf of NHSE. The latest audit undertaken on 5 April 2017 rated the overall risk assessment to patient safety as high with two major deficiencies. It was strongly recommended that the workload is not increased in the HRI facility and consideration must be given to close the facility if a business case for replacement is not approved.Capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards to enable the closure of the HRI facility.	Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. Self-audits of the unit External Audits of the HRI unit will be undertaken by the Quality Control Service on behalf of NHSE every 6 months. Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance. The capacity plan of the HRI unit will not be exceeded. A strategy of buying in ready to administer injectable medicines will be implemented but there are concerns about the sustainability of the current pharmaceutical supply chain.	If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance' rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.	15 3 x 5	15 3 x 5	3 3 x 1	6 July 2017 Draft business case received favourable response from FSS PRM. Improvements to be incorporated and draft to be submitted to August Commercial Investment and Strategy Group. 21 July 2017 The Regional Quality Assurance Pharmacist was invited to the HRI Unit to advise on alterations that would be required to enable the unit to function safely until the new unit at CRH is commissioned. These recommendations will be incorporated into the business case . August 22 08 2017 Business case currently being finalised - to be submitted for approval in September **September** Business case finalisation not yet complete. Will be completed for consideration by end of September	Oct-17	Oct-2017	DB	Brenda rown	Mike Claw

6924 (Baf ref 007)	All Departments/Wards 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	July Update All areas identified now at 75% or above training compliance with some areas scoring 90% or over. Training and reassessment in these areas will be delivered after 3 years. Further training is ongoing for new staff at induction and sessions have been planned for existing staff. Plan in place to identify 3 key trainers on all other ward areas who will be able to support areas where use is less frequent. Reassessment for this group will be delivered after 12 months. Teaching for medical staff has been timetabled in for early next year – CNS approaching training to ask if this can be expedited. Comms team have been approached to support trust wide communication regarding NG tubes, training and access. CNS plan to launch nutrition event and recruit link nurses across all areas – event planned for September with quarterly link meetings planned. No progress on medical staff training – package is ready to deliver need to agree medical staff sign up. Dr Uka is attending July task and finish group to progress. August 2017 update: Progress continues with nurse training with plan to introduce key trainers in low use areas Dr Uka is progressing approach and programme for training medical staff. Plan to utilise training from neighbouring trust currently working through how this will be delivered and captured. **September 2017** Agreement that NG training will now be captured as essential skills for medical and nursing colleagues. Meeting 14.9.17. worked through training plan. Training package available for nursing staff and e-learning package for medical staff being sourced.	Oct-17	Oct-17	QC	Brenda rown,	Jo Midd on
5747 (Baf ref 012)	Angiography & Fluoroscopy	Mar-2013	Keeping the base safe	The risk of failing to provide interventional vascular service due to challenges recruiting substantively to vacant posts at consultant interventional radiologist level. Resulting in: potential impact on service delivery and rota provision our ability to meet referral to treatment target our ability to deliver a viable vascular/interventional service in collaboration with Bradford.	1wte substantive consultant currently in post 1wte consultant on 6 month enforced sabbatical Vacant posts previously advertised with no successful appointment being made. Locums supporting the service 1 locum working with the Trust on a longer term basis and additional agency support also in place Progressing approach to further contingency using regional-wide approach	Failure to appoint to vacant post substantively - working in collaboration with regional network to advertise and recruit on a joint basis	16 4 x 4	15 5 x 3	6 2 x 3	July update Offered outgoing locum an 'as and when' trust contract, which has been accepted. Locum will work 3 weeks on, 3 weeks off 2 further short term part time locums sourced providing intermittent cover until end September 2017. August update Additional locum provisionally secured for longer term Progressing joint advert within regional network alongside development of business continuity planning **September update** No further update - joint advert not yet finalised and published	Oct-17	Oct-17	DB	Martin DeBono	Sarah Clenton

6011 (Baf ref 007)	Blood ences	May-2 4	Keepi the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBIT) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust).	Lack of electronic systems Lack of duplicate sampling Training compliance not at 100%	15 5 x 3	15 5 x 3	3 3 x 1	July 2017 Project team established, board and management team for scheme set up. Work to begin in August to establish the implementation plan, implementation will not begin until January 2018 due to requirement for Apex system update to LIMS prior to implementation. August 2017 Reviewing ability to bring forward Apex upgrade or part implement blood tracking system if not possible **September 2017** Implementation group met for first time in August. Project continuing and timescales to be signed off in Sep. Intention to implement Apex upgrade in October	Oct-2017	Mar-2019	PSQB	Martin I 3ono	Hayley ker
6715 (Baf ref 007)	All Departments/Wards 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.	Monthly clinical record audits (CRAS) with feed back available form ward to board A further qualitative audit is undertaken monthly by Matrons that includes patient understanding . Medical audits are undertaken Analysis and action planning is managed through divisional patient safety and quality board A multi professional clinical documentation group meets bi monthly to ensure new documentation is ratified, standards on documentation are addressed. This group also receives reports and audits with regard to documentation and identifies to the divisions areas (teams, wards departments) of concern as well as any specific areas of concern within a specific standard. Clinical records group monitors performance, highlighting best and worst performing wards and action plans are developed and managed through the divisions, including specific areas for improvement. January Update Work is progressing to devise and implement a ward assurance tool that will audit nursing documentation. The CRAS audits remain	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	July 2017 The group to review nursing standards of documentation has reformed and will report through the Nursing Practice Group.. The initial meeting agreed the focus of the work. August 2017 The work has commenced on reviewing the documentation standards and ensuring the ward assurance tool is aligned in order to ensure there is consistency with assurance and performance management. **September 2107** As the EPR starts to embed and end users become more familiar with it, guidance is being developed and standards of documentation are being updated. A user guide is almost complete and will be tested. The ward assurance document is also being tested. Risks are being identified and monitored through the EPR risk group along the clinical hazard group, the operational board and changes to the clinical document are managed through the change group. Recognising that EPR needs to transition into the Trusts governance a Risk panel has been developed which is chaired by the Medical Director. .	Oct-17	Oct-17	QC	Brendan Brown	Jackie Murphy

10. GOVERNANCE REPORT

Presented by Victoria Pickles

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th October 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - OCTOBER 2017 - This report brings together governance items for review and approval by the Board	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together governance items for review and approval by the Board:

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 to September 2017 is attached at appendix 1.

The Board is asked to NOTE the attendance register.

Certificate of Compliance with Licence Conditions

In January 2015 Monitor (the Regulator of Foundation Trusts at that time) declared the Trust to be in breach of licence as a result of an unplanned year-end deficit position of £4.3m which Monitor believed to be a breach of financial and board governance. Monitor wrote to the Trust setting out the undertakings it expected the Trust to deliver. The certificate of compliance with two of the three undertakings relating to Board governance and effectiveness and general actions - appendix 2.

The remaining undertaking requires the Trust to 'ensure the Licensee's clinical and financial stability is maintained from the end of the financial year 2016/2017'. The Full Business Case has been completed and submitted to NHS Improvement setting out how clinical and financial stability could be achieved by year five of implementation. In the meantime the Trust remains in a deficit position and therefore NHS Improvement has not certified compliance with this final undertaking.

The Board is asked to RECEIVE the certificate of compliance.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to RECEIVE the certificate of compliance and NOTE the attendance register.

Appendix

COMBINED GOVERNANCE REPORT PAPERS.pdf

Attendance	✓	Apologies	×	Not Exec BOD members	-

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

DIRECTOR	6.4.17	4.5.17	1.6.17	6.7.17	20.7.17 AGM	3.8.17	7.9.17	5.10.17	2.11.17	7.12.17	4.1.18	1.2.18	1.3.17	TOTAL
A Haigh (Chair)	√	No meeting held	√	√	√	√	√							/12
D Anderson	√	-	√	√	√	√	√							
Helen Barker	√	-	√	√	√	x	√							
D Birkenhead	√	-	x	√	√	√	√							
G Boothby (Interim DoF from 1.11.16)	√	-	√	√	√	√	√							
B Brown	√	-	√	√	√	√	√							
J Eddleston (Acting Dir WOD from 10.7.17 – 10.1.18)	-	-	-	√	√	√	x							
K Heaton	√	-	√	√	√	√	x							
L Hill	√	-	√	√	√	√	√							
R Hopkin	√	-	√	√	√	√	x							
P Oldfield	√	-	√	x	x	√	√							
L Patterson	√	-	√	√	√	√	√							
P Roberts	√	-	√	√	x	√	√							
I Warren (from 1.8.16 – 9.7.17)	√	-	√	x	-	-	-	-	-	-	-	-	-	2/12
O Williams	√	-	√	√	√	√	√							
J Wilson	x	-	√	√	√	√	√							
Vicky Pickles	x	-	√	√	√	√	√							
A Basford	√	-	√	√	√	√	x							
Mandy Griffin	x	-	√	√	√	√	√							
Cornelle Parker (for DB)	-	-	√	-	-	-	-							

BOD-ATTENDANCE REGISTER 2017-2018

CERTIFICATE OF COMPLIANCE

LICENSEE:

Calderdale and Huddersfield NHS Foundation Trust ('the Licensee ')
Trust Headquarters
Acre Street
Linley
Huddersfield
West Yorkshire
HD3 3EA

For the purposes of this certificate, "NHS Improvement" means Monitor.

In accordance with paragraph 12(1) of Schedule 11 to the Health and Social Care Act 2012, NHS Improvement hereby certifies that in respect of paragraph 2 (Board Effectiveness and Governance) and paragraph 3 (General), Licensee's Enforcement Undertakings accepted by NHS Improvement on 29 January 2015, the Licensee has been compliant.

Signed:

Position: Chair of the Regional Provider Support Group North Region

Date: 2 July 2017

a. BOD Attendance Register (April - September 2017)

b. Receipt of Licence Conditions

11. Emergency Preparedness, Resilience and Response (EPRRR) and Core Standards Annual Submission

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Alison Wilson, Head of Compliance & Support Services
Date: Thursday, 5th October 2017	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Emergency Preparedness, Resilience and Response (EPRR) Assurance - EPRR Statement of compliance following CHFT's self assessment against NHS England Core Standards; Action Plan and CHFT's EPRR Strategy	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The papers have been communicated at CHFT's Health and Safety Committee, Divisional Quality & Safety Board and Weekly Executive Board.	
Governance Requirements: The EPRR Statement of compliance following CHFT's self assessment against NHS England Core Standards; Action Plan and CHFT's EPRR Strategy provides CHFT with a assurance in terms of its current position and future plans to keep the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

Purpose of the paper is to provide Board with a position statement against the NHS Core Standards (Civil Contingencies Act 2004), an action plan and CHFT's EPRR strategy. The position statement illustrates partial compliance due to changes in the measuring criteria used by NHS England.

Main Body

Purpose:

Purpose of the supporting papers is to provide Board with an overview against the Civil Contingencies Act 2004 and provide a current position statement of compliance following the self-assessment against NHS Core Standards for EPRR. An action plan is included detailing the journey over the next 12 months complete with CHFT's EPRR Strategy.

Background/Overview:

NHS England EPRR Standards (Version 5) have developed progressively to self-review changing aspects of EPRR landscape. CHFT has routinely complied with the direction for submission however, the latest changes have seen an increase in the number of evaluation criteria. Significant work has taken place during the previous 12 months with Departments and Divisions developing individual business continuity plans for both their services and the EPR project; a number of areas have tested their plans. Learning has also taken place following external cyber incidents at North Lincolnshire and Goole and Leeds Teaching Hospitals.

Overview of this year’s standards against current EPRR portfolio practice is that there are similar significant pieces of work required following from the previous submission. The compliance level is proposed Partial with the caveat of fully implementing the associated action plan and implementing CHFT's EPRR Strategy.

The Issue:

Issues relating to a number of specialised Incident Response Plan requiring development or extensive review. Training needs analysis associated with crisis and emergency management training for management layers in the Trust. Testing and exercising formalised and Trust owned plans to demonstrate compliance with categorised responder status under the statutory guidance of the Civil Contingencies Act 2004 and NHS England Guidance

Next Steps:

To approve:-
1) CHFTs statement of compliance against NHS Core Standards
2) NHS Core standards improvement plan
3) CHFT’s EPRR strategy

To submit the statement of compliance to the Yorkshire and Humber Local Health Resilience Partnership (via the Accountable Emergency Officer)

Recommendations:

The Board is requested to approve the next steps.

Appendix

Attachment:

COMBINED EPRR LHRP PAPERS for SEPT 17 Board.pdf

Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Calderdale & Huddersfield NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Partial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

A live exercise (required at least every three years)	30th May 2017
A desktop exercise (required at least annually)	5th Oct 2017
A communications exercise (required at least every six months)	30th May 2017

I confirm that the relevant teams in my organisation have considered the debrief reports and actions required from the cyber incidents at North Lincolnshire and Goole NHS FT and Leeds Teaching Hospitals NHS Trust. A plan for the identified actions arising is available.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting Date signed

Organisation: Calderdale & Huddersfield NHS Foundation Trust

ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	8 of the prerequisite plans are out of date and/or require comprehensive update	Plan/Policy writing – requires review or introduction • CBRNe/HAZMAT • Severe Weather • Pandemic Flu • Fuel Supply disruption • Surge & Escalation • Lockdown • Evacuation • Mass casualties/fatalities Commissioned external consultant to work on the direction of the AEO/EPRR Manager to address plan writing required	April 2017
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	8 of the prerequisite plans are out of date, require development and/or require comprehensive update	See above	April 2017
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	No formal training presently delivered. Unclear how many Directors/SMOC have recently received any recognised training for competencies reasons. Enquiring and developing SLiC, TLiC, NDM, Dynamic E-learning package for identified staff	Develop training analysis in line with Chief Operating Officer, Accountable Emergency Officer and Head of Learning & Development Commission a provider to deliver to identified group. Forecast to develop TNA with L&OD for all management levels appropriate to accountability and authority	June 2017
34	Arrangements include a training plan with a training needs analysis and	Needs development	Enquiring about SLiC, TLiC, NDM, Dynamic E-Learning training needs analysis. Forecast to	April 2017

	ongoing training of staff required to deliver the response to emergencies and business continuity incidents		develop TNA with L&OD for all management levels	
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	Needs development in line with plan writing programme	Not at this time due to plan writing requirement. Engagement with external partner exercises will be facilitated	April 2017

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
12 13 14 16 18 19 21	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity	7 of the prerequisite plans are out of date and/or require comprehensive update	Plan/Policy writing – requires review or introduction • 12-Pandemic Flu • 13-Mass Countermeasures • 14–Mass Casualties • 16-Surge & Escalation • 18–Evacuation • 19-Lockdown • 21-Excess Deaths/Mass fatalities Commissioned external consultant to work on the direction of the AEO/EPRR Manager to address plan writing required	Apr 18
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	7 of the prerequisite plans are out of date, require development and/or require comprehensive update	See Above	Apr 18
49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	Needs development	Enquiring about SLiC, TLiC, NDM, Dynamic E-Learning training needs analysis. Forecast to develop TNA with L&OD for all management levels	Apr 18

50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	Needs development in line with plan writing programme	Not at this time due to plan writing requirement. Engagement with external partner exercises will be facilitated	Apr 18

Please attach a copy of the responses to the governance deep dive standards

Deep Dive standard reference	Deep Dive standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	Agreed	To ensure tha the topic is published according to the approved appointment	Jan 18
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	Agreed	To be identified	Jan 18
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	Agreed	AEO/Resilience Team to develop Terms Of Reference and establishment of the Resilience and Security Management Group	Jan 18
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	Agreed	See above	Jan 18

DOCUMENT NUMBER: G-111-2015
EQUIP-2017-011
Review Date: Sept 2020
Review Lead: Accountable Emergency Officer

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Emergency Preparedness, Resilience and Response (EPRR) Strategy

Version 2

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 NUMBER: G-111-2015
EQUIP-2017-011
Review Date: Sept 2020
Review Lead: Accountable Emergency Officer

Document Summary Table		
Unique Identifier Number	G-111-2015	
Status	Approved	
Version	2	
Implementation Date	July 2017	
Current/Last Review Dates	August 2017	
Next Formal Review	Sept 2020	
Sponsor	Executive Director of Planning, Estates and Facilities	
Author	Resilience and Security Management Specialist	
Where available	Staff Intranet	
Target audience	All Staff	
Ratifying Committees		
Executive Board		28th Sept 17
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Health and Safety Committee	Executive Director of Planning, Estates and Facilities	21 June 2017
Quality Committee	Non-Executive Director	3 July 2017
Other Stakeholders Consulted		
Divisional Operations Directors		
Chief Operating Officer		
Associate Director of Urgent Care		

Does this document map to other Regulatory requirements?	
Health & Social Care Act 2012	*Section 46*
Civil Contingencies Act 2004	
NHS Emergency Planning Guidance	

Document Version Control	
1.0	New Document
1.1	Revised document 30 November 2016 (out for governance)
1.2	Minor change. Added OPEL reference Dec 2016
2	Full review and update

[redacted]MBER: G-111-2015
EQUIP-2017-011
Review Date: Sept 2020
Review Lead: Accountable Emergency Officer

Contents

DOCUMENT NUMBER: G-111-2015
EQUIP-2017-011
Review Date: Sept 2020
Review Lead: Accountable Emergency Officer

1 Introduction

The Calderdale and Huddersfield NHS Foundation Trust (CHFT) Board of Directors is committed to achieving and maintaining compliance with the Civil Contingencies Act 2004 and associated NHS Emergency Planning Guidance 2015. By meeting statutory requirements and standards of best practice CHFT will ensure preparedness to respond and recover from a major incident affecting the Trust, or serious disruption to services whilst maintaining delivery of its critical functions and non-critical functions as far as it is practicable.

As a public sector body, CHFT have a duty of care to service users, especially those in vulnerable situations. The patients and the communities we serve expect the NHS to be there for them when they need it, no matter what the circumstances. Events such as Pandemic Flu, severe weather and power outages, show that the NHS needs to act quickly and effectively in the event of an emergency. CHFT's success in dealing with such events is dependent upon staff commitment, capability and detailed comprehensive planning.

2. Statutory and Legal Requirements:

The Civil Contingencies Act (CCA) 2004 places specific statutory duties on Category 1 Responders to perform certain activities in respect of preparing for emergencies. Category 1 Responders include:

- Local authorities.
- Emergency services (police and fire & rescue services).
- Health (ambulance services, NHS trusts, NHS foundation trusts, Public Health England).
- Environment Agency.

2.1 Statutory duties relating specifically to health include:

- Co-operation and information sharing with other Category 1 and 2 Responders, including involvement in Local Resilience Forum (LRF) arrangements.
- Risk Assessment.
- Emergency Planning.
- Business Continuity (BC) Management.
- Communicating with the public.

In addition, Section 46 of Health and Social Care Act 2012 stipulates the requirement for providers of funded health care to have appropriate arrangements in place for emergencies.

EQUIP-2017-011
Review Date: Sept 2020
Review Lead: Accountable Emergency Officer

3. Purpose

The policy is intended to establish and support EPRR, BC management and Recovery as an integral component of the Trust's normal working practices. NHS organisations are accustomed to normal fluctuations in daily demand for services. Whilst at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures by means of established management procedures and escalation procedures. This policy outlines the framework by which EPRR arrangements will be managed and co-ordinated across the Trust when established procedures are no longer sufficient to successfully manage the issue. It covers the EPRR management process that will lead to the production of Major Incident and Business Continuity plans and arrangements.

4. Emergency Preparedness, Resilience and Response (EPRR)

The NHS service-wide objective for EPRR is:

To ensure that the NHS is capable of responding to significant incidents or emergencies of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.

4.1 EPRR is a varied portfolio and can be separated into 7 work groups:

- **Special Operations** – Local or National Events which will impact on "Business as Usual" (Demonstrations, Public Disorder, Large Scale events or Mass Gatherings).
- **Acute Major Incidents** – Generic, Specialty, Mass Casualty and CBRN (Chemical Biological Radiological and Nuclear) where the Trust is an initial responder.
- **Threats to Public Health** – Outbreaks which threaten normal operating arrangements or require the implementation of special measures or preparations such as pandemic flu or Ebola.
- **Seasonal Variation** – Planning and Responding to Winter and Heatwaves.
- **Public Infrastructure Failures** – National Fuel disruption arrangements, Utilities Failures and Counter Terrorism Initiatives within the Health Service and as part of a Multi-agency Response.
- **Business Continuity Arrangements** – Loss of Site and Evacuation planning, Management of Bomb Threats and Security incidents, Service specific Business Continuity Arrangements and System wide resilience plans.
- **Surge and Escalation Planning** – Planning and responding to "Significant Incidents" whether internal or the result of another agency.

EQUIP-2017-011
Review Date: Sept 2020
Review Lead: Accountable Emergency Officer

5. Objectives

This policy describes the overarching approach to EPRR to which the following objectives and outcomes apply:

- Embed a culture of EPRR within CHFT
- Deliver duties as defined by the CCA 2004
- Identify and implement preventative actions that reduce the risk of disruption to key services
- Ensure continuity of essential services when faced with a range of disruptive challenges
- Ensure the recovery of critical functions and return to normal working as quickly as possible following a major incident or service disruption
- Ensure that plans are aligned with those of partner organisations, including the identification of triggers and protocols for activation of EPRR procedures and arrangements
- As a Category 1 responder, CHFT are required to co-operate with other local Category 1 and 2 Responders who are involved in planning for major incidents

6. Outcomes

The intended outcomes of the EPRR system are:

- The relevant legal and regulatory requirements for emergency planning and business continuity management will be clearly defined and understood
- Robust arrangements to respond to a major incident or service disruption including a senior management on-call system, and command, control and communications plans
- Operational, financial and reputational risks to the Trust will be reduced
- Compliance with legislation, regulations and standards, which require:
    - *A live exercise every 3 years*
    - *A yearly desktop exercise*
    - *Six-monthly communication cascade tests*
- To ensure that hazards, risk and threats are identified, recorded, assessed and control measures developed
- Establish and maintain a forum where EPRR and Business Continuity (BC) matters can be discussed
- A system of regular reporting and review across the organisation, which aligns with the Trust internal risk management and governance arrangements
- A training program for all levels of the organisation, which will link to multi-agency training through the Local Health Resilience Partnership (LHRP) and the Local Resilience Forum (LRF)
- To provide positive EPRR assurance to the Board of Directors, Commissioners, NHS England, healthcare partners and other Responders

EQUIP-2017-011
Review Date: Sept 2020
Review Lead: Accountable Emergency Officer

7. Definitions

The following definitions apply:

- **Category 1 Responders** – Organisations at the core of a response to most emergencies. Responding organisations are divided into categories by the Civil Contingencies Act (2004)
- **Category 2 Responders** – Those organisations whose function is likely to be in support, such as transport and utility companies
- **Emergency Planning** – The development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of a disruption or emergency
- **Business Continuity Plans** – Documented procedures that guide organisations/departments to respond, recover, resume and restore to a pre-defined level of operation following disruption (ISO 22301. 2012)
- **Resilience** – The ability of an organisation to adapt and respond to disruptions, whether internal or external, to deliver organisational agreed critical activities
- **Major Incident** – "An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies." - Cabinet Office revised 2016
- **Major Incident Plan** – The plan produced as a result of emergency planning to respond to a Major Incident. There are two types of MI plan:
    - For an event to which the Trust will respond
    - For an event affecting the Trust itself
- **Response** – Decisions and actions taken in accordance with the strategic, tactical and operational objectives to protect life, contain and mitigate the impacts of the emergency and create the conditions for a return to normal
- **Incident levels** – Operational Pressures Escalation Levels (**OPEL)** provides a standardised framework in which A&E Delivery boards can align their escalation protocols; Table 1. It provides a commonality across other NHS departments. This will be dealt with in more detail in Surge and Escalation plans

OPEL INCIDENT LEVEL	
LEVEL 1	An incident that can be responded to and managed by a local health provider organisation with their respective business as usual capabilities and Business continuity plans in liaison with local commissioners.
LEVEL 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS co-ordination by the local commissioner(s) in liaison with the local NHS office.

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LEVEL 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England will co-ordinate the NHS response in collaboration with local commissioners at the tactical level.
LEVEL 4	An incident that requires NHS England national command and control to support the NHS Response. NHS England will co-ordinate the NHS response in collaboration with local commissioners at tactical level.

Table 1: OPEL

8. Duties (Roles and Responsibilities)

Chief Executive has overall responsibility for compliance with the CCA 2004 and will:

- Ensure that the Trust complies with all statutory requirements of the Act
- Ensure the provision of sufficient resources to meet the requirements of CCA
- Assign an executive lead for EPRR
- Ensure effective BC and Major Incident plans (generic and specific) are in place which correspond with the major risks identified within the Trust and those identified on local community and national risk registers
- Oversee command and control in line with the Command and Control arrangements and, if appropriate, identify an Executive Director to lead on recovery
- Promote EPRR across the Trust and allocate it sufficient status and priority to ensure achievement

Executive Director of Planning, Performance, Estates and Facilities is the appointed Director with responsibility for EPRR and the designation Accountable Emergency Officer (AEO), and will:

- Manage the EPRR capability implementation and evaluation activity for the COO
- Provide executive support to the emergency planning programme
- Identify if further support is required from the Board (whether from a second Executive Director or Non-Executive Director) to provide assurance to the Board of Directors that the Trust is meeting its legal obligations
- Attend Local Health Resilience Partnerships (LHRP) meetings on behalf of the Trust (or ensure the trust has appropriate representation at the meeting) and that the Trust is appropriately represented at any relevant governance meetings, sub groups or working groups of the LHRP or Local Resilience Forum (LRF)
- Chair CHFT EPRR working group to ensure engagement with Divisions and key stakeholders

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General Manager, Estates and Facilities is the General Manager within Estates and Facilities with responsibility for statutory compliance and is responsible for:

- Ensuring the Ops Board receives regular reports, at least annually, on EPRR, including reports on exercises, training and tests undertaken
- Coordinating all EPRR capability development activity across the Trust
- Ensuring that the Trust is compliant with the EPRR requirements as set out in the Civil Contingencies Act 2004, The Health and Social Care Act 2012, the NHS planning framework and the NHS Standard Contract
- Ensuring that the Trust is properly prepared and resourced for dealing with a major incident or emergency event
- Ensuring the Trust and any providers they commission, have robust EPRR arrangements in place

Trust Resilience and Security Specialist will:

- Co-ordinate and capture EPRR analysis, in liaison with Trust Risk Management staff
- Co-ordinate all EPRR integrated management planning and draft the EPRR Implementation, Resourcing, Training and Evaluation Plans
- Manage the EPRR Training and Evaluation Programmes, capturing progress for upward reporting
- Implement a system of regular reporting and review across CHFT which aligns with the Trusts risk management and governance arrangements
- Support the AEO in implementing the Trusts EPRR Framework
- Develop, disseminate and maintain the Trust's corporate EPRR arrangements
- Attend appropriate local and regional planning meetings
- Support Divisional Directors, Assistant Divisional Directors, General Managers, Ward Managers and Matrons in the development of Business Continuity and Major Incident Plans (generic and specific)
- Retain archived version of Business Continuity and Major Incident plans (generic and specific) to ensure an audit trail of changes is available
- Ensure that hazards, risk and threats are identified, recorded, assessed and control measures developed, where appropriate
- Establish and maintain a Trust EPRR forum where EPRR and BC matters can be discussed
- Provide regular updates from the EPRR working group to the Executive Director with responsibility for EPRR
- Develop a training strategy for the Trust and facilitate delivery
- Arrange and coordinate exercises as required
- Maintain training records and records of attendance in relation to all EPRR and BC activities
- Produce an annual report for the Board of Directors summarising the current state of the Trust's EPRR arrangements

- Contribute to NHS England Situation and EPRR reports

In addition they will ensure the following tasks are carried out with External Agencies:

- Agree risk profiles for the West Yorkshire area and maintain a Community Risk Register
- Develop and participate in multi-agency plans and other documents, including protocols and agreements
- Co-ordinating multi-agency exercises and other training events
- Participate in multi-agency debriefs
- Provide expert advice and share knowledge, experience and best practice

Divisional Operations Directors will:

- Oversee the effective implementation of this EPRR policy and related plans within their areas of responsibility
- Effectively delegate emergency planning responsibilities within their areas of responsibility, including nominating a business continuity lead (ideally service leads/operational managers)
- Effectively support their managers' decisions and recommendations in terms of the provision of appropriate resources for emergency planning
- Ensure that managers have adequate training to participate effectively in the preparation for and response to major incidents
- Ensure the provision of appropriate resources including equipment and facilities to enable an effective response to a major incident
- Cascade Communications messages and Business Continuity and Major Incident plans (generic and specific) to staff within their areas

Departmental/Ward Managers, General Managers and Matrons will:

- Periodically review and update action cards for the department or ward
- Support the divisional BC leads to ensure that local continuity plans are maintained and developed
- Participate in the development of emergency plans
- Ensure the development and maintenance of Business Continuity and Major Incident plans (generic and specific) and submit these to the appropriate committee for ratification
- Maintain an emergency contact list for all staff in the department or ward
- Ensure that critical services and support systems (including IT) have been identified within their areas of responsibility
- Ensure that appropriate equipment is available and regularly maintained in order to respond to major incidents
- Implement all aspects of this policy, the Business Continuity Policy and Major Incident Plans (generic and specific) within their area of control
- Ensure that all staff receive training appropriate to their role in responding to an emergency

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- Maintain a local record of staff attendance and training in relation to all EPRR and BC activities
- Brief staff on the situation, any new developments and Trust actions
- Ensure that there is a departmental debrief following all major incidents and the recommendations of these are fed in to a Trust-wide debrief
- Provide appropriate representation at the Trust EPRR Committee

Senior Information Risk Officer (Chief Information Officer) will:

- Ensure that the Trust has resilient information assets and critical processes
- Ensure that Information Governance requirements are maintained during an emergency event and provide advice on data sharing when required
- Receive and record hazards, risks and threats that emerge from EPRR

All Staff will:

- Be familiar with the arrangements, their roles and responsibilities detailed in the Major Incident and Business Continuity plans
- Undergo training and participate in exercises that test response, recovery and continuity plans

9. Overarching EPRR Planning Framework:

EPRR is managed through the integrated emergency management (IEM) lifecycle. This consists of the steps shown in Table 2 below and these are to be followed by the Trust.

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Step	Name	Purpose
Anticipation Assessment / Prevention	Impact Analysis	Identifies a priority order for the recovery of services / processes
	Risk Register	Identified the types of incident that may occur, and the potential impact if they do occur. The results of this will be used to identify when a contingency plan is required
Preparation / Responding / Recovery	Command and Control Framework	To ensure effective management of any event requiring invocation of an emergency plan
	On call Manager/Director	Arrangements for ensuring the Trust has access to sufficiently senior staff 24x7
	Resource Escalation Action Plans	Structured sets of arrangements are implemented when 'normal' operating functions are challenged, for example through loss of staff, resources or periods of high demand.
	Major Incident Plan	Used when the hospital receives so many casualties from a major incident that special measures are necessary to deal with them
	Business Continuity Plans	Detail the response to interruptions of critical services and the action required to maintain services at an acceptable level and return them to normal operations as soon as possible.
	Specialty plan	The response when a response to a specific incident or threat is required and not contained within a generic incident plan previously mentioned

Table 2: IEM

10. Emergency Planning Overview

There are a number of interrelated planning levels, which the Trust will integrate with as follows:

10.1 Requirements within the NHS

Emergency planning at the local level, including within the Trust, is at the heart of the civil protection duty on Category 1 Responders under the Civil Contingencies Act. The Act requires Category 1 Responders to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies; and taking other action in the event of emergencies; this is the responsibility of the AEO. To do this, the Trust is to draw on risk assessments and is to have regard for the arrangements to warn, inform and advise the public at the time of an emergency. The Regulations require Trust plans to contain procedures for determining whether an emergency has occurred; the provision for training key staff; and provision for exercising the plan to ensure it is effective. Procedures are also be put in place to ensure that the plan is reviewed periodically and kept up to date. Specifically, the Trust, like all Category 1 Responders is to:

- Involve Category 2 Responders - and other organisations which are not subject to the Act's requirements - as appropriate throughout the planning process

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- Have regard to the activities of relevant voluntary organisations when developing plans. The Regulations permit Category 1 Responders to collaborate with other organisations in delivering the emergency planning duty
- Have a statutory duty to publish their emergency plans, to the extent necessary or desirable for the purpose of dealing with an emergency

10.2 Emergency planning at the sub-national level

Planning at a multi-LRF level is different from planning at the local (Trust) level. Co-operation at the sub-national level in England is a key element of the UK's civil protection framework. The sub-national tier is not a judgement on the local level; rather, it is a mechanism for improving co-ordination and communication into and out from the centre of government. Co-operation at the sub-national level involves the representatives of local Responders and central government bodies working together to address larger-scale civil protection issues. Co-operation may take place within a multi-agency setting or directly between 2 or more Responders. The Trust will be represented at this planning level by the AEO and the Trust Resilience and Security Specialist.

10.3 Emergency planning at the UK Government level

The UK government capabilities programme is the core framework through which the government is seeking to build resilience across all parts of the UK. The programme uses risk assessment over a 5-year period to identify the generic capabilities that underpin the UK's resilience to disruptive challenges and ensures that each of these is developed. These capabilities include dealing with mass casualties and fatalities, response to chemical, biological, radiological or nuclear (CBRN) incidents, provision of essential services and warning and informing the public. The government has in place a co-ordinated cross-governmental exercise programme covering a comprehensive range of domestic disruptive challenges, including accidents, natural disasters and acts of terrorism. The programme is designed to test rigorously the concept of operations from the co-ordinated central response, through the range of lead government department responsibilities and the involvement of the devolved administrations, to the sub-national tier and local Responders. More information is provided in the guide to emergency exercises and training. These national processes feed into the devolved administrations, sub-national and local levels to ensure fully integrated emergency planning at all levels throughout the UK. The AEO is responsible for Trust integration into this level of planning.

10.4 The role of the voluntary sector in emergency planning and response:

Where appropriate, the Trust is to consider, at an early stage in planning, whether voluntary organisations may have capabilities which could assist in responding to an emergency. The voluntary sector can provide a wide range of skills and services in responding to an emergency. These include: practical support (such as first aid, transportation, or provisions for Responders);

psycho-social support (such as counseling and help lines); equipment (radios, medical equipment); and information services (such as public training and communications). The Trust Resilience and Security Specialist will consult with voluntary organisations on the Trust's behalf.

11. Emergency Plans

The Trust will have operational, tactical, and strategic plans dependent on the type of incident, and on the scope and scale of response required. Emergency planning should aim to prevent emergencies occurring, and when they do occur, proactive and tested contingency plans, coupled with sound planning to address the perculiarities of the particular incident, should reduce, control or mitigate the effects of the emergency. It is a systematic and ongoing process which should evolve as lessons are learnt and circumstances change. Emergency planning should be viewed as part of a cycle of activities beginning with establishing a risk profile to help determine what should be the priorities for developing plans, and ending with review and revision, which then re-starts the whole cycle. The Trust will maintain plans which cover 3 different areas:

(i) Plans for preventing an emergency: In some circumstances there will be a short period before an emergency occurs when it might be avoided by prompt or decisive action. This will require departmental, directorate, divisional or Trust contingency plans and procedures, the production of which will be organised by the Trust Resilience and Security Specialist.

(ii) Plans for reducing, controlling or mitigating the effects of an emergency: The main bulk of planning should consider how to minimise the effects of an emergency, starting with the impact of the event (i.e. alerting procedures) and looking at remedial actions that can be taken to reduce effects. Recovery plans are also to be developed to reduce the effects of the emergency and ensure long term recovery. This will include internal and external Major Incident plans, and Business Continuity Plans which will be drafted by the Trust Resilience and Security Specialist and coordinated by the AEO.

(iii) Plans for taking other action in connection with an emergency: Not all actions to be taken in preparing for an emergency are directly concerned with controlling, reducing or mitigating its effects. Emergency planning should look beyond the immediate response and long term recovery issues and look also at secondary impacts. For example, the wave of reaction to an emergency can be quite overwhelming in terms of media attention and public response. Plans may need to consider how to handle this increased interest. This will require a Trust Recovery Plan to be coordinated by the AEO and drafted by the Trust Resilience and Security Specialist.

12. Activation and Maintenance of Plans

Trust emergency plans are to include procedures for determining whether an

emergency has occurred, and when to activate the plan in response to an emergency. This should include identifying an appropriately trained person who will take the decision, in consultation with others, on when an emergency has occurred. The maintenance of plans involves more than just their preparation. Once a plan has been prepared, it must be maintained systematically to ensure it remains up-to-date and fit for purpose at any time if an emergency occurs. It may be that multiple organisations develop a joint emergency plan where the partners agree that, for a successful combined response, they need a formal set of procedures governing them all. For example, in the event that evacuation is required, the police would need carefully pre-planned co-operation from various other organisations such as fire and ambulance services and the local authority, as well as involvement of others such as transport organisations.

13. Exercising Plans and Training Staff

The Trust Resilience and Security Specialist will design a training system to provide opportunities for staff involved in the planning for, or response to, an emergency, to receive appropriate training. Managers are resoponsible for ensuring staff have conducted the required training and are suitable capable to perform their duties. The Trust will test the effectiveness of all emergency plans by carrying out exercises at varying levels, to a plan drawn up and managed by the Trust Resilience and Security Specialist, against standards drafted by the same and approved by the AEO.

13.1 Training & Exercising Strategy

The Trust EPRR training and exercising strategy is to be drafted by the Trust Resilience and Security Specialist for AEO approval. It is to be placed in the Emergency Planning section on the Trust intranet. The strategy will also consider those non-Trust staff who have a role in the emergency plans such as contractors and civil protection partners. The plans themselves are to explicitly identify the nature and frequency of training and exercising required.

This is to be articulated as:

- a detailed 12-month strategy for the current FY
- an approved strategy in outline for the following FY;
- and a unapproved draft strategy for the 3rd FY.

In particular, the EPO is to ensure that National Occupational Standards are adopted for the training of commanders at all levels of response as part of the training and exercising strategy. This, as part of the core standards assurance process, proves “competency” in responding to incidents and emergencies and leads toward a level of professional development.

As a Category 1 responder, CHFT is required to undertake, at a minimum, the following level of strategic exercising, and this is to be articulated in the training

and exercising strategy, together with all supporting events which build EPRR capability:

- 6 monthly communications cascade test
- Annual Tabletop exercise
- Three Yearly Live exercise (activation of the Trust policy during this time will act as a live exercise if appropriate debriefing and lesson learning can be demonstrated)

14. Trust Equalities Statement

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

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

15. Assurance and Compliance with Legislative Duties

In 2016, NHS England EPRR Core Standards were issued as part of the framework of how Health EPRR would be managed. Part of this process was the EPRR Organisational Assurance Process to ensure that providers of NHS funded care were working towards meeting the requirements for EPRR, particularly as set out in the NHS England Core Standards Matrix, the NHS England planning framework, Everyone Counts: Planning for Patients 2013/14, and the 2013/14 NHS standard contract. The provision of this assurance gives confidence that Category 1 and 2 Responders are compliant with the requirements for EPRR within the new structures of the NHS.

There are 92 standards assigned to the revised EPRR assurance process divided into three main sections:

- Core Standards
- Hazmat/CBRN Standards
- Hazmat/CBRN Equipment

These are the minimum standards that CHFT **must** meet and the AEO is responsible for ensuring that these standards are achieved in accordance with the EPRR training and exercising strategy and with Table 3 below. All future NHS CB framework guidance will be linked to these standards and CHFT will be expected to provide assurance (including evidence) that these standards are being met. The AEO will therefore manage the delivery of the following

activities to ensure the Trust complies with national requirements where appropriate:

- Undertake an annual self-assessment against core standards identifying a level of compliance for each. For Acute Trusts these standards clarify the existing and on-going EPRR requirements, they are not additional. It is expected that the level of preparedness will be proportionate to the role of each organisation as well as the range of services they provide
- Review the divisional improvements plans and develop action plans to meet extant core standards; monitor action plan achievement and;
- Complete an annual statement of compliance (Full, Substantial, Partial or non-compliant) to be presented and approved by the Trust Board before submission to the LHRP

The Trust's statement of compliance and the associated improvement plans form part of the assurance to the NHS England Board and the Department of Health that robust and resilient EPRR arrangements are established and are maintained within NHS Organisations and in compliance with Legal and Regulatory standards directly related to EPRR; these are:

Legal / Regulatory Implications / NHS Constitution
Civil Contingencies Act 2004 and associated guidelines Health & Social Care Act 2012- Section 46 ISO 22301 and associated PAS2015 guidance NHS Commissioning Board EPRR Core Standards ISO 22301 and PAS 2015 guidance
Care Quality Commission Regulations (which apply)
Section 46

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16. Process for Monitoring Effective Compliance

Standard to be monitored	**Process for monitoring** e.g. audit, on-going evaluation etc.	**Frequency** e.g. annually 3 yearly	**Person responsible for:** undertaking monitoring & developing action plans	**Committee responsible for:** review of results, monitoring action plan & implementation
Review & update Pandemic Flu plan	Review of plan	At least annually	Trust Resilience and Security Specialist and nominated divisional leads.	Quality Committee
Review and update Business Continuity Plans	Review of plans	At least annually	Departmental BC Leads supported by Trust Resilience and Security Specialist	Divisional Boards or equivalent.
Communications Exercise	Exercise and report	6 monthly	AEO supported by Trust Resilience and Security Specialist	Quality Committee
Implement testing of Incident Control Centre set-up	Exercise and report	At least annually	AEO supported by Trust Resilience and Security Specialist	Quality Committee
Desktop tests of emergency plans	Exercise and report	Annually	AEO supported by Trust Resilience and Security Specialist	Quality Committee
Live test of Major incident plan	Exercise and report	3 years	AEO supported by Trust Resilience and Security Specialist	Quality Committee
Annual Report	Annual Report	Annually	AEO supported by Trust Resilience and Security Specialist	Executive Board Board of Directors

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17. References

There are a number of emergency planning guidelines which the Trust must adhere to in developing and maintaining its emergency response plans. These include:

- The Civil Contingencies Act (2004)
- Health and Social Care Act 2012
- Expectations and Indicators of Good Practice Set for Category 1 and 2 responders
- NHS England Emergency Preparedness Framework 2013
- NHS Commissioning Board frequently asked questions (FAQs) on the future arrangements for health Emergency Preparedness, Resilience and Response (EPRR) (Jan2013)
- Everyone Counts: Planning for Patients 2013/14
- NHS England Command and Control Framework for the NHS during significant incidents and emergencies (2013)
- NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)
- Summary of published key strategic guidance for health EPRR
- NHS England Business Continuity Management Framework (service resilience) (2013)
- Preparation and planning for emergencies: responsibilities of responder agencies and others
- NHS Emergency Planning Guidance: Planning for the management of burn-injured patients in the event of a major incident: interim strategic national guidance
- CBRN Incidents: A Guide to Clinical Management and Health Protection
- The United Kingdom's Strategy for Countering Chemical, Biological, Radiological and Nuclear (CBRN) Terrorism
- Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013
- Chapters 5 to 7 Revision to Emergency Preparedness.
- Management of Surge and Escalation in Critical Care Services Standard Operating Procedure for Adult & Paediatric Burns Care Services in England & Wales (2015)

https://www.england.nhs.uk/ourwork/eprr/
http://nww.cht.nhs.uk/divisions/emergency-planning/

NHS England Core Standards for Emergency preparedness, resilience and response

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

EPRR Core Standards tab: with core standards nos 1 - 37 (green tab)

Governance tab:-with deep dive questions to support the EPRR Governance'deep dive' for EPRR Assurance 2017 -18(blue) tab)

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard: designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards: designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V50. The following changes have been made :

• Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2017-18

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the	Action to be taken	Lead	Timescale
Governance																				
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.		**Demonstrate this through quarterly AEO/EPRR Manager meetings and out turn reports. Additionally, CHFT has developed the Resilience Supporting Role.**	**Resilience Manager**	
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: • the undertaking of risk assessments	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y			**Annual Work Programme developed to reflect gap analysis. Supporting document explains timescales.**	**Resilience Manager**	
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y			**EPRR & BCM Policy indicate expectations and approach. (Link in Overarching Structure).**	**Resilience Manager**	
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y			**As required and upon the direction of the AEO and in liaison with Resilience Manager. An analysis of a significant event needs to be defined. Additionally, a Security and Resilience Group requires establishment and implementation, to be chaired by AEO. Annual report and exercise reports require development as required.**	**Resilience Manager**	
Duty to assess risk																				

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the	Action to be taken	Lead	Timescale
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed		**EPRR Risk Assessment Profile requires setting on the DATIX system and recurrent management appraisal of threat levels. Principally present as part of the Gap Analysis and continuing development of the risk profile. Significant and identified risks of severe weather, staff absence, denial of access, fuel shortage, IT & Communications, Utilities Failure, Major Incident Response, Supply Chain, COMAH, Flooding, Surge & Escalation and reference to the WY Community Risk Register required periodic review**	**Resilience Manager**	
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Attendance at LRF, LHRP, Health Sub and Local Authority EP Groups established. WYAT ERP and NPAG further demonstartes enagement with wider EPRR community**		
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**See above, Subsequently action is as required.**		
Duty to maintain plans – emergency plans and business continuity plans																				
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable		**Plan present. To be reviewed and change name to Incident Response Plan (IRP).**		
9		corporate and service level Business Continuity (aligned to current nationally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Plan in date. To be reviewed, as required.**		
10		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y					Y				**Recently reviewed. Independantly reviewed by YAS relating to Audit during Aug 2017**		
11		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Reviewed Flood and Heating plans and ratified. Winter plan reviewed**		
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y			**Requires review**	**Resilience Manager**	**Apr-18**
13		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y				Y			**Requires review**	**Resilience Manager**	**Apr-18**
14		Mass Casualties	Y	Y	Y			Y		Y	Y				Y			**Requires review**	**Resilience Manager**	**Apr-18**
15		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Plan reviewed**		
16		Surge and Escalation Management (inc. links to appropriate clinical networks e.g.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y			**Requires review**	**Resilience Manager**	**Apr-18**
17		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y			**Reviewed plan**		
18		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y			**Requires review**	**Resilience Manager**	**Apr-18**
19		Lockdown	Y	Y	Y			Y	Y					Y	Y			**Requires review**	**Resilience Manaher**	**Apr-18**

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the	Action to be taken	Lead	Timescale
20		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.		**Plans in place**		
21		Excess Deaths/ Mass Fatalities	Y	Y	Y					Y	Y				Y			**Requires review**	**Resilience Manager**	**Apr-18**
22		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y															
23		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y															
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency		**Pre-requisite plans are out of date and/or require comprehensive update.**	**Resilience Manager**	**Apr-18**
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff		**Plan in place and comprehensive review of complete EPRR function being commissioned.**		
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**As part of the BCM process functions have been indentified with associated BIA process, BCP writing and implementation.**		
27	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y			Y	Y									**In line with Major Incident Planning principles. Requires minor development. Check VIP procedures**	**Resilience Manager**	
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Specifiy who has been consulted on the relevant documents/ plans etc				
29	Arrangements include a debrief process so as to identify learning and inform future	Explain the de-briefing process (hot, local and multi-agency, cold) at the end of an	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
Command and Control (C2)																				
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term				
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y		Y	Y	Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar		**No formal training presently delivered. Currently enquiring about SLiC, TLiC, NDM, Dynamic E-Learning process. That said, On Call Management protocall agreed by the Exec Board. To be aligned**	**Resilience Manager**	
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and		**Form part of the Major Incident Plan. Board Room at both sites to be used for ICC. A full risk assessment of HRI and CRH needs to identify and develop the ICC's full requirements.**		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the	Action to be taken	Lead	Timescale
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**Decision log available. EPRR Team will develop a programme to train up a Loggist Group.**		
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y					
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y													**YAS HART Team, PHE or WY Police. In addition, EPRR Manager. On Call Tactical Manager Training arranged. HAZMAT / CBRNE identified.**	**Resilience Manager**	
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y															
Duty to communicate with the public																				
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders		**Discussed with Communications Team.**		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the	Action to be taken	Lead	Timescale
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based				
Information Sharing – mandatory requirements																				
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups.				
Co-operation																				
40	Organisations actively participate in or are represented at the Local Resilience Forum (or		Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with				
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y					
42	Arrangements include how mutual aid agreemen	NB: mutual aid agreements are wider than s	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y					
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y					Y	Y				Y					
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y						Y				Y					
45	Arrangements demonstrate how organisations support NHS England locally in discharging its	Examples include completing of SITREPs, cascading of information, supporting	Y	Y	Y			Y	Y			Y		Y						
46	Plans define how links will be made between NHS England, the Department of Health and										Y									
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or									Y	Y									
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y			Y	Y	Y		Y			Y			**AEO attends and is Deputised by Resilience Manager if unable.**		
Training And Exercising																				
49	Arrangements include a curent training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • A training needs analysis undertaken within the last 12 months • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that peoople responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been		**Training Needs Analysis to be developed. Delivered EPRR strategy to Exec Board**	**Resilience Manager**	**Apr-18**
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			**As above**	**Resilience Ma**	**Apr-18**
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y	Y	Y	Y	Y			Y			**Recently attended Exercise King & Exercise Windsor - COMAH for Calderdale and Kirklees Council. TruMed Exercise arranged within CHFT Medical Gases Group**	**Resilience Manager**	
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio		Y	Y	Y		Y	Y	Y	Y	Y	Y			Y			**Portfolio requires writing, Link in Training & Exercising Passport.**	**Resilience Manager**	

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work	Action to be taken	Lead	Timescale
2015 Deep Dive																				
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Organisation's public Board/Governing Body report • Organisation's public website		**Last years submissions shared with WEB. To continue**		
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	Y	Y	Y	Y	Y	Y	Y			Y			Y	• Organisation's Annual Report • Organisation's public website		**Not previously submitted. To be reviewed and delivered upcoming year plan**	**AEO**	**Jan-18**
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings		**Trust need to identify NED**	**AEO**	**Jan-18**
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Minutes of meetings		**The Security & Resilience Group to be developed and chaired by AEO. Resilience Manager and Resilience Support Officer to support group but shared by all relevenat senior manager group to attend.**	**AEO/Resilienc**	**Jan-18**
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program.	Y	Y	Y	Y	Y	Y	Y			Y			Y	• Minutes of meetings		**See above**		**Jan-18**
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable	Y	Y	Y	Y	Y	Y	Y	Y		Y			Y	• Minutes of meetings		**To be followed**		

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness											
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control		**Plan reviewed**	**Resilience Manager**	
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump		**See above**		
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)		**To be completed.**	**Resilience Manager**	**Jan-18**
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements		**Following a YAS Audit for HAZMAT / CBRN. A Working Group has been established and a Task and Finish Group to implement requirements.**		
57	Staff on-duty know who to contact to obtain specialist advice in relation to a	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness		**Specialist Advisor - PHE & HART.**		
	Decontamination Equipment											

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonecn.nhs.uk/_store/doc	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))		**Following on from the YAS Audit, the Working Group to lead on requirements / findings. IOR DVD to be rolled out to ED Staff at HRI and CRH.**		
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is	Y		Y					**Working Group to ensure checks are carried out.**		
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump	There is a named role responsible for ensuring these checks take place	Y		Y					**Working Group to ensure checks are carried out.**		
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y					**Working Group to ensure checks are carried out.**		
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y					**Waste Management Team**		
	Training											

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the	Action to be taken	Lead	Timescale
Q	Core standard	Clarifying information						Evidence of assurance				
63	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y					**Trust follows National Guidance. Locally amongst WYAT Resilience Leads it is felt that urgent clarification from NHS England on trainng validation required through YAS for CBRNe Trainer(s) credentials and resilience in the team. CBRN Lead and Working Group to identify facilitators**		
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme		**Powerpoint Presentation and testing equipment and suits through designated staff within ED Facilitators**		
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Y		Y					**Faciliated and co-ordinated through HRI/CRH ED staff management**		
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials -	Y	Y	Y	Y	Y			**IOR DVD's 1,2,3,4 & 5 to be added to Mandatory Training for ED Reception Staff.**	**Resilience Manager**	**Jan-18**

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate NARU training and briefing DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organisations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organisations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organisations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organisations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organisations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organisations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organisations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y													
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y													
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

12. Guardian of Safe Working Hours Quarterly Report and Update on Role

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday, 5th October 2017	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: GUARDIAN OF SAFE WORKING HOURS Q3 REPORT - Guardian of Safe Working Hours Quarterly Report - The Board is asked to receive and approve the contents of the Q3 Safe Working Hours report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

This paper examines issues pertaining to junior doctors and their safe working hours, particularly in view of the 2016 TCS, onto which most of our junior doctors in training posts have moved in August 2017, and all will be on by October 2017. It follows the suggested format of a quarterly report from Guardians of Safe Working Hours provided by NHS Employers.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

Please see attached

Appendix

Attachment:

3rd quarterly report August 2017.pdf

Calderdale and Huddersfield NHS Foundation Trust

3rd QUARTERLY REPORT ON SAFE WORKING HOURS: August 2017

Miss Tamsyn Grey, Guardian of Safe Working Hours, CHFT

Executive summary

The 2016 TCS for junior doctors allows them to highlight issues with working hours via an exception reporting system, and has created the role of Guardian of Safe Working Hours to oversee this system and report to the board on a quarterly basis

Some junior doctors and supervisors have been engaging well with the exception reporting system

There is no formal admin support provided to the Guardian of Safe Working Hours with regard to managing the flow of exception reports. The regional Guardians' forum of Health Education England working across Yorkshire and the Humber has suggested that 1 WTE administrator is needed to support the Guardian from August 2017.

Among doctors on the contract so far, the majority of exception reports have fallen within the Surgery and Anaesthetics division (all in surgical specialties), seemingly due to a heavier workload in these specialties. 4 fines have been issued on the general/urology/vascular surgery F1 rota, although these were from reports from the last quarter which had been left unaddressed.

There has been a decrease in unfilled shifts this quarter, with increased use of bank staff to fill these (perhaps linked to more attractive bank rates). This should lead to improved junior doctor wellbeing, but has come at a slightly increased overall spend on locum/bank shifts.

Introduction

This paper examines issues pertaining to junior doctors and their safe working hours, particularly in view of the 2016 TCS, onto which most of our junior doctors in training posts have moved in August 2017, and all will be on by October 2017. It follows the suggested format of a quarterly report from Guardians of Safe Working Hours provided by NHS Employers.

High level data

Number of doctors / dentists in training (total):	Approx 215
Number of doctors / dentists in training on 2016 TCS (total):	Approx 185
Amount of time available in job plan for guardian to do the role:	2 PAs
Admin support provided to the guardian (if any):	No formal support
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee
Amount of job-planned time for clinical supervisors:	None

a) Exception reports (with regard to working hours) 1st May 2017 – 31st July 2017

All exception reports up to July 31st have been from FY1 doctors. Of the 45 doctors in the Trust at this grade, 16 have used the exception reporting system. I was not involved in the induction of the core and higher trainees who went onto the 2016 TCS in February, and have not received a contact list for them, so I am not convinced that they have received adequate information regarding the exception reporting system. At the end of July, I personally closed all the exception reports that were left open as the Trust was moving from the DRS system to Allocate, and the FY1s were moving on. This involved issuing payments and fines for reports dating back as far as December 2016. The table below contains new reports submitted from 1st May 2017, with the figures in parentheses the equivalent number in the last report (December 16 – April 17)

Specialty	No. doctors on rota	No. exceptions raised	Average exceptions/ doctor/month	No. exceptions closed	No. exceptions outstanding
General Medicine	23 (both sites)	0 (27)	0 (0.2)		
Surgery (General/Urology/Vascular)	13	2 (161)	0.06 (2.5)		
Trauma & Orthopaedics	1	9 (25)	3 (5)		
ED	3 (both sites)	0 (0)	0 (0)		
ENT	1	0 (16)	0 (3.2)		
Paediatrics	1	0 (0)	0 (0)		
Psychiatry	1	0 (0)	0 (0)		
Total	**44**	**11 (229)**	**0.08 (1)**	**11 (121)**	**0 (108)**

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

Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
0	0	11	0

There has been a dramatic decrease in exception reporting in this quarter. Some of this is due to work schedule reviews, for example in vascular surgery and ENT. However, there was also a difference in the reporting culture of doctors on the surgery F1 rota – as a surgeon I was aware of a similar proportion of this group of doctors finishing late to the previous group, but a lower proportion reporting (despite encouragement to do so).

The pattern from August (to be formally included in the next report) shows a lower than expected reporting rate, particularly amongst core and higher trainees. We had anticipated that this group, who had been working at the time of the 2016 industrial action, would at least initially have a high rate of reporting, but so far this does not appear to be the case.

Hours monitoring (2002 contract)

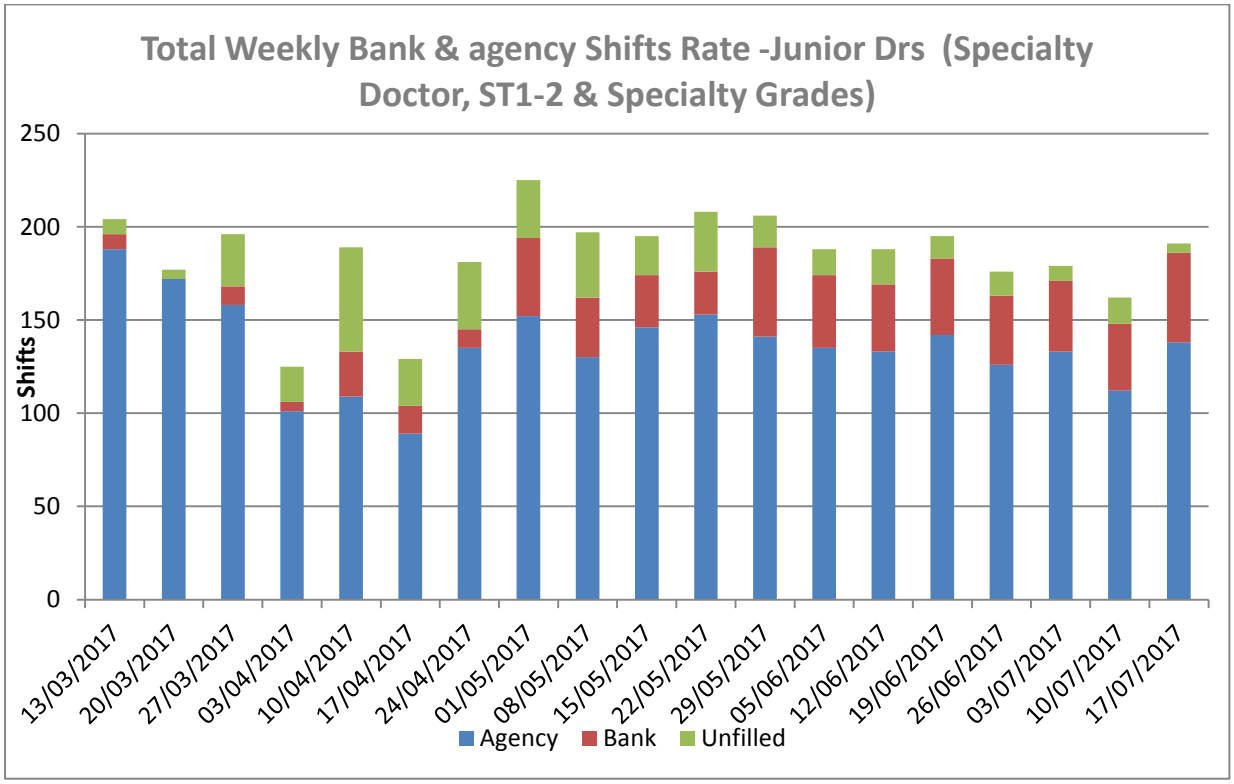
A pan-specialty monitoring exercise was held from 5th June. The only group who had enough returns for this exercise to be valid was ophthalmology trainees, who once again monitored at band 3, and back pay has been arranged. A new rota has started for this group from August, and so far there have been no exception reports on it (although not all doctors on this rota are on the new contract yet).

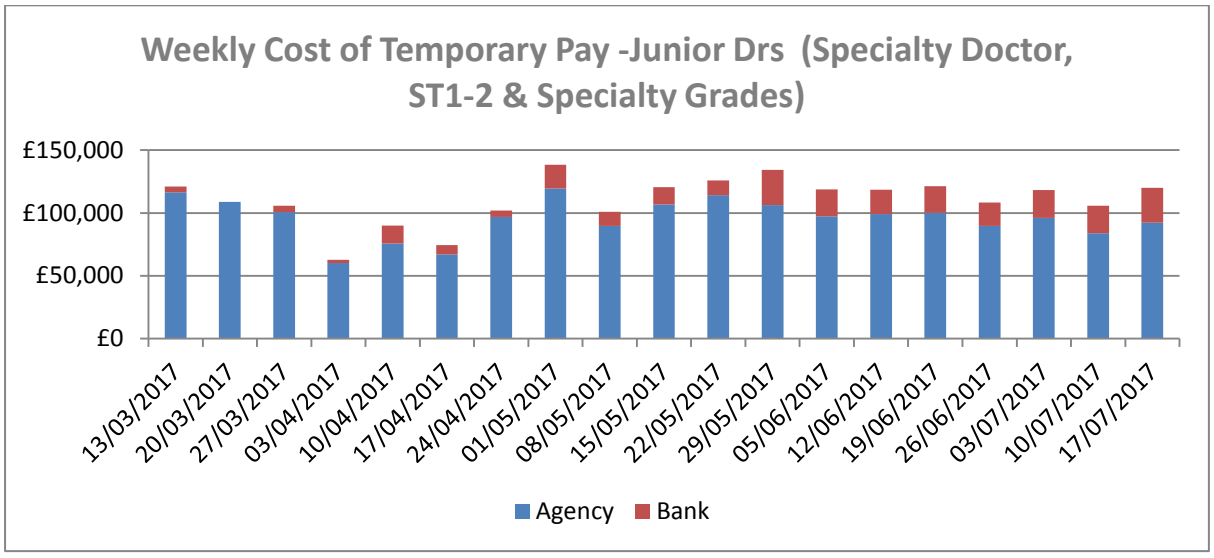
b) Work schedule reviews

1 work schedule review was requested for the FY1 in Trauma and Orthopaedics but not completed.

c) Locum bookings

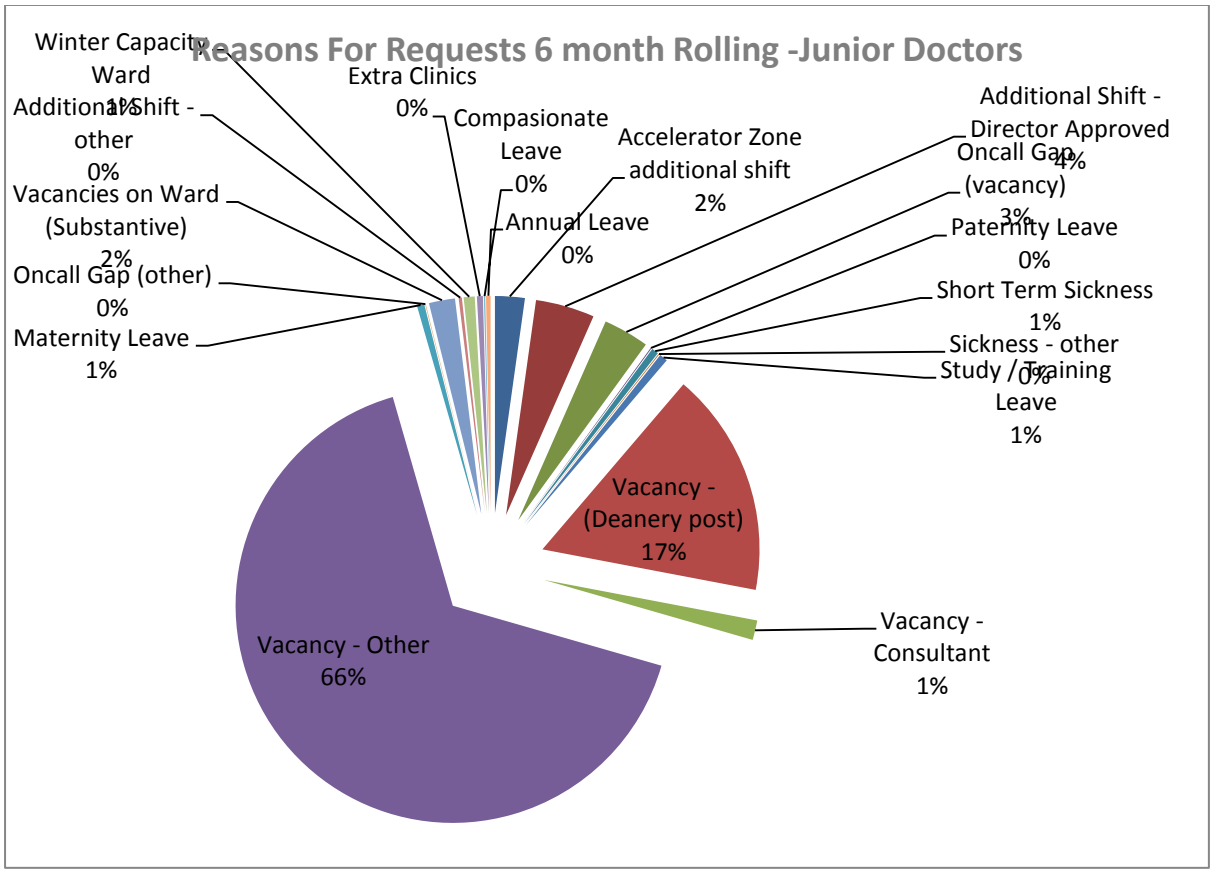
I have been provided with data from w/c 13/3/17 (when medical HR started collecting, none was held centrally before this) to w/c 17/7/17 (data from last quarter included for comparison). There has been an increase in bank shifts this quarter, and a decrease in unfilled shifts. The weekly cost for these shifts this quarter has remained consistently over £100,000, an increase compared to the previous quarter. The bank rate has increased to try to attract doctors from our own organisation to fill vacant shifts, as this is clearly safer. The decrease in unfilled shifts will have improved the working lives of those juniors who would otherwise be having to cover 2 roles, however, it has come with a slightly increased financial burden.





Reasons for request:

There has been a decrease in deanery vacancies and an increase in other vacancies from last quarter.



Average hourly cost:

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

d) Vacancies

This data comes from analysing rotas provided by rotamasters and has not been validated by HR (although some of the data held by HR is inaccurate eg they have name of a general surgery registrar down as working here when she never has). I have received some data from HR on vacancies but it is difficult to separate junior doctors from consultants within it.

Rota	Site	Grade	Gaps on rota May-August 2017	Usual cover (if known)
Surgery/ENT/ T&O	CRH	Core	5/10	Agency locum
General surgery/ vascular/ urology	HRI	Core/FY2	3/10	2 long term agency locum 1 ad hoc internal/agency cover
General surgery/ vascular/ urology	HRI	FY1	1/13	Usually internal cover
T&O	HRI	Core	6/10	Internal/agency cover for on call only (reduced ward cover)
ED	HRI	Core	1/8	Agency
ED	CRH	Core	1/8	Long term agency locum
ED	HRI/CRH	Higher	No data provided to GSW	
General Surgery	HRI	Higher	2/10	Usually agency locum, some internal cover
General Surgery	CRH	Higher	1/5	Usually internal cover
Urology	HRI	Higher	1/5	?
Medicine	HRI	Core/FY2	3/18	1 long term agency locum
Medicine	CRH	Core/FY2	2/17	?
Medicine	HRI	Higher	2/12	?
Medicine	CRH	Higher	0.5/12 (1 no nights)	2 long term agency on wards, not on call
Medicine	HRI	FY1	0/13	
Medicine	CRH	FY1	0	
O&G	CRH	Higher	3/13	?
O&G	CRH	Core	Cannot access	
Anaesthetics	HRI	Higher	?(definitely some gaps)	Often consultant covered
ENT	CRH	Higher	none	
Opthalmology		Higher	No specific gaps but sometimes consultant is first on	

Paediatrics	CRH	Higher	0/12 (4 slot shares)	
Paediatrics	CRH	Core	No data	

e) **Fines**

4 fines have been issued on the surgery FY1 rota this quarter. These were all historical from the previous quarter from exception reports that had not been addressed by the Educational Supervisors at the time. This rota runs at 47.76 hours so does not take much to warrant a fine if payment is awarded for an exception report. The recurring issues were having to stay late on normal days after consultants had been on call due to heavy work load, and being asked to stay for handover in the evening, which is not built into the rota.

Fines by department		
Department	Number of fines levied	Value of fines levied
Surgery	4	£1,337.55

There is now over £1200 in the fund managed by the Guardian and the Junior Doctors Forum from these and past fines. No money has yet been spent.

Qualitative information

In general our junior doctors at the Trust feel happy and well-supported, as evidenced by the GMC Training Survey. They do not appear to be particularly politicised and attendance at the Junior Doctors' Forum has not been particularly high, with most issues being raised by one FY2 doctor. Many new trainees joining the Trust in August expressed an interest in joining this group, so I hope this year's forum will be better attended and more productive.

Issues arising

Data on rota gaps is challenging to obtain, as Medical HR only hold central data on Deanery gaps, with most rotas being a blend of deanery doctors and trust-employed doctors. We need to move towards rostering and managing rotas on a system that is common to all juniors and can be viewed in one location (ie using Allocate).

We have now moved to a system where the Junior Doctor can send exception reports to their clinical supervisor, which should improve engagement with the process. However, due to lack of admin support available to the Guardian role, these exception reports are not being copied to educational supervisors, who have contractual responsibility for them, so this may leave us in a position where we can be challenged for breaching the contract. We currently offer no SPA time to Clinical Supervisors (national recommendation 0.25PAs), and as the burdens placed on supervisors by the new contract increase, we could end up having problems recruiting to these roles.

We still have some problem rotas (eg Surgery FY1) where doctors are frequently staying late and reporting this. The appointment of Physicians Associates (starting in September) may help with their workload, but the effect of this remains to be seen.

Some work has been done to reduce long term agency locums and recruit these doctors on trust contracts where appropriate.

Calderdale and Huddersfield NHS Foundation Trust

Actions taken to resolve issues

Medical HR have worked with rotamasters and directorates to ensure compliant rotas for this August. So far the level of exception reporting has been lower than anticipated.

Summary

Exception reporting has dramatically reduced this quarter, which from my experience in the surgical department is due to a group of doctors on the FY1 general surgery rota, which has been the main problem rota, not reporting as much as the previous group despite frequently staying late.

In common with many other Trusts, we have a number of rota gaps which cannot be filled. Pleasingly, more vacant shifts are now filled although this has slightly increased the cost to the Trust of weekly locum/bank cover.

Questions for consideration

In terms of supervisors using the system I still believe the board should recommend an increase in SPA time for educational and clinical supervisors to bring us in line with national recommendations and with our peers in HEYH.

We need to provide support for training on the Allocate e-rostering system for rotamasters so that rotas are centrally viewable by HR and the Guardian. This will allow for better data collection and potential resolution for rota gaps.

The issue of admin support for the Guardian still needs to be addressed, as currently we are breaching the new contract by not copying exception reports to Educational Supervisors. Also the Junior Doctors Forum invites went out with less than 1 week's notice, which will mean some useful and interested parties will be unable to attend. These, and other issues, should be dealt with by a single named person with responsibility for this role, rather than the current ad hoc support provided intermittently by medical HR and medical education.

The next report (1st annual report) will be prepared by Dr Anu Rajgopal, who takes over from me as Guardian of Safe Working Hours in October.

Tamsyn Grey

August 2017

13. Integrated Performance Report

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 5th October 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report: August 2017 - Integrated Performance Report: August 2017. The Board is asked to receive and approve the Integrated Board Report for August 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 (28/9/17), Quality Committee (2/10/17) and Finance and Performance Committee (3/10/17)	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

August's Performance Score stands at 60% for the Trust, an 8 point improvement in-month. The RESPONSIVE domain has improved to AMBER, following achievement of Cancer 2 week wait target and both Cancer 62 day targets. Finance domain has improved to Amber, with variance from plan and agency expenditure on plan in-month. All domains have improved performance with the exception of WORKFORCE, which is now RED due to short-term sickness YTD and 4 out of 5 Mandatory Training areas missing target.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the Integrated Board Report for August 2017

Appendix

Attachment:

IPR - August 2017 (short version).pdf

Board Report

August 2017

Report Produced by : The Health Informatics Service

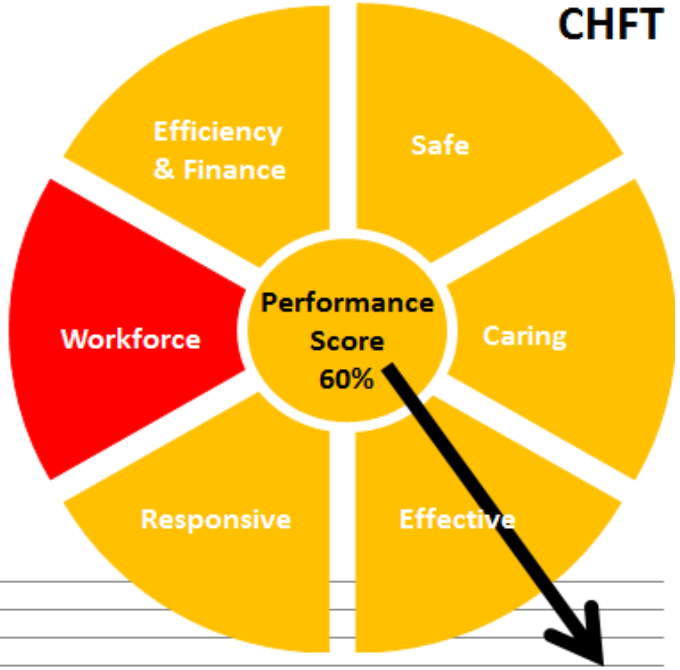
DataSource : various data sources syndication by VISTA

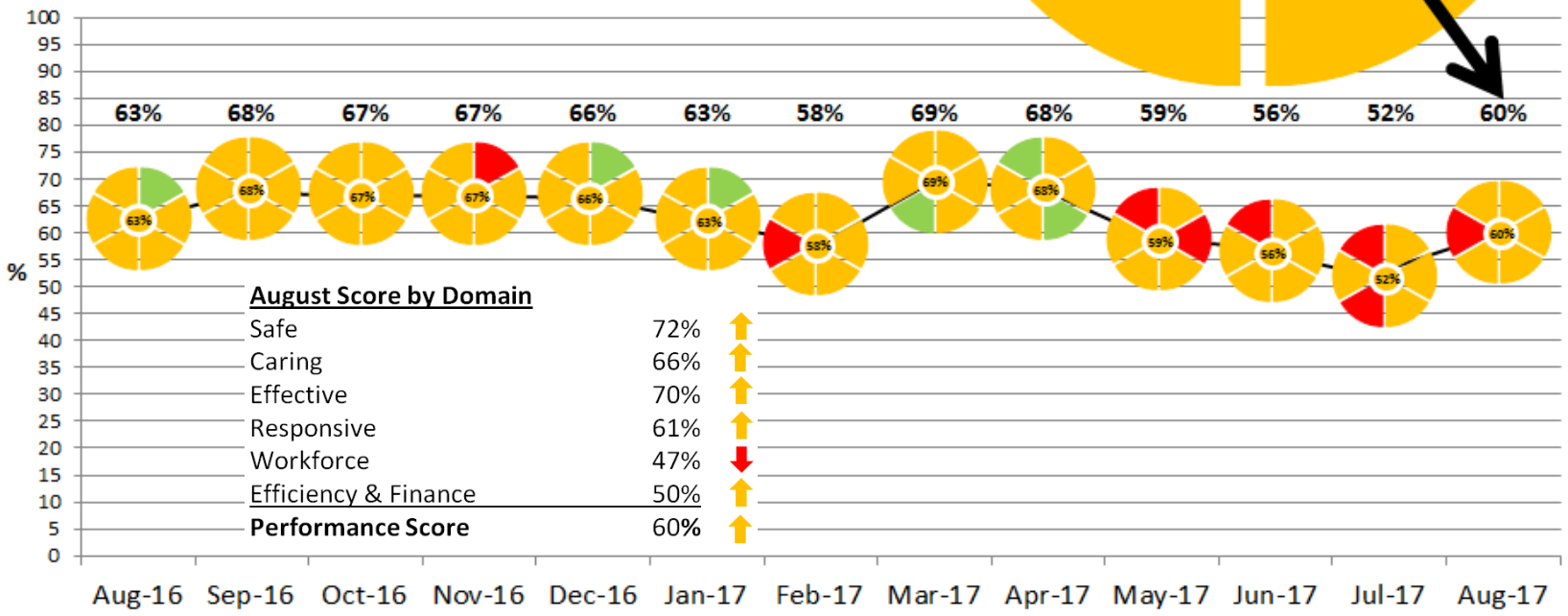
Performance Summary

August

RAG Movement

August's Performance Score stands at 60% for the Trust, an 8 point improvement in-month. The RESPONSIVE domain has improved to AMBER following achievement of Cancer 2 week wait target and both Cancer 62 day targets. Finance domain has improved to Amber with variance from plan and agency expenditure on plan in-month. All domains have improved performance with the exception of WORKFORCE which is now RED due to short-terms sickness YTD and 4 out of 5 Mandatory Training areas missing target.





SINGLE OVERSIGHT FRAMEWORK

SAFE	Emergency C-Section Rate
VTE Assessments	Never Events
CARING	FFT A&E
FFT Community FFT OP	FFT Maternity FFT IP
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

Safe | Caring | Effective | Responsive | Workforce | Efficiency/Finance | Activity | CQUIN

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
	Friends & Family Test (IP Survey) - % would recommend the Service	97.2%	96.1%	↑	96.3%
CARING	Inpatient Complaints per 1000 bed days	1.8	2.1	↓	TBC
	Average Length of Stay - Overall	4.70	4.77	↑	5.17
	Delayed Transfers of Care	4.54%	3.32%	↓	5%
EFFECTIVE	Green Cross Patients (Snapshot at month end)	104	107	↑	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	93.24	95.83	↑	100
	Theatre Utilisation (TT) - Trust	81.6%	83.0%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.69%	1.05%	↑	0.6%
	Emergency Care Standard 4 hours	93.59%	93.45%	↑	95%
	% Incomplete Pathways <18 Weeks	92.12%	92.63%	↓	92%
	62 Day GP Referral to Treatment	91.5%	83.3%	↑	85%
SAFE	% Harm Free Care	93.18%	94.27%	↓	95.0%
	Number of Outliers (Bed Days)	547	491	↓	495
	Number of Serious Incidents	7	9	↑	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: Hospital Standardised Mortality Rate (HSMR) continues to improve with latest 12 month figure at 93.24.

Improved: Crude Mortality Rate in August is at its lowest rate since September 2016.

Improved: Two Week Wait From Referral to Date First Seen/38 Day Referral to Tertiary - 2 week waits recovered well from last 3 months' performance and 38 day referral to tertiary at its highest position in 12 months at 62.5%.

MOST DETERIORATED

Deteriorated: Mandatory Training and Appraisals. Across the divisions Appraisals are below target. 4 out of 5 elements in focus are behind plan within Mandatory Training with only Fire Safety on plan.

Deteriorated: Theatre Utilisation - Main Theatres - % utilisation on both sites is lowest level in last 12 months.

Deteriorated: Emergency C-Section Rate - August rate is the highest in the last 12 months at 16.6%.

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: Appraisal training sessions with the HR Business Partners have taken place with further sessions scheduled in September. Where appraisal compliance is below the planned trajectory there has been direct intervention from General Managers and/or Matrons and recovery plans devised with Line Managers, which involve rescheduling of appraisals to ensure all are completed before 31st October. All line managers have been sent mandatory training lists for their teams, which show compliance across the 9 elements and mandatory training profilers have been created for Divisions to plan dates for the 5 elements in focus.

Action: Task and Finish group established to review cancelled operations and reasons. Anticipated impact is a reduction in on-day cancellations and a corresponding improvement in touchtime.

Action: A detailed analysis has commenced that will look at specific factors, impact on outcomes and compliance with guidance and theatre Standard Operating Procedures.

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	7.8	7.6	↑	
Sickness Absence Rate	4.13%	4.14%	↑	4.0%
Turnover rate (%) (Rolling 12m)	13.16%	13.13%	↓	12.3%
Vacancy	400.11	374.98	↓	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	81.2%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q1	62.8%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£5.53	-£5.27	🔴
Expenditure vs Plan var (£m)	£5.25	£5.42	🟢
Liquidity (Days)	-30.94	-28.09	🔴
I&E: Surplus / (Deficit) var - Control Total basis (£m)	£0.03	£0.02	🟢
CIP var (£m)	-£1.47	-£1.41	🔴
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	12.37%	13.16%	🔴

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care** - Performance remains within normal variation, declining slightly in-month to 93.18%. All divisions below target with the exception of FSS with Medicine worst position at 90.86%. • **Number of Category 4 Pressure Ulcers Acquired at CHFT** - 2 Category 4 pressure ulcers within Medicine. An investigation and action plan is currently being worked through.
Caring	• **Complaints closed within timeframe** - Of the 37 complaints closed in July, 47% were closed within target timeframe. The overall percentage for complaints closed within target timeframe last year (2016-17) was 45%. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance is still not achieving target. The task and finish group has identified areas for testing improvements. • **Friends and Family Test A & E Survey - Response Rate** - has fallen slightly to 11.7% in-month. Leads have been identified on both sites who will drive the FFT completion through the minors stream. • **Friends and Family Test A & E Survey - % would recommend the Service** - still just below 86.5% target. CRH is performing well whilst HRI needs to improve. Some focused work on communication and customer care has been identified. • **Friends and Family Test Community Survey** - Community FFT reported 86% would recommend the service against a 96% national average. A new server has been installed meaning that the web form can be used predominantly to collect FFT.
Effective	• **Stillbirths Rate and Neonatal Deaths** - There were 3 still births and 1 early neonatal death in August. • **Mortality Reviews** - The new Learning from Deaths policy was approved in August which describes the ambition to perform initial screening reviews on all deaths plus Structured Judgment Reviews (SJR) on selected cases from September. Expect improvements to be visible in the data from October, an additional measure will appear to record the % of applicable cases undergoing SJR. • **% Sign and Symptom as a Primary Diagnosis** - Since EPR go live the % Sign and Symptom has increased. This is due to documentation within Power Chart and the admitting primary diagnosis not being updated to the diagnosis at discharge. Communication is to go out from the Medical Director's office to clinical teams to highlight the issue and impact of the increase on HSMR and income. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge** - August's performance improved to 76%. CHFT has changed the process so there is better visibility of all Trauma patients which should improve the planning generally and improve the hip fracture patients having surgery in a timely way.

Background Context

The CQC preparedness has continued across the Trust in August with the collation of evidence for self assessment.

EPR deployment stabilisation continues with improved inpatient utilisation both medical and nursing. Issues remain with booking and outpatient services with a direct impact on efficiency and productivity.

Work has continued in August to ensure clinical activity is recorded and captured accurately.

Counting and coding is improving but has still not returned to pre-EPR levels with recovery plans managed through a Data Quality Board. The services of an external data quality team remain on site.

Whilst ECS performance has not been sustained at 95% the Trust remains on an upward trajectory. Delivery of the ECS has been challenging throughout August during the evenings and nights at HRI. The Urgent Care action plan has been developed and is key to getting long standing issues back on track.

Work on reconfiguring Cardiology, Respiratory and Elderly Services has continued with details being finalised in the business case.

Work continues to assess IPC compliance and standards of cleanliness with a deep cleaning plan in progress across the HRI site.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours improved again to 93.6**% for August - The ECS recovery and sustainability Plan actions continue to be worked through and implemented. • **% Diagnostic Waiting List Within 6 Weeks -** just missed the 99% target again with Medicine Echocardiograms underperforming. Longest waiters will be addressed by the end of the month. • **Two Week Wait From Referral to Date First Seen: Breast Symptoms -** missed the 93% for the 3rd month running. There is a new Oncoplastic Surgeon in post. The new outpatient clinic templates will ensure enough capacity for 2 week waits. • **38 Day Referral to Tertiary** - significant improvement in-month to 62.5% - best performance in last 12 months.
Workforce	• **Mandatory Training and Appraisals**. Across the divisions Appraisals are below target. 4 out of 5 elements in focus are behind plan within Mandatory Training with only Fire Safety on plan. A number of activities are taking place between HR Business Partners and divisions to try and improve performance.
Finance	• Finance: Reported year to date deficit position of £11.05m in line with agreed control total of £11.08m; • Delivery of CIP is behind the planned level at £3.97m against a planned level of £5.44m; • Capital expenditure is £3.29m below plan due to revised timescales; • Cash position stands at £1.92m as planned; • A Use of Resources score of level 3, in line with the plan. The Month 5 reported position is a deficit in line with the planned £11.08m on a control total basis. However there is an underlying adverse variance from plan due to the loss of £0.43m Sustainability and Transformation funding (STF) based on ECS performance. The financial position remains extremely precarious with activity and income continuing to be below the planned level and underperformance in CIP starting to impact. The underlying financial shortfall against the financial plan in the year to date is £7.1m. This is largely driven by the shortfall in activity, offset by the release of five sixths of the Trust's contingency reserves for the year alongside a number of non-recurrent benefits. M5 position prior to action: adverse variance to plan (£7.1m) Non-recurrent benefits M2 £1.1m Non-recurrent benefits M3 £1.5m Non-recurrent benefits M4 £2.0m Non-recurrent benefits M5 £0.8m Release of Contingency Reserves £1.7m Month 5 position to report: nil variance to plan £0.0m The Trust continues to forecast achievement of its Control Total and in so doing would secure the 70% of the STF allocation that is linked to financial performance. The forecast also assumes that the Q3 and Q4 ECS performance related to STF is secured. However, in order to achieve financial balance activity would need to return to the planned level from September, with no further EPR related income losses and any costs incurred as a result of the EPR stabilisation plan would need to be offset with additional savings. It is also reliant on finding a further £6.4m CIP that is currently unidentified in order to deliver the full £20m CIP target. The risk of failing to achieve the target deficit of £15.94m therefore remains extremely high and further action is required to stabilise the financial position.

Background Context

Consultant vacancies remain a challenge in Medical specialties particularly AED, Elderly Care and Respiratory which have been further compounded by sickness in Cardiology. Within Surgery there has been an increase in the casemix and length of stay of some patient groups. This has impacted on patient flow even with the lower levels of elective activity. There still remain a number of issues affecting the Division's ability to ensure Outpatient capacity is fully utilised and these require additional resources which will be in place by November. The same process is being followed for Ophthalmology. Ophthalmolgy and General Surgery have been identified as priority areas for the EPR Outpatient workflow review which will help with capacity. Further training is required to support booking staff for the Breast Screening service.

The Community division continues to work collaboratively with primary and social care.

The dressings pathway has been completed and is due to be launched in November with primary care. The launch will coincide with some training for practice nurses by the tissue viability nurse. A phlebotomy pathway is the next pathway to be worked up.

Focus continues to be on developing community models around rehabilitation at home. Once the pathway has been agreed with commissioners this will enable patients who have low level rehabilitation needs to leave hospital earlier.

In recent months there has been significant pressure within Hysteroscopy services following capacity issues relating to the fire within Endoscopy. Recovery plans are now in place and additional sessions will be taking place during the next 2 months.

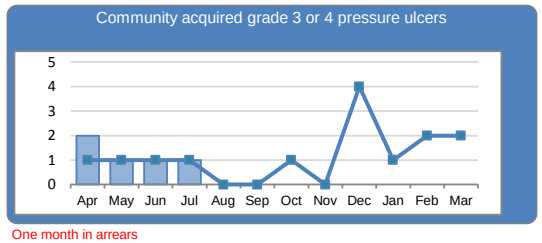
Safe, Effective, Caring, Responsive - Community Key messages

Area	Reality	Response	Result
Safe	Grade 3/4 pressure ulcers The Community division is maintaining a low prevalence of grade 3/4 pressure ulcers with one grade 3 being reported in July.	Grade 3/4 pressure ulcers Continued work is progressing with tissue viability. One senior nurse has been released to focus more dedicated time on wound care and pressure ulcers.	Grade 3/4 pressure ulcers Continue to maintain and improve performance in this area By when: Review October 2017 Accountable: ADN
Effective	Number of hospital admissions avoided There has been an increase in the number of hospital admissions recorded as being avoided this month.	Number of hospital admissions avoided Working with teams to inform them of the importance of recording admission avoidance as an outcome of care will help to demonstrate the effectiveness of community service delivery.	Number of hospital admissions avoided Increased % of interventions recorded as impacting on admission avoidance. By when: November 2017 Accountable: Matron Community Nursing services
Caring	Friends and Family Test The Friends and Family test for community services has consistently shown a poor level of patients who are satisfied with the service where the individual feedback received to services suggests many patients are happy with the service they receive. The current method of collecting FFT is not providing a true reflection of patient opinion and does not help to identify where services could improve their offer in relation to patient feedback.	Friends and family test. A new server has been installed meaning that the web form can be used predominantly to collect FFT. This provides a more robust data collection tool and also provides more accurate and timely feedback to services. It is important to note that response rates will be impacted by changing the methodology.	Friends and family Test An expected improvement FFT will be seen by November 2017 By when: Review November 2017 Accountable: Head of Therapies
Responsiveness	Physiotherapy waiting times Physiotherapy waiting times have improved significantly in August and now stand at 6 weeks compared with 16 week wait in July.	Physiotherapy waiting times The physiotherapy service has commenced a telephone assessment service. This is intended to reduce the number of people requiring face to face contact by a physiotherapist in order to reduce the waiting times and enable that people in need of hands on therapy can receive this in a timely manner. The physiotherapy band 5 new graduates have commenced in post and are being inducted.	Physiotherapy waiting times Physiotherapy waiting times to return to an acceptable performance level by the end of September. By when: September 2017 Accountable: Head of Therapies

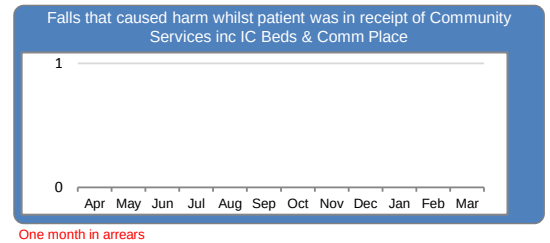
Dashboard - Community

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

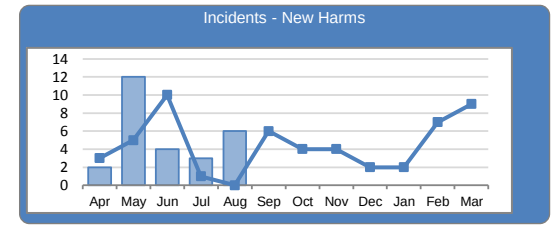
Safe

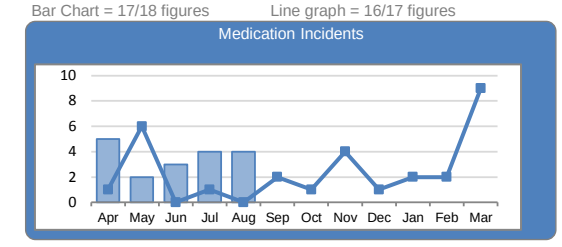


One month in arrears

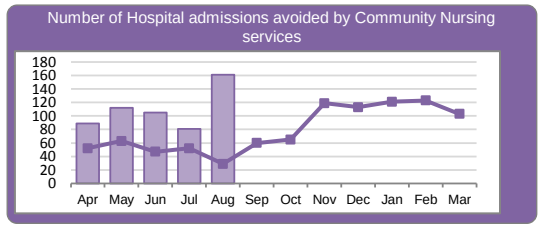


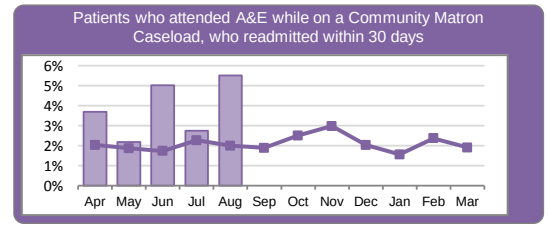
One month in arrears

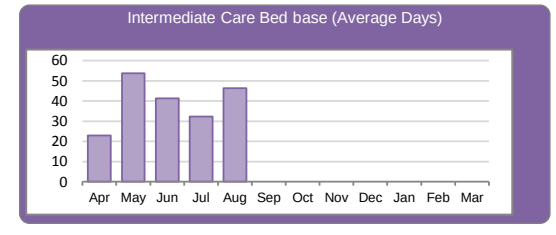


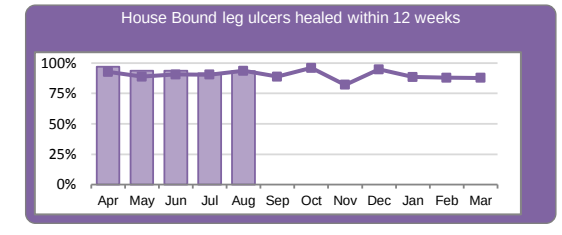


Effective

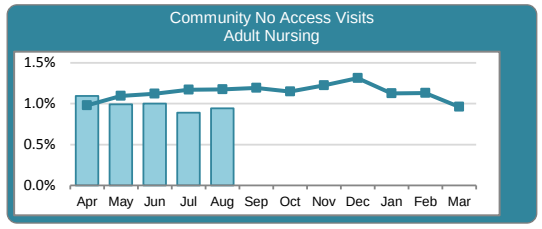


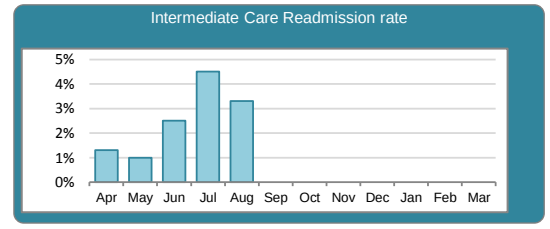


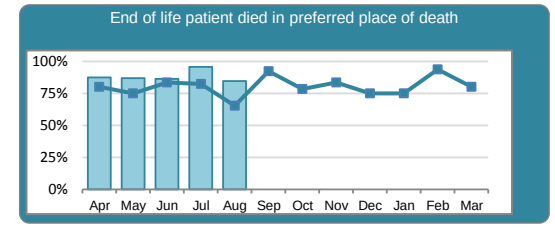


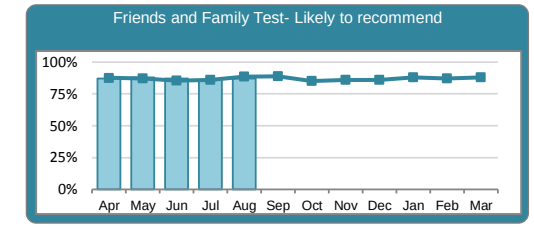


Caring

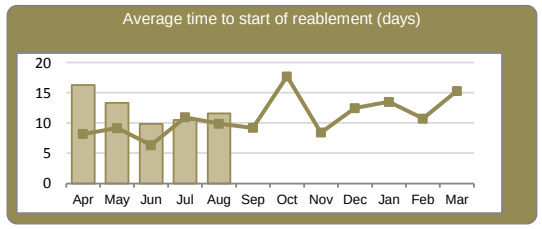


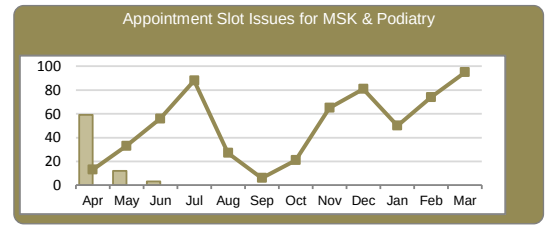


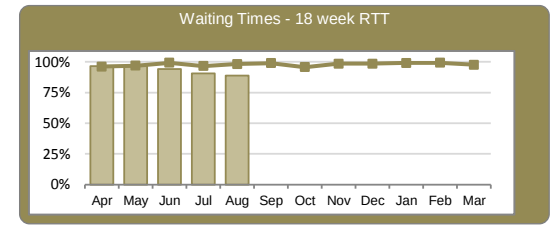


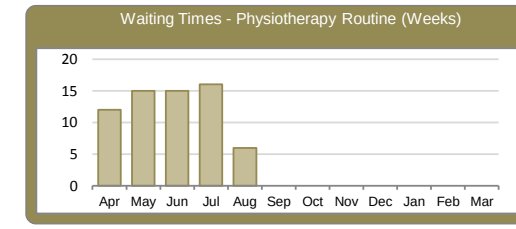


Responsive

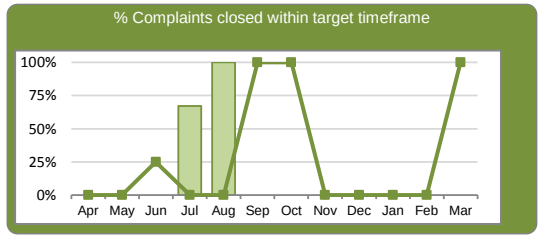


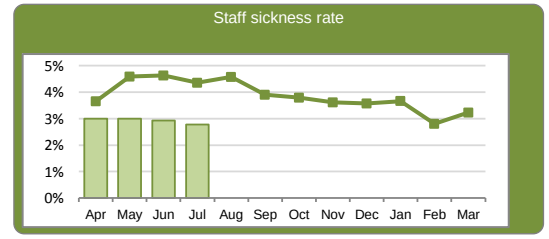




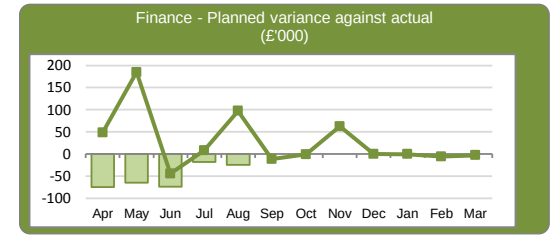


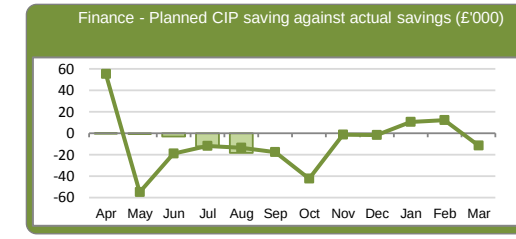
Well Led



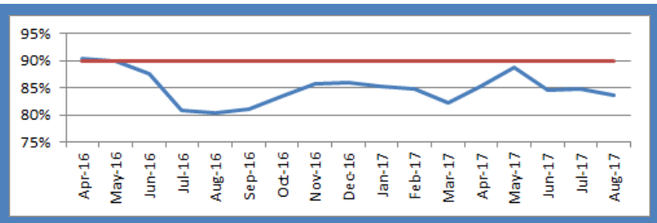
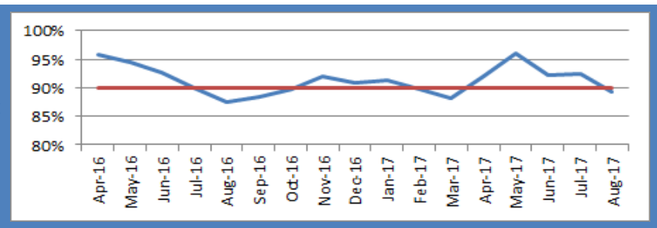
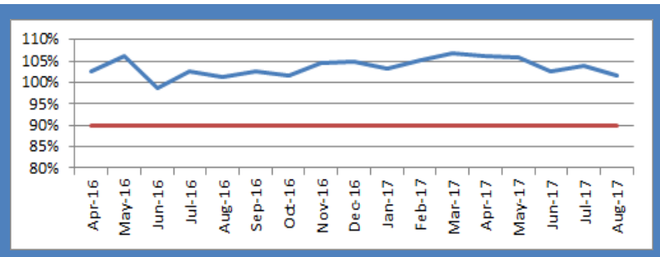
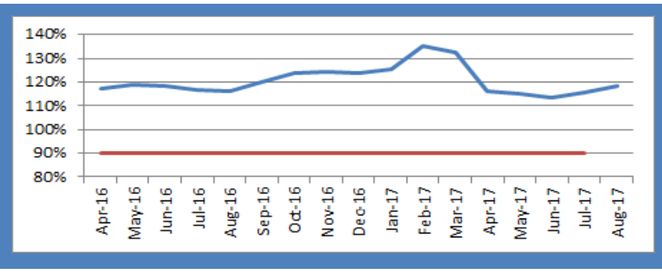


One month in arrears





Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation	Result
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	83.58% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% -WARD 6D : 71.1% -WARD 7BC : 70.3% -WARD 17 : 59.3% -WARD 21 : 69.6%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed & monitored within the divisions by the matron & senior nursing team to ensure safe staffing against patient acuity & dependency is achieved. The low fill rates reported in August 2017 are attributed to a level of vacancy.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	89.40 % of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% -WARD 8 : 68.8% -WARD 8AB : 63.6% -WARD 8D : 72.6% -WARD 10 : 66.7%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed & monitored within the divisions by the matron & senior nursing team to ensure safe staffing against patient acuity & dependency is achieved. The low fill rates reported in August 2017 are attributed to a level of
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	101.63 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at day <75% -WARD 7BC : 70.7% - WARD 8AB: 58.0% - WARD LDRP : 54.4% - WARD NICU : 51.9%	The low HCA fill rates in August are attributed to flucuating bed capacity & a level of HCA vacancy within the FSS division. This is managed on a daily basis against the acuity of the work load. Recruitment plans are in place for all vacent shifts. 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.
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	118.24 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% -WARD 7BC: 60.0%	The low HCA fill rates in August are attributed to flucuating bed capacity. 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 Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT					
		Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual		
CRH MAU	GENERAL MEDICINE	2511	1919.5	1674	1325	76.4%	79.2%	1364	1357	1023	1045	99.5%	102.2%
HRI MAU	GENERAL MEDICINE	2046	1892	1209	1820	92.5%	150.5%	1364	1633	1023	1320	119.7%	129.0%
WARD 2AB	GENERAL MEDICINE	1845	1481.4	1170	1664	80.3%	142.2%	1364	1293	682	1045	94.8%	153.2%
HRI Ward 5 (previously ward 4)	GERIATRIC MEDICINE	1674	1343	1209	1636	80.2%	135.3%	1023	1012	1023	1441	98.9%	140.9%
HRI Ward 11 (previously Ward 5)	CARDIOLOGY	2083.5	1729.45	1014	957	83.0%	94.4%	1364	1320	682	682	96.8%	100.0%
WARD 5AD	GERIATRIC MEDICINE	2139	1764	1581	2143.5	82.5%	135.6%	1364	1333	1364	1458	97.7%	106.9%
WARD 5C	GENERAL MEDICINE	1069.5	1004.5	837	821.5	93.9%	98.1%	682	682	341	407	100.0%	119.4%
WARD 6	GENERAL MEDICINE	1674	1507.5	1209	1126	90.1%	93.1%	1023	968	682	682	94.6%	100.0%
WARD 6BC	GENERAL MEDICINE	1674	1513.5	1209	1196.5	90.4%	99.0%	1364	1311.5	682	746	96.2%	109.4%
WARD 5B	GENERAL MEDICINE	1209	992	744	1281	82.1%	172.2%	682	660	682	1045	96.8%	153.2%
WARD 6A	GENERAL MEDICINE	976.5	815	976.5	743	83.5%	76.1%	682	677	341	358	99.3%	105.0%
WARD CCU	GENERAL MEDICINE	1674	1352.5	372	294.5	80.8%	79.2%	1023	985.5	0	12	96.3%	-
WARD 6D	GENERAL MEDICINE	1674	1191	837	919	71.1%	109.8%	1023	852.25	682	638	83.3%	93.5%
WARD 7AD	GENERAL MEDICINE	1674	1390.3	1581	1759.6	83.1%	111.3%	1023	1012	1023	1210	98.9%	118.3%
WARD 7BC	GENERAL MEDICINE	1674	1176.5	1581	1117	70.3%	70.7%	1023	814	1023	613.5	79.6%	60.0%
WARD 8	GERIATRIC MEDICINE	1441.5	1138.5	1209	1928	79.0%	159.5%	1023	704	1023	1644	68.8%	160.7%
WARD 12	MEDICAL ONCOLOGY	1674	1379	837	832	82.4%	99.4%	1023	877	341	678	85.7%	198.8%
WARD 17	GASTROENTEROLOGY	2046	1213.3	1209	1146	59.3%	94.8%	1023	773	682	685	75.6%	100.4%
WARD 21	REHABILITATION	1209	841	976.5	1245.3	69.6%	127.5%	682	682	682	1001	100.0%	146.8%
ICU	CRITICAL CARE	4030	3433	821.5	677	85.2%	82.4%	4278	3384	0	0	79.1%	-
WARD 3	GENERAL SURGERY	945.5	882.5	761.5	819	93.3%	107.6%	713	719.5	356.5	552	100.9%	154.8%
WARD 8AB	TRAUMA & ORTHOPAEDICS	1072	871.5	979	568	81.3%	58.0%	977.5	621.5	264.5	402.5	63.6%	152.2%
WARD 8D	ENT	821.5	792	821.5	679	96.4%	82.7%	713	517.5	0	218.5	72.6%	-
WARD 10	GENERAL SURGERY	1302	1136	761.5	932.5	87.3%	122.5%	1069.5	713	356.5	713	66.7%	200.0%
WARD 15	GENERAL SURGERY	1569.5	1404.5	1256	1119.5	89.5%	89.1%	1069.5	724.5	356.5	866.5	67.7%	243.1%
WARD 19	TRAUMA & ORTHOPAEDICS	1643	1312.5	1178	1369.4	79.9%	116.2%	1069.5	1015.5	1069.5	1081	95.0%	101.1%
WARD 20	TRAUMA & ORTHOPAEDICS	1999.5	1529.1	1410.5	1555.5	76.5%	110.3%	1069.5	1035	1069.5	1035	96.8%	96.8%
WARD 22	UROLOGY	1178	1384.5	1178	1100.8	117.5%	93.4%	713	713	713	701.5	100.0%	98.4%
SAU HRI	GENERAL SURGERY	1830	1489.5	943	883	81.4%	93.6%	1380	1306	345	367	94.6%	106.4%
WARD LDRP	OBSTETRICS	4278	3607	945.5	514.5	84.3%	54.4%	4278	3499.5	713	632.5	81.8%	88.7%
WARD NICU	PAEDIATRICS	2247.5	1817	930	482.5	80.8%	51.9%	2139	1748	713	632.5	81.7%	88.7%
WARD 1D	OBSTETRICS	1242	1099.5	356.5	339	88.5%	95.1%	713	699.8	356.5	333.5	98.1%	93.5%
WARD 3ABCD	PAEDIATRICS	2435	2427.5	1208	722	99.7%	59.8%	2070	2054.5	345	333.5	99.3%	96.7%
WARD 4C	GYNAECOLOGY	713	706.5	465	429.5	99.1%	92.4%	713	713	356.5	310.5	100.0%	87.1%
WARD 9	OBSTETRICS	1069.5	866	356.5	334.3	81.0%	93.8%	713	713	356.5	356.5	100.0%	100.0%
WARD 18	PAEDIATRICS	793.5	697	138	51	87.8%	37.0%	713	666.8	0	0	93.5%	-
Trust		**61137.5**	**51099.55**	**35945**	**36531.4**	**83.58%**	**101.63%**	**44511**	**39790.4**	**21352.5**	**25246.5**	**89.40%**	**118.24%**

Hard Truths: Safe Staffing Levels (3)

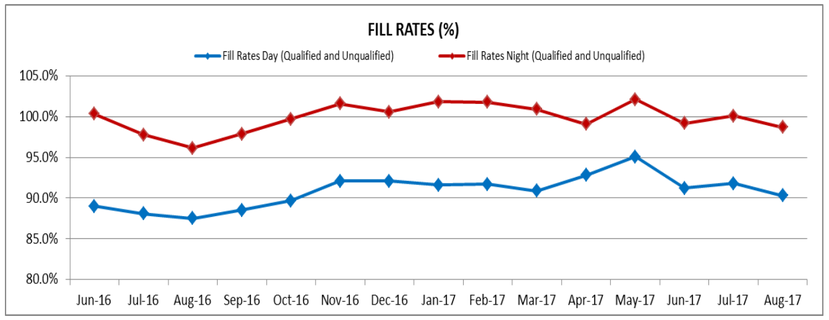
Care Hours per Patient Day

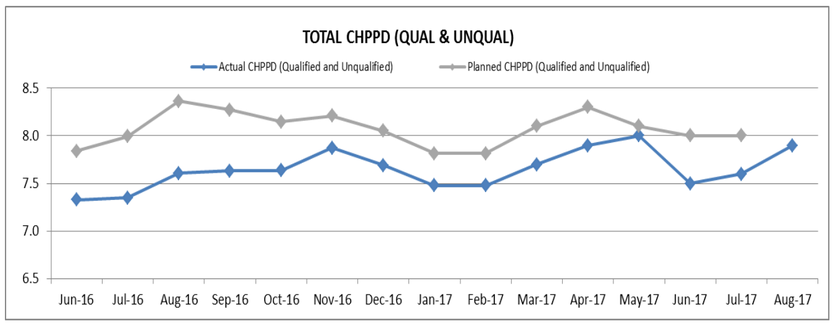
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Jun-17	Jul-17	Aug-17
Fill Rates Day (Qualified and Unqualified)	91.20%	91.80%	90.30%
Fill Rates Night (Qualified and Unqualified)	99.20%	100.10%	98.70%

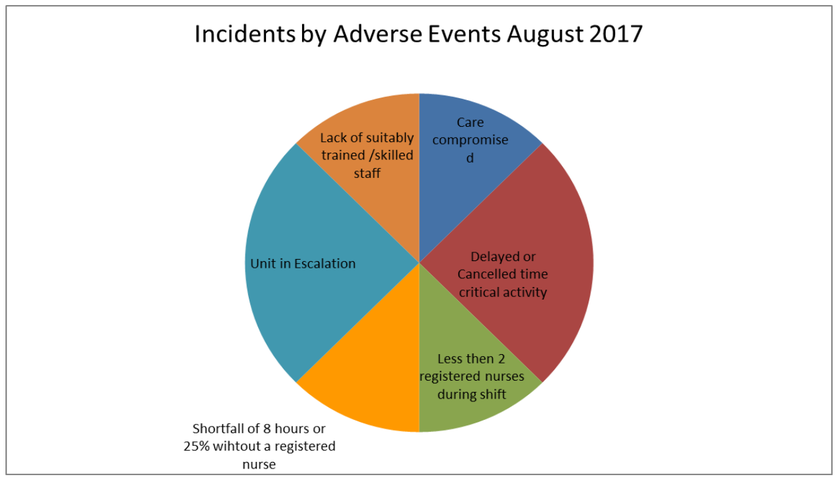
Planned CHPPD (Qualified and Unqualified)	8.0	8.0	8.4
Actual CHPPD (Qualified and Unqualified)	7.5	7.6	7.9

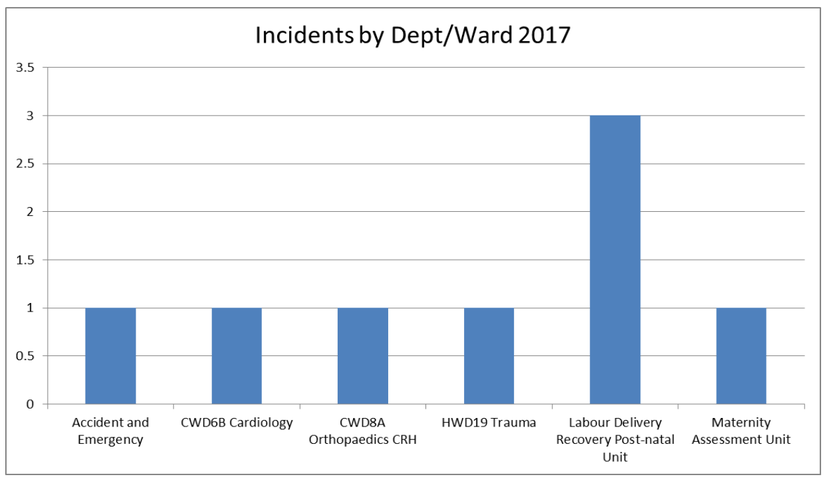
A review of Augusts 2017 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 25 clinical areas of the 37 reviewed had CHPPD less than planned. 2 areas reported CHPPD as planned. 10 areas' reported CHPPD slightly in excess of those planned. Arears with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





Red flagged events:

A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). In total there were **8 Trust Wide Red shifts** declared in **August 2017** . The Red flagged shifts were resolved within the Divisions and support for areas where staffing levels had fallen below planned levels was provided across the floor & by the duty night sister/site co-ordinator.

Hard Truths: Safe Staffing Levels (4)

Conclusions

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

On-going activity:
1.The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continue forspecific area.
2. Recruitment fairs are planned for October 2017 & march 2018.
2. Applications from international recruitement projects are progressing well and the first nurses are expected in Trust October 201.
3. CHFTis a fast follower pilot for the Nursing Associate (NA) role and has 5 NA who started in post in April 2017.
4. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment & retention of the graduate workforc. This is been further enhanced by the development of a year long perceptorship programme to support & develop new starters.
5. A new module of E roster called safecare will be introduced, benefits will be better reporting of red flag events, real-time data of
acuity and responsive deployment of staff.

14. Financial Narrative - Month 5 - 2017-2018

Presented by Gary Boothby

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 5th October 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: Financial Commentary for NHS Improvement - Month 5 - The attached commentary was submitted to NHS Improvement on the 15th of Sept 2017 alongside the Month 5 Monthly Monitoring financial return.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

For information - see attached.

Main Body

Purpose:

See attached

Background/Overview:

See attached

The Issue:

See attached

Next Steps:

See attached

Recommendations:

To note.

Appendix

Attachment:

NHSI Financial Commentary Month 5 Final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 5 AUGUST 2017, NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

The notes below provide a management commentary on the financial position of Calderdale & Huddersfield NHS Foundation Trust at the end of August 2017.

The report is structured into three sections to describe:

- Key messages;
- Detailed commentary for the period with variance analysis against the annual plan as submitted to NHSI;
- Use of Resources rating and forecast.

1. Key Messages

The Month 5 position is a deficit of £13.91m on a control total basis, in line with plan. This excludes year to date Sustainability and Transformation funding (STF) of £2.43m.

The final planning submission made to NHSI on 30th March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had a number of concerns regarding the scale of this challenge. Whilst appreciating the overall NHS Provider sector position, it was hoped that a revised control total could be considered. The key risks to delivery were outlined as the abnormal costs of implementation or short term loss of income as a result of EPR implementation and the scale of the CIP challenge at £20m, 5.3%. The original implementation of EPR was planned for 2016/17 and a revenue challenge was recognised by regulators during the planning round. Whilst this was not reflected in the control total, an original challenge of up to £7m (subsequently reduced to £5m), was recognised. Whilst this was again not recognised in agreeing control totals for 2017/18, the additional risk of implementing such large scale clinical change was highlighted at every opportunity. For 2017/18, the impact of EPR was estimated to be up to £5m, whilst only £17m of the required £20m CIP was believed to be achievable, leaving the Trust with a total risk of £8m plus any subsequent loss of STF funding.

As at Month 5 these concerns have not abated. Whilst the Trust is able to report delivery of the financial plan, there are a number of assumptions of a material value that have been made in order to deliver this position. The implementation of EPR continues to have a significant impact on both productivity and the capture of activity data and is driving a material clinical income variance year to date. The year to date position is reliant upon a number of non-recurrent income and expenditure benefits which cannot be replicated going forwards plus the use of five sixths of the total contingency reserve available for this financial year.

There is now a significant risk that the Trust will not be able to achieve the 17/18 control total due to a combination of slower than expected recovery of clinical activity levels and therefore income following EPR implementation, reduced operational capacity whilst resolving implementation issues and remaining unidentified CIP of £3m. A recovery action plan has been implemented which aims to tackle: the recovery of clinical income at risk due to issues with capture and coding in EPR, the development of Divisional financial recovery plans, a Trust wide establishment review and further tightening of budgetary controls. In addition, an EPR stabilisation plan has been put into action to regain activity performance levels to the maximum achievable. This in itself drives additional cost requirements. Every effort will be made to deliver the financial plan, but in this context full recovery may be impossible. Delivery of the financial plan remains the highest risk on the Trust risk register scoring the maximum of 25.

Month 5, August Position (Year to date)

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

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	154.93	149.40	(5.53)
Expenditure	(155.67)	(150.41)	5.25
EBITDA	**(0.74)**	**(1.02)**	**(0.28)**
Non-Operating items	(24.31)	(10.51)	13.80
Surplus / (Deficit)	**(25.04)**	**(11.52)**	**13.52**
Less: Items excluded from Control Total	13.96	0.04	(13.92)
Less: Loss of STF funding	0.00	0.43	0.43
Surplus / (Deficit) Control Total basis	**(11.08)**	**(11.05)**	**0.03**

- Delivery of CIP of £3.97m against the planned level of £5.44m.
- Contingency reserves of £1.67m have been released against pressures.
- Capital expenditure of £5.76m, this is below the planned level of £9.05m.
- Cash balance of £1.92m in line with the plan.
- Use of Resources score of level 3, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

Operating Income

Operating Income is £5.53m below plan year to date.

NHS Clinical Income

The year to date NHS Clinical income position is £126.19m, £5.78m below the planned level.

The Clinical Contract income position for Month 5 based upon activity coded and captured within EPR is £5.72m below plan. Data quality on EPR has improved compared to Quarter 1, but there remain a number of areas where activity is either not captured within EPR or a change to patient data is required in order to accurately price the activity. EPR implementation also resulted in a temporary decrease in the depth of coding and capture of co-morbidities, impacting across both Emergency Long Stay and A&E income, a reduction in the capture of Best Practice Tariff activity and a resulting impact on the Emergency Threshold. This has also improved compared to Quarter 1, but has not yet returned to pre-implementation standards.

Following discussions with external experts from Cymbio, the Trust's own Health Informatics and Divisional teams, £1.2m of income has been calculated as an estimate of the value of this missing data. The negotiation of a fixed value agreement with the Trust's main commissioners for Month 2 activity has secured £0.4m of this estimated activity and there is an agreement in principle with commissioners

to recognise some income for Months 3 and 4 where coding and capture issues are well understood. This income is included within the reported position 'at risk' pending formal agreement.

Following these adjustments, NHS Clinical contract income is still below plan by £4.51m and this appears to be driven by both case mix and activity volumes due to a reduction in productivity following the implementation of EPR, in particular impacting on Outpatient and Elective activity. In addition, there is an adverse variance of £1.27m on NHS Clinical income that is outside of contract. This is primarily due to lower than planned Cancer Drugs fund income, (offset within High Cost Drugs expenditure), offset by non-recurrent Accelerator zone funding of £0.77m.

The year to date position also assumes receipt of the full 2.5% of CQUIN including the STP and Risk Reserve elements.

The year to date reported position includes loss of STF funding linked to the A&E 4 hour performance target of £0.43m. Performance in Quarter 1 was 90.58% of patients seen within the 4 hour target. This is below the very high levels reported in Quarter 4 of 16/17 and against which our current performance is being compared. The deterioration is as a direct result of both the implementation of EPR and the adherence to IR35 guidance, and as such should be considered to be exceptional. It had been hoped that NHSI would recognise the exceptional nature of the impact of EPR upon A&E performance in the year to date against the backdrop of the Trust's underlying strong A&E performance in 2016/17. However, the Trust was unsuccessful in its appeal. Performance has continued to recover, but remains below the target trajectory of 94.46% for Quarter 2 and on this basis the Trust has taken a prudent position and the income has not been assumed in either the year to date or Quarter 2 forecast position, creating an adverse forecast variance of £0.53m.

Data for the Delivery Board confirms that as a Delivery Board the 95% trajectory for Month's 4 and 5 has been achieved, however early indications for Month 6 suggest that achieving the trajectory for the full Quarter remains a challenge. The Trust continues to work to this end and is optimistic that funding for Quarter 2 may yet be secured.

Receipt of full STF monies for financial performance and A&E front door streaming are assumed within the year to date and forecast position and it is assumed that A&E performance will be achieved in the final two quarters of the year. The forecast does not reflect the changes to STF guidance received on the 14th of September.

Other income

Overall other income is above plan by £0.24m year to date. Increased sales activity within our commercial operations has been offset to some extent by slippage in recovery of the Apprentice Levy compared to plan and lower than planned Car Parking income.

Operating expenditure

There is a cumulative £5.25m favourable variance from plan within operating expenditure across the following areas:

Pay costs	£1.26m favourable variance
Drugs costs	£0.09m favourable variance
Clinical supply and other costs	£3.90m favourable variance

Achieving the control total for Month 5 has relied on the release of five sixths (£1.67m) of our total Contingency Reserve and a number of non-recurrent benefits including: a £3.5m credit relating to a negotiated non-recurrent refund of PFI facilities management costs, a non-recurrent benefit of £0.57m

relating to prior year creditors, £0.36m of prior year benefits and non-recurrent Accelerator Zone income of £0.77m. The total of non-recurrent benefits in the year to date position is £5.43m.

Employee benefits expenses (Pay costs)

Pay costs are £1.26m lower than the planned level in the year to date, although this is primarily due to the release of Contingency Reserves of £1.67m. The underlying pressure on pay expenditure is non – clinical and is due to higher than planned Business as Usual costs linked to EPR. The Trust has seen a reduction in Agency costs compared to those reported in 16/17, particularly in Medical Staffing, where IR 35 has resulted in number of doctors transferring onto the payroll, although in some cases this has not resulted in a reduction in cost.

The Trust achieved the agency ceiling of £7.60m year to date, with total Agency expenditure of £6.62m.

Drug costs

Expenditure year to date on drugs is £0.09m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £1.05m below plan. Underlying drug budgets are therefore overspent by £0.96m, largely due to additional activity in the Pharmacy Manufacturing Unit which is a commercial operation.

Clinical supply and other costs

Clinical Support costs are £1.21m lower than planned. This underspend reflects some activity related underspend in clinical supplies, as well as a non-recurrent benefit of £0.57m relating to prior year creditors as described above.

Other costs are £2.69m lower than planned due to the £3.5m non recurrent benefit mentioned above, offset by the pressure of £0.8m of unidentified CIP in the year to date. This unidentified CIP forms part of the £3m additional CIP challenge that has been flagged as a significant risk to delivery of the 17/18 plan.

Non-operating Items and Restructuring Costs

Non-operating expenditure is £13.80m lower than plan in the year to date. This variance includes the impact of the delay of a planned £14m impairment that is now forecast to be accounted for later in the year. The Trust has also seen higher than planned Depreciation of £0.22m following year end asset revaluations and an increase in PFI Contingent Rent due to March's high level of RPI on which the PFI contract uplift is based.

Cost Improvement Programme (CIP) delivery

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

£3.97m of CIP has been delivered this year against a plan of £5.44m, an under performance of £1.47m. The Trust has now identified £17.0m of savings and continues to push hard for full delivery of the £20m target. The forecast assumes full delivery of the £20m target, but this remains extremely challenging with £3m of savings yet to be identified and a number of very high risk schemes where

delivery of savings is not yet assured. Should these very high risk schemes fail to deliver; further mitigation of around £3.4m will have to be found. Any non-recurrent opportunities that would have historically supported CIP delivery whilst further plans are developed have been used in year to support the other challenges within the year to date position.

Statement of Financial Position and Cash Flow

At the end of July 2017 the Trust had a cash balance of £1.92m, in line with the planned level.

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

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	13.52
	Non cash flows in operating deficit	(13.69)
	Other working capital movements	(1.97)
	Sub Total	**(2.13)**
Investing activities	Capital expenditure	3.29
	Movement in capital creditors / Other	(2.31)
	Sub Total	**0.98**
Financing activities	Drawdown of external DoH cash support	2.04
	Other financing activities	(0.92)
	Sub Total	**1.13**
	Grand Total	**(0.03)**

Operating activities

Operating activities show an adverse £2.13m variance against the plan. The unfavourable cash impact of £1.97m working capital variances is combined with an I&E variance due to the loss of £0.43m STF funding, (A&E 4 hour performance), offset by the cash benefit of higher than planned Depreciation charges of £0.21m. The large variance in both the deficit position and non-cash flows is linked to a planned impairment which will now take place later in the year. The working capital variance includes an increase in receivables due to the accounting of the £3.5m PFI credit described above, offset to some extent by an increase in Trade Payables. The cash benefit of the PFI credit is likely to fall at least in part into the next financial year and this combined with an increase in Payables will create a cash pressure for the organisation over the next few months. The Trust is already having to manage payments to creditors in order to retain sufficient cash to ensure that key payments are made and will need to pursue further discussions with NHS Improvement regarding cash support for working capital.

Investing activities (Capital)

Capital expenditure year to date is £3.29m lower than planned and the resulting cash benefit has offset some of the pressure on working capital described above. This cash benefit has been almost entirely offset by a reduction in Capital creditors due to the payment of EPR related invoices that were accounted for in the 16/17 capital programme. The requirement for cash support to cover these liabilities was included within the 17/18 cash plan, but has not been accessed in the year to date position. Cash support over and above the level of the planned deficit will be required to settle these liabilities over the next few months.

Financing activities

Borrowing to support capital expenditure is £5.08m year to date as planned. In addition the Trust has received £13.94m of Revenue Support linked to deficit and STF funding requirements. This is £2.04m more than planned and reflects additional funding provided to cover delays in receiving Quarter 1 Sustainability and Transformation funding planned for Month 5.

3. Use of Resources (UOR) rating and forecast

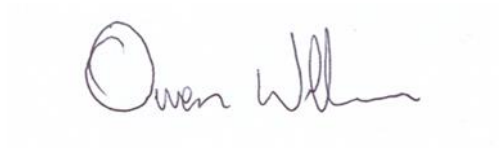
Against the UOR the Trust stands at level 3 in line with plan in year to date and forecast terms.

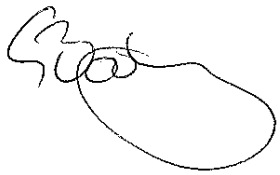
The forecast continues to assume that the Trust will achieve its Control Total and secure the £7.1m STF allocation for Financial Performance. However, the risk of failing to achieve our target deficit of £26.04m (excluding STF funding) remains extremely high, despite the Trust taking action to stabilise the financial position.

The forecast assumes:

- That the Trust is able to recover the £1.20m of estimated income in the year to date position.
- That clinical activity returns to the planned level from Month 6 or income is recovered by the year end.
- Full achievement of the £20m Cost Improvement programme including the £3.0m currently unidentified and a further £3.4m that is extremely high risk.
- Divisional recovery plans can be put in place to maintain the position in line with control total from month 6 to month 12.
- Full receipt of CQUIN funding, including the 0.5% Risk Reserve.
- Securing STF income in full for the finance (70%) and A&E Front Door Streaming (15%) and from Q3 for the A&E performance (15%) element of the target.
- That any further costs relating to EPR implementation, including those committed to a post go live stabilisation plan, can be either capitalised or offset by additional savings.
- That a programme of additional budgetary grip and control is successfully implemented as planned.

The scale of the challenge is evident from the above but the Trust continues to seek to maximise opportunities and do all within its power to secure delivery of the control total.





Owen Williams
Chief Executive

Gary Boothby
Executive Director of Finance

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

Presented by Andrew Haigh

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th October 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:
- Quality Committee – minutes of 4.9.17 and verbal update from meeting 2.10.17
- Finance and Performance Committee – minutes of 5.9.17 and verbal update from meeting 3.10.17
- Workforce Well Led Committee - minutes of 14.9.17
- Charitable Funds Committee - draft minutes of 16.8.17

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the updates and minutes from the sub-committees:
- Quality Committee – minutes of 4.9.17 and verbal update from meeting 2.10.17
- Finance and Performance Committee – minutes of 5.9.17 and verbal update from meeting 3.10.17
- Workforce Well Led Committee - minutes of 14.9.17
- Charitable Funds Committee - draft minutes of 16.8.17

Appendix

Attachment:

COMBINED MINS AND PAPERS - SUB CTTEES.pdf

QUALITY COMMITTEE

Monday, 4th September 2017
Discussion Room 3, Huddersfield Royal Infirmary

IN ATTENDANCE

Dr Linda Patterson ***(LP)***	Non-Executive Director ***(Chair)***
Dr David Anderson ***(DA)***	Non-Executive Director
Gemma Berriman ***(GB)***	Head Nurse for Medicine - Service Planning
Dr David Birkenhead ***(DB)***	Medical Director
Brendan Brown ***(BB)***	Executive Director of Nursing - Corporate
Juliette Cosgrove ***(JC)***	Assistant Director of Quality and Safety - Corporate
Andrea Dauris ***(AD)***	Associate Director of Nursing, Community Division
Anne-Marie Henshaw ***(AMH)***	Associate Nurse Director / Head of Midwifery, FSS Division
Lesley Hill ***(LH)***	Director of Planning, Performance, Estates & Facilities
Andrea McCourt ***(AMcC)***	Head of Governance and Risk
Jo Middleton ***(JM)***	Associate Director of Nursing, Surgical Division
Gemma Pickup ***(GP)***	Clinical Governance Manager, Community Division
Dr Ashwin Verma ***(AV)***	Divisional Director, Medical Division
Michelle Augustine ***(MA)***	Governance Administrator ***(Minutes)***

150/17 WELCOME AND INTRODUCTIONS

The Chair welcomed members to the meeting.

151/17 APOLOGIES

Lindsay Rudge	Deputy Director of Nursing
Mr Martin DeBono	Divisional Director, FSS Division
Dr Julie O'Riordan	Divisional Director, Surgical Division
Kristina Rutherford	Director of Operations, Surgical Division
Rob Aitchison	Director of Operations, FSS Division
Andrew Mooraby	Associate Director of Nursing, Medical Division
Dr Cornelle Parker	Deputy Medical Director
Jan Wilson	Non-Executive Director
Helen Barker	Chief Operating Officer
Peter Middleton	Membership Councillor

It was noted that this would have been Peter Middleton's last meeting attending this committee. Via an email, Peter expressed his thanks to the Chair of the Quality Committee for the attention given to him as a Governor and wished the Trust ongoing success in improving quality outcomes and patient experiences.

Thanks were conveyed to Peter for his contribution to the Committee.

152/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

153/17 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 31st July 2017 (appendix A) was approved as a correct record.

154/17 ACTION LOG AND MATTERS ARISING

Please see action log at the end of the minutes (Appendix B) for further updates on actions and matters arising.

Learning from Deaths paper / CQC mortality

DB reported on the circulated report (Appendix C) which describes the process for mortality reviews, structured judgement reviews and a new model for learning from death. A copy of the learning from death policy was also included in the report. Comments on the policy, which has already been signed off at the Weekly Executive Board, were welcomed. Discussion took place on how coding and the Electronic Patient Record (EPR) can be used more effectively with documentation.

The Chair conveyed that the report was a great testament to the hard work achieved with the reduction of the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

It was stated that an update on the new model of learning from death will be brought to the Quality Committee at a future date.

OUTCOME: The Committee received and noted the report.

155/17 ESTATES AND FACILITIES DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT – Q1

LH presented the report (Appendix D), briefly summarising:

- Patient Led Assessments of the Care Environment (PLACE) inspections have taken place (CRH in March and HRI in May) with positive scores in areas.
- Cleaning Industry Management Standard (CIMS) presentation of honours level award to take place 23 August 2017.
- Work is ongoing with Calderdale Council regarding car parking, and in the process of applying for planning permission for a multi-storey car park. The policy and updated action plan to be fed back to the Weekly Executive Board in September 2017. Discussion ensued on car parking issues which can add to patient anxiety, as well as impacting on colleagues who may be late to clinics.
- Sickness levels above target
- Issues with cleaning services and working with infection control colleagues on this
- Catering staff being patient-centred and very accommodating of patients and have relationship with nursing and dietetics.
- Patient safety issues to be incorporated into report.

OUTCOME: The Committee received and noted the report.

156/17 SURGERY AND ANAESTEHTICS DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT – Q1

JM presented the report (Appendix E), briefly summarising:

- Joint Advisory Group (JAG) accreditation – endoscopy not awarded accreditation following self-assessment in July 2017 and action plan in place to address issues identified. Next self-assessment due in October 2017. Action plan in place and being monitored through directorate meetings and working towards reaccreditation in formal assessment next year.

- Cancer breaches - 13 fast-track breach incidents open in the division. Clinical Governance lead has done some work with individuals to identify learning and facilitate improvement work.
- Cancer performance – work is ongoing with colleagues to identify foundations of breached pathways and agree any changes to existing pathways to prevent further breaches.
- Fractured neck of femur performance – previous improved performance slipped in quarter 1 and work is ongoing to develop guidelines and encourage more focus to maintain performance.
- Meticillin-resistant Staphylococcus Aureus (MRSA) bacteraemia – one pre-48 hour case admitted from community, however, informed that this will be assigned to CHFT.
- Complaints – division developed a standard operating procedure to ensure complaints are managed in a timely manner. There are currently 14 outstanding cases, and plan to close by 14th September 2017. It was stated that colleagues within Risk management have been very helpful.
- Risks – there are three high risks in the division and Electronic Patient Record (EPR) associated risks have been identified and will be managed through the division digital board from quarter 2. The division is represented at the EPR operational board and teams are working to validate risks. They are also in the process to have each risk described and are aware of mitigations.
- Serious incidents – an immediate review of two incidents which took place during quarter 1 is being undertaken through a cluster investigation. Division awaits report to implement recommendations.
- Nursing Quality Indicators (NQIs) – seen an increase in falls and working with falls collaborative to ensure revision of all falls prevention interventions.
- Infection control – review of cleaning taking place across the Trust as well as a review on the storing of food on wards. Aseptic Non-Touch Technique (ANTT) is now at 93% for nursing.
- Staffing levels – recruitment and retention in the Intensive Care Unit (ICU) has shown sustained improvement across quarter 1.
- Safety huddles – remain variable across division, and plan to use senior nursing clinical time to support with safety huddles
- Mixed sex accommodation – two breaches in ICU HRI, with a full review being undertaken to include escalation of patients who are ready to be stepped down.

Discussion ensued on whether there would be an improvement within the division in three months' time on fractured neck of femur, JAG and cancer breaches. It was reported that there was a detailed discussion on fractured neck of femur at the Performance Review Meeting (PRM), and it was also stated that Getting it right first time (GIRFT), CQC preparation work and self-assessments should be included in the report.

OUTCOME: The Committee received and noted the report.

157/17 COMMUNITY DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT – Q1

AD presented the report (Appendix F), briefly summarising:

- A new community structure has been developed, and new governance lead recruited – Gemma Pickup – who will be working on areas that were not progressing including audit, clinical guidelines development and review of NICE guidance.
- The Musculoskeletal (MSK) first point of contact went live on 1st June 2017. The service provides triage of all referrals to orthopaedics with new pathways for joint, pain and muscular conditions.
- The physiotherapy service has commenced a telephone assessment service, intended to reduce people requiring face to face contact by a physiotherapist

- The division appointed a new service manager into the senior team to focus on the intermediate tier services
- Incidents – 297 incidents reported in quarter 1, with no specific trends noted in teams or service areas. The division continues to maintain good performance in falls with no harm falls for 15 months. Harm free care performance was at 95.02% for quarter 1.
- Commissioning for Quality and Innovation (CQUIN) performance was on target in quarter 1, however, the division may need support with the submission of the personalised care and support training in quarter 2.
- Risks – two new risks opened during quarter 1, feedback of which has reported to the division's PRM.

OUTCOME: The Committee received and noted the report.

158/17 MEDICAL DIVISION PATIENT SAFETY AND QUALITY BOARD REPORT – Q1

AV presented the report (Appendix G), briefly summarising:

- Sepsis CQUIN – new processes being developed to integrate sepsis management on EPR. As the documentation of sepsis management has changed, the audit processes to monitor performance have to be adapted. Trustwide performance is currently at 21% and the division is at 23%. Work is ongoing to understand and accurately report sepsis management via EPR. From September 2017, the division will provide weekly accurate data on its sepsis management performance and will commence a trajectory to achieve performance standards required.
- Harm falls – notable achievements seen in total falls incidents, with each area working on their own action plan. There have been 77 days with no falls on ward 5AD
- Pressure ulcers – targeted improvement work is being undertaken at ward level with the tissue viability service to determine any contributory factors and learning required
- Frailty – the team at Huddersfield are now taking up to 170 new referrals a month and avoiding up to 39 admissions a month. The seven day service running from 8:00 am to 6:00 pm will be replicated at Calderdale.
- Infection control – auditing a new app Perfect Ward which will replace the Front Line Ownership (FLO) audits.
- CQC – Directorates are currently updating their CQC action plans and working with matrons and general managers through actions pertinent to their areas. Meetings have commenced in the division to prepare for the next CQC inspection.
- All Invited Service Reviews (ISRs) (stroke, elderly and respiratory) are on target. Reconfiguration with ISRs come with risk
- Incidents – During quarter 1, the division focussed on closing incidents that were greater than six months, and this will continue into quarter 2. The division continues to share monthly learning summaries from both incidents and complaints with all wards and departments
- Friends and Family Test (FFT) – the division recognises that it has specific areas that need to enhance response rates. The emergency department have revisited and refreshed their FFT action plan and encouraging patient participation. The response rate from text responses has improved and work needs to be focussed on the return of the FFT cards. Competition has been added into the process with a reward system in place.
- Recruitment and retention – vacancies remain high in the division and applicants from the international recruiting trip to the Philippines are progressing. The Trust made 120 offers and a number of them will be in the division.

OUTCOME: The Committee received and noted the report.

159/17 FAMILIES AND SPECIALIST SERVICES PATIENT SAFETY AND QUALITY BOARD REPORT – Q1

AMH presented the report (Appendix H), briefly summarising:

- Outpatients – continued issues with appointments post EPR with delays in answering telephones. Extra staff has been recruited.
- Pharmacy – the Aseptic Unit at HRI needs significant work to be done or closed down. A business case is being produced to improve the unit at CRH to comply with national standards and enable unit at HRI to be closed. Mike Culshaw, Clinical Director for Pharmacy will be retiring at the end of October, however, he will return in transition with appointing his replacement, which will hopefully be recruited by next Monday.
- Incidents – increase in number of incidents relating to 'unplanned admission / transfer to specialist care unit' is a result of a change in reporting, not a change in practice.
- Venous Thromboembolism (VTE) – target of >95% in division was met in April; however, this was not met in May and June. The data for August has much improved since June.
- Environmental audits – matrons and clinical managers undertake peer review FLO audits in their clinical areas as an opportunity to share best practice.
- Maternity – Bespoke maternity safety action plan is in place and on track with actions
- Engagement work – overview of work in both maternity and children's services will be shared within the division. It was reported that the division shared their patient experience approach work at the Patient Experience and Caring Group meeting.

OUTCOME: The Committee received and noted the report.

160/17 QUALITY AND PERFORMANCE REPORT

The quality and performance report (Appendix I) was summarised:

July's performance score currently stands at 54% for the Trust. The responsive domain is now red due to failing to meet the Emergency Care Standard, Diagnostic 6 weeks, both Cancer 2 week wait targets and both Cancer 62 day targets. The finance domain is now also red due to deterioration in income and expenditure surplus / (deficit) control total basis and agency expenditure.

Concern was raised with the decrease in performance and expectations on how this will improve. EPR implementation and issues with access targets were some of the concerns raised that are impacting on performance. The report is due to be discussed in detail at the Board of Directors meeting on Thursday.

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

161/17 INFECTION CONTROL COMMITTEE MINUTES

The infection control committee minutes (Appendix J) were summarised, and discussion took place on the MRSAs. The bacteraemia ceiling for 2017 / 2018 is 0 for avoidable cases and there have been four pre-48 hour cases during the first quarter, all of which have gone to arbitration, and a further case at HRI has been identified this week within the medical division.

It was stated that the meeting was poorly attended, and each member has been requested to nominate a deputy to attend in their absence. All issues within the minutes are being dealt with, and it was stated that if ongoing issues within cleaning can be resolved, other issues may also be resolved.

OUTCOME: The Committee received and noted the minutes.

162/17 ANY OTHER BUSINESS

There was no other business.

163/17 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Committee received good quality quarterly divisional reports and seen significant improvements in areas, as well as areas of concern, notably cancer breaches
- Committee highlighted a considerable amount of work regarding infection control
- Focus needed on complaints
- Staff retention is a huge issue
- That CQC issues are added to the quarterly divisional reports in future

164/17 QUALITY COMMITTEE WORK PLAN

The work plan (appendix K) was circulated and accepted.

165/17 EVALUATION OF MEETING

The effectiveness of the meeting was acknowledged as:

- Improvement in quality of divisional reports and will further improve with CQC dimensions
- CQC issues to be added to divisional quarterly reports templates
- Quality Committee not being able to have full discussion on the quality and performance report, however, this will be fully discussed at the Board of Directors meeting on Thursday.

NEXT MEETING

Monday, 2nd October 2017
3:00 – 5:30 pm
Acre Mill Room 4, 3rd Floor Acre Mill Outpatients Building, Huddersfield Royal Infirmary

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 1 September 2017 at 2.00pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer (in part)
Gary Boothby	Director of Finance
Phil Oldfield	Non-Executive Director (Chair)
Owen Williams	Chief Executive (in part)
Jan Wilson	Non-Executive Director (in part)

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance (in part)
Andrew Haigh	Chair of the Trust
Betty Sewell	PA (Minutes)

ITEM

WELCOME AND INTRODUCTIONS

129/17 The Chair welcomed attendees to the meeting.

130/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Anna Basford – Director of Transformation & Partnerships
Mandy Griffin – Director of Health Informatics
Richard Hopkin – Non-Executive Director
Brian Moore - Governor
Vicky Pickles – Company Secretary

131/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

13217 MINUTES OF THE MEETING HELD 1 AUGUST 2017

The Minutes of the meeting held 1 August 2017 were approved as an accurate record.

133/17 MATTERS ARISING AND ACTION LOG

All items to be covered as part of the agenda.

Due to the delay of Owen Williams and Helen Barker items on the agenda were covered out of sequence.

137/17 SERVICE LINE REPORTING BUBBLE CHARTS

The Deputy Director of Finance presented the paper which provided the Committee with an explanation of the Service Line Reporting (SLR) bubble charts, the report also described how these charts can be applied, together with other benchmarking

tools, to support strategic and operational decision making. It was acknowledged that this is only one way of presenting the data, which is circulated in different ways, it is also one way of representing the challenges for the Trust and how we engage with the organisation. Our Patient Level Information (PLICS) is audited and we usually perform well. It was noted that within our CIP portfolios we used our SLR information and it demonstrated some clinical variations, a data pack has been produced which includes some of this data to engage with clinical colleagues.

Discussions took place with regard to how engagement can take place it was also noted that all services are being reviewed, starting with Upper GI, ENT, Ophthalmology and Gynaecology.

The Committee noted the contents of the paper and the work being done.

139/17 EPR UPDATE AND HIGHLIGHT REPORT

The Associate Director of Finance confirmed that the information within the report is for CHFT only.

It was noted that capital for the EPR project has now concluded and that this is demonstrated in section 2.3 of the report. The key point of the report related to additional costs, it was also noted that any additional capital costs on the programme will create pressure to capital for the organisation. In month, a paper was presented to Weekly Executive Board which outlined the financial pressure in year of the EPR project. Discussions took place with regard to further additional costs, which includes our contingency plans over the Bradford go-live weekend, it was confirmed that at this point in time it is too early to quantify what the total costs will be. The Director of Finance pointed out that the organisation is committed to the EPR project and this will be discussed further as part of the Private Board Agenda.

It was acknowledged that we are working closely with colleagues to capture all additional costs the position is challenging, governance is in place and every case is being evaluated with informed decisions being made.

Helen Barker joined the meeting.

The Committee noted the contents of the paper.

140/17 FINANCIAL RISK RATING UPDATE

The Deputy Director of Finance presented a paper which reviewed the Trust's key financial risks relating to I&E, Capital and Cash, the paper also outlined the current position and context, highlighting anticipated issues going forward in the remainder of 2017/18 and into 2018/19. It was recognised by the Committee that the I&E risk had been increased to the highest level of **25.**

In depth discussions took place with regard to Capital and the level of risk, it was agreed after lengthy discussions that the in-year risk would be reduced to a score of **9,** however, the proposal for an additional risk to be placed on the risk register to separately identify the 2018/19 capital risk with a score of **20** was approved by the Committee.

Owen Williams joined the meeting.

The cash risk has been revised downwards from the previous score of 20 to a current score of **12.** The assessment of this risk will need to be agile on a monthly basis through 2017/18 taking into account two key considerations. Firstly, any mitigation that is used to offset the underlying I&E shortfall may have a different cash profile. Secondly, there is a residual capital related cash requirement as a legacy from 2016/17. Following discussions, it was agreed that the level of risk should stand at 12, with a view to reviewing the risk on a monthly basis.

The Committee approved the recommendations and supported the monthly review of all the 2017/18 financial risks.

134/17 INTEGRATED PERFORMANCE REPORT DEEP-DIVE MONTHS 1-4 2017

The Chief Operating Officer shared the presentation which had been presented to WEB.

It was noted that the performance score standard is still a deteriorating picture which stands at 54% as at July with two RED domains. The Trust's performance is measured against 71 chosen key targets and 36 regulatory targets.

The number of missed targets for March 2017 was 9, it was noted that during March the decision was made at Board to focus on the EPR implementation programme and mandatory training was frozen which had a positive impact on the Workforce KPIs.

The number of key targets missed in July 2017 was 17.5 with Complaints still being problematic also there was an increase in the number of Family & Friends KPIs missed and additional Cancer targets missed. It was noted that the Trust is working with an external organisation to look at specific patient experience around outpatients.

Discussions took place regarding the weekly performance meetings and how they could focus on what would make a difference, it was recognised that there was a need to ensure that there was a real performance rigour across the organisation.

It was noted that most targets are interlinked and there was a need to find the key areas and focus on those areas. It was agreed that Owen Williams and Helen Barker would meet off-line to discuss further how 'Results' can be achieved.

The Committee noted the contents of the presentation.

136/17 2017/18 CLINICAL INCOME & ACTIVITY – UPDATE ON THE IMPACT OF RECOVERY

The Director of Finance presented a report in response to the last Finance & Performance Committee where a deep-dive into activity was requested. The report presented the key lines of enquiry and actions taken, however, even though there has been some recovery we are still not where we expected to be. It was noted that the latest position shows we are still not hitting the plan and this is against a reduced plan for August.

Discussions took place with regard to the possible cause of the reduced activity it was recognised that some areas are moving in the right direction but it was also recognised that there are areas such as sickness absence and outpatients which need improvement. The realisation that we will not hit plan was acknowledged by the Committee. Further discussions took place with regard to how the plan for recovery can be communicated to the regulators a clearer view will be taken within the next 2/3 months.

It was noted that time would be given at the Private Session of the Board to give focus on the financial reality and stabilisation.

Jan Wilson and Stuart Baron left the meeting.

135/17 MONTH 4, FINANCE REPORT

It was noted that the challenges with regard to the financial position have already been discussed. It was also noted that the Month 4 position is a deficit in line with the plan, however, the underlying financial shortfall against the financial plan in year to date is £5.9m. It was confirmed that the Trust has a financial recovery plan, some actions had been deferred to focus on activity, this is now being fully implemented.

In addition, the cash balance at the end of the month was above plan this was purely down to the timing of the receipt of the STF payment.

A further challenge around CIP was called out by the Director of Finance which is still slipping. It was noted that £13.7m is being forecast, various workstreams will hopefully improve this position.

Discussions took place with regard to recent conversations with Commissioners and the System Recovery Plan.

141/17 MONTH 04 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee noted the contents of the paper.

142/17 MINUTES FROM SUB-COMMITTEES:

Cash Committee – Draft Minutes of meeting held 12 July 2017
Commercial Investment & Strategy Committee – Draft Minutes of meeting held 20 July 2017, it was noted that actions are being cleared from the action log.
Capital Management Group – Draft Minutes of meeting held 10 August 2017.

The level of apologies received for each Committee was questioned, it was noted that Owen Williams and Kirsty Archer will meet outside this forum to discuss attendance at the Cash Committee.

The Committee received the Minutes.

143/17 WORK PLAN

The Work Plan was received and noted by the Committee,

144/17 MATTERS TO CASCADE TO THE BOARD

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

- IPR / Stabilisation (Private Session)
- EPR (Private Session)
- Activity and Forecast
- Risk Management update
- SLR – clinical variation discussions

145/17 REVIEW OF MEETING

Attendees welcomed the open discussions.

146/17 ANY OTHER BUSINESS

The Chief Executive asked if any additional cost provision had been allocated to issues which may be raised as part of the next CQC visit. The Director and Deputy Director of Finance will review and feed back to this meeting.

DATE AND TIME OF NEXT MEETING

Tuesday 31 October, 9.00am – 12.00noon

Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 14 September 2017, 1.30 pm – 3.30 pm in the Board Room, Calderdale Royal Hospital

PRESENT:

David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Jason Eddleston	Director of Workforce and Organisational Development
Karen Heaton	Non-Executive Director (Chair)
Vicky Pickles	Company Secretary
Jan Wilson	Non-Executive Director

IN ATTENDANCE:

Adam Matthews	Workforce Information/Business Intelligence Analyst (for agenda item 118/17)
Michelle Bamforth	Head Nurse for Professional and Workforce Development (on behalf of Brendan Brown)
Chris Burton	Staff Side Chair
Rosemary Hedges	Membership Councillor
Samantha Lindl	Personal Assistant, Workforce and Organisational Development

111/17 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

112/17 **APOLOGIES FOR ABSENCE:**

David Birkenhead, Medical Director
Brendan Brown, Chief Nurse/Deputy Chief Executive

113/17 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

114/17 **MINUTES OF MEETING HELD ON 10 AUGUST 2017:**

The minutes of the meeting held on 10 August 2017 were approved as a true record.

115/17 **ACTION LOG (items due this month)**

The action log for September 2017 was received. Items due this month were discussed in the meeting.

67a - IR35 Regulations

KH requested an update with regard to the implications to the Trust of the IR35 regulations.

JE advised the IR35 has been subsumed by the Effective Workforce Programme. The Trust reviews compliance with IR35 regulations on a case by case basis through its Flexible Workforce Team.

KH queried the impact on agency worker availability of IR35 regulations. HB reported that some services had adversely been affected through the withdrawal of workers from the market.

RH queried if a reduction in costs has been secured. HB reported the introduction of IR35 has overall resulted in an increase in costs mainly in Accident and Emergency areas due to the reliance on bank and agency workers in relation to a high vacancy rate. HB advised that Neurology and Dermatology also noticed an increase in costs.

71/7 - Colleague Health and Wellbeing

JE confirmed a paper will be brought to the October 2017 Committee meeting providing an update on the Trust's approach.

ACTION: JE to provide a paper to the October 2017 Committee meeting

71/7 - Colleague Health and Wellbeing

VP reported work is being undertaken in conjunction with Ruth Mason (RM), Associate Director, to develop the sub-structure as lead of the OD and Engagement group. It was agreed the action relating to the requirement for colleagues to shift from a reactive measure to a focus on a preventative way of life through the organisation is essential to ensure the health and wellbeing of colleagues as agreed at the June 2017 Committee meeting.

ACTION: VP to link with RM and raise at OD and Engagement Group

FSS Workforce Plans and Strategy

It was noted the FSS Workforce Plans and Strategy presentation was unavailable. JE agreed to liaise with Anne-Marie Henshaw (AMH) and Rob Aitchison (RA) to secure a future date.

ACTION: JE to liaise with AMH and RA

MAIN AGENDA ITEMS

FOR ASSURANCE

116/17 **EFFECTIVE WORKFORCE PROGRAMME**

JE provided an overview of the Effective Workforce Programme presentation which had previously been delivered at Turnaround Executive and Executive Board. It was noted this Cost Improvement Programme (CIP) replaces the Right Skills Right Time Programme. Initial savings were forecast to be c£800k, however, the current forecast for the replacement scheme is £46k identifying a 2017/2018 savings risk. An overview of the presentation was provided.

Using a series of workforce metrics from the Model Hospital, Service Line Reporting, turnover, sickness and vacancies services have been identified for further examination to establish if savings opportunities exist. The Trust intends to adopt the Calderdale Framework methodology which will be used as a structured approach to reviewing skill mix and roles within services. The Framework is used in many NHS organisations and has delivered real results. An activity plan has been developed with tight timescales to create traction to progress the work which will identify a savings plan for 2018/2019 and if additional savings are available for 2017/2018 to the £46k forecast.

Programme leads have been identified and project management for each service scheme will be provided by Human Resources Business Partners and General Managers. Facilitator training will be delivered to create a minimum resource of 10 Calderdale Framework facilitators. The Calderdale Framework delivery plan will be developed once

the facilitator training is delivered in November 2017. It is anticipated each service area review will require a minimum of 6 months, however, the timeframe for each area will be service dependant.

RH queried the level of confidence with the new scheme due to the vast difference in predicted savings identified. JE explained colleagues are confident the scheme will deliver the savings due to its structured approach.

HB advised work is already underway in services to review different ways of working and the introduction of new roles, for example, Advanced Clinical Practitioners and Cardio Physiologists to sustain the workforce in the future as the availability of staff in traditional roles is not secure.

KH queried if the methodology is different to which was previously adopted. JE advised it was more structured and proven in other organisations. Critically, the approach has engagement and communication as a core activity.

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

117/17 **WORKFORCE (WELL LED) COMMITTEE MID-YEAR ASSESSMENT**

VP reported there is a requirement for a year-end self-assessment of the work of the Committee to be undertaken which is included in a short annual report. Following discussion it has been agreed that a year-end assessment will commence in January 2018.

ACTION: VP to progress in January 2018.

PERFORMANCE

118/17 **WORKFORCE PERFORMANCE REPORT (SEPTEMBER 2017)**

AM provided an overview of the main highlights:-

The Workforce Dashboard shows an increase in the number of FTE vacancies. MB placed a caveat on the figure as 60 of nursing graduates and 14 Healthcare Assistants Apprentices are to be recruited imminently. The recruitment of a cohort of Philippine nurses is progressing with 87 working towards achieving their International English Language Test System (IElTS). 11 candidates have passed the IELTS and 3 have been successful with their NMC application. It is anticipated the recruitment process will be completed in January 2018.

Attendance Management shows a decrease in sickness absence with a slight increase in the YTD figure.

Appraisal is currently 42% against a plan of 62%. 50% of colleagues are required to undertake an appraisal by the end of October 2017. KH queried if this was achievable. HB advised Executive Board has proposed to extend the appraisal season to 30 November 2107.

Mandatory training compliance shows a slight decrease in manual handling. Colleagues are required to complete the refresher course as the previous 2 year cycle is expiring.

The September 2017 data includes recruitment indicators sourced from the newly implemented system Trac. It was noted the data will become more relevant over the next 6 months

RH asked if the Trust has a full cohort of training junior doctors. HB reported that there are gaps, however, these are lower than previous years. Additional work has been undertaken with regard to the recruitment of Trust Grade Doctors and Advance Nurse Practitioners to fill the gaps. In addition, Executive Board has agreed to progress a piece of Electronic Patient Record (EPR) review work which Alistair Morris, Clinical Director for Modernisation, will lead on to promote the Trust's unique selling point (USP) and improve the recruitment of doctors from the Universities.

KH referred to higher levels of sickness absence in Estates and Ancillary and Additional Clinical Services which will impact on overall target rates. JE reported HR Business Managers are working with General Managers to identify hotspots to ensure continual clear support mechanisms are in place to assist colleagues in their return to work. In addition, colleagues are encouraged to remain healthy at work as part of the Colleague Health and Wellbeing activity.

KH queried the date of the reporting of the Agency Spend figure. AM advised that up to date agency spend data is unavailable at the time of producing the report. It was noted data is available on 11th day of each month. AM reported the figure of 1.47% in July 2017 and the most recent figure of 1.27% in August 2017. It was agreed an unvalidated figure will be detailed in the report and the actual figure will be reported verbally within the meeting.

HB noted that there will be a significant increase reported in August 2017 as a result of junior doctor change and increased staffing levels and the use of additional floor walkers for EPR. In addition, unsafe levels of nursing were identified over the bank holiday period.

ACTION: AM to document an unvalidated figure within the report and provide the actual figure for a verbal update at the Committee meeting.

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

INFORMATION

119/17 **BREXIT – WORKFORCE IMPLICATIONS**

The report had been circulated with papers to the Committee meeting.

JE provided an update of the position in relation to European Union (EU) workers. The paper sets out the current position in terms of the negotiation position, the national position and the local position. The Trust employs 129 EU nationals. However, 1,388 colleagues have not identified their nationality in the Electornic Staff Record (ESR). Work will progress to encourage colleagues to report their nationality to ensure full data collection is recorded within the ESR portal.

JW stated consideration will need to be given to the overseas cohort as Government decisions could affect groups outside of the EU. In addition, it was stated UK residents are choosing to work abroad. Processes are in place to support colleagues whilst working at the Trust to ensure it is the employer of choice in a competitive environment and to improve retention rates.

JE reported the promotion of the NHS social media campaign #LoveOurEUStaff has attracted over 10,000 people nationally. The campaign reinforces the contribution of colleagues from overseas.

MB advised a reduction in nursing staff has been noted with the introduction of the IELTS. As a result, the NMC has received a request to review the high standard required to achieve the IELTS

ACTION: AM to progress data validation work for the collection/reporting of nationality data in ESR.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

120/17 **STAFF SURVEY UPDATE**

The report had been circulated with papers to the Committee meeting.

JE advised the group the Staff Survey 2017 will move to a census survey. The survey will commence at the end of September 2017/beginning of October 2017. Surveys will be issued to colleagues using a mixed mode method of online and paper applications. The survey will close in the first week of December 2017. Picker Institute will continue to remain as the survey administrator.

An overview was provided of progress against the four themes from the 2016 staff survey, Engagement, Reward and Recognition, Learning and Development and Health and Wellbeing.

JE reported that the survey participation rate may decrease in percentage terms, however, additional responses will be received which will help to improve the staff experience. Colleagues will be encouraged to complete the 2017 staff survey questionnaire and be informed that their views will make a difference. Reminders will be issued to colleagues who do not complete the 2017 Staff Survey at regular intervals. JW queried how the improvement will be measured given that colleagues are undertaking a number surveys. JE reported a potential for survey fatigue and a decision has been taken to omit the questionnaire for the Investors in People activity so as not to deter from completion of the 2017 Staff Survey.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

ITEMS TO RECEIVE AND NOTE

121/17 **ANY OTHER BUSINESS:**

No other business was raised.

122/17 **MATTERS FOR ESCALATION:**

There were no matters for escalation.

DATE AND TIME OF NEXT MEETING:

Wednesday 18 October 2017, 2.00 pm – 4.00 pm, Discussion Room 1, Learning and Development Centre, Huddersfield Royal Infirmary

Calderdale and Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Wednesday, 16 August 2017

Present: Andrew Haigh, Brendan Brown, David Birkenhead, David Anderson, Phil Oldfield (by phone), Kate Wileman

In attendance: Zoe Quarmby**,** Carol Harrison, Antonia Cavalier (CCLA)

Apologies: Gary Boothby, Lyn Walsh

Andrew welcomed Antonia Cavalier to the meeting.

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. CCLA Investment Portfolio Presentation
Antonia gave an informative presentation to the Committee and provided a summary booklet referring to the Charity's portfolio, the performance of the COIF Charities Investment Fund and its asset allocation. She mentioned that other NHS Charities invested in the COIF Ethical Fund and it was agreed that this would be discussed at the next meeting.

Action (1):
Carol to include CCLA Investment Review (inc. Ethical Fund) as an agenda item for next meeting in November.

3. Minutes of the last meeting
The minutes of the last meeting held on 31 May 2017 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

4. Matters arising
~ *Recruitment of fundraiser update* – Andrew updated on his discussions with other chairmen and he agreed to work with Vicky Pickles to finalise the job description (grade, fixed period, accountability etc.). Phil offered his services.

~ *Risk Register amendments update* – Zoe reported that we now have access to the Register and have updated the active risks. This would be reviewed every six months and will be brought to the next meeting.

~ *Sub committee (Todmorden) update* – Andrew received a response from the Borough Council (10.08.17) regarding nominations from them. He will confirm membership from our Committee; initial thoughts were Andrew, David B/Brendan, one non executive member and Carol Harrison (in attendance re minutes).

~ *Incredible Farm visit* **–** Brendan reported on the visit and felt that it would be an inappropriate venture with which to be involved, due mainly to concerns regarding Health & Safety issues.

~ *Membership Council representative update* – Andrew confirmed that Kate Wileman has been recruited to this position and welcomed her back.

Action (2):
Andrew to work with Vicky re fundraising position.

Action (3):
Andrew to confirm sub committee membership to meet with Todmorden BC members.

5. Quarter 1 SOFA and Balance Sheet 2017/18
Zoe presented this paper and its contents were noted.

6. Quarter 1 2017/18 Expenditure Summary
Zoe presented this paper which Andrew requested to be a standing item for future meetings. The Committee was happy with the level of detail and its contents were noted.

7. Approval Form for General Purpose Funds
Zoe presented this draft approval form which is to be used for accessing the General Purpose funds. The Committee approved its use, with the proviso that any expenditure above £50,000 be referred back to the Committee. Carol will reflect this in the approval form and also amend some wording re Fund Managers.

Action (4):
Carol to amend the approval form.

8. Minutes from the Staff Lottery Committee meeting held on 8 June 2017
These were noted. Andrew asked that a meeting be arranged for him to meet the new chairman.

Action (5):
Carol to liaise with Karen Turkington to arrange meeting with Andrew.

9. Any other business

Zoe mentioned that if an item is over £5,000 and classed as Capital, then we need to ensure that the requestor has produced a business case (short version) which can be taken to the next Capital Planning meeting for approval.

10. Date and time of next meeting

The next meeting will be on Monday, 20 November 2017 at 2 pm in Meeting Room 4, Acre Mills.

CHARITABLE FUNDS COMMITTEE MEETING
20 November 2017
Action Log - 2017/18

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Development of a Brand for the Charity	07.12 - 3	'Look book' to be circulated.	**VP**	02.17	ongoing
Any other business	07.12 - 8	Explore recruitment of fundraiser	**AH**	02.17	ongoing
Matters arising	31.05 - 1	Ask VP to circulate 'lookbook' etc - see 07.12-3 above	**GB**	08.17	
CCLA Portfolio Presentation	16.08 - 1	Include CCLA review (inc. Ethical Fund) on agenda for Nov meeting	**CH**	11.17	completed
Matters arising	16.08 - 2	Recruitment of fundraiser - see 07.12-8 above	**AH/VP**	11.17	
Matters arising	16.08 - 3	Confirm sub committee membership for meetings with Todmorden BC	**AH**	11.17	
Approval form for General Purpose funds	16.08 - 4	Make agreed amendments	**CH**	08.17	completed
Minutes from Staff Lottery meeting June 17	16.08 - 5	Arrange meeting for new chair to meet with Andrew	**CH**	09.17	completed

a. Quality Committee - minutes of 4.9.17 and verbal update from meeting 2.10.17

b. Finance and Performance Committee - minutes of 5.9.17 and verbal update from meeting 3.10.17

c. Workforce Well Led Committee - minutes from meeting 14.9.17

d. Charitable Funds Committee - draft minutes 16.8.17

16. Date and time of next meeting - 2.11.17 - Boardroom, HRI