Calderdale and Huddersfield NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 7 September 2017 at 9.00 am

Venue: Boardroom, Huddersfield Royal Infirmary

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	Welcome and introductions: Peter Middleton, Public Elected Governor Nasim Banu Esmail, Public Elected Governor	Chair	**VERBAL**	Note
2	Apologies for absence: Karen Heaton, Non-Executive Director Richard Hopkin, Non-Executive Director Jason Eddleston, Executive Director of Workforce and OD	Chair	**VERBAL**	Note
3	Declaration of interests	All	**VERBAL**	Receive
Standing items				
4	Patient Story/Quality Report: Learning Disabilities Patient Story presented by Amanda McKie, Matron – Complex Care Needs Co-ordinator		**Presentation**	Receive
5	Minutes of the previous meeting held on 3 August 2017	Chair	**APP A**	Approve
6	Action log and matters arising	Chair	**APP B**	Review
7	Chairman's Report a. Nomination and Remuneration Committee (COG) Update on NED Appointments	Chair	**VERBAL**	Note
8	Chief Executive's Report: a. Full Business Case - Update	Chief Executive	**VERBAL**	Note
Keeping the base safe				
9	High Level Risk Register	Executive Director of Nursing	**APP C**	**Approve**
10	Governance Report - Board Workplan - Use of Trust Seal	Company Secretary	**APP D**	**Approve**

	- Board to Ward Visits Feedback			
11	Care of the Acutely Ill Patient	Executive Medical Director	**APP E**	**Approve**
12	CHFT Annual Fire Safety Report 1.4.16 – 31.3.17	Director of Planning, Estates & Facilities	**APP F**	**Approve**
13	Winter Plan 2017	Chief Operating Officer	**APP G**	**Approve**
14	Integrated Performance Report	Chief Operating Officer	**APP H**	**Approve**
Transforming and improving patient care				
15	EPR Stabilisation Plan	Chief Operating Officer	**APP I**	**Approve**
Financial Sustainability				
16	Month 4 – 2017-2018 – Financial Narrative	Executive Director of Finance	**APP J**	**Approve**
A workforce for the future – no items				
17	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 31.7.17 and verbal update from meeting 4.9.17 ▪ Finance and Performance Committee – minutes of 1.8.17 and verbal update from meeting 5.9.17 ▪ Workforce Well Led Committee - minutes 13.7.17 and 10.8.17 ▪ Audit and Risk Committee Minutes – from meeting 19.7.17 ▪ Council of Governors Meeting Minutes – from meeting 6.7.17		**APP K**	**Receive**
Date and time of next meeting Thursday 5 October 2017 commencing at 9.00 am **Venue: Todmorden Health Centre**				

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th September 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 3.8.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3.8.17.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3.8.17.

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 approve the minutes of the last Public Board of Directors Meeting held on Thursday 3.8.17.

Appendix

Attachment:

draft BOD MINS - PUBLIC - 3.8.17(2).pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 3 August 2017 in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

PRESENT

Andrew Haigh	Chairman
Owen Williams	Chief Executive
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
Jason Eddleston	Executive Director of Workforce & OD
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates and Facilities
Richard Hopkin,	Non-Executive Director
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Karen Barnett	Director of Operations/Acting COO
Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary (minute taker)
Mandy Griffin	Director of The Health Informatics Service
Victoria Pickles	Company Secretary
Anne-Marie Henshaw	Associate Director of Nursing (item 9)
Rob Aitchison	Director of Operations (item 9)
Lindsay Rudge	Deputy Director of Nursing (item 10)
Dr Andrew Hardy	Consultant – Acute Medicine (item 10)
Gill Harries	General Manager (item 9)
Juliette Cosgrove	Assistant Director for Quality & Safety (item 10)

OBSERVER

George Richardson	Publicly Elected Governor
Dianne Hughes	Publicly Elected Governor
Nicola Sheehan	Staff Elected Governor
2 Members of Public	)
3 Media/Journalists	) present for item 1

113/17 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

114/17 APOLOGIES FOR ABSENCE

Apologies were received from:
Helen Barker, Chief Operating Officer

115/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

116/17 MINUTES OF THE MEETING HELD ON 6 JULY 2017

The minutes were approved subject to the addition of “which had not been previously

covered on the Board's agenda" to the Finance and Performance Committee Update from Sub Committees report.

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

117/17 FULL BUSINESS CASE

The Chief Executive introduced the Full Business Case and highlighted that Board members had previously reviewed drafts of the document. He explained that the Board were being asked to make a decision in the full knowledge that there had been a great deal of concern from people in the Calderdale and Huddersfield and wider areas and that the Full Business Case had been shared without redaction to enable public scrutiny. The Chief Executive reminded the Board and public present that the full business case had been developed in partnership with clinical colleagues as the key drivers for the proposed changes were the clinical quality and safety reasons for change.
The Chief Executive highlighted the reference in the paper to the electronic link to the Joint Health Scrutiny Meeting held on Friday 21 July 2017. This covered the legitimate points raised about the proximity to intensive care arrangements and the issue of balance of planned and unplanned care.

It was noted that the enforcement notice issued by Monitor/NHS Improvement on the Trust still stands today. There is a case of balancing money and clinical services and PFI realities. Government now realise there were issues with the original PFI and the new PFI2 is thought to be a better model. It has been confirmed that there is no public money to borrow and following advice the only option available to the Trust is to look at putting a PFI2 in place. This decision has been endorsed by the Board and Regulators and will be subsequently reviewed by the CCGs when they get to the point of applying their own tests about the broader systems/health economy sustainability.

Thanks were given to the staff who had worked on the developing the business case in addition to their own roles within the Trust.

Individual Board members offered their views on the business case. It was acknowledged that there were a number of Board Members with clinical backgrounds who supported the business case as it would provide long term sustainable care for patients. The quality and safety of patients is paramount with a need to balance the financial position and it was felt that this business case would support that. The Board also felt it was important to be able to offer patients the best services possible in a modern, safe environment.

The Chief Executive mentioned that the Huddersfield Examiner had reported on the debate earlier that week and this was thought to be a balanced and true reflection of the position and emphasised that 'do nothing' was not an option. The Council of Governor representatives present felt it was important for the public to reflect on what the position might be in 10 years' time if no changes were made.

Discussion took place regarding the national picture and reference was made to a recent National Audit Office report which questioned the sustainability of the current NHS model.

The Chairman summarised the discussions by announcing that there was full support around the table and the Board would welcome the next stage when decisions are received from the Secretary of State and the Clinical Commissioning Group.

OUTCOME: The Board **APPROVED** the full business case.

118/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG

a. 9/17 – 5.1.17 - **INTERNATIONAL STAFF** – It was noted that the issue of abuse towards international staff was still on the Action Log and information was being taken to the Workforce Well Led Committee in September/October.

ACTION: Exec Director of Workforce and OD

b. 83/17 – 1.6.17 - **BOARD TO WARD VISITS** – It was noted that a programme of visits had been arranged and it was agreed that as far as possible the Board would stay with the programme and avoid cancellations. The Chief Executive stressed that in order to meet governance arrangements it was important that visibility is evidenced. It was noted that this was not a formal process and should not be seen as another inspection. The Company Secretary reported that a small number of reports had been received and these would be collated for the.

ACTION: All & Company Secretary

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

119/17 CHAIRMAN'S REPORT

a. Nomination and Remuneration Committee (CoG) Update on NED Appointments

The Chairman reported that the Nomination and Remuneration Committee had met on the 27 July and longlisted 10 applicants for the two Non-Executive posts which were due to arise later in the year. Shortlisting was scheduled for Friday 11 August and interviews would be held on Monday 4 September 2017.

b. Executive Director of Workforce and OD

It was noted that arrangements had been made for Jason Eddleston to take on the role of Executive Director of Workforce and OD for the initial period 11 July 2017 until 10 January 2018.

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

120/17 CHIEF EXECUTIVE'S REPORT

a. The Long Term Sustainability of the NHS and Adult Social Care

The Chief Executive advised that the House of Lords publication had been circulated to the Board for information. It was noted that this cross-party publication had been released during the parliamentary election period and therefore some issues were not currently accurate but some areas did highlight the current agenda for NHS Trusts. Productivity and technology were clearly important areas in the future and would need to be driven forward to realise the wider integration and delivery of high quality services with financial sustainability.

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

121/17 CQC UPDATE ON ACTION – PAEDIATRICS

As agreed at a previous Board meeting Anne-Marie Henshaw, Associate Director of Nursing, Rob Aitchison, Director of Operations and Gill Harries, General Manager attended the meeting to update the Board on the progress with the CQC Action Plan around Paediatrics.

The presentation highlighted the actions undertaken to address the recommendations made from the inspection undertaken in March 2017. The work needed to ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.

Work was underway across Emergency Department, Outpatients and Paediatric Assessment Unit to focus on:-

- Workforce e.g. seasonal workforce model to reflect activity, embedding escalation policy with 'nurse in charge training'
- Environment e.g. NICU and ED
- Review and update guidelines and protocols e.g. High dependency care, sepsis
- Refreshed education and training programme to support implementation of updated guidelines and protocols e.g. MATRIX days
- Enhanced supervision to ensure education and training is embedded
- Sharing learning from incidents and complaints.

The Board thanked the team for attending and felt assured that the work undertaken to date had improved the patient experience. It was appreciated that the model of care was reliant on the reconfiguration of services and interim solutions were being worked on. It was noted that a narrative would be developed before the next CQC inspection so that all staff were aware of the progress made and services available. It was noted that training and coaching circles were available to test out the messages.

The Board acknowledged that this was the last deep-dive into the progress of the CQC Action plan and it was felt that the three presentations had helped assure the Board on the actions undertaken and planned.

OUTCOME: The Board RECEIVED and NOTED the progress with the Paediatric CQC Action Plan

122/17 QUARTERLY QUALITY REPORT FOCUSSING ON NASOGASTRIC TUBE RISK AND FALLS

a. FALLS

Dr Andy Hardy and Juliette Cosgrove gave a presentation on the work undertaken within the Trust to reduce falls. .

The Board heard about the Action Plan which had been developed to capture the 5 themes:-

- Prevention – risk assessment/medicine review/early therapy input
- Individualised care – care plans/toileting/visual assessment/footwear assessment
- Integration – community/discharge/acute frailty team
- Learning from incidents – FISH for falls – potential for falls
- Culture of safety – safety huddles/noticeboards/falls champions/awareness week/celebrating success

The work of the Acute Medicine Unit and the improvement science centre 'Haelo', working to improve quality improvement, theory and practice and support and train teams to deliver change was noted. Learning from good practice had also been obtained from Salford Trust.

The Board thanked Dr Hardy and Juliette Cosgrove for providing the clinical leadership which had resulted in a reduction in the number of falls in the last year from 173 to 156 and requested that the good work continue.

b. NASOGASTRIC TUBES

Lindsay Rudge, Deputy Director of Nursing gave a presentation to highlight the work of the Trust following receipt of the National Patient Safety Alert received in 2016 and the NHS Improvement correspondence received in April 2017, reinforcing key messages regarding the safe management of Nasogatric Tubes.

The Board heard what the Trust had done to address and embed this throughout the organisation by:-

- A nutrition task and finish group being established.
- Training reviewed and revised
- Nutritional policy developed in partnership with clinical colleagues
- Procurement issues had been addressed
- Risks identified and described on high level risk register
- High use areas identified for targeted approach to training
- Database established to monitor compliance
- NPSA self-assessment completed

Ongoing areas of focus were:-

- Risk remains rated at 15 due to progress with medical staff training
- Completion of sign off of nutritional policy
- Process to establish previous training and competency for junior doctors and all medical staff on transfer to the CHFT.

Dr Patterson reported that this item had been discussed at the Quality Committee and learning was in place.

The Executive Director of Planning, Estates and Facilities asked that this presentation might be shared with the Health and Safety Committee

ACTION: Deputy Director of Nursing/H&S Committee

OUTCOME: The Board **NOTED** the update on Falls and Nasogastric Tube Risk

123/17 HIGH LEVEL RISK REGISTER

The Executive Director of Nursing reported on 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
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Staffing risk, nursing and medical
6131 (20): Service reconfiguration
5806 (20): Urgent estates schemes not undertaken
6968 (20): Cash flow risk
6969 (20): Capital programme
6903 (20): Estates/ ICU risk, HRI

Risks with increased score

6967 Non delivery of 2017/18 financial plan has increased from 20 to 25. This had been discussed at the July Board of Directors Meeting.

Risks with reduced scores

Risk 6693, regarding financial penalties and reputational damage due to non-compliance with the NHS agency cap rules, had been reduced on the risk register to a score of 12 from 15 during July. The rationale given for this is no recorded adverse publicity since the risk was initiated and further work undertaken to reduce agency spend. The risk remains on the summary risk register list pending conversations between workforce and organisational development and finance departments regarding the reduced score.

Risk 6886, regarding seven day services has been reduced from 15 to 10 as an

action plan to address gaps was in development and the Trust was compliant in several areas.

New risks
One new risk was added to the high level risk register in June following discussion at the Risk and Compliance Group on 20 June 2017 relating to completion of mandatory training, risk 6977, scored at 16.

Closed risks
Risk 6503, previously scored at 20, delivery of Electronic Patient Record Programme, had been reduced to its target risk score of 5 following implementation and had now been closed.

The Company Secretary reported that work was on going with Internal Audit and the risk management team to revise this document and it was hoped that this would be available for the October Audit and Risk Committee.

The Executive Director of Finance reported that cash flow had been discussed at the Finance and Performance Committee and the risk rating had been reduced to 12 from 20. It was expected that further discussion would take place at the next meeting around the challenges regarding capital risk and an update would be brought to the next Board of Directors Meeting through receipt of the F&P Minutes.

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

124/17 RISK MANAGEMENT POLICY

The Company Secretary advised that under the Board of Directors' Scheme of Delegation, approval of arrangements for the management of risks are reserved to the Board. The Risk Management Policy had been reviewed in detail by the Risk and Compliance Group and the Audit and Risk Committee.

The Board noted that the policy had been updated to reflect the revised Risk Management Strategy approved by the Board earlier in the year and approved its circulation within the Trust. It was agreed that the roles and responsibilities of the Board would be clarified within the document.

ACTION: Company Secretary

OUTCOME: The Board **APPROVED** the Risk Management Policy.

125/17 COMPLAINTS POLICY

The Company Secretary reported that under the Board of Director's Scheme of Delegation, the approval arrangements for the management of complaints was reserved to the Board. The Board noted that this document had been reviewed in detail by the Risk and Compliance Group and Executive Board. Discussion took place regarding the depth of information within the policies and it was noted that these documents were published on the Trust Intranet and accessible to all staff.

OUTCOME: The Board **APPROVED** the Complaints Policy.

126/17 FREEDOM TO SPEAK/WHISTLEBLOWING UPDATE

The Executive Director of Workforce and OD updated the Board on the current position. It was noted that a policy had been developed within the Trust and the Senior Independent Non-Executive Director (Dr David Anderson) was the Freedom to Speak Up Guardian.

The Workforce and Well Led Committee had received a detailed report in June about the approach and two pieces of work were being put in place:

- Big Brief – message about embedding the policy within the organisation and encouraging staff to express concerns
- Staff Survey – to test out staff awareness, experience and willingness to speak up

It was noted, as evidenced by the CQC Inspection that the Trust was a comparatively low 'whistleblowing organisation' and was not a significant outlier. The Board discussed how the culture of the organisation led to more informal raising of concerns rather than formal whistleblowing. The Board was encouraged by the progress being made.

OUTCOME: The Board **NOTED** the Freedom Speak/Whistleblowing update.

127/17 INTEGRATED PERFORMANCE REPORT

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

- June's Performance Score stands at 58% for the Trust.
- The CARING domain now AMBER due to improvements in FFT performance. The RESPONSIVE domain remains Amber due to failing to meet the Emergency Care Standard and the Cancer 2 week wait targets. Issues are a combination of increased referrals through fast track, IR35 and EPR impact.
- The WORKFORCE domain had fallen 10 points in-month due to underachievement in Mandatory Training.

EPR still continued to impact on the provision of several indicators this month including 18 weeks admitted and non-admitted and VTE. The Director of the Health Informatics Service took the opportunity to update the Board on the activity following the implementation of EPR which included technical data improvements – ability to track patients and coding of activity. The Director of Transformation and Partnerships reported that detailed discussion had taken place at the Finance and Performance Committee regarding clinical income which had reduced against the plan. Adjustments were being made to capture data although there still appeared to be a gap in income. Work to improve the impact for pre-op assessments/theatre sessions and variability of size in waiting list per consultant were showing improvements. Other areas being worked on included ensuring that duplication of pre-op assessment appointments did not impact on the position.

Richard Heaton expressed concern that at the May/June Quality Committee reference was made to a 'Never Event' taking place but this did not appear on the report. It was noted that this was due to a time lapse in the reporting mechanism.

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

128/17 MONTH 3 – 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance presented the Month 3 Financial Narrative which had been submitted to NHS Improvement.

Key Issues:

The Month 3 planned position is a deficit of £8.00m on a control total basis, including year to date Sustainability and Transformation funding (STF) of £1.52m.

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%.

As at Month 3 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 50% 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 following EPR implementation and remaining unidentified CIP of £3.2m. 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 3, June Position (Year to date)

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

Income and Expenditure Summary	£m	£m	£m
Income	92.91	88.68	(4.24)
Expenditure	(94.82)	(90.41)	4.41
EBITDA	(1.90)	(1.74)	0.17
Non-Operating items	(20.09)	(6.29)	13.80
Surplus / (Deficit)	(22.00)	(8.03)	13.97
Less: Items excluded from Control Total	13.98	0.02	(13.95)
Surplus / (Deficit) Control Total basis	(8.02)	(8.00)	0.02

- Delivery of CIP of £2.15m against the planned level of £2.32m.
- Contingency reserves of £1.00m have been released against pressures.
- Capital expenditure of £4.62m, this is below the planned level of £5.43m.
- Cash balance of £1.90m, in line with the plan.
- Use of Resources score of level 3, in line with the plan.

OUTCOME: The Board NOTED the contents of the report.

129/17 MEDICAL REVALIDATION AND APPRAISAL

The Executive Medical Director presented a positive Medical Revalidation and Appraisal update report.

It was noted that the purpose of the report was to update the Board on the progress of the Trust's management of medical appraisal and revalidation.

The key points included:

- As at 31 March 2017, 331 doctors had a connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 309 on 31 March 2016)
- In the 2016/17 revalidation year (1 April 2016 – 31 March 2017) 20 non training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC), as compared to 94 non training grade medical staff in 2015/2016.
- Based on headcount, 93.3% of non-training grade appraisals were completed and submitted in the appraisal year (93.5% in 2015/2016). 6.3% of non-training grade medical staff were not required to complete an appraisal (due to recently joining the Trust, maternity leave, recent return from secondment etc). This compares to 5.5% in 2015/16.

OUTCOME: The Board RECEIVED and NOTED the content of the Medical Revalidation and Appraisal report.

130/17 WORKPLACE RACE EQUALITY STANDARD (WRES) 2017

The Executive Director of Workforce and OD presented to the Board the Trust's position against the Workforce Race Equality Standard (WRES) for 2017. The Trust was required to publish this information on 1 August 2017 and the Workforce Well-Led Committee had approved the statement at the last meeting held on 13 July 2017 and this was now on the Trust Website.

OUTCOME: The Board **RECEIVED** the WRES report and noted that this had now been published on the Trust Website.

131/17 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 31 July 2017 which had not been previously covered on the Board's agenda:-

The main areas discussed included:-

- Complaints Policy and Annual Report
- Progress on Stroke Services – suggested a future presentation to Board
- Infection Control issues – C.Diff being monitored
- EPR – Coding – clinical information input around secondary conditions – being monitored.

ACTION: Future BOD presentation on Stroke Services

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 3.7.17 and the verbal update of the meeting held on 31.7.17.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 1 August 2017 which had not been previously covered on the Board's agenda:-

The main areas discussed included:-

- Income and productivity gap issues
- Recovery from issues on productivity
- Reporting to Regulator at Q2 - narrative

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 4.7.17 and verbal update from 1.8.7.17.

c. Workforce Well-Led Committee

Karen Heaton, Chair of the Workforce Well-Led Committee reported on the items discussed at the meeting held on 13 July which had not been previously covered on the Board's agenda which included:-

- Compassionate Leadership in Practice – programme underway with the first two cohorts with positive feedback

OUTCOME: The Board **RECEIVED** a verbal update of the meeting held on 13 July 2017.

c. Audit and Risk Committee

Prof Peter Roberts, Chair of the Audit and Risk Committee reported on the items discussed at the meeting held on the 19 July 2017 which had not been previously covered on the Board's agenda.

The main areas discussed included:-

- BAF review
- Risk Management Policy approved
- Waiving of Standing Orders – Cymbio and Bluespier – further procurement work being undertaken
- Mandatory Training – needed more focus to ensure compliance
- Estates recommendations – Naylor review

The Chairman reminded the Board that this had been Prof. Roberts last Audit and Risk Committee and Richard Heaton would take on the Chairmanship of this Committee when Prof. Roberts tenure ceased on the 22 September 2017. Thanks were given to Prof. Roberts for his stewardship and chairmanship of the Audit and Risk Committee over the past 3 years.

OUTCOME: The Board **RECEIVED** a verbal update of the meeting held on 19 July 2017.

d. Draft Minutes – Board of Directors/Council of Governors Annual General Meeting – 20.7.17

The Minutes from the joint Board of Directors/Council of Governors Meeting held on Thursday 20 July 2017 were approved, subject to the Director of Finance presentation being amended to read '2016/17' and ratification by the Council of Governors at its next meeting to be held on Thursday 18 October 2017.

ACTION: Council of Governors Agenda Item

OUTCOME: The Board **APPROVED** the draft minutes subject to ratification by the Council of Governors at its next meeting to be held on 18 October 2017.

132/17 DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 7 September 2017 commencing at 9.00 am in the Boardroom, Huddersfield Royal Infirmary.

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th September 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 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 Action Log for the Public Board of Directors Meeting as at 1 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 Action Log for the Public Board of Directors Meeting as at 1 September 2017.

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 1 September 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	Oct.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 July ARC. It was agreed that the revised policy would be brought to the BOD.			
31/17 2.2.17	**WHISTLEBLOWING ANNUAL REPORT** It was agreed that a greater awareness of the Raising Concerns/Whistleblowing process was required in the Trust and this would be taken through the Workforce Well-led Committee and reported back to the Board.	IW	**3.8.17** Report received. Board encouraged by the progress being made.	3.8.17		3.8.17
28/17 2.2.17	**RISK REGISTER** Board agreed that a review of the EPR risk and its relation to a potential CQC re-inspection be considered alongside a review of the narrative at year-end in order to archive risks as appropriate and identify tolerance ratings for endemic risks. It was agreed that this would be undertaken by BB and VP and would be taken through the Audit and Risk Committee for review before returning to Board in June 2017.	BB	**2.3.17** Discussion took place regarding the nasogastric tube risk and it was agreed that a position statement would be brought to the Board in June. **6.4.17** Dr Linda Patterson reported that discussion had taken place at the Quality Committee regarding the nasogastric tube risk and it was noted that a task and finish group had been convened to oversee the outstanding work and a further report was expected to the June Board meeting. **1.6.17**	July/Aug 2017		3.8.17

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			It was noted that further would was being undertaken and the Board would receive a position statement on the nasogastric tube risk at a future meeting (July or August) **3.8.17** Presentation received and assurance given. Presentation to be shared with the Health and Safety Committee in the future.			
9/17 5.1.17	**INTERNATIONAL STAFF** The Acting Chief Executive reported that discussions had taken place regarding abuse towards international staff from patients or their families. The Board agreed that this would not be tolerated and the Executive Director of Workforce and OD agreed that a system would be put in place to safeguard against this via NHS Protect.	IW	**2.3.17** The Executive Director of Workforce and OD reported that work was still being undertaken nationally and once this was complete feedback would be brought to the Board. **3.8.17** Information was being taken to the Workforce Well Led Committee in September/October.			3.8.17
6.4.17 66/17	**CQC UPDATE ON ACTION PLAN** It was noted that deep dives would be undertaken into the Action plan key themes:- Maternity, CDU and ICU to the next three Board meetings.	BB		1.6.17 – Maternity 6.7.17 – Critical Care 3.8.17 – Paediatrics		3.8.17

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
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		
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		
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		

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
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 in September.			Nov 2017		

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, 7th September 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 29 August 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 22 August 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 29 August 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 August five new risks have been added to the high level risk register. These are:

- Risk 5747, risk score 15 - service delivery risk for vascular / interventional radiology service

- Risk 6011, risk score 15 - Wrong blood in rube (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:

- Risk 7049. risk score 20 - financial risk due to increased costs and decreased income

- Risk 7046 risk score 16 - EPR quality and safety risks

- Risk 7047, risk score 16 - performance risk of failed regulatory standards, contractual key performance indicators etc.

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

Recommendations:

Board members are requested to:

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

Appendix

Attachment:

Risk Register Report as at 290817 combined.pdf

HIGH LEVEL RISK REGISTER REPORT

Risks as at 29 August 2017

TOP RISKS

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 SCORE

6693 (12): NHS Improvement Agency Cap risk.

Following discussions between Workforce and Development and Finance teams, and 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:

- 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

CLOSED RISKS

No risks have been closed this month.

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

Risk ref	Strategic Objective	Risk	Executive Lead	MONTH							
Strategic Risks				**Jan 16**	**Feb 17**	**Mar 17**	**Apr 17**	**May 17**	**Jun 17**	**July 17**	**Aug 17**
Safety and Quality Risks											
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	↑ 20	=20	=20	=20	=20	=20	=20	=20
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=16	=16	=16	=16	=16	=16	=16	=16
2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20	=20	=20
6990	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/18	Medical Director (DB)	=16	=16	=16	=16	=16	=16	=16	=16
5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	=16	=16	=16	=16	=16	=16	=15	=15
6829	Keeping the Base Safe	Aseptic Pharmacy Unit production	Director of Nursing	=15	=15	=15	=15	=15	=15	=15	=15
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20	=20	=20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD (JE)	=16	=16	=16	=16	=16	=16	=16	=16
6977	Keeping the base safe	Mandatory training 2017/18	Director of Workforce and OD (JE)	-	-	-	-	-	! 16	=16	=16
6903	Keeping the base safe	ICU/Estates joint risk	Director of Estates and Performance (LH)	-	-	-	!16	↑ 20	=20	=20	=20
6924	Keeping the base safe	Misplaced naso gastric tube for feeding	Director of Nursing (BB)	-	-	!15	=15	=15	=15	=15	=15
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15	=15	=15
6841	Keeping the base safe	EPR post go live	Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15	=15	=15

Risk ref	Strategic Objective	Risk	Executive Lead	MONTH							
6971	Keeping the base safe	Endoscopy provision	Divisional Director of Surgery and Anaesthetics (J O'R)					!15	= 15	=15	=15
7046	**Keeping the base safe**	**EPR Quality and safety risks**	**Exec Medical Director (DB)**								!16
5747	**Keeping the base safe**	**Vascular / interventional radiology service**	**Divisional Director of FSS**								!15
6011	**Keeping the base safe**	**Blood transfusion process**	**Divisional Director of FSS**								!15
Finance Risks											
6967	Financial sustainability	Non delivery of 2017/18 financial plan	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	↑25	=25
6968	Financial sustainability	Cash flow risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20
6969	Financial sustainability	Capital programme	Director of Finance (GB)	=15	=15	=15	=15	↑ 20	=20	=20	=20
7049	**Financial sustainability**	**EPR Financial risk due to increased costs and decreased income**	**Director of Finance (GB)**								**!20**
Performance and Regulation Risks											
6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
7047	**Keeping the base safe**	**EPR Performance – failed regulatory standards, contractual KPIs, patient / staff performance**	**Chief Operating Officer (HB)**								**!16**
People Risks											
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce	=20	=20	=20	=20	=20	=20	=20	=20

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

Bold text indicates new risks added in month

Trust Risk Profile as at 29/08/2017

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	= 6967 Not delivering 2017/18 financial plan
Likely (4)				= 4783 Outlier on mortality levels = 6658 Inefficient patient flow = 6300 CQC improvement actions = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 5862 Falls risk = 6990 CQUIN sepsis = 6977 mandatory training ! 7046 EPR q uality and safety risks ! 7047 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 = 6968 Cash Flow risk = 6903 ICU/ resus estates risk = 6969 Capital programme
Possible (3)					= 6841 EPR operational readiness = 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)					

High Level Risk register (15+)

Risk No	Div	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6967	Trustwide	Apr-2017	Financial sustainability	The Trust is planning to deliver a £15.9m deficit in 2017/18. There is a high risk that the Trust fails to achieve its financial plans for 2017/18 due to: - £20m (5.3% efficiency) Cost Improvement Plan challenge is not fully delivered - loss of productivity during EPR implementation phase and unplanned revenue costs - inability to reduce costs should commissioner QIPP plans deliver as per their 17/18 plans - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level	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	**August 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 £16.9m of the £17m CIP target, but only £13.9m 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 £0.7m 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 two thirds 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.	Sep-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell

6968	Trustw[illegible]	Apr-20[illegible]	Financ[illegible] sustainability	Risk that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as going concern.	* Agreed £8m capital loan from Independent Trust Financing Facility. * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from NHS Improvement * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Revenue support loan has been made available year to date to cover the deficit and delays in the receipt of Sustainability and Transformation funding.	The level of outstanding debt held by the Trust is being closely monitored but is not entirely within the Trust's ability to control. The majority of this is owed by other NHS organisations. Revenue Support Loan to support working capital as planned for 17/18 has not been confirmed.	20	5 x 4	20	5 x 4	15	5 x 3	**August 2017** The Trust plan for 17/18 is reliant on cash support from Department of Heath of £28.80m. £8m of Capital funding has been approved as part of an existing Capital Loan facility, the remaining revenue support loan requirements will have to be applied for on a monthly basis and will be subject to a potentially variable interest rate. Revenue support has been made available year to date to cover the deficit and delays in the receipt of Sustainability and Transformation funding and assurance has been received that deficit related cash support will continue to be forthcoming. As such the level of cash risk has been reduced this month. However, there is no automatic availability of funding from Department of Health to support the working capital movements that are built into the 17/18 financial plan. A large proportion of our EPR expenditure in 16/17 was not paid in cash terms and has the potential to create pressure on the organisation's working capital in this financial year unless loan funding can be secured. The Department of Health will only provide working capital support in exceptional circumstances, after all other options have been explored and will not provide working capital support for Capital expenditure or Capital loan repayments.	Sep-17	Mar-2018	FPC	Gary B[illegible]nby	Philippa Russell
6969	Trustwide	Apr-2017	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2017/18 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. Following a mandate from NHS Improvement to reduce Capital expenditure for 2017/18 due to national funding pressures, the Trust's Capital Programme has been severely curtailed and a number of capital schemes have had to be removed. This has increased the risk to the development and sustainability of services and has the potential to impact on clinical, safety and performance issues.	Agreed £8m capital loan from Independent Trust Financing Facility (ITFF) to support capital programme, specifically the Electronic Patient Record (EPR) investment. Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Capital Management Group has reprioritised the Capital programme and unapproved schemes have been risk assessed. A small contingency remains in place to cover any further changes.	.	20	5 x 4	20	5 x 4	12	4 x 3	**August 2017** The planned capital expenditure for 17/18 is £14.40m. From a cash perspective, all capital expenditure, including any slippage on the EPR programme, must be contained within available internally generated capital funding, supplemented in 17/18 by the remaining £8m of our pre-approved capital loan facility. Capital Management Group has reprioritised the Capital programme in order to make best use of the funds available and minimise the risk to the organisation. Based upon the residual risk as assessed by scheme where the timescale of investment has been pushed back from the original higher value plan, the overall capital risk has been reduced from 20 to 15.	Sep-17	Mar-2018	FPC	Gary Boothby	Philippa Russell
6903	Estates & Facilities	Dec-2016	Keeping the base safe	Collective ICU & Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to inadequate access granted to estates maintenance and capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU & RESUS, currently this is not achievable due to inadequate access and budget constraints.	20	5 x 4	20	5 x 4	0	0 x 0	June Update - Business Continuity Plans discussed with surgery, contingencies and resilience. Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. 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.	Sep-2017	Sep-2017	RC	Lesley Hilll / David McGarrigan	Chris Davies

7049	Trustw e	Aug-2 7	Finan sustainability	Financial risk with increased costs and decreased income. Due to: Reduction in activity arising from [illegible] 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			FC	Gary B nby	Kirsty A ner
5806	Estates & Facilities	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure.	Each of the risks above has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	The lack of funding is the main gap in control. Also the time it takes to deliver some of the repairs required. In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.	16 4 x 4	20 5 x 4	6 3 x 2	June 17 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The level of risk to the services at HRI is increasing as the number of major building risks increases 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.	Sep-2017	Mar-2018	RC	Lesley Hill / David McGarrigan	Paul Gilling / Chris Davies

2827	Medic	Apr-20	Devel[illegible]ng our workforce	The inability to recruit sufficient middle grade and consultant emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Development of CESR programme ACP development Continued recruitment drive for Consultant and Middle Grade doctors Weekly meeting attended by flexible workforce department, finance, CD for ED and GM	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level CESR training will extended time to reach Consultant level with no guarantee of retention	20	4 x 5	20	5 x 4	12	4 x 3	June 2017: 3 Locum Consultants recruited onto bank contracts (all picking up a line on the MG rota). Awaiting start date of 2 substantive consultants. 2 Middle grade doctors being pursued following successful interview (1 is starting the CESR programme). Experienced ACP recruited - will go onto junior doctor rota. 2 junior doctors being pursued for substantive posts through successful recruitment. 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 Certificate for Entry on Sepcialsit Registetr) 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)	Sep-2017	Aug-2018	WEB	David E enhead	Dr Mark avies/Mrs Caroline Smith
6131	Corporate	Oct-2014	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25	5 x 5	20	5 x 4	10	5 x 2	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.	Sep-2017	Sep-2017	WEB	Anna Basford	Catherine Riley

6345	Corpo	Jul-20	Keepi	Staffing Risk Risk of not being able to deliver safe, effective and high quality care with a positive [illegible] for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas - lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements Therapy Staffing - posts designed to be as flexible as possible - review of skill mix and development of Assistant Practitioners. - flexible working - aim to increase availability of flexible work force through additional resources / bank staff	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	**August 2017** 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.	Sep-2017	Jan-2018	WF	David E enhead, Brendan Brown, Jason Eddleston	Rachae ierce

6596	Corpo a	Jan-20 6	Keepi the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	June 2017 Reviewing capacity of corporate staff to assist with investigations to support clinical investigators. 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.	Jul-2017	Sep-2017	QC	Directo Nursing, Brendan Brown	Juliette sgrove

6598	Corpo a	Jan-20	Keepin 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/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. 4/ There are issues with PC settings which leads to completed e-learning not been recorded as complete. 5/ Planned updates to system not due until April 2017 so limitations as above will remain until this time. 6/ There are frequent requests for new essential skills to be added with no clear process to approve such requests. 7/ Heavy focus on EPR training and implementation has an impact on staff being able to complete essential skills training due to time and resource implications.	16 4 x 4	16 4 x 4	12 4 x 3	June 2017 Tissue Viability essential skills e-learning package now available to staff and TA is now set. Clarification is being sought around the issue with competences differing between bank / substantive contracts for some staff members. 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.	Sep-2017	Oct-2017	WF	Jason E leston	Ruth M on

6658	Medic	Mar-20	Keepin the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and [illegible]. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20	4 x 5	16	4 x 4	9	3 x 3	June 2017 Flow out of the departments had initially improved at the beginning of the month but with increasing attendances and lower discharges we continue to see increasing waiting times. Further actions taken- Point prevalence on the medical wards to understand delays. Senior attendance on ward rounds offering support and challenge to improve discharge planning. Cancellation of non urgent surgical elective patients. **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.	Sep-2017	Sep-2017	BOD	COO H n Barker	Bev We r

6300	Trustwide	May-2015	Keeping the base safe	As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services.	-CQC Response Group monitors improvements and progress with actions System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being held to monitor progress with the action plans chaired by the Chief Nurse - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, has been conducted and an action plan developed. Nearly all actions have been delivered and assurance gained. The Risk and Compliance Group will now oversee any areas outstanding.	The inspection report has shown us to be in the "requires improvement" category.	16	4 x 4	16	4 x 4	8	4 x 2	June 2017 Year end report has been presented to the Board of Directors. Position with the plan remains as the Mary 17 position. Updates are being provided to the Board of Directors by core services rated requires improvement. A number of activities have now commenced to enable the Trust to prepare for a re-inspection this is being overseen by the Risk and Compliance Group. There is no date yet known for re-inspection. 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.	Sep-2017	Dec-2017	WEB	Brenda Crown	Juliette Cosgrove
4783	Corporate	Aug-2011	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	3 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine, Stroke and Complex Medicine which will give guidance on areas of further improvement. Action plans for these areas being developed based on preliminary report findings. Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised 2016 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Improvement to standardised clinical care not yet consistent. Care bundles not reliably commenced and completed	20	4 x 5	16	4 x 4	12	4 x 3	June 2017 update HSMR is 100.37 and SHMI 108 and remain in the expected range. Structured Judgement Reviews have replaced our 2nd level reviews from April deaths. 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.	Aug-2017	Sep-2017	COB	David Birkenhead	Juliette Cosgrove

5862	Medic	Aug-2 3	Keepi 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	June update Actions as per plan,team meeting monthly, no improvement noted in falls numbers but there is an improvement in reliability of some care factors. 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 2017 update** To continue with safety huddle daily. All staff to be trained in the falls prevention equipment, including training about the falls bundle.	Sep-2017	Sep-2017	PSQB	Brenda rown	Janette ockroft
6977	Corporate	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 WEB (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 2017** A mandatory training lead has been identified in Workforce & OD who is providing additional overview and scrutiny.	Sep-2017	Mar-2018	WF	Jason Eddleston	Ruth Mason

7046	Trustw e	Aug-2 7	Keepir the base safe	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 infomation to GP. Lack of understand on use of 'Encounters' leading to activity being connected with the incorrect episode. A 45day pruge of all activity within the Message Centre including correspondence unkown 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 recieved by Medical Director, Chief Nurse & Chief Operating Officer. Clinical Risk Panel established and Stabilisation plan developed. SWAT team deployed to undertake DeepDives/RCAs. MDT meeting undertaken as required Visible leadership and feedback. Manual workarounds. Targeted support and training. Ongoing 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.	Nov-2017		QC	David E enhead	Alistair rris

7047	Trustw e	Aug-2 7	Keepin the base safe	Performance risk of failed regulatory standards, contractual key performance indicators or other patient/staff focussed [illegible] 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 responsivness & 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.			QC	Helen E ker	Division Directors
6990	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	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	Sep-2017	Dec-2017	SC	David Birkenhead	Juliette Cosgrove

6971	Surgery & Anaesthetics	Apr-20	Keeping the base safe	Business continuity risk relating to reduced endoscopy provision / capacity due to increased demand on the Automatic Endoscope Reprocessing (AER's) machines at HRI following fire in endoscopy at CRH and additional workload for AER machines at HRI, which increases the risk of machine failure and potentially fire resulting in further reduction in capacity / service delivery if machines need to be turned off. The risk of a complete equipment failure would result in a seizure of endoscopy services at CHFT due to individual AER failures reducing service delivery and disruption of the service. This would adversely impact the Trust's ability to achieve all access targets, list down time, reputational damage, complaints/litigation associated with poor patient experience/delayed diagnosis, delayed / cancelled procedures may cause distress to patients, extended waiting time in the Endoscopy Department for procedures and additional cost in resource and repairs could result in escalation of costs and further cancellation of procedure. Patient safety risk due to impact of reduced endoscopy provision and an increasing back log of patient's awaiting flexible sigmoidoscopy under the bowel cancer screening programme (BCSP) , diagnostic cystoscopy's, fast track haematuria's and gastro intestinal activity.	Machines checked and monitored daily by endoscopy technicians whilst in use and all cycles are now conducted under physical supervision. The trust fire officer has ensured that there is adequate fire fighting equipment and decontamination staff are compliant in their use. Increased estates support and improved access to gettinge (maintenance contractor) technicians in place for all AER's across both sites A full downtime 36 hour period for maintenance schedules to be completed and all relevant tests to ensure all compliance is met. In sourced provider (medinet) contracted to deliver up to 60 lists worth of activity concentrating on fast track patient cohort (23/04/17 - 06/08/2017. (update 23/0617 lists populated for medinet service delivery on Saturdays through CRH)	Reliance on HRI AER's due to AER's failures in testing at CRH (review June 17)	20	5 x 4	15	5 x 3	5	5 x 1	To replace all AER's as part of the endoscopy decontamination replacement scheme, by expediting the scheme the risk will be mitigated. CRH decontamination to have replacement AER's in place and commissioned by mid July focus will be concentrated on recovering the flexible sigmoidoscopy patients by increasing lists from 5.5 this will take approx. 6 weeks. Early July invites will be sent out to out to patients on the bowel cancer screening programme to ensure continuity is maintained in service delivery following a lead time of weeks for invite to appointment. (update 23/06/17 enabling works completed today, equipment delivered 26/06/17 installation and commissioning works to commence July 17) September, supporting decontamination unit to be built at HRI that will support the decontamination replacement on both sites. (Update 23/06/17 Still in line with project plan)	Sep-2017	Sep-2017	DB	Julie Ordan	Jason Ashby

6924	Corpo [illegible]	Feb-2[illegible]7	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.	Sep-2017	Sep-2017	QC	Brenda [illegible]rown,	Jo Midd[illegible]on
6011	Family & Specialist Services	May-2014	Keeping the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBIT) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust).	Lack of electronic systems Lack of duplicate sampling Training compliance not at 100%	15	5 x 3	15	5 x 3	3	3 x 1	June 2017 No update expected 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	Sep-2017	Mar-2019	PSQB	Martin DeBono	Hayley Baker

6829	Family Specialist Services	Aug-2[illegible]	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	22 June 2017 A draft business case to be presented to the FSS Divisional Performance Meeting on 5 July 2017. 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 2017** 22 08 2017 Business case currently being finalised - to be submitted for approval in September	Sep-2017	Oct-2017	DB	Brenda rown	Mike C[illegible]aw
6841	Corporate	Sep-2016	Keeping the base safe	POST GO LIVE Inability to use the system effectively once the extended support mechanisms start to reduce following Early Live Support. Lack of confidence of the system due to any quality and/or performance issues. Efficiency and productivity may reduce due to inexperience of using the system Inability to report against regulatory standards Resulting in: Reputational damage arising from inability to go live with the EPR , financial impact, impact at every point of patient care (appointments, patient flow, records, MDT s, payment) and continued use of paper records which can impact on safe, efficient and effective patient care. National and local targets may be put in jeopardy. Contractual Penalties for the Trust	Pre go-live - A robust governance structure is in place to support the implementation of the EPR, including EPR specific risk register reviewed at weekly EPR meeting. - Weekly EPR operational board with direct escalation to WEB (and sponsoring group) - 90/60/30 day plans will aid control - 1:1 consultant plan Cut over: - Strong cut over plan with a developed support structure for BAU post ELS. - Command and control arrangements for cut over (Gold, Silver, Bronze) Post go-live: - gap - CYMBIO Support - CHFT Support/BTHFT Programme resource gap covered (£320k capital)	1. Need to address requests for 'Mop up' Training in some areas 2. Address Hardware requirements (Walk around 23/24th May) 3. Further work from CYMBIO around DQ 4. Time to understand reporting position	15 5 x 3	15 5 x 3	10 5 x 2	June 2017 Update - In reference to the 'Post go-live' risk. There are still a number of un-resolved issues following ELS. Around 1300 logged on RoD and further issues remaining from Silver Command. A process has been agreed at WEB (15th June) supporting a focused approach in clinical areas with the priority being set by the Divisional Ops Board. There are currently 10 focus areas plus 4 over arching areas (e.g. Access etc). Until these remaining issues are reduced the impact and likelihood of this risk remain the same. **August 2017 Update** Unresolved issues post go-live have, to some extent, reduced since the previous update. There are now around 850 logged calls on RoD (reduced by 35%) and the number of calls being submitted to service desk have reduced. There are still over 450 issues logged on the prioritisation list that the BAU team and the divisions are working on, some of these are duplicates and the remaining have been apportioned for checking to divisions at the fortnightly Ops Board. The top 10 focus areas remain the same and this is being taken into account when prioritising the order in which the issues are dealt with. Overall an improved position but still some way to go the close the gaps in order to meet the target score. Next update will be just prior to the BTHFT cut-over that will have an impact on approach and resource.	Sep-2017	Sep-2017	RC	Helen Barker	Mandy Griffin

5747	Family Specialist Services	Mar-2(3	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 3 x 2	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	Aug-2017	Aug-2017	DB	Martin I 3ono	Sarah (nton
6715	Corporate	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication and multidisciplinary working.	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 suspended. There has been little progress in fluid balance documentation which has been noted by the Director of Nursing as a result he is revising the improvement methodology and leadership to support this. August 2017 The ward assurance framework is being tested including the information that will be generated from EPR. The Deputy Chief Nurse and Deputy Director of Nursing are meeting on the 10th August to develop the action plan in order to ensure work is being undertaken regarding the standards of documentation and assurance are linked.	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	June 2107 The EPR has been implemented since the 1st May; on the 30th June, the Deputy Director of Nursing is leading a session with the nursing colleagues, the agenda is to review CQC guidance, ascertain how to ensure nurses are using the system to produce excellent nursing records, understand the reports produced from the system and ensure assurance is linked to the ward assurance tool. The intention is that the improvement work identified will be delivered by Matrons supported by the senior nurse team. 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. .	Aug-2017	Aug-2017	QC	Brendan Brown	Jackie Murphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th September 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - SEPTEMBER 2017 - This report brings together a number of governance items for review and approval by the Board	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:-
- Board Workplan
- Use of Trust Seal
- Board to Ward Visits Feedback

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

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

- Board Workplan
The Board work plan has been updated and is presented to the Board for review at appendix 1.
The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and APPROVE the work plan.

- Use of Trust Seal
One document has been sealed since the last report to the Board. This was in relation to the Compulsory Purchase Order by Calderdale Council for the strip of land at front of CRH on the 26 May 2017.
The Board is asked to NOTE the use of the Trust Seal.

- Board to Ward Visits Feedback
It has been agreed that the key themes from each visit will be collated for discussion at a Board workshop and reported to Board every six months.

Next Steps:

Please see attached

Recommendations:

This report brings together a number of governance items for review and approval by the Board

Appendix

Attachment:

COMBINED GOV REPORT - SEPT 2017.pdf

Date of meeting	6 April 2017	MEETING CANCELLED ~~4 May 2017~~	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	4 Jan 2018	1 Feb 2018	1 March 2018
Date of agenda setting/Paper Review of drafts	28.3.17	24.4.17	22.5.17	26.6.17	24.7.17	28.8.17	25.9.17	23.10.17	27.11.17	11.12.17	15.1.18	14.2.18
Date final reports required	29.3.17	26.4.17	24.5.17	28.6.17	26.7.17	30.8.17	27.9.17	25.10.17	29.11.17	27.12.17	24.1.18	21.2.18
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework (Quarterly)	-	✓	-	-	✓	-	-	✓	-	-	✓	-
DIPC report	-	✓	-	Annual Report	✓	-	-	✓	-	-	✓	-
Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Care of the acutely ill patient report	✓			✓		✓		✓		✓		✓
CQC Assessment Update on Action Plan			✓ Deepdrive Maternity	✓ Deepdrive Critical Care	✓ Deepdrive Paeds					✓		
Patient Survey				✓								✓

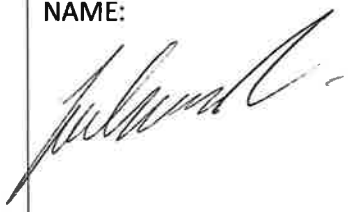
Date of meeting	6 April 2017	~~4 May 2017~~	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
Quarterly Quality Slide Report + Presentation focussed on one topic (may be used as patient/staff story) (NB – Quality Account in Annual Report)	✓	Quality A/cs	✓		✓ Naso. Risk & Falls				✓			✓
Colleague Engagement /Staff Survey (NB - Gold Standard by 2018 and Platinum Standard by 2020 agreed at 25.2.16 BOD)	✓						✓					✓
Nursing and Midwifery Staffing – Hard Truths Requirement		✓						✓				
Safeguarding update – Adults & Children		✓ Annual report						✓				
Review of progress against strategy (Qly)			✓					✓				
Plan on a Page Strategy Update			✓									
Quality Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Audit and Risk Committee update & mins	✓	✓		✓	✓			✓		✓	✓	
F&P Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Well Led Workforce Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Performance Management Framework – update on work from sub-committee workplans		✓										
Guardian of Safe Working Quarterly Report								✓				
Governance report: to include such items as:												
- Standing Orders/SFIs/SOD review								✓				
- Non-Executive appointments (+ Nov - SINED & Deputy)								✓				
- Board workplan			✓			✓			✓			✓
- Board skills / competency									✓			
- Code of Governance	✓											
- Board meeting dates			✓									

Date of meeting	6 April 2017	~~4 May 2017~~	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
- Committee review and annual report												✓
- Annual review of NED roles								✓				
- Use of Trust Seal			✓			✓			✓			✓
- Quarterly Feedback from NHSI			✓			✓			✓			✓
- Declaration of Interests (annually)												✓
- Declaration of Interests Policy (Jan 2018)			TBC									
- Declaration of Interest – outcome from Consultation			TBC				✓					
- Attendance Register (Apr+Oct 2017)	✓						✓					
- BOD TOR + Sub Committees												✓
- Constitutional changes (+as required)											✓	
- Compliance with Licence Conditions (April 2018)												
- Board to Ward Visits Feedback						✓			✓			✓
ANNUAL ITEMS												
Annual Plan												✓
Annual Plan feedback from Monitor						✓						
Annual report and accounts (private)		✓ EO										
Annual Quality Accounts		✓ EO										
Annual Governance Statement		✓ EO										
Appointment of Deputy Chair / SINED								✓				
Board Development Plan											✓	
Emergency Planning annual report						✓						
HPS Annual Report		✓										
HPS Business Plan											✓	

Date of meeting	6 April 2017	~~4 May 2017~~	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
Health and Safety annual report			✓					✓ (update)				
Capital Programme												✓
Equality & Inclusion				✓ (update)						✓(AR)		
DIPC annual report (ALSO SEE REGULAR ITEMS)				✓								
Fire Safety annual report						✓						
Medical revalidation & appraisal					✓							
Whistleblowing Annual Report							✓				✓	
Review of Board Sub Committee TOR								✓				
Risk Appetite Statement from Board (Nov 2017)								✓				
Safeguarding update – Adults & Children		✓ Annual report										
Winter Plan						✓			✓			
ONE-OFF ITEMS												
Membership Council Elections				✓							✓	
Single Oversight Framework (VP/GB)								✓				
Hospital Pharmacy Transformation Plan (AB/Mike Culshaw)							? later summer 2017					
Risk Management Strategy										✓		
Workforce Strategy											✓	
LHRP Core Standards (LH/Ian Kilroy)							✓					

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

REGISTER OF SEALING OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
252	26.5.17	26.5.17	Compulsory Purchase Order by Calderdale Council for strip at front of CRH	NAME:  TITLE: Executive Director of Nursing/Deputy CE NAME:  TITLE: Executive Director of Workforce & OD

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, 7th September 2017	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient - The Board is asked to receive and approve the contents of the CAIP report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Clinical Outcomes Group and Quality Committee	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

The Care of the Acutely Ill Patient (CAIP) programme has an overall aim to reduce mortality and 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

A CAIP improvement plan has been revised. This is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee.

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:

CAIP programme summary for BoD September 2017 SU.pdf

NHS
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Care of the Acutely Ill Patient programme

Progress Report for Board of Directors September 2017

The Care of the Acutely Ill Patient (CAIP) programme has an overall aim to reduce mortality and 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

A CAIP improvement plan has been revised. This is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee. Performance is measured in the CAIP dashboard (appendix 1) and a brief progress against themes noted below.

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	**SHMI** Data released in July showed the SHMI for October 2015 to September 2016 = **104.7** (categorised as Band 2 – as expected **HSMR** Data released in Aug 17 showed the HSMR for May 16 – April 17 was **98.71** **Alerting Conditions** AKI (Acute Kidney Injury) continues to alert on CUSUM. A review of deaths over a 12 month period has been completed. There was cause for concern in 4 cases and these are being investigated by divisions. **Learning from Death** The number of initial screening reviews remains low. The new online tool for	SHMI and HSMR performance continues to be monitored and reported monthly to the Mortality Surveillance Group (MSG) There are a number of actions relating to AKI including use of bundle on EPR and regrouping of an AKI collaborative group led by one of the Renal Physicians. This will report to the new Deterioration Programme (see below). The process to allocate initial screening reviews to every consultant will be agreed in September 2017. The ambition

	data collection is completed and tested. This makes the process easier and faster with automated alerts for reviews assessed with either poor or very poor quality of care. These cases are escalated for Structured judgement reviews (SJR). Speciality specific reviews continue in Stroke, Gastro, General Surgery, Orthopaedics, Critical Care, Paediatrics and Obstetrics. A new Learning from Death policy has been approved at WEB on Thursday 24 August for implementation in September 2017.	remains that there will be an initial screening review for every death that occurs in hospital. Each of the specialities performing their own mortality reviews have been invited to report 6 monthly to the MSG. An additional resource is required to support this to fund an additional 2 PAs to the existing 3 PAs to perform SJRs. This capacity should allow for in depth reviews of approximately a quarter of all deaths. Additional training will be required for these new reviewers but this available in house.
2) Reliability in clinical care	AKI and Sepsis continue to be prioritised for evidence-based care bundle improvement work. A sepsis behavioural change focus group was held and led by the improvement academy. This was held with a small group of frontline staff to identify the barriers to recognise and response to sepsis in the trust. A weekly sepsis tracker has been developed which shows the compliance with screening patients for sepsis showing where focused work is required; this is predominantly the admission areas.	Work continues to see how improvement work can be captured within EPR, what outputs can be measured, and whether EPR can help facilitate care. The Sepsis group is to be refreshed to ensure the correct membership and to identify and lead the improvement work. A further focus group has been arranged with the Improvement Academy on 15th September to analyse the barriers and identify effective interventions for behavioural change.

3) Early recognition and treatment of deteriorating patients.	The Deteriorating Patient Group is currently on hold however a new programme is being developed. The new Deterioration Programme will focus on three specific areas namely Recognition, Response and Prevention of deterioration. A project plan is in development with support from the Improvement Academy. Further updates will follow in due course.	Ward observation work has commenced with NEWS observations looking at which staff are performing the NEWS and their understanding of abnormal observations and escalation processes to identify training needs. Improvement work will be focused on SAU and MAU at HRI.
4) End of life care	End of Life Care (EOLC) facilitator in post; Successful engagement day with 4 working groups addressing communication skills, education, discharge planning and community project to address unnecessary admissions working on key areas; EOLC training continues to be included in nurse preceptorship training; Training DVD on communicating about the Individualised Care of the Dying Document in production; Two Specialist Palliative Care (SPC) Clinical Nurse Specialists in post in Macmillan project in MAU/A&E; Insufficient resource at present within hospital SPCT for dedicated 7 day service.	Enhanced education package (2 hours on EOLC communication skills) for nurses/AHPs/HCAs to commence October; EOLC to be included in induction programme for registered nurses from September; Need to consider how best to educate, influence and embed best practise with doctors; Over-arching review of mortality data, linked with complaints data, to inform best practise; Second engagement day with Madni Mosque in Halifax in September; EOLC Champions to be rolled out with CHFT Community Nurses later this year; EOLC facilitator to attend huddles on ward 5; Continued plan for eventual 7 day SPCT.
5) Caring for frail patients	HRI has a 7 day service 8-6PM comprising of a multidisciplinary team of Nurses, Therapy, Medical, social services and community staff. Every patient identified as frail coming to ED, MAU, SSU and AMU is referred to the frailty team and reviewed within 1 hour. All patients have a comprehensive geriatric assessment carried out on them from the team. This assessment assesses the patient holistically and not just on the cause that has brought them to hospital. This	The next phase is a pilot service at CRH which will commence at the end of September. It will initially be a 5 day service 8-5PM. HRI to have a designated triage area for our frail patients away from the busy ED. The frailty team to be skilled in advance care planning

	will result in patients being reviewed out in the community for other concerns and addressed to prevent readmission. If a patient requires a packages of care at home to support them living at home then this is provided on the day to prevent admission and ensuring our patients are cared for in the right place.	
6) Clinical coding	The piece of work to add all the Charlson co-morbidities captured in PAS and add them to the 'Problem' section in Power Chart was completed at the end of July and May – July activity has been re-coded to reflect the additional co-morbidities. This should mitigate the risk of any negative impact on HSMR/SHMI. Clinical teams will need to continue to validate the Problem/LTC's each time a patient is admitted to ensure they are accurate, complete and relevant to the current admission. Clinical Coding KPI targets (national upper quartile) for Coding Depth and Average Charlson have both been met for each month since go-live. However % Sign and Symptom as a Primary Diagnosis has increased and has not achieved target since April. There is variation at Division and specialty level across each of the coding targets.	Update to the clinical teams regards the improvement in co-morbidity capture is to go out from the Medical Director's office at the end of August. The update will also cover importance of ensuring Power Chart documentation has a definitive diagnosis rather than a sign/symptom. Work is underway to address the capture of chronic health issue capture in pre-operative assessment. The team are likely to have 3 or 4 wte retiring in the second half of 2017-18. Discussions are taking place to mitigate loss of the experience and knowledge from the team. Explore the potential of how a Clinical Coding training App (developed by 3M) might be used by clinical teams to improve the quality of the documentation (and therefore the coded data) within EPR and other systems. When there is capacity in coding, to start a project with 'on ward coders'. Work needs to be done to clarify the project structure and data capture. The aim is to improve the quality of the documentation within Power Chart at admission and then pre-discharge and therefore improve coding KPI's.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Keith Rawnsley, Fire Manager
Date: Thursday, 7th September 2017	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Annual Fire Safety Report - The Trust Fire Safety Report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: H & S meeting, tabled on the 19th July 2017	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The paper informs the Board about what has happened within the Trust relating to Fire issues. What progress has been achieved and where there is still room for improvement.

Main Body

Purpose:

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

Background/Overview:

This paper reports on this year's issues and follows on from the previous year's annual fire safety report.

The Issue:

Training statistics and areas of weakness, Fire Wardens and lack of trained staff across the Trust
Fire Alarm actuations and improvements made in reducing these
The two fires within the Trust
The need to have a budget that allows for safe premises
It mentions:
Compartmentation and progress made
Areas changing use
Space utilisation
Mobile workstations

Next Steps:

Our work plan for 2017/18

Recommendations:

The board receive and note the contents of the annual fire report

Appendix

Attachment:

CHFT Annual Fire Report Aug 2017.pdf

Calderdale and Huddersfield NHS Foundation Trust

CHFT Annual Fire Safety Report 1st April 2016 – 31st March 2017

1. Introduction

This report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2016/2017 (1st April 2016 to 31st March 2017) in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

The Trust has made progress over the last 12 months in terms of fire safety however there is further work to implement to ensure compliance.

2. Executive Summary

The RRO provides the legal framework for the implementation of fire safety in organisations and the HTM provides guidance on how to manage fire safety in healthcare premises detailing the responsibilities placed on the Trust and its employees.

Fire safety advice, support and training is provided by the Deputy Fire Manager who resides within the Estates and Facilities Division. The Trust is provided with independent advice from the formally appointed authorising fire engineer AE(Fire) as required by HTM 05.

The current financial constraints faced by CHFT and reduced capital will impact on the journey towards safer and compliant buildings. Whilst the future of HRI is to be decided by the Secretary of State CHFT must ensure standards are achieved and capital funds are made available to ensure we keep the HRI base safe.

Improvements with the building compartmentation at HRI were delayed due to the removal of asbestos containing materials (ACMs) which took longer than expected. Compartmentation concerns in PFI buildings across the UK have shown how vulnerable buildings are if compartmentation issues are not managed appropriately and, once installed, must be maintained. Fortunately Calderdale Royal Hospital does not fall within the poor state some PFI hospital buildings find themselves in. However, HRI continues to have major weaknesses in compartmentation which will require sustained investment over many years to achieve our legal duties. The change of use of areas from clinical to office based functions (eg: such as in the old OPD area) requires major compartmentation work and should not be underestimated, as a fire in this area would have significant implications for the whole block (eg: ED, CDU etc).

HRI fire detection upgrade programme has resulted in an improved detection system making good progress towards a compliant system and has significantly improved from the previous year. CRH fire alarm system is being upgraded via the life cycle programme and a floor per year is being achieved. Work commenced at the top of the building and has now reached the ground floor.

Face to face fire training this year has been essential in educating staff in what to do in case of fire, due to the continual changing environment we face including the cutbacks from the fire service cover.

Space utilisation continues to be a challenge with the requirements to move departments rapidly resulting in missed opportunities to check adequate fire precautions / compartmentation / fire alarms are in place for the change of use. Often fire risk assessments are not considered or reviewed once the move has taken place.

The Trust must also ensure departments change their working practices and refrain from placing combustible materials (i.e. beds and chairs) in corridors which is dangerous due to the impact this can have on evacuation and also increases the fire load; unfortunately, this continues to be common practice which has been added to due to the use of the new mobile work stations (EPR). This practice is a major contravention of fire legislation and one which the Fire Authority takes a serious view of.

3. REPORT

3.1 Fire Risk Assessments

Fire Risk assessments are a legal requirement and have been carried out for all CHFT premises. A total of 120 plus fire risk assessments have been provided to areas for review at Quality and Safety Boards. The responsibility of implementing action plans resides with local areas and it is challenging to provide assurance that all actions have been implemented and completed. To address this, an audit of the Fire Risk Assessments is being carried out to ensure we have a clear view of the current position.

The main areas for improvement are fire compartmentation (HRI) and fire door maintenance (HRI). Other common findings include poor housekeeping and storage with particular storage issues at CRH resulting in beds being located on corridors.

The continual movement of departments and staff to different locations necessitates the need for a review of the fire risk assessment due to a change in use, staff and potentially the patient group. More thought and planning is needed in the use of space so it is appropriate both in terms of location and appropriate from a fire safety perspective.

3.2 Fires and Fire Alarms

Fires

There have been two fires during the last 12 months at CRH and fortunately none at HRI

3rd January 2017	Seized motor in ventilation duct at CRH
10th February 2017	Scope cleaning machine in Endoscopy at CRH

False Alarms

There remain a high number of false alarms on both sites and efforts are being made to reduce these and are detailed below. Life cycle upgrades on the fire alarm system at CRH is helping to reduce the activations. The Trust is required to monitor fire alarm activations to ensure they are kept to a reasonable level and determine the reason for the activation and actions to prevent a reoccurrence.

Table 1 - Fire Alarm Statistics

2016/17	Actuations	Fires	False Alarms	Unwanted Fire Signals
HRI	35	0	35	0
CRH + Dales	33 + 10	2 +1	31+9	1
2015/16				
HRI	36	2	34	0
CRH	62	2	60	3
2014/15				
HRI	53	4	51	4
CRH	100	0	100	5
2013/14				
HRI	67	5	40	6
CRH	95	2	93	6

An unwanted fire signal (UFS) is a fire alarm where the fire service attend site and there is no fire. West Yorkshire Fire and Rescue Authority charge organisations £450 for each UFS. Their objective is to reduce the number of UFS thus ensuring fire tenders are available for actual fire calls. CHFT's Deputy Fire Manager and AFE continue to work closely with the Authority, Estates and Facilities, Engie and ISS to ensure, where possible, we manage UFS internally and are not charged.

3.3 Fire Safety Training

Fire training has been face to face and has been carried out, where possible, in the trainee's workplace or an area which simulates their place of work, which has been well received by staff. Unfortunately only 74% of Trust staff attended which leaves 26% untrained. The Trust would find it difficult defending this position if any of those untrained were injured during a fire incident. Table 2 illustrates fire safety training statistics.

Table 2 - Fire Safety Training

	2013/14	2014/15	2015/16	2016/17
Fire Safety Training	2460	4976	4171	4452
Fire Warden Training -	826	1042	1089	151

This coming year's fire training will revert back to the booklet and a newsletter to update the information, which will allow the Deputy Fire Manager to concentrate on other fire safety initiatives. 2017/18 will see fire training being delivered face to face.

Fire Response Team Training
Additional training, including using fire extinguishers, has been provided to CHFT's fire response teams which include Site Coordinators, Porters, Estates and Security.

3.3.1 Fire Evacuation Training
Due to the risk to patients there are limited options to undertake live fire evacuation training on wards. However in numerous areas some staff evacuations with staff actually practicing "hands on" training for the event has occurred. Further evacuation training is planned for 2017 but these exercises depend on the

availability of suitable facilities and staff being available. The health centres where we have control have all completed an evacuation drill, (Allan House, Brighouse and St John's).

4. GOVERNANCE

4.1 Audits

CHFT's AFE has commenced auditing the CHFT's premises in 2017 to measure compliance against the Fire Safety (Regulatory Reform) Order and HTM 05. An in depth compliance report will be produced by the AFE detailing both strengths and areas for improvement.

Health & Safety Committee

Monthly performance reports are provided to the Health and Safety Committee with quarterly updates detailing progress against the annual action plan.

Fire Safety Meetings

Monthly meetings take place which involve the Fire Manager, Deputy Fire Safety Manager, AFE and other key stakeholders ensuring any new and emerging risks are captured and managed accordingly.

5. CAPITAL WORKS

5.1 Fire Compartmentation

The Trusts buildings are made up of a number of fire resisting compartments to reduce the spread of fire from one location to another. This fire compartmentation allows the Trust to use progressive horizontal evacuation as its primary evacuation method.

The fire compartmentation at HRI has deteriorated due to works been carried out by Contractors over a many years and the fire compartmentation has not been reinstated following the completion of the work. A fire survey identified works necessary to reinstate the compartmentation back to its original design; a plan is in place to ensure all high risk areas are reinstated, but this a massive task and comes with a large financial cost. There is no option but to do this work, as it is a legal requirement.

Over the period there have been a number of capital schemes that have improved the fire precautions within the Trust these are:

- HRI Penthouse Plant rooms (on going)
- HRI Theatres and plant room (on going)
- HRI Service ducts which run at various levels throughout the Trust

CRH does not have major capital works due to an annual life cycle programme which keeps the areas to a good standard and the premises are newer.

5.2 Fire Detection

Improved fire detection has been installed in nearly all the areas where there was old detection at HRI. There has been some major work carried out to update and improve coverage at HRI bringing the system up to the required standard with approximately 1000 new detectors being fitted. The better detection should see a reduction in fire alarm calls, despite there being more detectors installed.

CRH fire detection is also being upgraded with the lifecycle programme that is in place and so a further reduction of calls is anticipated.

6. West Yorkshire Fire & Rescue

There is a dialogue between West Yorkshire Fire & Rescue Service, the Trust Deputy Fire Manager and AFE. This happens when fires occur and whenever upgrade work is planned through building control. The regular contact also gives them reassurance the Trust is progressing and hence they have not made a formal visit during the last 36 months however, this could change if progress is not being made. There has also been dialogue over cladding following the Grenfell Tower disaster.

Operational Visits
There have been a steady number of both operational and familiarisation visits by local Fire Crews. These ensure that fire crews have a better understanding of the problems they will face in the event of a fire or evacuation which will enable them manage and deal with the situation better. Some of the unoccupied buildings are to be used to facilitate fire service training, at both Acre House Avenue and the old nurses accommodation block.

7. FIRE SAFETY WORKPLAN FOR 2017/2018

	WHAT	WHO	WHEN
1.	Provide fire safety data Trust and DoH following Grenfell fire incident.	Deputy Fire Manager / Head of Estates	As and when required
2.	**Policy** Update Fire Safety Strategy	Deputy Fire Manager / Head of Estates	31.8.17
3	**Fire Risk Assessments** Embed fire risk assessments as part of Divisions local governance structure (eg: Div. Quality & Safety Boards). These should be cascaded upon review.	Deputy Fire Manager / Director of Estates, Facilities Planning & Performance	31.8.17 – 31.3.18
3.1	**Audit** Complete HRI / CRH audit of fire safety Vs HTM (including Fire Risk Assessments).	Authorised Fire Engineer (AFE)	31.12.17
3.2	Complete Community audit of fire safety Vs HTM (including Fire Risk Assessments).	AFE	31.3.18
4.1	**Training** Fire warden training (Refresher & New)	Deputy Fire Management / AFE	Paper to WEB 10.8.17
4.2	Training Monitor staff to ensure understanding of Fire safety awareness training	Deputy Fire Manager	31.3.18
4.3	Training Fire extinguishers training for key staff (practical)	Deputy Fire Manager	31.3.18
4.4	Training Develop training for 2018/19	Deputy Fire Manager	31.12.17
4.5	Training Plan and deliver practical evacuation training including off site office areas	Deputy Fire Manager	31.3.18

Calderdale and Huddersfield NHS Foundation Trust

5.1	Capital Works Progress Fire Compartmentation Works at HRI	Deputy Fire Manager / Head of Estates	31.3.18
5.2	Capital Works Progress installation of fire detection at HRI	Deputy Fire Manager / Head of Estates	31.3.18
5.3	Capital Works Continue to provide overview of CRH new Fire detection system	Deputy Fire Manager / Head of Engie Estates	31.3.18
6.	Fire Alarm Activation Continue to reduce the number of fire alarm activations across CHFT	Deputy Fire Manager / CHFT Colleagues	31.3.18

8. RECOMMENDATION

The Executive Board is requested to receive and note the contents of the annual report and agree the draft work plan for 2017 / 2018.

7th August 2017
Keith Rawnsley
Deputy Fire Manager

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, 7th September 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Winter Plan 2017/18 - The Winter Plan describes the structure within which operational pressures, during the winter period, will be anticipated and managed. It provides the framework for Managers and Clinicians in the Trust to work together, and with other organisations.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Internal Winter Planning Group	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Winter Plan describes the structure within which operational pressures, during the winter period, will be anticipated and managed. It provides the framework for Managers and Clinicians in the Trust to work together, and with other organisations.

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 2017/18 Winter Plan

Appendix

Attachment:

PUBLIC BOARD - FINAL Winter Plan 2017.pdf

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Calderdale and Huddersfield NHS
NHS Foundation Trust

Winter Plan 2017/18

Version 1

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Document Summary Table		
Unique Identifier Number		
Status	Draft 1	
Version	1	
Implementation Date	October 2017	
Current/Last Review Dates	October 2016	
Next Formal Review	June 2018	
Author	Associate Director of Urgent Care	
Where available	Preparing for Emergencies Section of the Trust Intranet.	
Target audience	Executive Directors, On-call General Managers, Directors on-call, Duty Matrons, Senior ward & department staff, Estates and procurement.	
Ratifying Committees		
Weekly Executive Board		September 2017
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Board of Directors		
A&E Delivery Board	Matt Walsh	

Does this document map to other Regulator requirements?	
Care Quality Commission	Outcomes 4B, 6D, 10E and 14A

Document Version Control	
V1	Updated for Winter 2017/18

Contents

Appendices

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Introduction

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

The winter period is normally defined as being from early November to late March with specific emphasis on the 'Critical Period' early December to the end of January. However NHS England expectations of Trusts to implement improvements as described below do not and cannot be achieved if just focused on planning through the winter but must be the focus throughout the year.

Purpose

The objectives of the Plan are as follows:

- To support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the winter response
- To provide a framework for the development of other plans
- To provide the basis for agreement and working with other partners & organisations
- To provide reference material for use in the Trust
- To set out the information systems to be used to manage the response.

NHS England has reiterated that trusts are expected to respond appropriately to the demands of winter through attention to the following areas:

- Reducing Delayed Transfer of Care
- Reducing variation in best practice (Improving patient flow and effective discharge planning)
- Demand and capacity planning
- Planning for Peaks in demand over weekends and Bank Holidays.

1. Definitions

Critcon - The status report that is used to manage intensive care capacity across the network

Elective restarts - This is the point at which elective surgery is restarted, either completely or in part, following the planned stopping of it during a period of acute workload pressure.

ImmForm - The monthly report on take up of influenza vaccination in staff.

Organisational resilience - The ability to adapt and respond to disruptions to deliver organisationally-agreed critical activities

Sitrep - A daily report to Monitor which highlights pressures in Trusts' capacity. Sign off will be required by 11:00, Monday-Sunday from the beginning of November until the end of March 2018. THIS will support the reporting of the Sitrep on a daily basis and the Associate Director of Urgent care or deputy will complete the sign off, a rota will be created.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

2. Duties (roles and responsibilities)

Director of Estates and Facilities

- Reportable officer at executive level for Winter Planning

Chief Operating Officer

- Will represent Trust on the A&E Delivery Board

Associate Director of Urgent Care

- Chair the Winter Planning Group
- Represent the Trust on the Joint Surge and Escalation Teleconferences
- Compile a situation report for the Joint Surge and Escalation Teleconferences
- Cascade the situation report from the Joint Surge and Escalation Teleconferences / Update the winter planning group and divisional leads of the situation across the local healthcare system
- Respond to requests for assurance from the CCG and NHS England
- Benchmark and share good practice from partner organisations
- Ensure that winter plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period
- Ensure that contingency plans that are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases are appropriate and will deliver safe patient care and experience and organisational resilience.
- Ensure that the Trust Winter Plan aligns with those across the local health & social care system.

Divisional Directors

- Ensure adherence to the Emergency Care Standard action plan as agreed at Executive Board
- Ensure each Division takes responsibility for securing sufficient capacity to meet out of hours demands on a daily basis
- Ensure collaboration across Divisions to ensure compliance with Patient First principles
- Ensure each Division has robust arrangements for escalation and any associate bronze and silver meetings

Winter Planning Group (Division Winter Leads)

- Ensure that appropriate plans are in place to manage an increase in activity through the winter period within the division
- Ensure that divisional plans are joined up across the organisation
- Ensure that contingency plans are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases.
- Ensure that key staff groups are aware of the risks and response arrangements for winter

Estates, Clinical Site Commanders and Night Matrons

- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements
- Contact alternative transport providers if required

Estates and Facilities

- Ensure that there is sufficient supplies of salt/grit for clearing car parks, pathways and roads on site
- Liaise with contractors to arrange access to 4X4 vehicles for transport services if required
- Ensure that additional staff accommodation is available if required
- Cascade weather updates throughout the year including winter.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

3. The Trust's Winter Strategy

The winter plan is based on the following strategic aims;

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs
- To work collaboratively with other health and social care providers to effectively manage capacity
- To assess risks to continued service provision and put plans in place to mitigate those risks
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels over the winter period to minimise the risk of harm
- To ensure patients do not wait in any part of the system unless clinically appropriate

Winter planning arrangements

The Trust Lead for winter planning is the Associate Director of Urgent Care in collaboration with the Divisional Senior Management Teams.

The A&E Delivery Board has overall responsibility for ensuring that the health and social care service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity and acuity over the winter period. The CHFT Winter Planning Group reports to the A&E Delivery Board and, in addition to internal escalation arrangements, is responsible for ensuring that the Trust has plans in place for severe winter weather, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

Command, control and coordination

During the period 1 November – 29 February, a daily SitRep (Mon-Fri) will be completed for submitting to NHS England by the Health Informatics Service. The Monday SitRep will include details from the preceding weekend. SitReps will be signed off by the Associate Director of Urgent/Director of Operations after high level validation with fully validated data submitted monthly. Arrangements will be confirmed to ensure that there is adequate cover in case of absence.

The National Escalation Framework

4 Hour Emergency Care Standard Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An Emergency Department (ED) could be experiencing isolated difficulties but the rest of the system is coping well; there are sufficient beds available and there is good flow through the system. Alternatively, an ED could be managing well whilst the rest of the hospital, and the wider system; community beds, community services and social care are experiencing high pressures due to a lack of capacity.

Escalation triggers at each level

Local A&E Delivery Boards should align their existing systems to the escalation triggers and terminology used below, and adds to the triggers listed as appropriate. The escalation criteria detailed over the following pages are not an exhaustive list of triggers, nor do they constitute a rigid system where criteria must be met sequentially for escalation to take place. **Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally.**

Local A&E Delivery Boards should be able to demonstrate that appropriate triggers have been met to warrant escalation. NHS England and NHS Improvement sub-regional and regional teams will also use the framework to moderate and challenge in discussions with local systems.

National terminology (OPEL) has now been adopted and has been used within the Trust throughout 2017.

To ascertain the OPEL status of acute hospitals within Yorkshire the Clinical Site Commanders will be contacted by Yorkshire Ambulance Service twice daily either by phone or email. The Clinical Site Commanders will be contacted at 09:00 each morning for the new national escalation level (OPEL) status for inpatient capacity and any associated comments noted by hospitals on the Daily Bed Alert Status Report.

Operational Pressures Escalation Levels	
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Figure 1

OPEL-Winter command and control arrangements (internal)

Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4

however, it would be expected that there would be more executive level involvement across the A&E Delivery Board, as agreed locally.

A second assessment of capacity alerts will be made at 16:00 and the capacity status for each hospital again reported.

The three hourly SAFER Patient Flow Hospital Meetings chaired by the Clinical Site Commanders involving the patient Flow Team and Divisional Managers of the day, Matrons and on call managers/Matron of the day will monitor activity on each site and determine operational actions using a standard operating procedure and escalation policy to manage capacity issues. The level (OPEL) at which the hospitals are working within will be determined at these meetings. The Associate Director of Urgent Care will report direct into the partner organisations involved in the Joint Surge and Escalation Plan.

The Associate Director of Urgent Care for Calderdale and Huddersfield Foundation Trust is responsible for representing the Trust at the Calderdale, Kirklees and Wakefield Joint Surge and Escalation meetings where situation reports are shared and healthcare system-wide actions to manage demand and capacity are determined.

Each division and department is responsible for the successful implementation of their escalation plans. In the event that significant pressures are identified the Associate Director of Urgent Care or the Divisional Directors of Operations will decide to implement the Trust Emergency Management Arrangements (Strategic (Gold) and Tactical (Silver) and Operational (Bronze).

Workforce

Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services over the 7 day period. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover an arrangement especially over the Xmas and New Year period and to ensure annual leave is managed appropriately over this period. Staffing gaps should be identified and mitigated by Divisional teams in hours, only last minute absences will be actioned by on-call, out of hours teams

> **For Xmas & New Year a further review will be completed weekly from the beginning of December with a final sign off and escalation of any risks with mitigation plans by the 12th December 2017.**

Vaccination

The CQUIN target for this year for Calderdale and Huddersfield is to achieve at least 75% of frontline staff. The emphasis will be on staff in clinical and clinical support roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, ‘myth busting’ and league tables of performance have been advertised on the intranet. Additional groups of staff have been trained to administer the vaccine so that it can be more accessible to staff. District nursing services provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Personal Winter Plan/Engagement Plans

All members of staff have a personal responsibility to ensure that they are available for work and that they have alternative arrangements for carer responsibilities and journeys to work. All staff will be reminded of preparations they should make for winter – seasonal flu vaccination, checking public transport alternative routes, vehicle preparation as well as contingency plans. This will continue to be reinforced through the business continuity management system and staff communications strategy. In severe weather conditions staff in District nursing will report to their nearest team to their home not necessarily where they usually work. The Trust's attendance management, carer leave and adverse weather policies will be used to support staff and to maintain service levels.

Strengthened Operational Management

Daily support for patient flow from the Clinical Divisions is already in place, additional senior support is provided by the Associate Director of Urgent Care or a Director of Operations as point of escalation and chair of the critical 12pm Patient Flow Meeting. From the beginning of December 2017 until the end of January 2018 that will increase to the 9am and 3pm patient flow to ensure any surge in activity above expected levels are acted upon immediately and provide additional assurance that good control and command is in place.

Lead Nurse-Patient Flow

Clinical Site Commander
The Clinical Site Commander will effectively manage the Trusts bed capacity, ensuring the patient's journey is safe and their experience is good. This is in conjunction with the Divisional operational teams. They will be the point of escalation if surge is being experienced.

Divisional Operational Teams
There will be a Divisional manager and Matron of the day who will support the patient's journey, ensuring safe effective admissions, transfers and discharge. They will work to a standard operating procedure.

"On call/site manager of the day"
There is an on call manager designated on site daily.

Duty Matron
There will be a duty matron on site daily.

Reducing admissions
Ambulatory Care in medicine and Medical Admission avoidance will be available on each hospital site to prevent avoidable medical admissions. Surgical Ambulatory will be available on the HRI site with dedicated additional surgical registrars on specific days over the x-mas and new year period and Gynaecology Ambulatory will be available on the CRH site.

Reducing delayed discharges to support length of stay reduction
SAFER Patient Flow Transformational Programme is supporting initiatives to improve flow, prevent avoidable admissions, reduce LOS, improving discharges at the weekend by introducing additional medical staff to focus on discharge and completing of TTOs and occupancy levels, reduce patients on a green cross pathway and find alternatives for patients who do not require acute hospital services.

A fortnightly senior management meeting for all partners to ensure robust discharge plans are in place for all patients on a green cross pathway.

With the introduction of Nervecentre Task Management there is an improved communication and joint working across all specialities. This will support earlier discharge throughout the winter period by prioritising tasks associated with discharge and liaising with the appropriate professionals to ensure that the task is completed timely.

Pharmacy
Will ensure that flexible capacity wards are stocked with appropriate medicines, a regular clinical pharmacy visit will be established and maximise the use of pharmacist prescribers to assist with medicines reconciliation and transcribing TTOs.

Ward based ATOs will be targeted to high turnover areas to assist with transferring medicines.

Pharmacy staff will work with medical and nursing staff to prioritise supply of medicines for discharge.

Wards should identify patients due for discharge on all ward areas as soon as possible, and e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Where possible, discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge.

Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines at home before a request is made for a supply for discharge, which will enable pharmacy to dispense items which are genuinely required more quickly.

Winter Inpatient Flexible Capacity Plan

CHFT's Divisional teams have prepared their winter plans through analysing their expected demand, tracking assumptions against their business plans and understanding the impact transformational work is having.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Medical Divisional Plans

The Medical Division will have completed the alignment of all elderly, cardiology and respiratory wards which will provide improvements in how patients with needs that require a specialist assessment and ongoing review are cared for. There will be an introduction of more specialist weekend reviews. All wards will have a daily ward round. The Medical Division has developed specific plans to provide escalation capacity to meet the expected increased demand on inpatient capacity. With the improvements seen in reducing the longest lengths of stay within the hospital these plans will be operationalised **only** if a surge in activity described in figure 1 impact on operational performance and patient safety.

Acute Medical Care

Hot clinics:

Diabetes & Endocrine: Consultant to work with DNS team in identifying patients to be discharged from the wards with a view to returning to clinic before the weekend. This prevents patients then having a weekend stay where they will require work-up on a Monday and subsequent discharge planning.

Acute Medical Unit/General Medicine*:* This will be delivered from the Ambulatory Assessment Unit (AAU) on a daily basis by the Acute Medical team. AAU will be extended to provide ambulatory care until 10pm daily on each hospital site Monday to Friday. An Emergency Floor planned will be opened on the Calderdale Royal Site to extend the ambulatory care offer.

Care of the Elderly*:* This will be delivered by the Care of the Elderly team with support from the Frailty team in AAU or 6 bedded frailty area on the Acute Medical Unit at HRI and a designated elderly ward.
A Frailty Team will be in place at the Calderdale Royal from September 2017 onwards.

Surge in Non-Elective Demand

Overview							
Impact							
• Unpredicted increase activity in ED's, SAUs and MAUs • Increase in bed occupancy across the Trust • Increased pressure on community healthcare services to support discharges above predicted • Potential of the need to outlie patients into another speciality. • Greater potential for inpatient outbreaks of infection and outbreaks in nursing homes preventing discharges	**Impact**	**1**	**2**	**3**	**4**	**5**
	Likelihood **1**					
	2					
	3				X	
	4					
	5					
Proactive strategy- Actioned by the Director of Operations							
• Identify flexible beds that can be opened in the short term to support increased admissions and staffing requirements • Trigger escalation							

Reactive strategy		
• Use of winter strategy & plan • Implement the joint surge and escalation plan- Silver & gold • Activate business continuity plans and escalation plans • Increase inpatient capacity by opening flexible beds		
Trigger	**Received by**	**Immediate action**
ED reporting of increased activity	Emergency department matron/manager	• Reallocate junior medical/nursing staff to support the Emergency Department • Establish additional trauma lists as required • Review the availability of trauma surgery equipment • Move from elective beds to trauma as demand dictates • Use of flexible capacity- short term • Surge & Escalation plan actions to be followed
YAS reporting of increased activity	Emergency department. Patient flow team	
Low temperatures Met Office - proactive	Emergency Planning Officer	• Prepare for increased attendance by patients in the at-risk groups
Community nursing workload	General Manager – Adult Community Nursing	• Review community case load to prioritise at risk patients • Trigger business continuity plans
Assess bed capacity issues in line with regional plan	Director Of Operations	• Implement the escalation policy. • Implement joint partner surge & escalation plan
Requirement to expedite discharge	Clinical Site Commander Discharge Matron/Discharge Team.	• Liaise with YAS to agree priority order for patient movement. • Initiate spot purchasing agreements • Start discharges with medicines to follow. (Use of taxis of transportation of medicines post discharge.) • Use of day rooms and discharge lounges to facilitate expedite discharge.

Figure 1

Escalation Capacity

Division	Flexible Capacity	Trigger & Action	Lead
Medicine	24 escalation beds are planned.	Triggered through SAFER Hospital Meetings using demand management data/daily predicted discharges after all other admission avoidance has been exhausted. **Risk assessments must be completed.**	Divisional Manager/Matron/Clinical Site Commander. Director of Operations

	Gynaecology Assessment Unit x 6 beds.	Daily tracking will be in place and Senior Divisional Team will monitor winter demand. A robust nurse staffing plan will be developed and signed off by the Chief Nurse. The identified ward to be opened will have an inventory of equipment/medicines/essential consumables/linen & pillows available and stored in a secure facility (appendix 2) It will also be EPR ready. Plan to flex these beds as required (overnight). Staffing Plan developed to provide flexible capacity overnight.	Associate Directors of Nursing

Figure 2

Emergency Department

The Emergency Department (ED) will have;

- Surge triggers developed for ED Consultants will be implemented to extend the working hours of the consultant until midnight.
- Additional assessment capacity will be created, adjacent to the ED to ensure **all** ambulance and ambulatory major's patients even at times of surge are seen through EDIT/WEDIT. This will be managed by the ED team but supported through triggers and escalation (described in the Surge & Escalation Plan) by the hospital matrons providing the required staff.
- Daily analysis of 'reasons for breaches' shared with Specialty colleagues for learning and action to prevent, monthly review meeting will be in place to ensure ownership of actions and improvements being made, chaired by the Associate Director of Urgent Care.
- Daily representation at Patient Flow Meetings with consultant attendance at critical pressure points. Actions fed back to the department and two-way communication in place.
- Robust internal Escalation Plans are in place to manage surges in demand.
- In order to improve communication between AMU, ED and site management team, the ED team will strengthen communication via bed management team by providing an ED update at each SAFER Patient Flow Meeting.
- Planned increased medical staffing over the X-mas and New Year period as mitigation against the expected increase in demand especially over the out of hours period .
- The Senior Lead Nurse B7 for each department will be supernumery
- Each department will have trackers to support the internal flow and escalation within each department.
- The Frailty Team will work closely with the ED team to ensure all opportunities to support avoidable admissions are taken.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Surgical Divisional Plans

The Surgical Division has developed plans to mitigate increased non-elective demand whilst planning for a reduction in elective activity.

- In addition to current planned trauma lists (17) all additional demand will be delivered by following the Trauma Surge Pathway (Figure 3).
- There will be the ability to provide patients with a fractured neck of femur surgery over the x-mas and New Year period.
- Current medical workforce on SAU will be increased with an additional middle grade to minimise impact on patient flow. Improved timely access to theatre will reduce pre-op bed days and overall LOS for some Minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

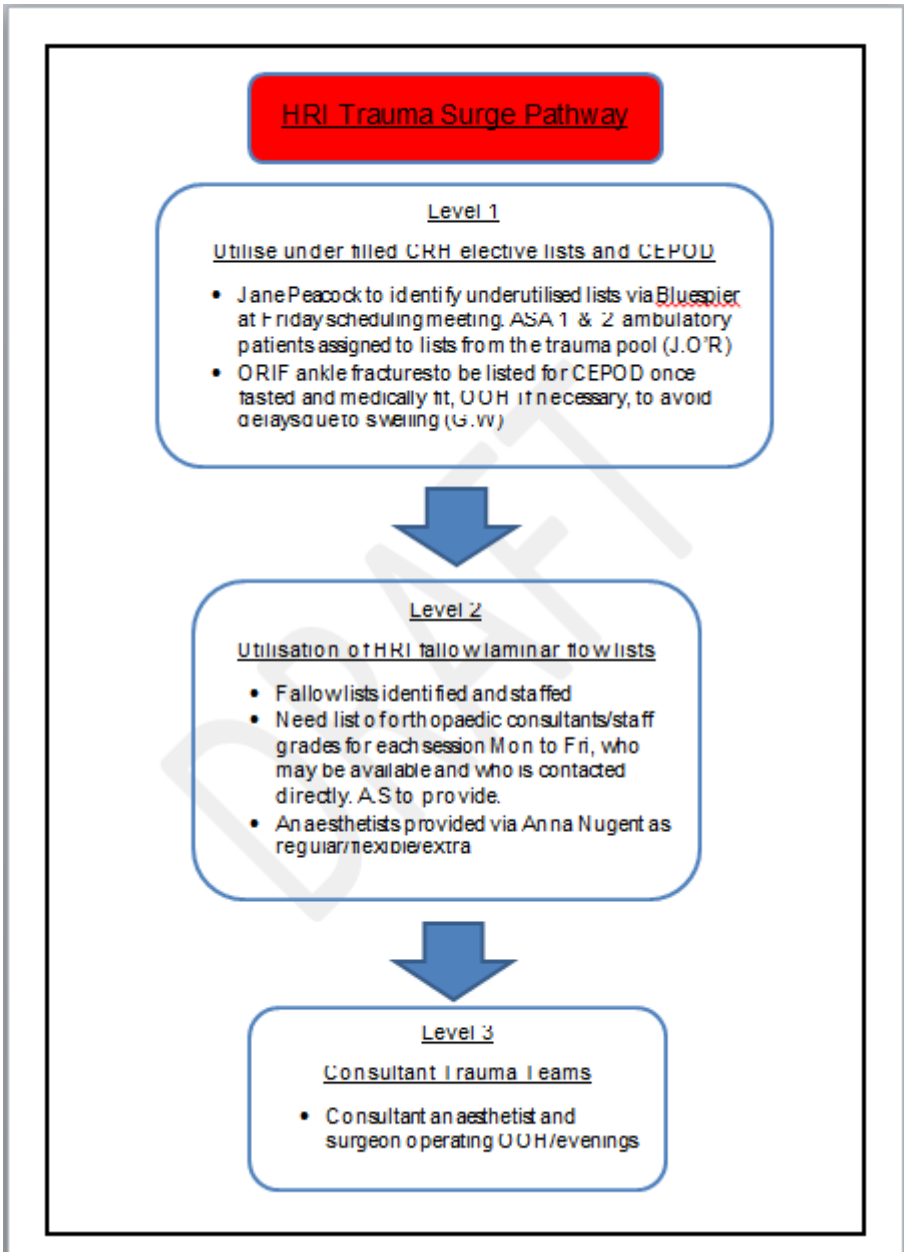


Figure 3

Reduction in elective Orthopaedic activity

The surgical division will reduce elective orthopaedic surgery providing additional inpatient capacity for the peak periods from Mid-December to the end of February. If additional beds are not required the staff will be redeployed as directed by the ADN.

From January 3 the Surgical Division will introduce additional Laparoscopy Cholecystectomy lists that reflect the Upper GI Surgeon on CEPOD week. This will improve the scheduling of acute/emergency patients with cholecystitis based on clinical urgency, over and above the CEPOD list. This will improve LOS for these patients, prevent readmission and improve patient experience.

The Division have progressively moved more work to day-case this year and from 5 December will open a 5 day ward are exploring options to develop this further which may include a short stay unit, thereby reducing the risk of elective cancellations over the winter period?

Central Operations (COT)

Lead Nurses for the COT will provide cross site cover into the Patient Flow Team over the x-mas and New Year period

Discharge Coordinators

- A daily huddle will be introduced to focus resource of the team when triggers on any specific pending delays occur this must be without reducing the robust management of the complex discharges. Working hours will be reviewed daily as part of the huddle and extended as required. Staff will work flexibly to support the service.
- A process for linking GP practices with MDTs will be introduced to ensure primary care support for complex discharges.
- Weekly 'stranded patient' meeting will be in place to prevent any clinical delays.

Patient Flow Team

- There will an Operations centre developed on each acute hospital site to be the hub for all Patient Flow Meetings and as required for escalation meetings using learning from EPR go live.
- A twice weekly Cross Divisional Business Meeting will be chaired by the Associate Director of Urgent Care/Associate Director of Nursing for FSS to gather intelligence, share information on divisional issues/risks affecting patients flowing through the hospital in a safe and effective way. To then agree solutions and implement supplemental actions to address these.
- A cross divisional QIA Panel will be in place to review all x-mas and New Year rosters. Panel consisting of Deputy Chief Nurse, Associate Directors of Nursing for each division and the Associate Director of Urgent Care. A weekly Nurse Staffing Assurance Panel will then be in place to monitor.

Discharge Planning

- Implement the 8 High Impact Changes to improving Patient flow and discharge.
- Continue to roll out the 'Supported consultant ward round/MDT initiative'

Family & Specialist Services

Paediatrics

- Escalation Plan (Appendix 5)
- Continued support paediatric stream in the EDs with PNPs during surge in both EDs and planned at Huddersfield Royal Infirmary (Appendix 6).

Maternity

- Escalation Plan (Appendix 7)

Diagnostics
Daily attendance in Patient Flow meetings of Operational management from FSS to support flow, support prioritisation of diagnostics during increased demand.

Community Division

CHFT Community Division accesses on-call support via the Trust on-call rota.

For Winter 2017, a Community Division on-call rota will be implemented to support community services out-of-hours in a more formal and routine way.

The community division on-call manager will be the first point of contact for Community staff and staff escalating a concern about responsiveness of community services out-of-hours and the on-call divisional manager will escalate to the Trust on-call manager and on-call Director for support if the situation cannot be managed locally.

On-call staff can be accessed by contacting Calderdale switchboard on **01422 357171.** All staff are made aware of the route to access on-call staff.

Priority 1 Clinical Services

The following services have been deemed as **Priority 1 Clinical Services:-**

- District Nursing priority one patients
- Blocked catheters
- Administration of medications including IV therapy
- Support for discharge out of hospital
- Palliative Care
- Crisis Intervention Team
- Intermediate Care bed base
- IV Therapy priority one patients
- Palliative care priority one patients
- Gateway to Care
- Quest Matron support to Care Homes
- Community Respiratory Service
- Community Heart Failure Service

Community Services Available

Gateway to Care

The service supports the co-ordination of intermediate care services and prevention of hospital admissions. The service accepts patient referrals from GPs, community clinicians, Social Workers and patients.

Referral should be made to Gateway to Care for the following services:-

- Crisis Intervention Team
- Support and Independence Team including Stroke early Supported Discharge Team, Falls Prevention Team
- Intermediate Care Beds
- Heatherstones

Hours of Operation	8.45am-5.30pm Monday to Thursday and 8.45am-5.00pm Friday
Contact Details	01422 393000

Intermediate Care

The intermediate care service is delivered by an integrated partnership of health and independent care home provider, ensuring a multi-disciplinary approach to care. Care is provided in one of our bed bases i.e.

Brackenbed View (32 beds) or Ferney Lea (12 beds) and Heatherstones (12 apartments)

The Service Aims to:-
- Promote a faster recovery from illness
- Prevent unnecessary presentation and admission to an acute hospital bed
- Prevent premature and unnecessary admission to long term care
- Maintain independence as long as possible

Service Criteria:
- Service user/patient must be over 18 years of age
- Medically stable
- A resident of Calderdale or Registered with a Calderdale GP
- Consent to rehabilitation

Hours of Operation	24 hours a day, 7 days a week
Referrals Accepted	Via Gateway to Care (in-hours) and via Crisis Intervention Team (weekends)
Lead Manager	Claire Folan
Contact Details	07879 447218 (for IMC Beds)

Heatherstones provides temporary accommodation for adults for up to 6 weeks and facilitates early discharge, or prevents the need for admission to hospital, residential or respite care. The service is most appropriate for people who want to live independently but need short-term alternative accommodation or short-term help and support to achieve this.

The service aims to reduce individuals' dependency and reliance on direct services and prevent their level of need from increasing with people returning to their own home with the confidence and

level of care required to enable them to cope long term. Residents are expected to cook their own meals and do their own shopping and laundry. Reablement assistants provide support where needed.

Hours of Operation	Monday to Sunday 8.00am – 9.45pm 7 day service
Lead Manager	June Warman
Contact Details	01422 392229

Community Place

This is a partnership arrangement between CHFT and Calderdale Council and operates from Ward 4B at Calderdale Royal Hospital.

The service assists in early identification of patients appropriate for discharge from hospital who can be supported by Community services upon discharge and require a step down goal focussed approach. There is an expectation that the individual can focus and be involved in higher level of rehabilitation functioning up to 6 times per day through goal led functional rehabilitation and a transition to self-care.

The ethos of the Community Place is self-management and individualised care planning within an MDT approach (Therapy, Support workers and Social Workers) with a view to maximising independence and returning home as planned with the most appropriate and proportionate care services that reduce continuing dependency on care and support services. This serves to prevent prolonged hospital stays and premature admissions to long term residential care.

Personalisation and community are the key building blocks of the Community Place service, community membership, living in their own homes, maintaining or gaining employment and making a positive contribution to the communities they live in.

Hours of Operation	24 hours a day, 7 days a week
Lead Manager	Alistair Mirfin
Contact Details	01422 223406

Reablement

The reablement service provides therapeutic care and support; with therapy care plans provided by CHFT community therapy team and then delivered by social care reablement staff. Access to reablement is via Gateway to Care following an assessment by a social worker.

Reablement is offered for up to 4 visits a day for a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	8.00am-9.00pm, 7 day service
Lead Manager	Tracey Proctor
Contact Details	07748 797896

Reablement Team	Allocator	Contact number
Lower Valley	Julia Green	01484 728943
Upper Valley	Stephanie Brooks	01422 264640
Central	Jo-Anne Rice	01422 383584

Crisis Intervention Team

Crisis Intervention Team will provide support to someone in crisis in their own home for up to 72 hours. For example if someone is struggling in their own home after a fall, or discharge from hospital where packages of care cannot start immediately. They also assess suitability for intermediate care beds. They are a responsive service and will assess within 2 hours for urgent referrals and 24-48 hours for routine referrals.

The team consists of nurses and a physiotherapist who undertakes assessments and set care plans. Rehabilitation assistants in the team offer up to 4 visits a day for a period of 72 hours with the aim to increase function and reduce dependence. If further reablement is required after 72 hours, the locality reablement teams continue the care.

Hours of Operation Assessors	8.00am–7.00pm 7 days a week
Reablement Service Work	8.00am-9.00pm 7 days a week
Lead Nurse	Susan Johnson
Contact Details	01422 307333/07917 106263

End of Life Out-of-Hours Crisis Team

This is collaboration between Overgate Hospice, Marie Curie and CHFT. This small team provide crisis support to people out of hours who are near the end of their life. The Specialist Palliative Nurse supports the person with symptom control, physical and emotional support and works with a Marie Curie Support Worker. They provide support to the person, carers and families.

Hours of Operation	7 day service
Lead Nurse	Abbie Thompson
Contact Details (9am-5pm Mon-Fri)	01422 310874
Contact Details (Out-of-Hours)	07917 106263 Out-of-Hours Service/ 01422 379151

OPAT/ IV Therapy

This team provides antibiotic intravenous therapy to patients in their own homes. Patients remain under the care of their Physician or Consultant. This prevents some admissions and certainly reduces the LOS for many more.

- Patients have to be medically stable. Need to be under consultant referrals
- Commissioned for 12 administrations a day
- Compatible drugs need to be administered within 30 minutes

Hours of Operation	7 day/24 hour service
Lead Nurse	Jayne Woodhead
Contact Details	07795 825106

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Community Nursing Services

District Nurses visit housebound patients that have complex health care needs. Patients that are able to be transported are expected to attend treatment rooms.

Hours of Operation	7 day/24 hour service
Contact Details Core Hours (8am-6pm)	07917 106263
Contact Details Evening/Night (6pm-8am)	07917 106263

Only **priority 1/urgent patients** are seen at night i.e. palliative care requiring symptom management, blocked catheters and patients requiring prescribed medication at agreed intervals.

Quest for Quality Service

CHFT have established a multi-disciplinary team consisting of Community Matrons, pharmacist, therapist and consultant Geriatrician who caseload residents in all Residential and Nursing Homes in Calderdale. This scheme's main role is to reduce the number of calls made to General Practitioners to prevent avoidable admissions. They use Telecare and Tunstall Telehealth to promote health and wellbeing to the residents within the Care Homes.

The team have a responsive function to the Care Homes dealing with calls that would have been received by a GP and managing the residents. They also provide support to the care home staff to better manage their residents through training and education.

The pharmacist role has greatly helped with reviewing patient medication, reduction in poly-pharmacy and education and training of care home staff.

Hours of Operation	9am-6pm, 7 days a week
Lead	Liz Morley
Contact Details	07917 086450

Community Matron Service

Community Matrons provide a service to people with Long Term Conditions (LTC) who have complex health and social care needs which without effective case management are likely to result in the individual having repeated and avoidable hospital admissions and increased lengths of stay in hospital and frequent contact with primary care services.

They are based in localities with District Nursing Teams.

Hours of Operation	8.30am-4.30pm, Mon-Fri
Lead	Andrea Beevers

Locality	Base	Matron	Contact Details
Upper Valley	Todmorden Health Centre	Jenny Dyson/Vacancy	07795 252396

Lower Valley	Church Lane Surgery Rastrick	Rachel Clegg/ Andrea Beevers Mandy Kazmieski	07795 801112 07795 825037 07795 825084
South Halifax		Sheila Kalanovic/Vacancy	07795 825139
North Halifax		Julie Norris/Vacancy	07770 734748
Halifax Central		Sheryl McGinn/Louise Watson	07769 365247 07717 347547

Specialist Nursing

There are a range of specialist nursing services that support people in community settings.

Service Area	Hours of Operation	Lead Nurse	Contact Details
Continence	7.00am-4.30pm Mon-Fri	Sharon Holroyd	01422 252086
Respiratory	8.30am-4.30pm 7 days/Week	Sue Scriven	01422 307328
Heart Failure **Cardiac Rehab**	9.30am-5.30pm Mon-Fri 7.30am-4.30pm Mon-Fri	Ian Ormerod Caroline Lane	07500 553892 01422 224260/ 07713 739144
Parkinson's	9.00am-5.00pm Mon-Fri	Paula Roberts	01484 712515
TB	9.00am-5.00pm Mon-Fri	Mary Hardcastle Dale Richardson	07824 343770 07795 825070 01422 307307
Lymphoedema	9.00am-5.00pm Mon-Fri	Sarah Wilson	01422 350755

Respiratory Team

This team provides 7 day admission avoidance in the community to patients and early supported discharge from hospital. GPs, practice nurses and patients known to the service can refer via the Respiratory Single Point of Access.

Hours of Operation	8.30am-4.30pm 7 days a week
Lead Nurse	Sue Scriven
Contact Details	01422 307328

Early Supported Discharge for Stroke

This team provides support to enable patients who have had a stroke to be supported at home to reduce length of stay and increase function by facilitating people to be as active as possible.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Sally Grose
Contact Details	01422 358146

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Elective Orthopaedic Rehabilitation

The EOR service facilitates a smooth discharge home from the orthopaedic unit at Calderdale Royal Hospital. Most people are medically fit and safely mobile enough to return home within a few days following joint surgery to replace a hip or knee. Rehabilitation is started on the ward by EOR and continues following discharge home. EOR assess, advise and offer treatment, enabling a timely recovery and return to independence. This includes an exercise programme to gain improvement with walking, both indoors and out. Any equipment previously supplied is assessed to ensure it is still appropriate and if required, new equipment is provided.

Hours of Operation	8.00am-4.00pm, 7 day service
Lead Manager	Joanne Vaughan
Contact Details	01422 306723

Community Falls Service

The Falls Prevention Team is part of the Support and Independence Team who assess and advise people over the age of 50 who have had a fall or who are worried about their balance and frightened of falling. The team raise public awareness of falls and how to prevent them, identify older people who are at risk of falling using a simple five question screening tool, undertake detailed falls risk screening and refer patients to appropriate services to help, manage the risk of falling, provide education and advice to older people including advice on physical activity, diet, footwear and environmental hazards. The team provide strength and balance groups in local settings and /or tailored exercises in older people's homes.

Hours of Operation	8.30am-5.00pm, 5 day service
Lead Therapist	Claire Folan
Contact Details	01422 307323

Senior Managers in Community Division

Senior Managers on-call rota, contact Calderdale Royal Switchboard on **01422 357171.**

The Community senior manager on-call rota is available here Z:\Annual Leave\on call rota.xlsx

Senior manager contact details are as follows:-

Name	Role	Work mobile
Karen Barnett	Director of Operations	07785 416708
Nicola Ventress	Assistant Director of Finance/ Deputy Director of Operations	07765 306617
Andrea Dauris	Associate Director of Nursing	07920251715

Nicola Sheehan	Head of Therapies and Service Manager for OP and Children's Therapies	07917 234931
Liz Morley	Matron for Community Nursing	07747630989
Debbie Wolfe	Service Manager for Community Therapies	07825 902363
Mandy Gibbons-Phelan	Service Manager for Specialist Nursing	07795 825137
Suzie Dore	Service Manager for Intermediate Tier Services	07584 612950

Transportation and 4X4 Vehicles in Severe Weather

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. The Estates Department have access to a 4X4 vehicle. The Hospital Transport Service can also arrange to hire 4X4 vehicles through their vehicle contractor, Arrow.

The following voluntary organisations in Yorkshire and the Humber have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather.

The adult community nursing teams also work closely with Calderdale Council Adult Social Care to make best use of resources.

Equipment Ordering and Provision

Patients in the community may require equipment to keep them safe, assist daily living skills and improve mobility/function in their own home.

Physiotherapists, Occupational Therapists, Nursing Teams and the Crisis Intervention Team are regular referrers to access equipment. Equipment is arranged via the Loan Stores for Calderdale Royal Hospital patients based at the Community Support Centre, Salterhebble.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Loan Stores Hours of Operation	8.00am-4.30pm Monday-Friday 8.00am-12.00pm Saturday
Lead Manager	Andrew Mould
Contact Details	01422 306725

Escalation plans and business continuity plans

There are escalation plans that have been developed to support operations across all divisions. All escalation plans are found on the intranet, the ED and Paediatric escalation plan will be included in the On Call Managers Pack.

Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services.

Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously and this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of Consultants that are off at any one time over this period.

Severe Winter Weather

Overview						
Business Impact						
• Absence of staff because they cannot get to work • Difficulty for staff and patients to travel around and between sites • Difficulty for community staff to access patienst homes • Increase in minor injuries from slips, trips and falls • Reduced patient transport service • Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities • Difficulty for suppliers to get supplies to hospital	**Impact**	**1**	**2**	**3**	**4**	**5**
	Likelihood **1**					
	2				X	
	3					
	4					
	5					
Proactive strategy						
• Adverse winter weather plan in place and reviewed. • Weather forecasts and gritting information published on the local authority websites. • Stockpile of salt/grit for car parks and access ways to Hospital sites. • Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes. • Yorkshire Ambulance Service winter plan. • Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work. • Community staff advised to work to nearest location to their homes						
Reactive strategy						
• Implement flexible working arrangements where possible (adult community nursing) • Implement the joint surge and escalation plan • Contact Local Council Highways to request roads are gritted for essential appointments and						

discharges (this will not always be possible).
• Provide accommodation for essential staff who cannot get home from work
• Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible)

Trigger	Received by	Immediate action
Met Office Cold Weather Alert	Estates/Associate Director of Urgent Care	• Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments. • Clinical Site Commanders will assess the consequences for discharges • The Estates Department and VLL (CRH) have a planned process for maintaining the Hospital grounds. • Review by the outpatients and surgical management teams of impact on performance.
YAS PTS notification that journeys are affected or have been stopped	Clinical Site Commander	
Significant number of out-patient DNA	Outpatient manager	
Staff absence reporting	Department managers	• All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty. • Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager • All service areas will maintain up-to-date contact lists for all their staff • Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence. • Staff will be reallocated according to service need.

Cold Weather Alerts

Alert trigger	Trust Actions
Level 1 Winter Preparedness	• Work with partner agencies to co-ordinate cold weather plans • Work with partners and staff on risk reduction awareness • Plan for a winter surge in demand for services • Identify those at risk on your caseload
Level 2 Alert and readiness (60% risk of severe weather)	• Communicate public media messages • Communicate alerts to staff and make sure that they are aware of winter plans • Implement business continuity plans • Identify those most at risk • Check client's room temperature when visiting
Level 3 Severe Weather Action	• Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that staff can help and advise clients • Signpost clients to appropriate benefits

	• Maintain business continuity
Level 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days	• Activate emergency management arrangements • Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that the hospital sites are kept clear and accessible • Maintain business continuity

Road Clearance

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at –

http://www2.kirklees.gov.uk/winterUpdates/default.aspx
http://www.calderdale.gov.uk/transport/highways/winter-service/index.html

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations the Local Councils may assist with road clearance where possible.

Kirklees Council will be operating “gritter twitter” this winter which gives real time information on the council’s response to the winter forecast. This information can be used to plan journeys and has been used by schools to assess whether or not to open. The link to twitter is can be found at the Kirklees Council weblink above. Calderdale Council regularly update their website with information about planned gritting routes during periods of severe weather.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the patient flow team who will be responsible for liaising with Kirklees Council Highways.

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

Transportation and 4X4 vehicles

The following voluntary organisations in Yorkshire and the Humber have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather. The adult community nursing teams also work closely with Calderdale Council adult social care to make best use of resources.

Managing absence

The Trust Adverse Winter Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

In the event that essential have difficulty getting to work and there are no alternate travel options including car sharing or public transport it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

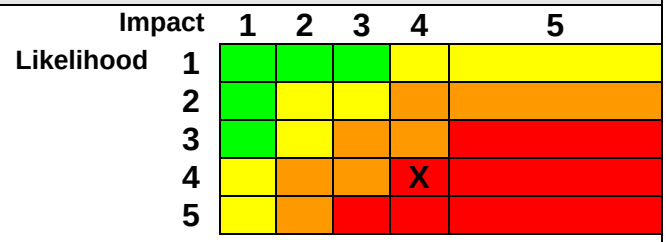
The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

Useful contact information

Organisation	Contact Name	Telephone / Email
4X4 Response	24hr call out number	Available in patient flow office
British Red Cross		
Calderdale Council Highways		01422 288002
		OOH 01422 288000
Calderdale Council Emergency Planning Team		01422 393134
CHFT Accommodation		Via General Office
CHFT Hospital Transport Service		Via help desk
Kirklees Council Emergency Planning Team		01484 221000
Kirklees Council		01484 414818

Highways		
St John Ambulance		
	24hr pager	Via switchboard

Seasonal influenza

Overview		
Business Impact		
• Absence of staff due to influenza illness • Spread of the virus to staff due to ineffective use of personal protective equipment • Lack of available supplies of personal protective equipment • Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas • Lack of available side rooms to isolate infectious patients • Lack of available capacity on intensive care units to treat flu patients with serious illness • Closure of ward areas and loss of bed days due to outbreaks of infection • Increased monitoring and reporting requirements for flu-related activity		
Proactive strategy		
• Immunise staff for seasonal flu • Community staff continue support people to stay at home • Restate the risks and infection control requirements for managing flu patients • Key messages reinforced by community staff • Purchase additional supplies of face masks, gowns and goggles • Create and manage a stockpile of FFP3 masks • Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in A&E, ICU, Respiratory and MAU)		
Reactive strategy		
• Promote key flu messages for patients (if you've got flu, stay at home) • Follow standard infection control precautions for managing flu patients • Reassign or redeploy staff in high-risk groups as appropriate • Implement the joint surge and escalation plan • Implement the escalation plan for critical care if required		
Trigger	**Received by**	**Immediate action**
DH reporting - proactive	DIPC	• Alert forwarded by email rule to Director of Operations, Director of Nursing, Director of Infection Prevention and Control. • Staff in the Emergency Departments and out patient departments will remind relevant patients to have their flu jabs if they have not already done so. • Implement management of flu arrangements.
Surge in flu related activity	ED matron/CD	
Surge in flu admissions	Infection control team	

Infection Control

Patients that require admission with suspected or confirmed influenza should be nursed in a side room with the door closed. A respiratory isolation sign should be displayed (further information on isolation of patients is available in the isolation policy section K). All staff must wear personal protective clothing (PPE) when entering the side room. When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum.

In the event that there are number of admissions with confirmed or suspected influenza it may become appropriate to cohort patients in a single bed bay or ward area.

Some members of staff will be at greater risk from flu because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols.

Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons and surgical masks.

A central stockpile of surgical masks, gowns and eye protection will be established on each site. The stockpile will be managed by the materials management team and accessible to the relevant wards and departments.

FFP3 masks, gowns and eye protection are only required by staff performing cough inducing procedures for patients with suspected or confirmed influenza. FFP3 respirators must be used as an alternative to a surgical face mask when performing the following procedures.

- intubation and related procedures, e.g. manual ventilation and ET tube suctioning
- cardiopulmonary resuscitation
- bronchoscopy
- surgery and post-mortem procedures in which high-speed devices are used.

Staff performing these types of procedures will include A&E medical staff, Anaesthetists and Intensivists, respiratory physicians, medical physicians, physiotherapists (chest) and some nursing staff in ICU, respiratory and MAU. Other wards and departments should not routinely stock these masks.

FFP3 masks are held on wards 1, 6, 11, 18, ICU, SAU, Emergency Department at HRI; wards 2AB, MAU, 3, 5, ICU and Emergency Department at CRH); A central stockpile of FFP3 masks will also be established on each site but will be managed by the infection control team. The site coordinator can be contacted out-of-hours if FFP3 masks are required.
A central stockpile of FFP3 masks will also be established on each site but will be managed by the infection control team. The site coordinator can be contacted out-of-hours if FFP3 masks are required.

Fit Testing For FFP3 Masks

Prior to using a face mask respirator the user must first test that an air-tight seal can be attained. Face masks come in various shape sizes so users can determine the most effective.

There are fit test kits on all ward areas within the Trust. Fit test kits will be used to fit test initially. It is the responsibility of leads in each of the areas identified to fit test their staff, that perform aerosolizing procedures, and to record the type of mask that they require. For those staff that have been fit tested need adding onto the equipment training database to ensure an accurate training record is maintained.

Where a member or staff does not successfully fit test with the mask in the central stock areas (wards 1, 5, 6, 18, ICU, SAU, Emergency Departments at HRI; wards 2AB, MAU, 3, CCU, ICU and Emergency Department at CRH); or a reusable mask held by the ward or department, each management team must put in place appropriate risk mitigation measures to protect the member of staff from contracting the flu virus at work. This may involve:

- Purchasing an alternative model of mask (if available)
- Reassigning to an alternative task
- Redeploying to a different area where they will not be required to perform aerosolising procedures with flu patients

FFP3 portable hood systems have been purchased for use in the emergency departments on both sites. Training is being undertaken in both ED's in the use of the FFP3 hood systems.

Critical Care Escalation Plan

The Local Critical Care Network has developed a critical care network escalation plan that includes triggers and escalation levels (see appendix 2). The Trust Critical Care Escalation Plan details the arrangements for increasing level 3 capacity in the event of a surge in demand.

Christmas and New Year Bank Holidays

Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays over the Christmas, New Year period and the during this period when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period.

Reduced services

The Christmas and Bank Holiday arrangements for different services will be shared in the on callpack which will be available in each Patient Flow office. Copies of the operational arrangements for theatres and clinical support services over the Christmas and Bank Holiday period will be again available for the on call teams over the Christmas and New Year period.

Partner organisations

The Christmas and New Year cover arrangements for primary care, social care and safeguarding will be shared with the on call teams for the Christmas and New Year period and stored in the patient flow offices on both CRH and HRI sites.

Communications

The communications team will issue media statements during winter to reinforce key health messages.

When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

Prior to the Christmas and New Year period a press release will be issued reminding the public them when it is appropriate to use primary care services rather than accident and emergency departments and to stock of home medicines cabinets prior to the holiday.

In the event of a significant infection outbreak the Trust communications team will work with Calderdale and Greater Huddersfield CCG to implement a media and communications strategy utilising key messages which will include advice for visitors.

Training and Implementation of the Winter Plan

The winter planning group is overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by;

- Involvement of leads from each division in winter planning group
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news;
- Publication of related documents on the Preparing for Emergencies section of the staff intranet;
- Publication of the plan on the Trust intranet; and,
- **Winter Plan briefings for Managers, Directors, Matrons, Ward/department sisters from September 2017.**

Equality Impact Statement

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

Monitoring Compliance with this procedural document

The winter planning group is responsible for the successful implementation and monitoring of the winter plan. The winter planning group will continue monitor the plan (October 2017 to March 2017) to review its effectiveness and update the document where appropriate.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Associated Documents/Further Reading- Intranet

The Trust has a number of policies and plans that would be used in dealing with problems caused by winter conditions. They are both clinical and non-clinical and some are season-specific and others are for general use.

a. Adverse weather policy
b. Pandemic influenza
c. Major Outbreak of infection Policy
d. Emergency Management Arrangements
e. Escalation guidelines for the maternity units
f. Discharge policy/Transfer of Care policy

There are also some whole system plans that will be implemented as appropriate:

g. Joint Surge and Escalation Plan

Appendix 1

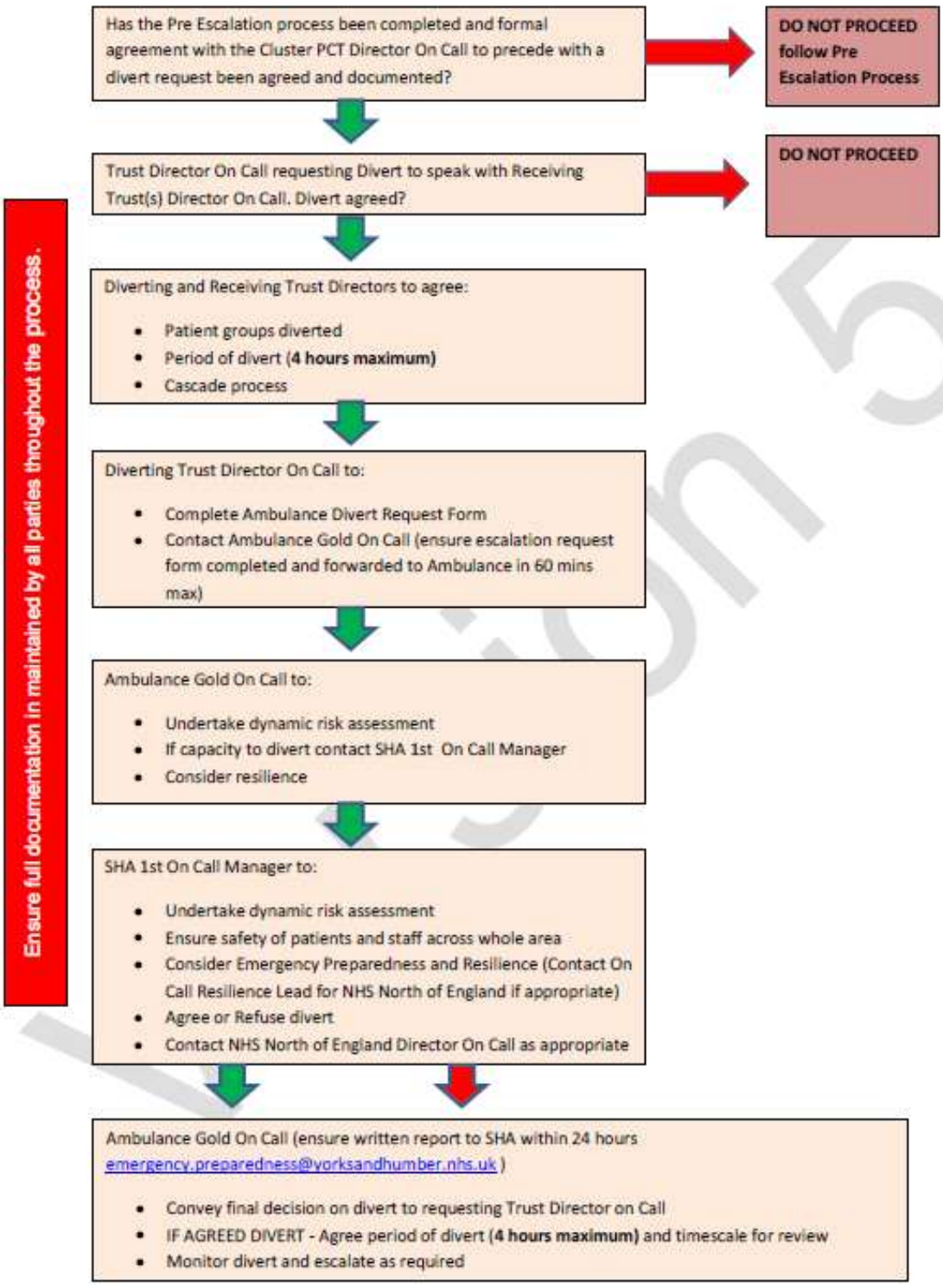
SECONDARY CARE (including Acute, Specialist & Foundation Trusts etc)	
DEFINITION	**STATUS**
NORMAL	
'Business as usual' • Normal, able to meet all critical care needs, without impact on other services. • Current status as 'normal' for season	**CRITCON 0 (FLUCON 0)**
LOW SURGE	
'Swine Flu impacting beyond 'normal' winter pressures' • May include limited local expansion, elective cancellation, and/or non-clinical patient transfers.	**CRITCON 1 (FLUCON 1)**
MEDIUM SURGE	
'Unprecedented' • Level of pressure on critical care which is previously unseen in most organisations. • May include significant expansion into non-ICU areas, and/or use of adult facilities for paediatric critical care. • Staff working outside normal areas, or at increased patient:nurse ratios. • Significant critical care transfers (clinical and non-clinical). • Trusts beginning mutual aid and phased reduction of elective work as necessary to support critical care needs, by local decision. • No triage (refusal or withdrawal of critical care due to resources). • When a significant proportion of Trusts in Yorkshire and The Humber are reporting CRITCON 2 the SHA will assume command and control arrangements	**CRITCON 2 (FLUCON 2)**
HIGH SURGE	
'Full stretch' • Maximum expansion for mutual aid with extensive impact on services. • SHA instruction for all critical care units in region to double capacity (so all organisations in SHA move to CRITCON 3 in one step). • Trusts at or near maximum physical capacity (may be more than double in some cases). • Elective operating reduced to lifesaving surgery only. • Elective medical and other procedures similarly prioritised to free staff, space, or equipment. • No triage (refusal or withdrawal of critical care due to resources).	**CRITCON 3 (FLUCON 3)**
TRIAGE	
'Last resort' • SHA will declare CRITCON 4 for all of region when region is unable to meet all critical care needs despite full surge capacity in place. • Triage processes for accessing critical care will be instigated. This will result in adverse outcomes to one or more flu or non-flu patients due to resource limits caused by the pandemic. • Will be reviewed every 12 hours.	**CRITCON 4 (FLUCON 3)**

Appendix 2: Criteria and SOP for open and referral to flexible capacity

Checklist on opening additional beds.docm

Appendix 3

Escalation Request Flow – NHS North of England Yorkshire and the Humber Footprint



Appendix 4

CRITERIA FOR MEDICAL TRANSFERS TO: - THE GYNAECOLOGY AREAS

Prior to transferring to ward 4C or GAU the patient must be assessed against essential criteria as outlined below.

If the criteria to outlie are not met please escalate to the Matron for Gynaecology, On Call Duty Matron or Night Matron as appropriate.

- No acute delirium, confusion, disorientation
- Patient is not on the End of Life Care Pathway
- Minimal risk of falling
- For patients requiring re-ablement, intermediate or 24 hour care section 2 physio and OT referrals must have been completed
- NEWS within expected limits
- Patient does not require specialist nursing skills i.e. Nippy, peg feeds, unstable cardiac symptoms, unstable diabetic, active seizures, probable CVA
- Patient with a known ongoing complaint/ grievance must have Senior review to assure that a move is in the best interest of the patient
- Patient has not been admitted with a diagnosis of long term substance misuse (e.g. alcohol or drugs)

Paediatric Escalation Plan, Advanced Paediatric Nurse Practitioner Escalation Plan and Maternity Escalation Policy

Appendices 5, 6 and 7

2016__Feb__-_Paediatric_Escalation_-_v3

2016__Sept__-_APNP_escalation_process

Escalation Policy (Maternity).pdf

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, 7th September 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report - July 2017 - 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, both Cancer 2 week wait targets and both Cancer 62 day targets. Finance domain is now also RED due to deterioration in I&E: Surplus / (Deficit) Control Total Basis and Agency expenditure.	
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 31/8/17	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

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, both Cancer 2 week wait targets and both Cancer 62 day targets. Finance domain is now also RED due to deterioration in I&E: Surplus / (Deficit) Control Total Basis and Agency expenditure.

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 Performance Report for July 2017

Appendix

Attachment:

SHORT VERSION - IPR Report.pdf

compassionate care

Calderdale and Huddersfield NHS
NHS Foundation Trust

Board Report

July 2017

Report Produced by : The Health Informatics Service

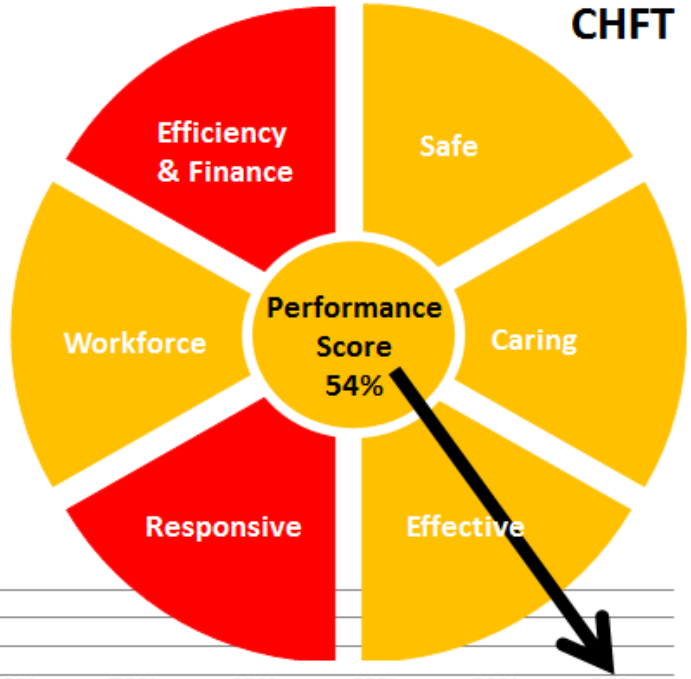
DataSource : various data sources syndication by VISTA

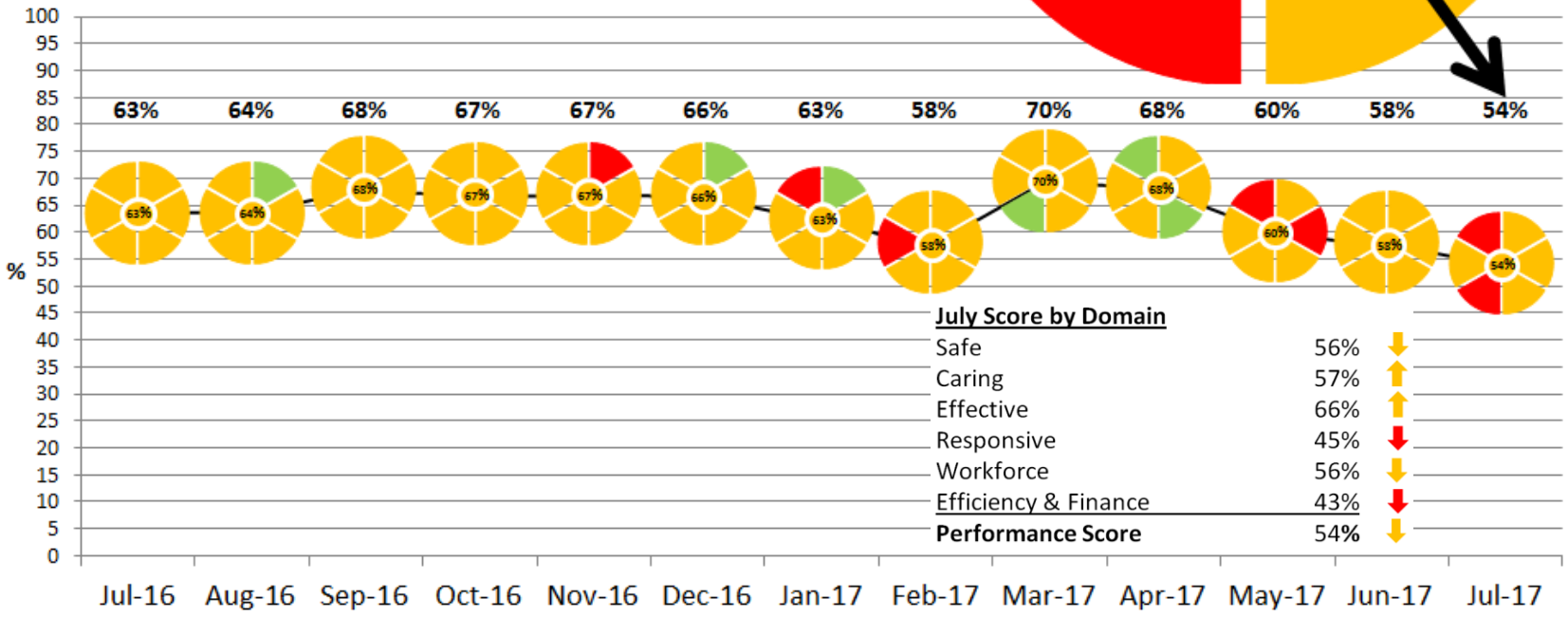
Performance Summary

July

RAG Movement

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, both Cancer 2 week wait targets and both Cancer 62 day targets. Finance domain is now also RED due to a deterioration in I&E: Surplus / (Deficit) Control Total Basis and Agency expenditure.





SINGLE OVERSIGHT FRAMEWORK

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

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

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	96.1%	95.3%	↑	96.3%
	Inpatient Complaints per 1000 bed days	2.0	1.8	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	4.32	4.38	↑	5.17
	Delayed Transfers of Care	3.32%	2.80%	↓	5%
	Green Cross Patients (Snapshot at month end)	107	77	↓	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	98.71	100.85	↑	100
	Theatre Utilisation (TT) - Trust	83.0%	81.8%	↑	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	1.05%	0.66%	↓	0.6%
	Emergency Care Standard 4 hours	93.45%	92.03%	↑	95%
	% Incomplete Pathways <18 Weeks	92.63%	92.58%	↑	92%
	62 Day GP Referral to Treatment	83.2%	88.5%	↓	85%
SAFE	% Harm Free Care	94.27%	93.14%	↑	95.0%
	Number of Outliers (Bed Days)	491	575	↑	495
	Number of Serious Incidents	9	6	↓	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: Hospital Standardised Mortality Rate (HSMR) is now < 100 for both weekday and weekend for the 12 month period to April 2017.

Improved: Complaints re-opened - only 2 in July. Lowest number in over 12 months.

Improved: Average co-morbidity score/Average Diagnosis per Coded Episode - both areas have peaked in performance following the introduction of EPR and the associated improvement in depth of coding.

MOST DETERIORATED

Deteriorated: Cancer performance across Two Week Waits continued to be poor impacting on both day 38 and 62 days. Issues are a combination of increased referrals through fast track, IR35 and EPR impact.

Deteriorated: 62 Day GP Referral to Treatment/Referral from Screening to Treatment both missed target in-month as expected following poor performance in 2 week waits.

Deteriorated: % Sign and Symptom as a Primary Diagnosis. Since EPR go live the % S&S has increased. This is due to documentation within Power Chart and the admitting primary diagnosis not being updated to the diagnosis at discharge.

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: Escalated performance reviews of each tumour site to deep dive into issues with presentation to Executive Board. Daily review of fast track registration implemented. All tumour sites reviewing pathways and escalation response to be tracked.

Action: All pathways manually marked to identify factors/delays that create breaches. All actions required to avoid breaches are generated to the General Manager responsible for the area. Local trusts have been approached (Leeds NHS FT/Christie) for Urology support due to capacity problems at Bradford NHS FT Trust (approaching South Yorks network).

Action: Communication to go out from the Medical Director's office to clinical teams to highlight the issues and impact – potential reduced income, patients being assigned to incorrect HSMR groups and increase in excess bed days. The coding team will continue to highlight and work with clinical colleagues to raise awareness of the importance of a definitive diagnosis.

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	7.6	7.5	↑	
Sickness Absence Rate	4.14%	3.88%	↓	4.0%
Turnover rate (%) (Rolling 12m)	13.13%	12.97%	↓	12.3%
Vacancy	374.98	380.54	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	81%	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	63%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£5.27	-£4.24	🔴
Expenditure vs Plan var (£m)	£5.42	£4.41	🟢
Liquidity (Days)	-28.09	-22.92	🔴
I&E: Surplus / (Deficit) var - Control Total basis (£m)	£0.02	£0.02	🟢
CIP var (£m)	-£1.41	-£0.17	🔴
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	13.16%	13.51%	🔴

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care** - Performance has improved to 94.27% just below target. The deep dive has highlighted areas for improvement and the need for clarity around data definitions in some instances. • **Number of Incidents with Harm** - Numbers peaked in July with 206. This is a higher than usual level of incidents with harm but is still within normal variation. The underlying themes are being explored and will be monitored for any trends. • **Number of Category 3 and 4 Pressure Ulcers Acquired at CHFT** - One Category 4 and a peak of 15 Category 3 pressure ulcers in June. To achieve a sustained reduction in the number of pressure ulcers, the Improvement Collaborative will be relaunched in Q2 to ensure key themes from RCAs are focussed into improvement actions.
Caring	• **Complaints closed within timeframe** - Of the 47 complaints closed in July, 46% were closed within target timeframe. The number of overdue complaints was 25 at the end of July; which was a 16% decrease from June. The overall percentage for complaints closed within target timeframe last year (2016-17) was 45%. • **Friends & Family Test (IP Survey) - % would recommend the Service** - performance remained below target. The Trust recognises that there are specific clinical areas that need to be targeted to improve performance. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance is still not achieving target. A task and finish group has been established by the ADN to drive forward improvement and monitor impact of interventions. • **Friends and Family Test A & E Survey - Response Rate** - improved further to 12.5% 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. • **Friends and Family Test Community Survey** - Community FFT reported 86% would recommend the service against a 96% national average. 4% of people would not recommend services and new FFT system will be running from September.
Effective	• **Number of MRSA Bacteraemias – Trust assigned** - 1 in month in Medicine which was the first one since February 2017. This was a cross-transmission. • **Number of E.Coli - Post 48 Hours** - another 5 in month. Handwashing audits are weekly and FLO (Front line audit) and peer review starts next month. • **Mortality Reviews/Crude Mortality Rate** - The new Learning from Deaths policy has been approved (24th August) which describes the ambition to perform initial screening reviews on all deaths plus Structured Judgment Reviews on selected cases from September. • **% Sign and Symptom as a Primary Diagnosis** - Since EPR go live the % S&S 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. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge** - July's performance continued the pattern seen for the last 3 months 20 percentage points below target. 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

July sees the start of holiday season for Trust staff with changes to normal planned activity levels.
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. A meeting has been held with Cerner, the EPR partner, where issues were directly demonstrated by front-line users and actions required to improve the position clearly articulated.

Outpatient services have seen a significant impact from the EPR deployment with several elements still waiting for final resolution. This has impacted on high volumes of patients and clinicians from booking services through to correspondence. There has been a decrease on completion of Friends and Family as well as a decrease in overall satisfaction as a result of these issues.

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.

Non-elective demand has been constant and slightly above expected levels however day case and inpatient activity, including Endoscopy, remain challenging.

During July the Surgical Division prepared a mock CQC inspection in Critical Care which was held 4th August with initial feedback positive.

The Division also experienced an increase in sickness absence as well as key vacancies which had an impact on the Division's capacity to provide Trauma, surgeons, operating services at CRH and Pre-op services. As a result there has been a reduced appetite for WLI capacity which has affected the Division's ability to deliver against a number of key metrics.

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 July 2016 to allow comparison with historic performance. However the key messages and targets relate to July 2017 for the financial year 2017/18.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours improved to 93.45**% for July - The ECS recovery and sustainability Plan actions continue to be worked through and implemented. • **Stroke -** % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival improved to 67% in month. 39% Stroke patients were scanned within 1 hour of hospital arrival (where indicated) against 48% target. % Stroke patients spending 90% of their stay on a stroke unit dropped to 82% lowest position since January. A full review of the SSNAP dashboard has been undertaken and an action plan is being developed, specifically targeting potential efficiencies in therapy provision to Stroke. • **% Diagnostic Waiting List Within 6 Weeks -** just missed the 99% target with Medicine Echocardiograms underperforming. • **Two Week Wait From Referral to Date First Seen -** missed the 93% target for the 2nd month. All pathways manually marked to identify factors/delays that create breaches. All actions required to avoid breaches are generated to the General Manager responsible for the area (Radiology/Histology etc.) and chased within 24 hours if no response. • **Two Week Wait From Referral to Date First Seen: Breast Symptoms -** missed the 93% for the first time in last 12 months. A Root Cause Analysis carried out by the General Manager, Lead Breast Nurse and PPC Manager has found an issue with appointments (patients booked as routine not Fast Track). This has created delays and breaches but has now been rectified. • **38 Day Referral to Tertiary** - at 27% still well below the 85% target and below 42.4% achieved in 2016/17. • **62 Day GP Referral to Treatment** - lowest performance in over 12 months at 83%. Impact from failure to meet 2 week waits. • **62 Day Referral From Screening to Treatment** - lowest performance since February at 86%. Back on track to achieve in August.
Workforce	• **Sickness Absence rate (%)** has increased in-month with long term sickness at highest rate since December. HR Business Partner within Surgery and Anaesthetics has been running drop-in sessions for ward managers to troubleshoot sickness absence cases and share learning with other managers. Following these drop-in sessions monthly Health and Attendance training sessions have been established, commencing in September 2017. These sessions will then be rolled out across all other Divisions.
Finance	• **Finance:** Reported year to date deficit position in line with agreed control total of £8.72m; • Delivery of CIP is behind the planned level at £2.93m against a planned level of £4.34m; • Capital expenditure is £2.55m below plan due to revised timescales; • Cash position stands at £4.34m against a planned £1.91m due to timing of receipt of STF; • A Use of Resources score of level 3, in line with the plan. The Month 4 reported position is a deficit in line with the planned £8.72m on a control total basis, including year to date Sustainability and Transformation funding (STF) of £2.2m. However, the financial position remains extremely precarious with activity and income continuing to be below the planned level. EPR implementation continues to have a significant impact on both productivity and the capture of activity data. As in recent months, the income position remains inclusive of a level of estimated income based upon activity data not currently correctly represented in EPR. The underlying financial shortfall against the financial plan in the year to date is £5.9m. This is driven by the shortfall in activity and CIP underperformance in the year to date. This has been offset by the release of two thirds of the Trust's contingency reserves for the year alongside a number of non-recurrent benefits. **M4 position prior to action: adverse variance to plan (£5.9m)** Non-recurrent benefits M2 £1.1m Non-recurrent benefits M3 £1.5m Non-recurrent benefits M4 £2.0m Release of Contingency Reserves £1.3m **Month 4 position to report: nil variance to plan £0.0m** The Trust continues to report that the Trust will achieve its Control Total and secure the £10.1m STF allocation. However, the forecast assumes that activity returns to the planned level from August, with no further EPR related income losses. It also assumes that the full £20m CIP target is delivered, whilst the total forecast against identified CIP schemes is currently only £13.76m. The risk of failing to achieve our 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 Surgical specialties Urology and Ophthalmology continue to be underestablished impacting on activity. Where clinical safety is identified as a risk, be that direct inpatient or delayed access, agency staff have been deployed where possible.

Within AED availability of substantive and locum staff has significantly impacted on flow particularly out of hours. In addition EPR has changed the role of the clinical coordinators within AED reducing direct patient facing time. Non-clinical trackers have been recruited to for both departments to ensure appropriate clinical capacity; these postholders start early September.

Several workforce initiatives have been actioned in month with a large cohort of Physician Associates, Advanced Clinical Practitioners and Cardiophysiologists appointed into training to ensure a more robust clinical workforce in the future, this has been positively received by clinical teams.

A large cohort of Enhanced Care Workers to provide 1:1 care commenced in-month improving care and support to vulnerable patients whilst also reducing agency costs.

There has been a considerable focus in July on developing the new model for Rehabilitation with partners. The new model focusses on Rehabilitation being offered through an out of hospital, recovery at home model thus enabling beds in the hospital to be closed.

In terms of capacity management, July has been a positive month, with a reduction in the number of Medical outlier bed days. July has also seen the closure of 7c at CRH and ward 4 at HRI.

The MSK single point of contact has been running now since June and the team have been working hard to ensure the smooth running of the service. This has been challenging due to some of the appointment issues associated with EPR and the challenges of implementing new referrals systems for GPs. Work has progressed on the hand/wrist pathway with ACP's working closely with the consultant to develop skills and knowledge.

The Radiology team have been finalising details of the contract for a new PACS system which will be launched in early 2019. This work is part of the regional Radiology collaborative work.

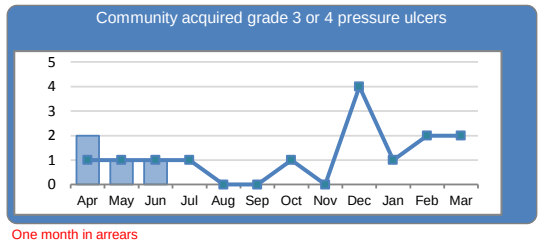
Safe, Effective, Caring, Responsive - Community Key messages

Area	Reality	Response	Result
Safe	Medication Incidents 4 medication incidents in Community in July. One of these relates to poor discharge and has been fed back to the ward in question.	Medication incidents Community pharmacist reviews all medication incidents and summarises issues at quarterly PSQB. She has been asked to look at any further actions that could support increased learning around medication incidents in Community in order to reduce prevalence.	Medication Incidents Aim to have a reduced medication incident prevalence and increased learning and awareness of medication incidents across Community staff.
Effective	Readmission rates from Community matron caseload There has been a reduction in readmissions from patients on a Community matron's caseload this month. In recent months there had been a number of readmissions due to falls. This month there were no readmissions as a result of falls.	Readmission rates from Community matron caseload Continue to monitor the readmission reasons and review any actions that can reduce the number of readmissions to hospital for patients of a community matron's caseload. Community matrons now have view access to EPR to support their understanding of their patients when they are admitted to hospital.	Readmission rates from Community matron caseload Maintain a low % of readmissions within 30 days for patients on a Community matron's caseload. By when: October 2017 Accountable: Matron Community Nursing services
Caring	End of life patients Continue to focus on ensuring that patients are supported appropriately at the end of their life and that they die in their preferred place of death. All hospital deaths this month were appropriate.	End of life patients Continue to monitor each patient and review each case where the preferred place of death and the actual place of death are different.	End of life patients To support patients and their families so that anyone wishing to die at home gets the support they need to remain at home even when they deteriorate. By when: Review September 2017 Accountable: ADN
Responsiveness	Physiotherapy waiting times Physiotherapy waiting times at the end of July were 16 weeks	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 people in need of hands-on therapy to receive this in a timely manner. Whilst initial impact wasn't seen in July the waiting list as of 21/8/2017 stands at 8 weeks with an expectation of further improvement in the coming weeks.	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

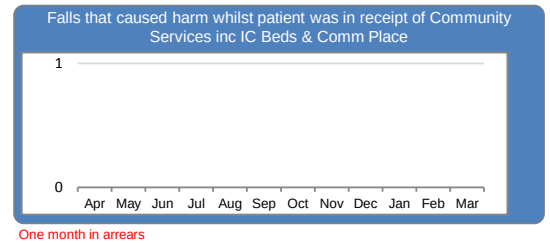
Dashboard - Community

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

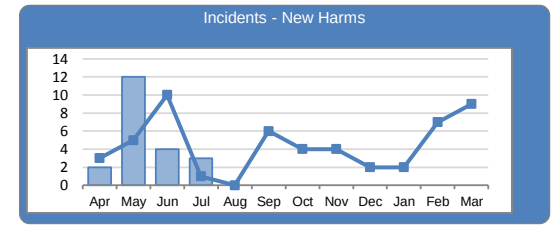
Safe

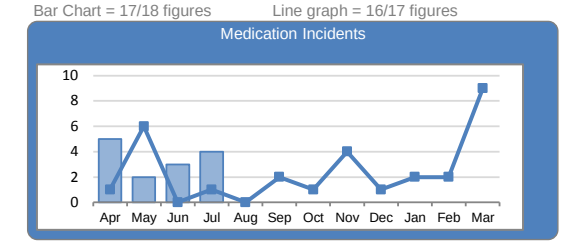


One month in arrears

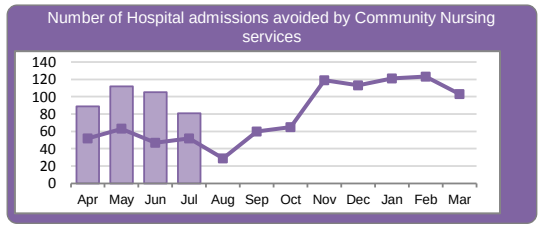


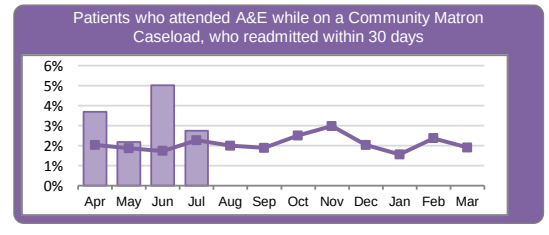
One month in arrears

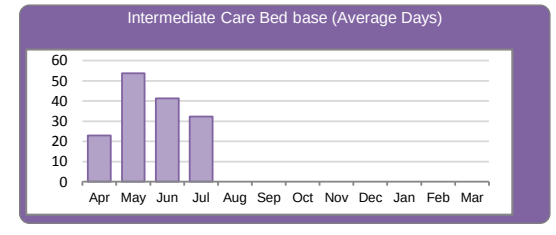


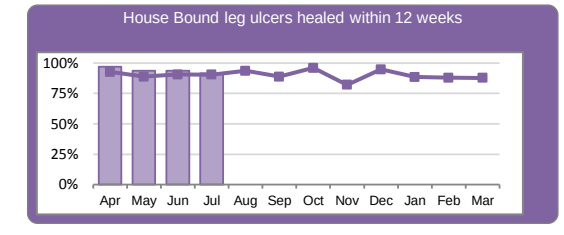


Effective

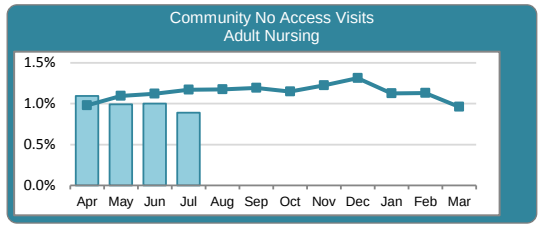


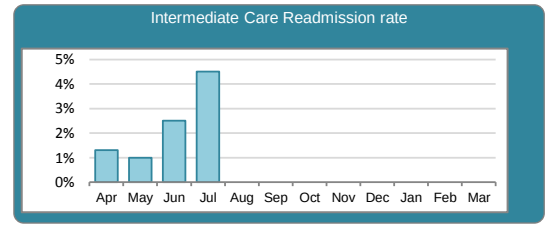


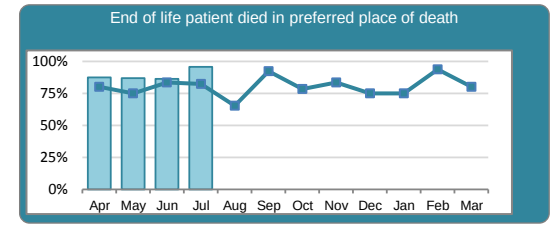


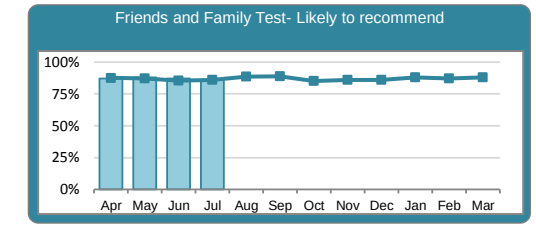


Caring

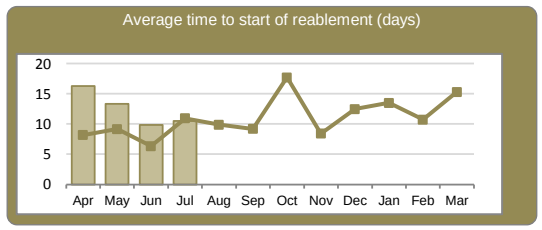


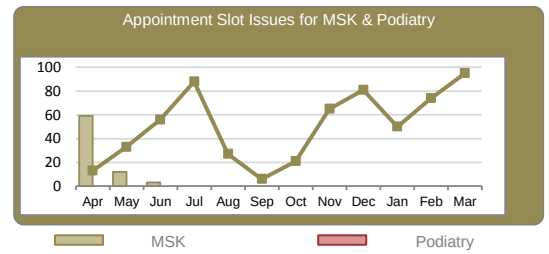


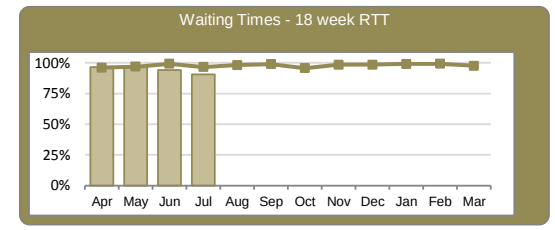


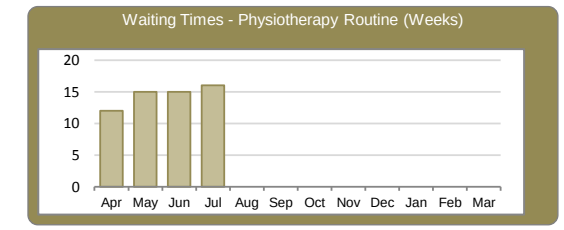


Responsive

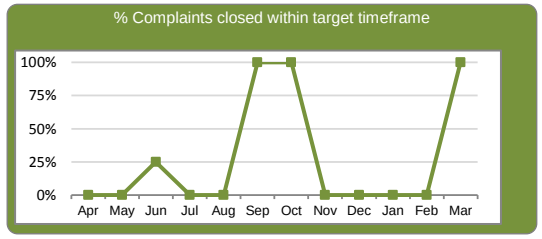


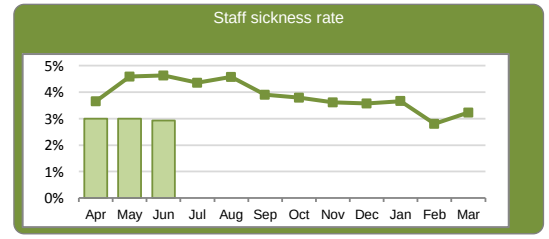




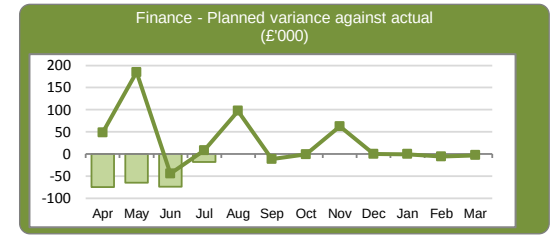


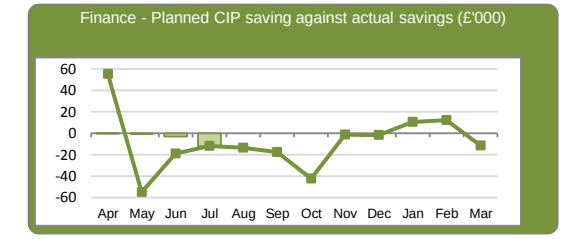
Well Led



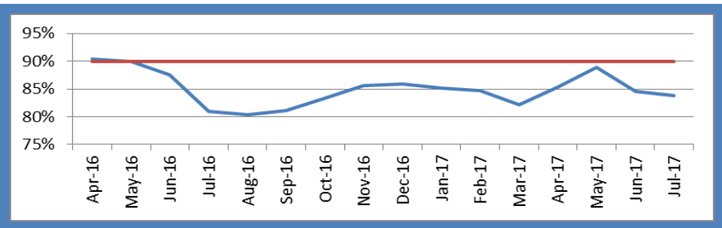
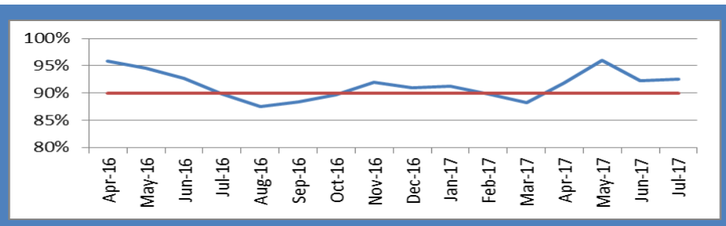
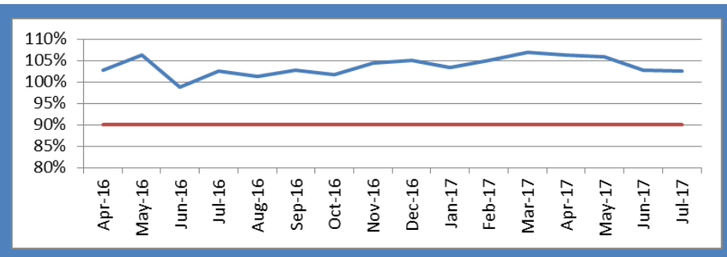
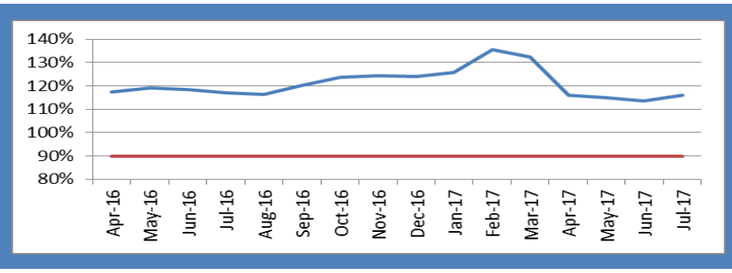


One month in arrears





Hard Truths: Safe Staffing Levels

Description	Aggregate Position	Trend	Variation
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	83.82% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% -WARD HRI MAU: 70.7% -WARD 5AD : 70.5% -WARD 6D : 74.8% -WARD 17 : 62.4% -WARD 21 : 72.9%
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	92.54% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% -WARD 8 : 71.0% -WARD 12 : 68.8% -WARD 17 : 67.3% -WARD 8AB : 67.4% -WARD 10 : 66.9%
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	102.48 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at day <75% -WARD 8AB : 64.5% - WARD NICU : 73.7% - WARD 3ABCD : 63.5% - WARD 18 : 55.6%
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	115.87 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% -WARD NICU : 72.6%

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

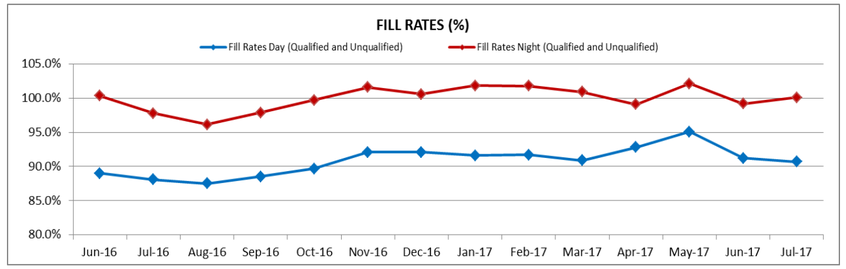
Ward	Main Specialty on Each Ward	DAY						NIGHT					
		Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual		
CRH MAU	GENERAL MEDICINE	2511	1944.5	1674	1315.75	77.4%	78.6%	1364	1398	1023	1023	102.5%	100.0%
HRI MAU	GENERAL MEDICINE	2743.5	1939.5	1674	1938	70.7%	115.8%	1364	1639	1023	1364	120.2%	133.3%
WARD 2AB	GENERAL MEDICINE	1906.5	1591	1209	1567.5	83.5%	129.7%	1364	1375	682	825	100.8%	121.0%
HRI Ward 5 (previously ward 4)	GERIATRIC MEDICINE	1674	1455.05	1209	1334.5	86.9%	110.4%	1023	1023	1023	1199	100.0%	117.2%
HRI Ward 11 (previously Ward 5)	CARDIOLOGY	2076	1701.5	1006.5	1384.5	82.0%	137.6%	1364	1353	682	670	99.2%	98.2%
WARD 5AD	GERIATRIC MEDICINE	2139	1509	1581	2090	70.5%	132.2%	1364	1269	1364	1613	93.0%	118.3%
WARD 5C	GENERAL MEDICINE	1069.5	954	837	793	89.2%	94.7%	682	682	341	341	100.0%	100.0%
WARD 6	GENERAL MEDICINE	1674	1417.5	1209	1119.5	84.7%	92.6%	1023	1001	682	682	97.8%	100.0%
WARD 6BC	GENERAL MEDICINE	1674	1522	1209	1201	90.9%	99.3%	1364	1331	682	825	97.6%	121.0%
WARD 5B	GENERAL MEDICINE	1209	986	744	1171	81.6%	157.4%	682	671	682	935	98.4%	137.1%
WARD 6A	GENERAL MEDICINE	976.5	833	976.5	740	85.3%	75.8%	682	685	341	364	100.4%	106.7%
WARD CCU	GENERAL MEDICINE	1674	1363.5	372	317	81.5%	85.2%	1023	997.5	0	11	97.5%	-
WARD 6D	GENERAL MEDICINE	1674	1252.5	837	881	74.8%	105.3%	1023	946	682	638	92.5%	93.5%
WARD 7AD	GENERAL MEDICINE	1674	1446	1581	1649.5	86.4%	104.3%	1023	1036	1023	995	101.3%	97.3%
WARD 7BC	GENERAL MEDICINE	1674	1710.5	1581	1717	102.2%	108.6%	1023	1023	1023	1023	100.0%	100.0%
WARD 8	GERIATRIC MEDICINE	1441.5	1149	1209	2095	79.7%	173.3%	1023	726	1023	1573	71.0%	153.8%
WARD 12	MEDICAL ONCOLOGY	1674	1298.5	837	772	77.6%	92.2%	1023	704	341	660	68.8%	193.5%
WARD 17	GASTROENTEROLOGY	2046	1276.5	1209	1043	62.4%	86.3%	1023	688	682	722	67.3%	105.9%
WARD 21	REHABILITATION	1209	881	976.5	1237.9	72.9%	126.8%	682	704	682	803	103.2%	117.7%
ICU	CRITICAL CARE	4030	3535.5	821.5	697	87.7%	84.8%	3921.5	3464.5	0	0	88.3%	-
WARD 3	GENERAL SURGERY	945.5	909	746.5	755	96.1%	101.1%	713	713	356.5	379.5	100.0%	106.5%
WARD 8AB	TRAUMA & ORTHOPAEDICS	1045.5	925.5	919	592.5	88.5%	64.5%	954.5	643	241.5	414	67.4%	171.4%
WARD 8D	ENT	821.5	799.5	821.5	777	97.3%	94.6%	713	540.5	0	195.5	75.8%	-
WARD 10	GENERAL SURGERY	1302	1138	746.5	860	87.4%	115.2%	1069.5	715	356.5	736	66.9%	206.5%
WARD 15	GENERAL SURGERY	1562.5	1400.5	1244.5	1063	89.6%	85.4%	1069.5	725	356.5	931.5	67.8%	261.3%
WARD 19	TRAUMA & ORTHOPAEDICS	1643	1254	1178	1417.5	76.3%	120.3%	1069.5	1000.5	1069.5	1104	93.5%	103.2%
WARD 20	TRAUMA & ORTHOPAEDICS	1999.5	1494.5	1410.5	1469	74.7%	104.1%	1069.5	1077	1069.5	1088	100.7%	101.7%
WARD 22	UROLOGY	1178	1090.5	1178	1124.5	92.6%	95.5%	713	713	713	769.5	100.0%	107.9%
SAU HRI	GENERAL SURGERY	1891	1570	954.5	817	83.0%	85.6%	1426	1405	356.5	356	98.5%	99.9%
WARD LDRP	OBSTETRICS	4278	3693	945.5	722.5	86.3%	76.4%	4278	3723	713	670.5	87.0%	94.0%
WARD NICU	PAEDIATRICS	2247.5	1791.5	930	685	79.7%	73.7%	2139	1978	713	517.5	92.5%	72.6%
WARD 1D	OBSTETRICS	1227	1207.5	356.5	299	98.4%	83.9%	713	709	356.5	301.6	99.4%	84.6%
WARD 3ABCD	PAEDIATRICS	2390	2537.5	1215.5	772	106.2%	63.5%	2139	2222	356.5	322	103.9%	90.3%
WARD 4C	GYNAECOLOGY	713	713	465	376.5	100.0%	81.0%	713	713	356.5	333.5	100.0%	93.5%
WARD 9	OBSTETRICS	1069.5	881.5	356.5	382.3	82.4%	107.2%	713	713	356.5	356.5	100.0%	100.0%
WARD 18	PAEDIATRICS	786.5	668.5	126	70	85.0%	55.6%	713	640	0	0	89.8%	-
Trust		**61849.5**	**51840.05**	**36347**	**37247**	**83.82%**	**102.48%**	**44246**	**40946**	**21352.5**	**24741.6**	**92.54%**	**115.87%**

Hard Truths: Safe Staffing Levels

Care Hours per Patient Day

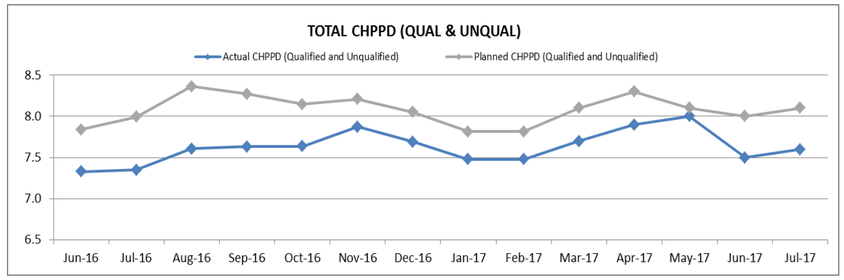
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	May-17	Jun-17	Jul-17
Fill Rates Day (Qualified and Unqualified)	95.10%	91.20%	90.70%
Fill Rates Night (Qualified and Unqualified)	102.10%	99.20%	100.10%
Planned CHPPD (Qualified and Unqualified)	8.1	8.0	8.1
Actual CHPPD (Qualified and Unqualified)	8.0	7.5	7.6

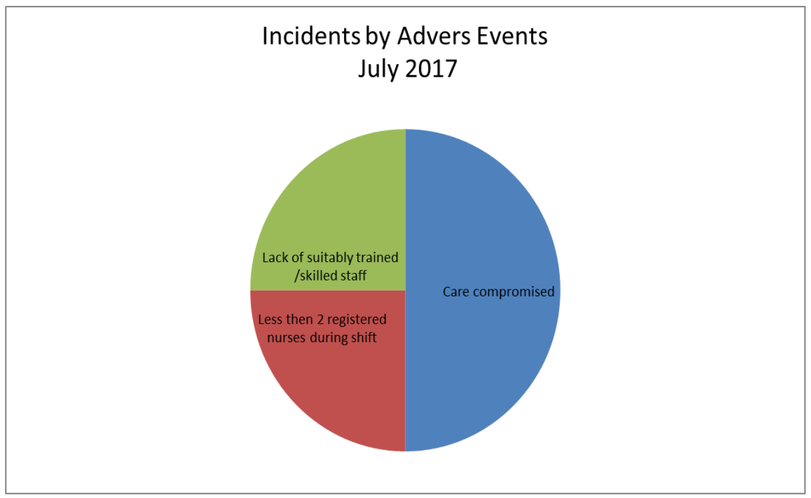


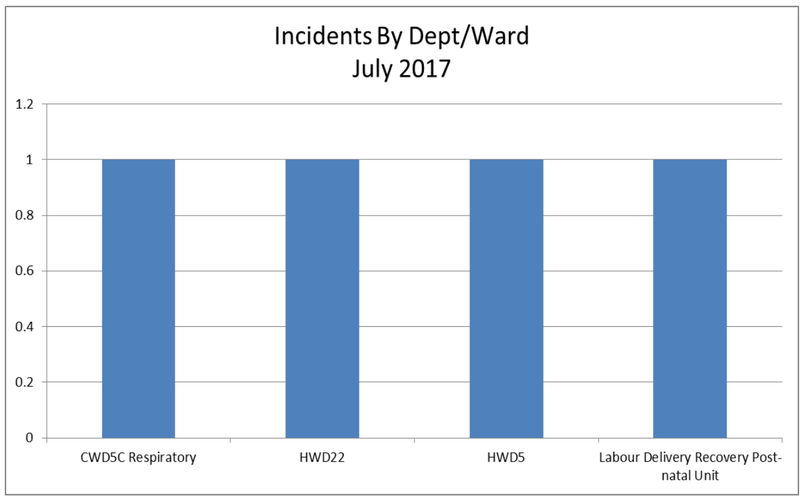
A review of July 2017 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 25 clinical areas of the 37 reviewed had CHPPD less than planned. 3 areas reported CHPPD as planned. 8 areas' reported CHPPD slightly in excess of those planned. Arears with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.

The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. In July 2017 eleven wards reported fill rates of less than 75% for registered nurses. 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 July 2017 are attributed to a level of vacancy and the teams not been able to achieve their WFM. Interim WFM have been developed within the divisions & going forward will be worked to.



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 **4 Trust Wide Red shifts** declared in **July** . The Red flagged shifts were resolved within the Divisions without there being an impact upon patient care or patient safety.

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, 7th September 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: EPR Stabilisation Plan - CHFT implemented the Cerner Millennium Electronic Patient Record on 1/5/17. This is a joint programme with Bradford Teaching Hospitals Foundation Trust (BTHFT) going live on 22/9/17 and is the largest and broadest deployment for Cerner across England so far i.e. the majority of systems changed in a single deployment, and the first of type joint programme. Whilst much of the system is working well, and feedback on the chosen approach for the deployment has been positive from external partners, there remain a number of key issues that have not been resolved and, at 17weeks post go-live, there are growing concerns from clinical and operational staff relating to the speed of resolution. This paper covers the areas concerned.	
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 31/8/17	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

CHFT implemented the Cerner Millennium Electronic Patient Record on 1/5/17. This is a joint programme with Bradford Teaching Hospitals Foundation Trust (BTHFT) going live on 22/9/17 and is the largest and broadest deployment for Cerner across England so far i.e. the majority of systems changed in a single deployment, and the first of type joint programme.

Whilst much of the system is working well, and feedback on the chosen approach for the deployment has been positive from external partners, there remain a number of key issues that have not been resolved and, at 17weeks post go-live, there are growing concerns from clinical and operational staff relating to the speed of resolution.

This paper covers the areas concerned.

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 Data Quality Post EPR Report

Appendix

Attachment:

FINAL PUBLIC BOARD EPR Stabilisation plan.pdf

BOARD OF DIRECTORS	
PAPER TITLE: **EPR Stabilisation Plan**	**REPORTING AUTHOR: H Barker**
DATE OF MEETING: 8th September 2017	**SPONSORING DIRECTOR: H Barker**
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUMS: Directors Meeting, EPR Operations Board	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	

EXECUTIVE SUMMARY:

Calderdale and Huddersfield NHS Foundation Trust (CHFT) implemented the Cerner Millennium Electronic Patient Record on the 1st May 2017. This is a joint programme with Bradford Teaching Hospitals Foundation Trust (BTHFT) going live on 22nd September 2017 and is the largest and broadest deployment for Cerner across England so far i.e. the majority of systems changed in a single deployment, and the first of type joint programme.

Whilst much of the system is working well, and feedback on the chosen approach for the deployment has been positive from external partners, there remain a number of key issues that have not been resolved and, at 17weeks post go-live, there are growing concerns from clinical and operational staff relating to the speed of resolution.

The Operational Board continues to meet 2 weekly and at the meeting on 15th August several significant unresolved risks were escalated. On 16th August, in response to these, the Exec Directors held an emergency meeting to review the known issues and agree the CHFT response.

The key theme are:
Clinical Risk
Engagement internally and externally
Operational Performance
Finance
Bradford Go-live
Other

Within these the outstanding issues include:
- 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
- Other

Regular meetings have taken place between Cerner, the Chief Operating Officer and the Director of Informatics where issues and requests for solutions have been made but progress has been slow. A session was held with senior Cerner colleagues in late July where some specific build issues were demonstrated, including outpatient booking that takes significantly longer than pre EPR, the lack of a solution for regular day attenders and the out-coming of clinic activity. Cerner are currently working to identify solutions but no formal feedback has yet been received that would provide assurance of deliverability and timescale. Cerner intend to visit the trust 7th September when further assurance will be sought.

The Directors have been meeting weekly to develop a response to the concerns raised and this has been discussed in detail at the EPR Operations Board. Meetings have also taken place with Bradford to share learning, support their commissioning of data quality expertise and to agree priorities for resolution.

Key responses include:

- Establishment of a Risk Panel and review of governance for Business As usual (BAU)
- Work with primary care to safely manage communications between secondary care and GPs
- Director meetings with every specialty, as an MDT, to listen directly to concerns and ideas
- A refreshed communication and engagement plan
- Retention of some Data quality expertise & focussed external deep dives into key services
- Increased booking team capacity
- Ongoing dialogue with regulators
- Business case for additional hardware
- Clinical and operational support to Bradford for Go-live and increased 'front end' capacity at CHFT for the Bradford cutover and first week of deployment
- Testing of Business continuity plans
- Formal system testing between the 2 Trusts
- Increased BAU capacity
- Review of the post deployment Tactical programme
- Review of SOPs and associated training

FINANCIAL IMPLICATIONS OF THIS REPORT: Currently being assessed

RECOMMENDATION:

The Board are asked to:

- Note this is not a review of deployment but specifically focusses on areas yet to stabilise
- Note the stabilisation issues as identified and key actions agreed in response
- Note the refresh of the communication and engagement plan
- Note the establishment of the time limited Risk Panel and approach to long term governance arrangements
- Note the position in relation to data quality
- Note that all issues highlighted have been formally communicated with BTHFT to support a successful phase 2 deployment and mitigate any additional risks to CHFT.

APPENDIX ATTACHED: NO

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 7th September 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: Finance Commentary for NHS Improvement - M4 - The attached commentary was submitted to NHS Improvement on the 15th of August 2017 alongside the Month 4 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 4 Final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 4 JULY 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 July 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 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 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 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.

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, July 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	124.27	119.00	(5.27)
Expenditure	(124.76)	(119.34)	5.42
EBITDA	**(0.49)**	**(0.34)**	**0.15**
Non-operating items	(22.20)	(8.40)	13.80
Surplus / (Deficit)	**(22.69)**	**(8.73)**	**13.95**
Less: Items excluded from Control Total	13.97	0.03	(13.93)
Surplus / (Deficit) Control Total basis	**(8.72)**	**(8.70)**	**0.02**

- Delivery of CIP of £2.93m against the planned level of £4.34m.
- Contingency reserves of £1.33m have been released against pressures.
- Capital expenditure of £5.26m, this is below the planned level of £7.81m.
- Cash balance of £4.34m; this is above the planned level of £1.91m.
- Use of Resources score of level 3, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

Operating Income

Operating Income is £5.27m below plan year to date.

NHS Clinical Income

The year to date NHS Clinical income position is £105.00m, £5.33m below the planned level.

The Clinical Contract income position for Month 4 based upon activity coded and captured within EPR is £4.99m below plan. Data quality on EPR has improved compared to Months 2 and 3, 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 the previous two months, 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, £0.75m of income has been calculated as an estimate of the value of this missing data. The size of this year to date estimate is much reduced compared to Month 3 due to action taken to add or correct within EPR, the negotiation of a fixed value agreement with the Trust's main commissioners for Month 2 activity and an agreement in principle with commissioners to recognise some income for Months 3 and 4 where coding and capture issues are well understood.

Following these adjustments, NHS Clinical contract income is still below plan by £4.24m 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 addition, there is an adverse variance of £1.10m 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).

The reported position assumes full receipt of STF funding including the 30% linked to A&E performance targets. 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. The Trust has submitted a letter seeking exception for Quarter 1 on this basis. Performance has continued to recover with 93.45% reported in July. It is assumed that NHSI will 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. Receipt of full STF monies are assumed within the year to date and forecast position.

The Delivery Board sections have not been completed as the Trust is seeking further clarity on this; we are not aware of any requirement or agreement of performance at this level. If this could be clarified we can then review with the delivery Board Chair and respond.

Other income

Overall other income is above plan by £0.07m 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 £5.42m favourable variance from plan within operating expenditure across the following areas:

Pay costs	£1.23m favourable variance
Drugs costs	£0.41m favourable variance
Clinical supply and other costs	£3.78m favourable variance

Achieving the control total for Month 4 has relied on the release of two thirds (£1.33m) of our total Contingency Reserve, and a £3.5m credit relating to a negotiated non-recurrent refund of PFI facilities management costs. This is in addition to the non-recurrent benefit of £0.57m relating to prior year creditors and £0.36m of prior year benefits that were released within the Month 2 position and £0.2m non-recurrent income received in Month 1. The total of non-recurrent benefits in the year to date position is £4.64m.

Employee benefits expenses (Pay costs)

Pay costs are £1.23m lower than the planned level in the year to date, primarily due to the release of Contingency Reserves. 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 £6.34m year to date, with total Agency expenditure of £5.38m.

Drug costs

Expenditure year to date on drugs is £0.41m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £1.07m below plan. Underlying drug budgets are therefore overspent by £0.66m, largely due to additional activity in the Pharmacy Manufacturing Unit which is a commercial operation.

Clinical supply and other costs

Clinical Support costs are £1.05m 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 £2.73m 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 £0.21m 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.

£2.93m of CIP has been delivered this year against a plan of £4.34m, an under performance of £1.41m. 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 high risk schemes fail to deliver; further mitigation of around £3.1m will have to be found.

During June, colleagues from NHSI visited to review the process of CIP identification and governance. The governance in place has been commended and as yet no further CIP opportunities have been identified by NHS I following the CIP deep dive. The Trust continues to explore all avenues to deliver savings in support of CIP delivery and financial recovery against the current underlying run rate.

Statement of Financial Position and Cash Flow

At the end of July 2017 the Trust had a cash balance of £4.34m, £2.43m more than planned. In July the Trust received payment for the 16/17 Quarter 4 Sustainability and Transformation funding of £4.18m, but repayment of the Revenue Support loan that was draw-down in lieu of this payment is not due to be paid until August. There was therefore a requirement to retain sufficient cash to ensure funds were available to make the required repayment.

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	13.95
	Non cash flows in operating deficit	(13.71)
	Other working capital movements	0.16
	Sub Total	**0.40**
Investing activities	Capital expenditure	2.55
	Movement in capital creditors / Other	(2.98)
	Sub Total	**(0.44)**
Financing activities	Drawdown of external DoH cash support	2.62
	Other financing activities	(0.19)
	Sub Total	**2.42**
	Grand Total	**2.39**

Operating activities

Operating activities show a favourable £0.40m variance against the plan. The favourable cash impact of £0.16m working capital variances is combined with 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 Trust received the delayed payment of the Quarter 4 Sustainability and Transformation funding in Month 4 bringing working capital variances much closer to the planned level. However, the small overall working capital variance hides an increase in receivables due to the accounting of the £3.5m PFI credit described above, offset by an equivalent 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 is likely to create a cash pressure for the organisation later in the year. The Trust will need to pursue further discussions with NHS Improvement regarding cash support for working capital.

Investing activities (Capital)

Capital expenditure year to date is £2.55m lower than planned and the resulting cash benefit has offset some of the pressure on working capital described above. Capital creditors have reduced significantly in month with a number of EPR related invoices falling due for payment.

Financing activities

Borrowing to support capital expenditure is £3.48m year to date as planned. In addition the Trust has received £15.06m of Revenue Support linked to deficit funding requirements. This is £2.65m more than planned and reflects additional funding provided to cover delays in receiving Quarter 4 Sustainability and Transformation funding of £4.18m planned for Month 3, but is offset by not receiving Revenue Support as planned to pay capital creditors accounted for in 16/17. As described in the commentary accompanying submission of the annual plan, cash support over and above the level of the planned deficit will be required to settle these liabilities over the next few months.

3. Use of Resources (UOR) rating and forecast

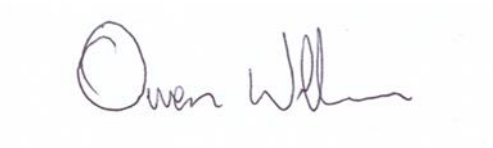
Against the UOR the Trust stands at level 3 in line with plan in year to date and forecast terms.

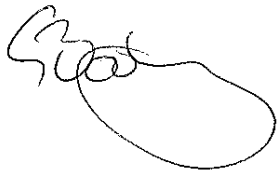
The forecast continues to assume that the Trust will achieve its Control Total and secure the £10.1m STF allocation. However, the risk of failing to achieve our target deficit of £15.94m which was high from the outset, has now increased further despite the Trust taking action to stabilise the financial position.

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.

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th September 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: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from the sub-committees:
- Quality Committee – minutes of 31.7.17 and verbal update from meeting 4.9.17
- Finance and Performance Committee – minutes of 1.8.17 and verbal update from meeting 5.9.17
- Workforce Well Led Committee - minutes 13.7.17 and 10.8.17
- Audit and Risk Committee Minutes – from meeting 19.7.17
- Council of Governors Meeting Minutes – from meeting 6.7.17

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.

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES.pdf

QUALITY COMMITTEE

Monday, 31st July 2017
Board Room, Huddersfield Royal Infirmary

IN ATTENDANCE

Dr Linda Patterson *(LP)*	Non-Executive Director ***(Chair)***
Dr David Anderson *(DA)*	Non-Executive Director
Karen Barnett *(KB)*	Director of Operations, Community Division
Gemma Berriman *(GB)*	Head Nurse for Medicine - Service Planning
Brendan Brown *(BB)*	Executive Director of Nursing
Juliette Cosgrove *(JC)*	Assistant Director for Quality and Safety
Andrew Haigh *(AH)*	Chairman ***(Observing)***
Lesley Hill *(LH)*	Executive Director of Planning, Performance, Estates and Facilities
Chris Lord-Tyrer *(CLT)*	Matron - Service Planning
Dr Cornelle Parker *(CP)*	Deputy Medical Director
Lindsay Rudge *(LR)*	Associate Director of Nursing
Jan Wilson *(JW)*	Non-Executive Director
Michelle Augustine *(MA)*	Governance Administrator ***(Minutes)***

124/17 WELCOME AND INTRODUCTIONS

The Chair welcomed members to the meeting.

125/17 APOLOGIES

Andrea McCourt	Head of Governance and Risk
Helen Barker	Chief Operating Officer
Peter Middleton	Membership Councillor
Andrew Mooraby	Assistant Director of Nursing, Medical Division
Dr David Birkenhead	Medical Director
Martin DeBono	Divisional Director, FSS Division
Anne-Marie Henshaw	Associate Nurse Director/Head of Midwifery, FSS Division

126/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note

127/17 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 3rd July 2017 (appendix A) was approved as a correct record.

128/17 ACTION LOG AND MATTERS ARISING

Please see action log at the end of the minutes (appendix B) for further updates on actions.

Update on the business case for hospital reconfiguration clinical model – this is due to be presented to the Board of Directors for scrutiny – this continues to be work in progress.

129/17 BOARD ASSURANCE FRAMEWORK

A copy of the latest updated Board Assurance Report for July 2017 was circulated for information (appendix C).

130/17 SERIOUS INCIDENT REPORT

JC presented the above report (appendix D) which summarises the new and completed serious incidents reported to the Clinical Commissioning Group between 30th June to 21st July 2017:

- There were 10 new incidents:
  - Five within the Medical Division
  - Four within the Surgery and Anaesthetics Division.
  - One within the Families and Specialist Services Division

  The four new incidents within the surgical division were all from ophthalmology, an area that has not had any previously reported serious incidents. Work is ongoing to recognise if there is a trend.

- Six completed reports were submitted to commissioners:
  - One fall
  - Four pressure ulcers
  - One treatment delay

  The case summaries for all the above were also enclosed in the report.

OUTCOME: The Committee received and noted the report.

131/17 SERIOUS INCIDENT ANNUAL REPORT

JC presented the above report (appendix E) which gave an overview of the serious incident activity within the Trust during 2016/2017, and the key themes and improvement work that have taken place as a result of the investigations.

The key points to note:

- Serious incidents represent 0.7% of all incidents reported during April 2016 and March 2017. A breakdown of the types of incidents was also included in the report.

- The medical division had the highest number of serious incidents in 2016/2017, with 53 incidents, accounting for 79% of serious incidents.

- the most frequent types of serious incidents were:
  - avoidable falls with harm
  - hospital acquired pressure ulcers
  - delayed diagnoses, a key theme in previous years, continued to be identified and is the third most frequent type of serious incident reported.

- Improvement work has taken place as a result of the investigations for slips, trips and falls, pressure ulcers, delayed diagnosis, treatment delay and maternity incidents.

- That there has been no change in the number of pressure ulcers since the changes in reporting, and it was suggested that a report from the Tissue Viability team is brought to this Committee to go through the impact of the new processes and to present work that has been done on the wards.
  Action: JC to liaise with Gemma Berriman.

- There were two never events in 2016/2017 – one misplaced nasogastric tube and one retained swab following a surgical procedure - the same number as in 2015/2016, with improvement work also taking place on those.

- A significant amount of work on Duty of Candour has taken place to ensure early sharing of learning with those who have been involved in an incident. This has led to increased confidence in colleagues talking to patients and relatives where harm has been caused, as well as positive verbal feedback from relatives on how the investigation process has been handled and how they have felt listened to and involved. Discussion ensued on work being done to target patients at their end of life and how their families want to be involved.

OUTCOME: The Committee received and noted the report

132/17 CORPORATE RISK REGISTER

JC presented the high level risk register (appendix F), as at 13th July 2017, with a summary of the changes from June. There were:

- Eight top risks
- Two risks with a reduced score, one from 15 to 12 and one from 15 to 10
- One risk with an increased score from 20 to 25
- One new risks scored at 16
- One closed risk previously scored at 20, reduced to 5

A copy of the high level risk register by type, and a copy of the risk register were also available. It was also reported that work is being done to develop an EPR risk register.

OUTCOME: The Committee received and noted the report

133/17 SAFEGUARDING ADULTS AND CHILDREN'S ANNUAL REPORT

A copy of the annual safeguarding adults and children's report (appendix G) was circulated for information, as it was previously submitted and received by the Board of Directors.

OUTCOME: The Committee received and noted the report.

134/17 HEALTH AND SAFETY COMMITTEE

LH gave a verbal update from the Health and Safety Committee meeting held on 19th July 2017, and summarised that:

- The Sharps Injury Group meeting is to be reinstated on a bi-monthly basis, with representatives from Infection Control, Occupational Therapy, Risk Management and Health & Safety in attendance.
- An action plan for waste management will commence immediately following a recent audit report
- The Security and Management of Violence and Aggression Policy are currently being reviewed the latest fire warden report is being taking to the Weekly Executive Board (WEB) outlining the reduction if fire wardens and the need to get more through training.

A copy of the minutes from the meeting is available at the end of these minutes ***(Appendix 1).***

OUTCOME: The Committee received and noted the report

135/17 ORGAN DONATION ANNUAL REPORT

A copy of the annual organ donation for the trust (appendix I) was circulated for information. The report outlined the donor outcomes from the Trust between April 2016 and March 2017.

AH, who chairs the Organ Donation Committee, reported that a new organ donation clinical lead – Dr Paul Knight, will be taking over from Dr Tim Jackson.

OUTCOME: The Committee received and noted the report

136/17 STROKE SERVICES REPORT

CLT was in attendance to present the above report (appendix J) which highlighted the improvement work undertaken following the Independent Service Review (ISR) in December 2016:

- Thrombolysis – the stroke service now has a bleep system that from the Ambulance Service picking up a suspected stroke patient, will alert all relevant colleagues who will then greet the patient on arrival and escort them straight to the CT scanning unit. The national average is 11.6%, however, the Sentinel Stroke National Audit Programme (SSNAP) target is 20%. To date, the service is at 14% and this was improved since the implementation of the system. Further work is being scoped around the possibility of an assessment area in Accident and Emergency for the stroke consultant and thrombolysis nurse to base themselves in so that more patients can be quickly assessed and diagnosed which may further improve the above figures.

- Therapy triage / improved working times - a huge improvement was made by therapists, which increased the score from a B to an A on the SSNAP data and continues to maintain at an A.

- Computerised Tomography (CT) – the trial with CT scanning has stopped and the Trust has now returned to a C on the SSNAP for CT within one hour. Work is ongoing to try to improve this.

CLT was asked what he was most proud of within the service. Nine months ago, there were a significant number of vacancies, and he stated that he was proud of the way the team worked to achieve the SSNAP score of B considering that the ward was closed due to norovirus. The team are being entered for a Celebrating Success award.

Discussion ensued on maintaining and prioritising stroke services despite capacity issues in radiology with CT and Magnetic Resonance Imaging (MRI) scanning, and it was agreed that a discussion is needed with both the medical and FSS divisions in order for progress to be made.

CLT was thanked for his report and was asked to include more detail as to current position of SNAPP data for next time. Congratulations were conveyed to all involved in achieving targets.

OUTCOME: The Committee received and noted the report.

137/17 CLINICAL OUTCOMES GROUP REPORT

CP presented the above report (appendix K) following the meeting held on 19th June 2017, highlighting:

- The improvement in the Summary Hospital-level Mortality Indicator (SHMI) – now at 105 down from 108, and expected to further improve. The Hospital Standardised Mortality Ratio (HSMR) has slightly increased to 100.85, which puts the Trust slightly above the national average.
- A Cumulative Sum Control Chart (CUSUM) alert on Acute Kidney Injury (AKI), currently at 121. An earlier downward trend suggested successful improvement, and work is being restored with casenote reviews. This fits together with work currently being done

on deteriorating patient and sepsis.

- A workshop on sepsis run by the Improvement Academy was well attended. Significant improvements have been seen in patients with sepsis in the emergency department, but further work needs to be done to improve sepsis recognition and response with inpatients.
- Concerns over the reduction in the depth of coding since the introduction of the Electronic Patient Record (EPR). Work is ongoing with the potential for coding to be recaptured. Discussion ensued on having coding support on wards
  Action: CP to liaise with David Birkenhead and Helen Barker regarding coding support

The Chair acknowledged the great achievement seen with HSMR.

OUTCOME: The Committee received and noted the report

138/17 MORTALITY SURVEILLANCE GROUP REPORT

CP presented the above report (appendix L) following the meeting held on 7th July 2017, highlighting that the learning from death policy has been drafted from the current Mortality Review Protocol, which is required to be in place by September 2017. The policy will be submitted to the Weekly Executive Board (WEB) and the Board of Directors in August for approval, and then subsequently brought to this Committee in September. The new policy is required to include how we will involve family and carers in our review processes and how we will share our learning.

OUTCOME: The Committee received and noted the report

139/17 CQC MORTALITY UPDATE REPORT

This report relates to the learning from deaths policy mentioned above and will be deferred to next month's meeting in order for the updated learning policy to be signed off.

140/17 PATIENT EXPERIENCE AND CARING GROUP REPORT

JC presented the above report (Appendix M) following the meeting held on 3rd July highlighting:

- The group working to a new format of one assurance and one improvement meeting per quarter.
- The 3rd July meeting was an improvement meeting, which included:
  - The results of the national inpatient survey - the Trust scores were classified as 'about the same' as other trusts for all but one of the questions, which the Trust scored 'better' than the majority of other Trusts for the question: 'If you brought your own medication into hospital, were you able to take it when you needed to?'. Comments provided by patients who completed the surveys are being reviewed, and patients discharged during July 2017, will receive a questionnaire as part of the next annual survey. Key messages from this survey will be shared with matrons and ward managers via the Deputy Director of Nursing.
  - The results of a local bereavement survey which were mainly positive but identified some opportunities for improvement. These have been factored into the work plan being taken forward by the End of Life Care steering group, which includes a 'co-design' focus group in September 2017 for staff and relatives to work together on some of the issues raised.
  - An update of the 2017/2018 programme with good progress being made with the patient experience work programme.
  - A drop in the Friends and Family Test (FFT) response rate for May 2017, which was detailed in the Trust Quality and Performance Report. This was mainly linked to the recent process change with the introduction of the Electronic Patient Record (EPR).

The FFT performance group has addressed the issues and an improvement position has been achieved during June 2017.

Discussion ensued on improvements, processes in place and support for divisions regarding mixed sex wards. Work is ongoing with commissioners on how to monitor and report data.

OUTCOME: The Committee received and noted the report

141/17 QUALITY AND PERFORMANCE REPORT

KB presented the above report (Appendix N) which summarised the Trust's performance score of 58% for June 2017.

The caring domain is now amber due to improvements in Friends and Family Test (FFT) performance. The responsive domain remains amber due to failing to meet the Emergency Care Standard and both cancer two-week wait targets. The workforce domain has fallen 10 points due to underachievement in mandatory training. The Electronic Patient Record (EPR) still continues to impact on the provision of several indicators this month.

A large cohort of Enhanced Care Workers to provide one-to-one care commenced, improving care and support to vulnerable patients whilst also reducing agency costs. The Musculoskeletal (MSK) first point of contact went live on 1st June.

Discussion ensued on infection control, and the possibility of a deep clean which will require the decanting of patients. It was stated that a significant amount of cleaning currently takes place, and issues are being highlighted with cleaning services. Discussion also took place on antibiotic use, and possible progress that could have been made on last year's CQUIN, which needs to be focussed on this year. It is anticipated that EPR will assist in the reduction of the overall consumption. It was stated that this will be raised at the Board meeting later this week.

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

142/17 QUALITY COMMITTEE ANNUAL REPORT

JC presented the above report (appendix O) which outlines the activities of the Quality Committee during 2016/2017, describing how the Committee met the duties within the terms of reference, the overview of the role of the Committee, details of membership and attendance during 2016/2017, and information of the work of the Committee in the following areas:

- quality improvement
- governance and risk / patient safety
- audit and assurance
- quality and safety reporting

The responses received following the self-assessment of the effectiveness of the Committee were also summarised in the report.

The Committee were asked for any comments and discussion ensued on the purpose of the Committee, the possibility of a Committee name change, the size of the agenda for the meeting, the need to include more non-clinical issues, for example, items relating to estates, and an evaluation at the end of each meeting.

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

143/17 PATIENT ADVICE AND COMPLAINTS ANNUAL REPORT 2016/2017

JC presented the above report (Appendix P) which sets out a detailed analysis of the nature and number of complaints and contacts with Patient Advice and Complaints at the Trust during 2016/2017using information held on the Trust's Patient Advice and Complaints database.

Key points to note for 2016/2017 are:

- A decrease of 7% in the number of complaints received in 2016/2017 compared to 2015/2016.
- The majority of complaints (58%) were graded as yellow or green, ie no lasting harm / minimal impact on care
- Communication, clinical treatment and patient care (including nutrition / hydration) are the main subjects of complaints; this was the same as the financial year.
- Appointments (including delays and cancellations) remain the main subject of concern received.
- Medicine is the division with the highest number of complaints; however, it is also the largest division and the number of complaints reflects its size.
- Significant work undertaken to improve the timeliness of responses to complainants. Whilst the Trust still has a small proportion of complaints responses which are overdue, there are no longer any responses which are over four weeks overdue.

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

144/17 RESEARCH AND DEVELOPMENT REPORT

CP presented the above report (Appendix Q) which gave a six-month update on research and development activities since the last report in January 2017:

- At the end of the 2016/2017 financial year the Trust superseded its recruitment target of 1342 by achieving a recruitment of 2,623 - the number of patients and participants recruited into studies. A large observational study enabled the Trust to recruit 1,500 which heavily contributed to the final number.
- The total Clinical Research Network (CRN) allocation for 2017-18 for the Trust is £736,040 which is a 3% reduction from the previous year. The Trust has been set a 2017-2018 recruitment into studies target of 1,473 – this is an increase of 131 from the previous year.
- The Recruitment to Time and Target (RTT) is on course with vacancies.
- The research portfolio of studies is changing and new areas are being targeted such as diabetes, musculoskeletal and anaesthesia. However, opening new studies relies heavily on Consultants to take on the role of principal investigator and clinical areas to support them alongside the research delivery team. A draft policy on Income Distribution from Commercial Research has been prepared and in principle approved by Director of Finance. This policy will ensure that income generated from commercial research is used to support the growth of research and incentivise clinical divisions and those staff undertaking the research. A paper to WEB on the Trusts commercial research activity and options for growth will be presented in September.

The Chair congratulated the Research team on achieving and superseding its recruitment target. CP stated that the target for the following year will be a challenge.

A further paper on the progress against the strategic objectives was also circulated

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

145/17 QUALITY COMMITTEE MEETING DATES 2018

A copy of the Committee meeting dates for 2018 was circulated for information.

146/17 ANY OTHER BUSINESS

There was no other business.

147/17 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Report received from stroke services
- Supporting concerns on infection control and debate taken place
- Debate taken place regarding coding
- Report received on complaints

148/17 QUALITY COMMITTEE WORK PLAN

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

149/17 EVALUATION OF MEETING

The effectiveness of the meeting was acknowledged as:

- Good timing
- Good debates
- Would be better if papers were shorter
- Possibility of more personal presentations from services in order to animate discussion

NEXT MEETING

Monday, 4th September 2017
3:00 – 5:30 pm
Discussion Room 3, Sub Basement, Huddersfield Royal Infirmary

This meeting will focus on the Q1 Patient Safety and Quality Board (PSQB) reporting and divisional representation is expected to be in attendance.

APPENDIX 1

Notes of the Health & Safety Committee
Wednesday, 19th July 2017
At 12.00 noon in Meeting Room 2, Acre Mill

Present:	Lesley Hill (Chair)	Director of Planning, Performance, Estates & Facilities
	John Hardy	Microbiology
	Ian Kilroy	Trust Resilience and Security Lead
	Kenn Benson	ISS
	Eleanor Berridge	Albany SPC
	Jayne Blakey	Medical Device Training Co-ordinator
	Luke Whitley	Medical Device Safety Officer
	Christine Bouckley	Occupational Therapy Advisor
	Don Mackenzie	Sustainability, Energy & Waste Manager
	Keith Rawnsley	Trust Fire Officer
	Rachel Roberts	FSS Division Representative
	Tracy Mundell	THIS Business Manager
	Alison Wilson	General Manager, Estates & Facilities
	Jo Atkins	Medical Division Representative
	James Meehan	Risk Management Representative
In Attendance:	Karen Bates	Risk & Compliance Co-ordinator

1. **Apologies:** Gill Harries, Andrea Dinsdale, Lucy Pittaway

   No Attendance from Surgery, Community and Staff Side.
   Action: Lesley Hill to contact Divisions and ask for representation to each meeting.

2. **Minutes of the Last Meeting:**
   Kenn Benson stated that Infection Control Guidelines for Dishwashers were not attached to the minutes as written:
   Alison Wilson stated that Infection Control have advised that there is no risk and Dishwashers reach 82^{o} for the final rinse cycle as stated in the Food Hygiene Regulations. – **Close Out.**
   All then agreed that the minutes were an accurate account of the meeting.

3. **Actions and Matters Arising:**
   Current Actions:
   - **Storage of beds at CRH –** Issues still ongoing, meeting to be arranged between Lesley Hill and Eleanor Berridge to discuss the possibility of cleaning up Old Theatres to store beds. – **Remain Open**
     Action: Arrange the meeting (Karen Bates)
   - **RIDDOR Reporting for Patients –** Alison met with James Meehan and Juliette Cosgrove and all had different perceptions on the issues. Alison will contact other Health & Safety colleagues and also HSE for clarity on procedures and to raise awareness. – **Remain Open**
   - **Medical Gas Incident –** Alison had contacted Anita Hill who has confirmed that there are trained Staff in Radiology to regulate oxygen, and also any Patient transferred from wards requiring oxygen or wearing a face mask must be accompanied by a Nurse. Any incidents that arise with no escort must be reported on DATIX and fed back to this meeting.
     Rachel confirmed that the criteria guidance is currently being worked on and will also be included in the Transfer Policy. Eleanor is meeting with Christine Bentley and will produce guidance notes for Porter's for both sites. – **Remain Open for feedback at August Meeting.**
   - **Bariatric Beds –** Lesley confirmed the beds do fit the side rooms and were tested during a Go See visit. – **Close Out.**
   - **Fire Warden Report –** Alison is taking the latest report to Weekly Executive Board (WEB) outlining the reduction if Fire Wardens and the need to get more through the training. Keith added that it is

the responsibility of Manager's and Matron's to ensure their areas are covered by a Fire Warden at all times – **Close Out but update at the next meeting.**
Action: Agenda item (Karen Bates)

- **HSE Water Investigation –** Lesley reported that this item is to be reported at WEB this week and add to the Agenda for next month.
  Action: Agenda item (Karen Bates)
- **Sharps Incidents Meetings –** To arrange bi-monthly and add to the Agenda – **Close Out**
  Action: Arrange Meetings and add to the Agenda (Karen Bates)
- **Medical Devices Safety Officer –** Interim Officer is Luke Whitley – **Close Out**

Forward Actions

- **Slip, Trips & Falls Policy –** To bring to August meeting

4. Reporting Schedule

a. Health & Safety Annual Plan – Alison apologised for not having the report ready for this meeting and will bring it to August meeting.
Action: Work on H&S Annual Plan (Alison Wilson)

b. Waste Management – Don highlighted areas of concern following a recent audit report from Healthcare Environmental Services (HES): All wards with the compliance issues have been visited.

- Waste bags not being labelled
- Orange infectious "Bag to Bed" small bags have been placed in larger non-hazardous offensive bags
- Larger orange bags mixed in yellow wheelie bins and mis-consigned
- Sharps bin placed in the bottom of an offensive waste bin, then filled up with offensive waste (reported on DATIX).

The following Action Plan has been sent to HES and will commence immediately.

Action	Implemented by	Timescale	Initial Feedback
Bin audits in the waste yard to check compliance and ensure corrective measures are taken	Waste Manager	Immediately: weekly until August and then monthly	Compliance issues that emerged have been addressed with wards and departments.
Domestic staff must label bags	Facilities Management Supervisors	Briefings of staff on13th and 14th June	Labels are available but use of them has dropped and will need to be monitored more closely.
Exceptions reported more fully	Waste Manager	Immediately through FM Supervisors	Importance of compliance needs to be reinforced and need for staff to escalate concerns.
Improved labelling of bins within sluices and waste rooms	Waste Manager	w/c 17th July	Original laminated posters have generally fallen or been knocked off.

Action: Don Mackenzie to contact Jacqui Booth in Communications to produce a screensaver to remind staff on segregation of waste, that non-compliance could lead to prosecution and not to overfill bags.
Action: Don to send the information to Carole Gorman to add to the Agenda of the Estates & Facilities Quality & Safety Board Meeting.
Action: Rachel Roberts to cascade through Matron's Forum

Anatomical Waste – Work ongoing with Theatres to ensure that anatomical waste is consigned in red topped bins.
Microbiology Labs – Reverting back to yellow waste stream.

c. **Medical Devices Update –** Luke reported that Medical Engineering are currently working on updating Policies and Processes and ensuring that PPM data is correct.
Action: Luke and Jayne to review Policy and bring back to the meeting for comments before escalating to ratification.
Medical Devices Training – Jayne reported on the following actions from the Audit recommendations:

- No decision has been made on whether the training process should form part of the appraisal objective.
Action: Lesley to raise this with Brendan Brown.
- Currently trialling linked databases between ESR and MD Training databases and are feeding back issues to John Greenhalgh. Jayne and Brian are currently updating the training records rather than departments inputting their own.
- The department are currently promoting awareness and details of training sessions through the Newsletters and Training Group.
- Scanning or uploading competency statements can be uploaded but John Greenhalgh is having issues with assigning the records to the right area. Paper copies are still required for CQC evidence.
- More training sessions for specific departments – Paediatrics / Maternity events are organised. OPD equipment is limited and specialised, there are in house specialised trainers and Jayne will look to arrange on Audit Days or before clinics open.
- Work closely with Procurement and Suppliers on a process to ensure all devices are delivered to the ME Department and not directly to Ward / Department areas. The process should be designed to be used by ME Department and MD Training.

5. Nasal / Gastro Tube Training Update

High use areas: Ward 17, ASU, ICU and 7ABCD are on average 85% trained, which is a slight drop of 1% due to new starters. There is a plan in place to identify 3 key trainers for all other areas. Good attendances at the monthly training sessions.
Action: Jayne to link in with Janette Cockroft

6. Divisional Updates

THIS – Tracy reported that THIS have arranged on-site Extinguisher Training for staff based at Oak House.
Tracy added that THIS will hopefully be moving out of Oak House and are looking for alternative accommodation. Tom Donaghey is aware and assisting THIS.

FSS – Rachel advised that she took part in an offsite CQC Inspection, and a lack of responsiveness to a device alert within a Cardiology Department was raised.
Action: **Divisional Representatives to remind all colleagues to respond quickly to all device / safety alerts.**

Rachel reported that an allegation has been reported that FSS Staff behaved inappropriately with a difficult member of public, is there a way to flag up on the system that staff can be alerted. Ian Kilroy added that all incidents need reporting on DATIX and communicating out to relevant parties following duty of CANDOUR.
Action: Rachel Roberts to contact Mandy Griffin, Gerard Curran and Ian Kilroy if more advice is required.

Albany – KB to arrange meeting to discuss Bed Storage at CRH, Ligature and B-Braun Trolleys.
To discuss Loading Bay at CRH and storage of gas cylinders with Alison in a meeting arranged for Thursday 20th July.

Estates & Facilities – Alison informed staff of the Crime, Security & Fire Roadshow which took place on Tuesday, 18th July at HRI. The event gave positive feedback from our partnering organisations, staff and members of the public. An event will also take place at CRH.
Action: **Alison to liaise with Eleanor and Val.**

Alison reported that the Security and Management of Violence & Aggression Policy are currently being reviewed and will be presented at this meeting for comments before ratification escalation.

Ian is currently working with Workforce Development on a new Conflict Resolution package and will communicate commencement date.

The Trust are liaising with Calderdale and Kirklees Police to provide drop-in sessions at both Costa Coffee's for staff to raise any concerns / issues with PCSO's.

Ian Law from Counter Terrorism Unit has provided the Trust with Project Griffin presentations, raising awareness within the organisation and Project Argus sessions are arranged in August for Trust General Managers; four from each Division, and November for Executive Board Members.
Action: Divisional Representatives to cascade to General Managers and names of attendees to be sent to Karen Bates

7. Standing Items

7a Health & Safety – Alison stated that Trust seem to be under reporting incidents on DATIX; 114 incidents reported in June 2017 against 135 from May and 125 from June 2016.
The trend in the 'Accident that may result in personal injury' category for June was Dirty & Clean Sharps incidents and Christine added that these were insulin needle injuries and asked that the Sharps Injury Group Meeting be reinstated.
Action: Karen Bates to arrange Bi-monthly meetings with representatives from Infection Control, Occupational Therapy, Risk Management, Health & Safety.

Alison raised concerns on under-reporting for Security and Abuse incidents and added that more work is required to raise awareness in the importance of reporting all incidents on DATIX.

7b. Fire Safety – June's training figure show non – compliance for the Trust at 21% and Keith asked that all Divisional Representatives cascade the importance of compliance in training especially after the recent Grenfell incident.
Action: Lesley asked for the Fire Training information to take to WEB.

Keith expressed concerns on fire alarm incidents at HRI and that 4 out of the 8 incidents involved toasters in Wards and Departments.

7c. Medical Device Training – Jayne reported that Trust are 79% compliant in training and that the last event was well attended. Jo Atkins stated that she would raise training figures issues with the Medical Division.
Action: Jo Atkins to raise issues on Medical Device Training figures with Division.
Action: Jayne to send out the training information to Divisional Directors monthly.

- Jayne advised that the Audit Forms need to be returned to Jayne.
- There is a training event taking place in August
- September the new Inductions commence and devices are to be included in the training

7d. Safety Action Bulletins – All SAB's are up – to – date from Estates and Medical Engineering

8. Staff Side Health & Safety Risks

Kenn Benson reported that members of ISS Cleaning Staff are unable to carry out their tasks safely when numbers of visitors are exceeding the allowed amount. Kenn added that incidents are happening regularly, and there are risks to staff, visitors and patients; and that issues have been reported to Ward Staff. Rachel asked that ISS Managers report any issues to Duty Matron.
Action: Lesley Hill to also raise the issues with Brendan Brown.

9. Items for Escalation

- **a.** Sharps Incidents
- **b.** Abusive Patients
- **c.** Fire Wardens / Training / Toasters
- **d.** Waste Compliance

10. Any Other Business

Alison informed the group that James Meehan will be leaving the Trust in September and that his last meeting is August. Alison thanked James for his attendance and help.

Ian Kilroy and Christine Bouckley announced that they will be providing reports for the next meeting.
John Hardy reported that staff are still using the EPR Trollies that are too high and heavy. Christine Bouckley advised that Manual Handling are going back to manufacturer and requesting a re-design on height and monitor positioning.

Keith raised concerns that the LOWS or COWS are being charged on corridors and that staff are unable to move beds around safely. Lesley suggested marked areas for charging and will provide an update at the next meeting.
Action: Lesley to provide update on areas for charging LOWS at the next meeting.

11. Date and Time of Next Meeting

Wednesday, 16th August 2017 at 12 noon – 14.00 in Meeting Room 3, Acre Mill

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Tuesday 1 August 2017 at 9.00am Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Anna Basford	Director of Transformation & Partnerships
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)

IN ATTENDANCE

Stuart Baron	Associate Director of Finance
Helen Gaukroger	Assistant Director of Finance – Income & Contracting
Andrew Haigh	Chair of the Trust
Peter Keogh	Assistant Director of Operations
Brian Moore	Governor
Philippa Russell	Assistant Director of Finance – Financial Performance
Betty Sewell	PA (Minutes)
Bev Walker	Associate Director for Urgent Care

ITEM

WELCOME AND INTRODUCTIONS

111/17 The Chair welcomed attendees to the meeting.

112/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Kirsty Archer – Deputy Director of Finance
Helen Barker – Chief Operating Officer
Mandy Griffin – Director of Health Informatics
Vicky Pickles – Company Secretary
Owen Williams – Chief Executive
Jan Wilson – Non-Executive Director

113/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

114/17 MINUTES OF THE MEETING HELD 2017

The Minutes of the meeting held 4 July 2017 were approved as an accurate record subject to the change of role for Brian Moore.

115/17 MATTERS ARISING AND ACTION LOG

170/16: Consultant Investment Principles – The Director of Finance presented the Committee with a paper outlining a set of key principles that must be met before any future investment decisions are made to engage external consultants. The rationale with regard to CIP was discussed and it was noted that where external investment has been agreed to support the delivery of CIP, the CIP would be shown as gross which would make it consistent. It was also noted that guidelines for benefits need

to have a timeframe and a measurement for KPIs needs to be established with a starting point. The Director of Finance agreed that he would have a conversation with NHSI with regard their expectations from their KPIs – **action closed**.

116/17 MONTH 03 FINANCE REPORT

The Assistant Director of Finance, Philippa Russell, took the Committee through the Finance Report for Month 03. It was noted that the Month 3 planned position is a deficit of £8m on a control basis, including year to date Sustainability and Transformation funding (STF). However, the financial position remains precarious with activity and income even further below the planned level than that seen in Month 02. EPR implementation continues to have a significant impact on both productivity and the capture of activity data. Ignoring non-recurrent benefits, the Month 03, year to date position, is £5m adverse variance to plan.

The agency spend in month was in line with plan and in line with NHSI agency ceiling, however, this excludes agency expenditure capitalised as part of EPR implementation costs. The number of reported Agency Cap breaches remains high, but was slightly lower than the level seen in May.

Risks for the organisation, which includes the receipt of the total STF allocation, recovery of the full planned value of the Apprentice Levy and planned activity delivery was discussed in detail and acknowledged. It was confirmed that correspondence had been forwarded to Warren Brown at NHSI to appeal against the non receipt of the performance element of the funding following the exceptional challenge due to ERP implementation.

The Committee noted the real challenges and risks ahead for the organisations.

117/17 PROTOCOL FOR FINANCIAL FORECAST CHANGE

The Director of Finance provided the Committee with a paper which outlined the guidance for changes to the in-year forecast.

The following headlines were called out:-

- Revisions to forecast can only be made at the Quarterly reporting points in the year.
- The Board, Finance & Performance Committee and Chair should be fully sighted.

It was noted that a Financial Recovery Plan is being discussed at WEB in terms of tightened controls which will be progressed. Gary Boothby also confirmed that he had attended the launch of the development of the STP Finance Strategy where financial advisors have been commissioned to assess the scale of challenge within the STP footprint and advise of opportunities to bridge the gap. It was also noted that a further meeting with NHSI and NHSE to assess the financial position of the patch has taken place.

It was agreed that the organisation has had regular dialogue with NHSI in which we have flagged our risks and that to continue to do so is important.

The Committee noted the paper and the timescales therein.

118/17 2017/18 CLINICAL INCOME & ACTIVITY ANALYSIS

The Director of Transformation & Partnerships gave a presentation with regard to the key lines of enquiry (KLOE) into the 2017/18 Clinical Income and Activity. Following the analysis which was circulated with the papers for the meeting, today's presentation concentrated on identifying the possible cause and the progress by the organisation to respond to the issues and resolve our income position.

The following headlines were noted for Month 03:-

- ALL points of delivery are down on plan, with the exception of non-elective
- Elective income -£1.1m
- Outpatients income -£1.3m
- Critical care, bowel scope and cancer screening also down on plan

Elective

The KLOE identified the following possible causes

- Pre-op Sickness absence
- EPR generating duplicate pre-op requests
- Individual Consultant waiting lists
- Fewer patients listed due to extra time for EPR admin
- Some information collected in Bluespier is not captured in EPR

The responses to these areas of concern are being monitored on a daily/weekly basis; the main focus of discussion for the Committee was the lack of monitoring of these situations through the Divisional PRM especially the sickness absence in Pre-op. It was noted that EPR implementation could have been a contributing factor with difficult operational issues having to be prioritised.

Outpatients

The KLOE identified the following possible causes:

- DNAs
- Clinical Utilisation/Empty Slots
- Clinic Templates
- RTT and Clinic Outcomes
- Cardiology

It was noted that DNAs peaked in May but have now reduced and are improving. It was also noted that clinic utilisation was the biggest issue and is currently at 87%, the aim is to achieve a 96% utilisation and actions which are now in place should start to impact.

With regard to RTT tracking, the Committee were assured that this issue is a top priority. Weekly Data Quality meetings are monitoring RTT and the next stage of work for Cymbio is to review 10,000 episodes. It was acknowledged that dependant on the scale of the fix changes, the structure of the EPR system cannot take place until after the Bradford go-live.

The Committee recognise the risks with regard to productivity, and the responses to mitigate those risks.

ACTIONS:

- A further update and a review of KPIs was requested for next month – **AB**
- A re-forecasting exercise, to quantify the value of risk, was requested by the Committee by the end of Month 05 - **GB**

119/17 CIP UPDATE

The Director of Transformation & Partnerships updated the Committee with the key headlines:-

- CIP is £170k off plan
- The current forecast is £16.7m which includes non-recurrent schemes and some rated high risk schemes.
- A number of schemes still remain at GW1 despite the request for all schemes to progress to GW2.

Further dialogue at TE today will focus on the priority for all schemes to proceed to GW2 and how this can be achieved noting that colleagues are faced with multiple priorities. A review of portfolios focusing where gains can be made will be undertaken. It was noted that following the NHS I deep-dive, no further areas for CIP for us to pursue have been identified by them.

The Committee noted the cumulative risk with the year-end forecast and the competing priorities for the organisation.

120/17 EPR UPDATE & HIGHLIGHT REPORT

The Associate Director of Finance presented the paper which went to the EPR Transformation Board, the reported financial position up to 30 June 2017 for CHFT and the following key points were noted as follows:-

- £1.1m has been spent on the EPR project
- June is the final month for capital spend, the capital overspend against the original business case stands at £5.6m
- Additional costs are being tracked to ensure control

The following headlines were noted from the Transformation Board:-

- Bradford have been rated Amber for a September go-live.
- Airedale and data migration are two main pressures for Bradford
- Resources prioritised to Bradford for their go-live
- Mandy Griffin continues to push for a meeting with Bradford to discuss resource and the delay in their go-live.

The Chair of the Trust updated the Committee with regard to discussion from the last EPR Assurance Board. It was noted that CHFT are being as supportive as we can, lessons learnt from different aspects of our go-live have been shared. It has been suggested to Bradford that they keep their PAS system “live” longer which will hopefully avoid some of the data issues experienced by ourselves. There has been slippage in Bradford’s training programme and this is being managed.

ACTION: It was agreed that due to conversations which have taken place within this meeting, the EPR Benefit Realisation programme would be reviewed sooner than logged on the Work Plan and this will be amended accordingly - **BS**

121/17 INTEGRATED PERFORMANCE REPORT

The Assistant Director of Operations reported as follows for June 2017:-

June has been a challenging month for performance with our performance score standing at 58% for the Trust. Within Workforce the Mandatory Training KPI reports a worsening in 3 areas which has led to a 10 point reduction. We have failed to meet the Emergency Care Standard (ECS) and both cancer 2 week wait targets, issues are a combination of increased referrals through fast track, IR35 and EPR impact. However, the Caring domain had improved from Red to Amber in month.

In terms of other areas, EPR still continues to impact on the provision of several indicators this month including 18 weeks admitted and non-admitted and VTE. The Cymbio work has improved depth of coding issues. Increases in the number of MRSA and CDiff cases have been discussed by the Quality Committee and were noted by this forum.

It was also noted that the growth reduction within Radiology has been picked up within the Performance Reviews, useage is down but this is thought to be linked to the reduction of outpatient activity, it is too early to determine if outpatients are getting back on track.

The Committee noted the contents of the report and the overall performance score for June.

122/17 RISK RATING UPDATE

Following discussions at the last F&P Committee, the challenge for the Director of Finance was to reconsider the risk ratings for Cash and Capital.

Following further discussions it was agreed to lower the Cash Risk to 12, however, with regard to the Capital Risk of 20 it was thought that this should be reconsidered yet again to review the short (in-year) and longer-medium term Capital risk to the organisation.

ACTION: To reconsider through the appropriate channels the Capital risk rating and come back to the next meeting of the Committee, the description of the risk will also be reviewed – **GB, 1/9/17**

123/17 MONTH 03 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee noted the contents of the paper.

124/17 MINUTES FROM SUB-COMMITTEES:

Capital Management Group – Draft Minutes of meeting held 13 July 2017.

The Committee received the Minutes, it was noted that CMG members had

undertaken a walk round of the HRI estate, the opportunity put into context the true challenge for the Estates team within the building which the members appreciated.

125/17 WORK PLAN

The Work Plan was received by the Committee, it was noted that this would be updated with regard to actions following this meeting.

126/17 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee summarised the following points:-

- Risk to the year-end forecast
- Stretch for the organisation in progressing CIP
- Qtr 2 re-forecasting and how we prepare a plan
- Activity in relation to EPR to be reviewed
- IPR – CQUINS risk
- Risk relating to Capital – balance between short term vs long term
- The overall key message for the Board will be around activity and performance and the level of risk

127/17 REVIEW OF MEETING

Attendees appreciated the particular focus on the challenges and the assurances provided in relation to activity.

238/17 ANY OTHER BUSINESS

No items.

DATE AND TIME OF NEXT MEETING

Friday 1 September 2017, 2.00pm – 5.00pm,
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 13 July 2017, 2.00pm – 4.00pm in Room 4, Acre Mill Outpatients, Huddersfield

PRESENT:

Brendan Brown	Executive Director of Nursing / Deputy Chief Executive
Jason Eddleston	Deputy Director of Workforce and Organisational Development
David Anderson	Non-Executive Director
Karen Heaton	Non-Executive Director (Chair)
Jan Wilson	Non-Executive Director

IN ATTENDANCE:

Kirsty Archer	Deputy Director of Finance
Sue Burton	Medical Education Manager (for agenda item 84/17)
Nigel Collins	ESR Manager (for agenda item 85/17)
Ruth Mason	Associate Director, Organisational Development (for agenda item 89/17)
Cornelle Parker	Deputy Medical Director
Vicky Pickles	Company Secretary
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development
Claire Wilson	Assistant Director of Human Resources
Di Wharmby	Council of Governors

79/17 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

80/17 **APOLOGIES FOR ABSENCE:**
Helen Barker, Chief Operating Officer
David Birkenhead, Medical Director
Chris Burton, Chair of Staff Side
Rosemary Hedges, Membership Councillor
Kristina Rutherford, Director of Operations , Surgery and Anaesthetics

81/17 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

82/17 **MINUTES OF MEETING HELD ON 8 JUNE 2017:**

The minutes of the meeting held on 8 June 2017 were approved as a true record.

83/17 **ACTION LOG (items due this month)**

Doctors in Training Feedback Summary

The Committee agreed to defer this item to the August 2017 Committee meeting.

Apprentice Levy Guidance

A paper is to be submitted to the Executive Board on 20 July 2017. Update to be reported at August 2017 Committee meeting followed by quarterly updates.

Workforce Strategy – Right Skills Right Time Programme

The Programme is to be discussed at Turnaround Executive on 17 July 2017. Progress will be reported at August 2017 Committee meeting.

Flexible Workforce Report – IR35 Regulations

A position report is to be submitted to the Executive Board on 3 August 2017. The report to be discussed at August 2017 Committee meeting.

MAIN AGENDA ITEMS

FOR ASSURANCE

84/17 **MEDICAL REVALIDATION AND APPRAISAL REPORT**

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

SB gave an overview of the progress of the Trust's management of medical appraisal and revalidation since the introduction of revalidation in 2012 and provided an update on performance for the year ending 31 March 2017.

331 doctors have a prescribed connection with the Trust, an increase of 22 from last year. The Trust reached 93% of non-training grade doctors completing an appraisal (NHS England requirement is 90%).

The majority of non-training medical staff were allocated a revalidation date by the GMC prior to Year 4. 20 doctors had a revalidation date in Year 4. Four of these doctors had their recommendation for revalidation deferred. The reason for deferrals was insufficient evidence being presented, typically due to doctors being relatively new to the organisation and not providing sufficient or relevant evidence from previous employers for a recommendation to be made.

Year 5 will see doctors being revalidated for the second time round.

Focus is being given to the quality as well as quantity of appraisals, for example a self-service electronic appraisal system for all non-training grade medical staff was Introduced on 1 April 2017.

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

85/17 **ELECTRONIC STAFF RECORD (ESR) ENHANCEMENTS – PORTAL LANDING PAGE**

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

NC presented key developments in ESR functionality.

The new link to the landing page will be rolled out to all staff during July and August 2017. The Business Intelligence Team and the Communication team are working together to develop a communication plan ahead of the roll out.

As the programme of ESR developments is further rolled out managers will be able to access workforce, patient and financial data from any internet connection and benchmark their department's performance against that of the Trust as a whole with manager self-service being accessible from any internet enabled device.

In order to monitor progress of developments, the Committee requested to see at its

next meeting a next steps report detailing timeline and benefits of the programme.

ACTION: CW to provide a timeline and functionality benefits to August 2017 Committee meeting.

OUTCOME: The Committee **RECEIVED**, **NOTED** and **SUPPORTED** the approach.

86/17 **IMPLEMENTATION OF ALLOCATE E-ROSTERING – MEDICAL WORKFORCE**

CP provided a verbal update on progress since the last Committee meeting.

- CP is to chair a new recruitment and retention forum commencing in August 2017.
- The Trust is expanding to variable pay to improve recruitment and retention.
- A significant number of consultant appointments had been made this year.
- Utilising the agency pay tracker to enable informed decisions.
- Continuing to work with other organisations to increase knowledge and understanding.
- The external consultancy support available to the Trust had reduced. CP will discuss with JE outside of the meeting.

ACTION: CP to provide further progress update at the next Committee meeting.

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

87/17 **BOARD ASSURANCE FRAMEWORK**

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

VP reported that the BAF had been reviewed by the Board of Directors at its meeting in July 2017 where it was agreed to reduce the risk relating to one of the risks under 'A workforce fit for the future'.

The risk '*failure to attract and develop appropriate clinical leadership across the Trust'* is reduced from 16 to 12.

There had been significant progress in the last month leading to the decision to reduce the score.

ACTION: VP to provide further update at the next Committee meeting.

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

88/17 **WORKFORCE RACE EQUALITY STANDARD (WRES) 2017**

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

CW outlined the progress Trust has made against the Workforce Race Equality Standard (WRES) for 2017. The Trust is required to set out its position against nine indicators and publish these on 1 August 2017. This information is set out in Appendix 1 of the report.

An action plan has been established to progress indicators which require improvement.

The Board of Directors will receive the WRES for information at its meeting on 3 August 2017.

ACTION: CW to build BAME data into the Workforce Performance Report.

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

89/17 **COMPASSIONATE LEADERSHIP IN PRACTICE (CLIP) PROGRAMME**

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

RM presented an overview of the CLIP Programme.

The programme has been developed and delivered by Healthskills, a company who have worked with many NHS Trusts. The programme was launched in the Trust on 27 June 2017 with an initial tranche comprising 2 cohorts of colleagues, those who are currently in leadership roles and those who are aspiring to leadership.

Colleagues were nominated by their divisional and corporate senior leaders.

The programme is 8 months long and consists of individual and group coaching; master classes; action learning sets and cross cutting sessions where cohorts work together with each other. Initial feedback from participants is very positive.

CLIP is planned to run for 2 additional tranches and then the programme will be reviewed.

ACTION: RM to present a leadership and development update to a future Committee meeting including attendance of participants on the CLIP programme.

OUTCOME: The Committee **RECEIVED**, **NOTED** and **SUPPORTED** the approach.

PERFORMANCE

90/17 **WORKFORCE PERFORMANCE REPORT (JUNE 2017)**

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

CW reported meeting the Workforce Performance Report has been revised to align with the 7 key areas outlined in the Workforce Strategy.

The report also includes Key Performance Indicators outlined in the Workforce Strategy enabling the Trust to plot progress against the agreed measures.

CW updated the Committee on a new section of the Workforce Performance Report which provides information on the progress made with regard to the workforce planning agenda. Products are being explored to enhance the Trust's approach to workforce planning. A workforce tool WrAPT (Workforce Repository Action Planning Tool) which extracts data from ESR is being considered to support workforce modelling. The report outlined the time-table for the roll-out of the Strategic Workforce Planning model approach – The CHFT Way.

ACTION: CW to circulate WrAPT website link to Committee members.

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

INFORMATION

91/17 **CQC INSPECTION /WELL LED REVIEW**

BB advised the Committee that within the next 12 months the CQC will be undertaking a well led review as part of the Trust's CQC inspection.

Trusts are required to undertake self-assessment reviews on a regular basis. A Board of Directors workshop is taking place on 18 July 2017 to examine how the Trust is responding to the assessments it had carried out.

A paper will be submitted to the Executive Board which will identify the Trust's positive progress against improvement activities.

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

92/17 **GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORT**

The quarterly report had been approved at the 6 July 2017 Board of Directors and was submitted to the Committee for information.

The Committee noted the current postholder has resigned from the role. A meeting is to take place between the postholder, Medical Director and Deputy Director of Workforce and Organisational Development to discuss administrative support to the role.

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

93/17 **2016 STAFF SURVEY RESPONSE**

The Trust's response to the 2016 Staff Survey was approved at the 6 July 2017 Board of Directors meeting.

ACTION: JE to provide progress update at the next Committee meeting.

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

ITEMS TO RECEIVE AND NOTE

94/17 **ANY OTHER BUSINESS:**

It was noted that it had been agreed that from July 2017 Directors will work from the Calderdale site every Thursday unless absolutely unavoidable. From September 2017 Committee meetings falling on a Thursday will take place in the Board Room, Calderdale Royal Hospital.

ACTION: TR to confirm the changed venue arrangements to Committee members.

95/17 **MATTERS FOR ESCALATION:**

There were no matters for escalation.

DATE AND TIME OF NEXT MEETING:

Thursday 10 August, 2.00 pm – 4.00 pm, Room 4, 3rd Floor, Acre Mill Outpatients.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 10 August 2017, 2.00pm – 4.00pm in Room 4, Acre Mill Outpatients, Huddersfield

PRESENT:

Jason Eddleston	Director of Workforce and Organisational Development
David Anderson	Non-Executive Director
Karen Heaton	Non-Executive Director (Chair)
Helen Barker	Chief Operating Officer

IN ATTENDANCE:

Lindsay Rudge	Deputy Chief Nurse
Sue Burton	Medical Education Manager (for agenda item 102/17)
Chris Burton	Staff Side Chair
Samantha Lindl	Personal Assistant, Workforce and Organisational Development
Ruth Mason	Associate Director, Organisational Development (for agenda item 106/17)
Claire Wilson	Assistant Director of Human Resources (for agenda items 104/17, 105/17)

96/17 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

97/17 **APOLOGIES FOR ABSENCE:**

David Birkenhead, Medical Director
Brendan Brown, Chief Nurse/Deputy Chief Executive
Rosemary Hedges, Membership Councillor
Anne-Marie Henshaw, Head of Midwifery/Associate Director of Nursing (for agenda item 101/17)
Vicky Pickles, Company Secretary
Jan Wilson, Non-Executive Director

ACTION: SL to provide the up to date membership of the Committee to KH.

98/17 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

99/17 **MINUTES OF MEETING HELD ON 13 JULY 2017:**

The minutes of the meeting held on 13 July 2017 were approved as a true record.

100/17 **ACTION LOG (items due this month)**

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

Board Assurance Framework

VP to provide an update to the September 2017 Committee meeting

MAIN AGENDA ITEMS

FOR ASSURANCE

101/17 **FSS WORKFORCE PLANS AND STRATEGY**

Apologies were received from AMH. AMH will be invited to present the FSS Workforce Plans and Strategy at the next meeting of the Committee.

ACTION: SL to invite AMH to the September 2017 meeting.

102/17 **GMC NATIONAL SURVEY OF TRAINEE DOCTORS 2017**

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

SB provided a brief overview of the annual GMC National Survey of Trainee Doctors survey. The data collated feeds into Health Education England (HEE).

The 2017 survey was conducted between 21 March 2017 and 3 May 2017. The response rate for the Trust was 100% which is the highest in the region for the 5th year running.

The survey showed the Trust is 5th this year in terms of overall satisfaction compared to 4th in previous years. The results show a slight drop in overall satisfaction locally and regionally. This was anticipated and is largely due to the implementation of the new junior doctor contract. The GMC has provided overarching comments for the first time this year and the response reflects the unhappiness of the junior doctor workforce in relation to the contract.

The Trust is the best in the region for overall satisfaction in Acute Internal Medicine, Orthopaedics, Emergency Medicine FY1 and Emergency Medicine GP Specialty Trainees.

In addition, the Trust is a positive outlier for Emergency Medicine FY1 and Emergency Medicine GP Specialty Trainees.

Ophthalmology and Anaesthetics have improved dramatically and are rated 2nd and 5th highest in the region respectively.

Core medical training is a pink outlier and a recovery plan is being developed.

Obstetrics and gynaecology is a significant cause for concern. This is due to 5 out of 12 posts being vacant therefore leaving gaps in the rota. It was noted that HEE is happy with the results and have placed no conditions on the Trust.

The Trust has no red outlier specialties or specialty grades this year however, there are some areas with slippage and these will be reviewed on an ongoing basis.

SB reported a variance with the questions and agreed to interrogate the individual questions and answers provided and liaise with the survey providers.

HB suggested a proactive meeting with each new intake of doctors to appraise them of the staffing position. SB advised Medicine, Surgery and Obstetrics and Gynaecology have a junior doctor forum with the college tutor as Chair.

A more detailed report, including full action plans for each specialty, will be submitted to Executive Board in September 2017 and thereafter with the Committee.

HB requested the PRMs receive and review the action plans.

ACTION: SB to provide the full report and action plans to the Committee after its submission to Executive Board in September 2017.

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

103/17 **WORKFORCE STRATEGY – RIGHT SKILLS RIGHT TIME**

JE provided a verbal update in relation to the Cost Improvement Programme (CIP) scheme with a value of £800k for 2017/2018. At present the scheme is not delivering savings as originally expected and planned. The principles of the scheme are accepted and supported in the Trust, however, a complete re-set of the scheme with appropriate engagement with operational colleagues is required to ensure that it is successful.

A refreshed scheme will be designed and considered by the Turnaround Executive. Savings in 2017/2018 will be identified although it is likely that any significant savings attributable to the scheme will be available in 2018/2019.

Options to mitigate the non-delivery of savings through the scheme are currently being explored.

ACTION: JE to provide a report to the September 2017 Committee meeting.

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

104/17 **ELECTRONIC STAFF RECORD PROJECT – TIMELINE OVERVIEW**

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

CW provided an overview of the timeline including actions and benefits to date and going forward.

The new ESR Landing Portal page will become operational on 1 September 2017.

The ESR Project Board will receive a revised Project Implementation Document (PID) for sign off at its meeting in September 2017.

Employee and manager self service will be rolled out until December 2017 at which point the 'old' version of ESR will no longer be operational. User guides will be developed to provide support and guidance.

ACTION: CW to provide bi-monthly updates on how employees/managers respond to the functionality of the system.

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

PERFORMANCE

105/17 **WORKFORCE PERFORMANCE REPORT (JULY 2017)**

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

CW provided an overview of the main highlights:-

The Workforce Dashboard numbers show a reduction in headcount and staff in post.

This is as a result of the health visitors leaving the Trust under Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE).

Attendance Management shows a slight increase in sickness figures in the last 3 months across the workforce. The long term sickness absence rate is underachieving in terms of target at 2.73%.

Recruitment KPIs have been added to the Dashboard :-

vacancy created to conditional offer (average days)
vacancy authorisation to start date (average days)
vacancy success.

Once historical data is created trends can be monitored on an on-going basis.

The current data shows a 60% success rate with appointment and 40% of posts are re-advertised. This was considered to be too high.

KH noted the increase in turnover with the Healthcare Science posts. It was noted, this group of staffing is relatively small. FSS is cognisant of the increase and are progressing a piece of skill mix work.

DA queried the reduction in compliance with infection control. CW explained it refers explicitly to mandatory training and is as a result of colleagues not completing this training element of the mandatory training programme. JE advised that the Trust expects excellent performance with regard to appraisal compliance for 2017/2018, however, 3 areas of mandatory training are giving a rise for concern. A robust communication and engagement plan is required to ensure that the appraisal season is successful. It was noted that the Trust's performance is strong relative to that of other Trusts.

Agency spend shows data through to July 2017 and remains an area of concern, however, this does remain within plan and under trajectory.

Following a request at the July 2017 meeting, black and minority ethnic data has been built into the Workforce Performance report at the end of the report.

ACTION: CW to add 'from interview and decision to appoint to conditional offer' as a KPI. In addition, progress will be explored with regard to 'confirmation of shortlisting' and 'confirmation of decision'.

ACTION: CW and HB to work with Peter Keogh outside of the Committee to work together to ensure the report provided through the Dashboard mirrors the Integrated Performance Report.

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

INFORMATION

106/17 **APPRENTICE LEVY – REVIEW OF FINANCIAL IMPACT**

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

RM provided an overview of the implications of the apprentice levy, the challenges it presents in terms of financial pressures, recruitment and levy fund utilisation. The Trust designed an approach built on a set of assumptions which have since been amended. The Trust had originally projected an in-year pressure of £220k in 2017/2018. Further analysis estimates this could be £322k.

The paper sets out recommendations to ensure the Trust maximises the investment through the levy. It was noted the Executive Board approved the recommendations and work is now being progressed to implement the actions.

The recommendations included revising pay arrangements for non-clinical apprentices with the Executive Board agreeing to offer apprentice minimum wage for the first 6 months of employment. On successful completion of a probationary period pay increase the pay to a higher rate.

KH advised a similar pathway is used at the University of Manchester with all apprentices being paid the same on entry with pay progression once the qualification is achieved.

JE advised that a financial pressure will remain for 2017/2018, however, it is envisaged with the implementation of all the approved recommendations that this will reduce in-year to £116k.

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

107/17 **2016 STAFF SURVEY RESPONSE UPDATE**

JE provided a verbal update. A small group of colleagues has recently met with lead responsibility identified for a component part of the staff survey response which comprises four elements - engagement, reward and recognition, health and wellbeing and learning and development.

It was agreed a paper will be developed for the Committee to identify what promotional communication activity the Trust is planning for in advance of the staff survey being launched at the end of September 2017.

JE reported that a census staff survey, rather than a sample survey, will be conducted between October 2017 and December 2017 to provide a clearer picture of the views of colleagues. Local questions will be included in the survey which comprises a core nationally determined set of questions. Questions relating to raising concerns will again be included.

KH suggested incentivising the scheme and gave examples of a prize draw for iPads and charitable donations.

ACTION: JE to provide a paper identifying progress and detail the approach for the 2017 staff survey for the September 2017 meeting of the Committee.

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

108/17 **BREXIT WORKFORCE CHALLENGES**

ACTION: JE committed to provide a paper at the September 2017 meeting of the Committee.

ITEMS TO RECEIVE AND NOTE

109/17 **ANY OTHER BUSINESS:**

Staff Side Attendance

CB requested the attendance of an additional staff side representative to observe the process and provide cover as a deputy in his absence.

ACTION: CB to liaise with staff side colleagues to identify a nomination.

Go Engage

JE reported the Trust has secured, on a no cost basis, a 'Go Engage' pulse survey tool from Wrightington, Wigan and Leigh NHS Foundation Trust. Improvement in colleague engagement has been noted generally and the Trust progressing the implementation of the tool.

ACTION: JE to provide an update at a future meeting of the Committee.

110/17 **MATTERS FOR ESCALATION:**

There were no matters for escalation.

DATE AND TIME OF NEXT MEETING:

Thursday 14 September 2017, 2.00pm – 4.00pm, Board Room, Calderdale Royal Hospital

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Audit and Risk Committee Meeting held on Wednesday 19 July 2017 in Room 4, Acre Mill, Huddersfield Royal Infirmary commencing at 10:45am

Prof Peter Roberts	Chair, Non-Executive
Richard Hopkins	Non-Executive Director
Phil Oldfield	Non-Executive Director (by teleconference)

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Michael George	Internal Audit Manager
Adele Jowett	Local Counter Fraud Specialist
Andrea McCourt	Head of Governance and Risk
Peter Middleton	Lead Governor
Alastair Newall	External Auditor (KPMG)
Victoria Pickles	Company Secretary (minutes)

Item

40/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Helen Barker, Chief Operating Officer
Gary Boothby, Executive Director of Finance
Brendan Brown, Chief Nurse
Clare Partridge, Engagement Lead, KPMG

41/17 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

42/17 MINUTES OF THE MEETING HELD ON 25 May 2017

35/17 Quality Report should read 'It was highlighted that a qualified limited assurance opinion had been given…….'

Subject to this amendment the minutes were approved as a true record.

43/17 ACTION LOG AND MATTERS ARISING

It was noted that there were no items outstanding.

46/16 Payroll update

The Committee received an update in relation to improvement work associated with payroll processes in the Trust.

The Committee asked about monitoring of tax and NI status of employees with multiple assignments. It was clarified that the work had identified people who are on the staff bank who are also employees which can have implications as to how we treat tax and NI.

The Internal Audit Manager highlighted that there is a link to the outstanding internal audit recommendations and that this would be picked up in the re-audit in quarter 3. The External Audit Manager commented that these would also be followed up as part of the next external audit. It was agreed to receive a further report at the Committee meeting in October.

ACTION: Agenda item for October

It was noted that the move to e-timesheets will present a risk however there are only a

small number of staff on e-timesheets. The Internal Audit Manager confirmed that this would be subject to a separate audit.

44/17 COMPANY SECRETARY'S BUSINESS

44/17 (1) Review of Board Assurance Framework (BAF)

The Company Secretary presented the updated BAF. She explained that as it is two years since this version of the BAF was adopted by the Board, it would be reviewed to ensure that it remains fit for purpose, working with colleagues from across West Yorkshire and Harrogate. The Committee suggested that Internal Audit undertake a benchmarking review to support this work.

The Head of Governance and Risk also suggested that the BAF and risk register be reviewed to identify learning between the two documents and this be shared as part of the annual report on the review of risk management arrangements.

OUTCOME: The Committee **RECEIVED** the Board Assurance Framework

44/17 (2) Audit and Risk Committee meeting dates 2018

OUTCOME: The Committee **APPROVED** the meeting dates for 2018.

44/17 (3) Review of ARC Chair Role Description

Each year the Committee reviews the role description for the Chair of the ARC to ensure that it fits with the terms of reference of the Committee and fulfils the statutory function requirements. The Company Secretary presented the reviewed role description and highlighted the minor amendments.

OUTCOME: The Committee **APPROVED** the role description.

44/17 (4) Risk Management Policy

The Head of Governance and Risk presented the Risk Management Policy. She explained that it had been reviewed and minor changes made to bring it into line with the Risk Management Strategy.

OUTCOME: The Committee **APPROVED** the Risk Management Policy.

44/17 (5) Terms of Reference

The Company Secretary explained that the Committee's terms of reference had been reviewed against the latest NHS and Treasury guidance for Audit Committees and highlighted the minor amendments made. It was noted that in future these will be reviewed as part of an annual cycle alongside the committee's self-assessment and annual report.

OUTCOME: The Committee **APPROVED** the terms of reference**.**

45/17 EXECUTIVE DIRECTOR OF FINANCE BUSINESS

45/17 (1) Waiving of standing orders

The Deputy Director of Finance reported that during the first financial quarter of 2017/2018. During this quarter, 10 orders were placed as a result of standing orders being waived, at a total cost of £239,732.70. These were evenly spread across the divisions. No amendments to earlier single sources were made during the quarter. The biggest individual order subject to waiver was for an order placed with Cymbio requiring specialist knowledge related to EPR. Four of the waivers were to do with continuity from an earlier project; five relating to specialist expertise; and one with no

alternative supplier.

The Committee asked about the service offered by Cymbio. The Deputy Director of Finance explained that this was part of early live support and the work was addressing the issues of data capture and the complexity of coding of data transferred to EPR. There was an urgent need to progress this work and Cymbio have a unique set of experience in this field. The Committee commented on the need to learn from the implementation in relation to the design of the EPR and the testing process, and also to consider an alternative way of securing the services of Cymbio on a normal procurement basis.

The Committee also asked about the continuation of the Bluespier contract. The Deputy Director of Finance explained that there was a need to maintain the service while an assessment of the most appropriate software solution is undertaken for the future.

OUTCOME: The Committee **APPROVED** the waivers of standing orders.

45/17 (2) Losses and Special Payments

The Deputy Director of Finance reported that losses and special payments over the quarter totalled £28,000 which is lower than the average over 2016/17. He confirmed that the processes around pharmacy expired stock are rigorous and that losses are minimal in comparison to the overall value of the stock. This is regularly reviewed against benchmarking information and has been looked at in detail by the Cash Committee.

OUTCOME: The Committee **NOTED** the losses and special payments report.

46/17 INTERNAL AUDIT

46/17 (1) Internal Audit Follow-up Report

The Internal Audit Manager provided an overview of the outstanding internal audit recommendations. He highlighted that over 50% of the high priority recommendations are overdue and that there are a number that have been on the radar for a significant period. The Company Secretary explained that the report did not fully reflect those recommendations where an extension had been agreed. The Committee requested that the report be thoroughly reviewed and reasons for non-closure provided. The report should be considered by the Executive Team prior to the next Committee meeting in October.
ACTION: WEB

OUTCOME: The Committee **RECEIVED** the Internal Audit follow-up report.

46/17 (2) Internal Audit Progress Report

The Internal Audit Manager presented the report setting out that since the last Audit and Risk Committee, seven reports have been finalised with four further reports in draft and work underway on eight other audits. Only the Cyber Security Audit remains outstanding from the 2016/17 Audit Plan, with audits on Hospital Configuration, Vanguard/ Community and Clinical Coding being deferred to this year's plan.

Of the seven completed reports, one received full assurance (Performance Management – cancer waiting times); five gave significant assurance (EPR follow-up; CQC visit; Attendance Management; Tendering processes and detailed follow-ups).

Only the mandatory training audit report received limited assurance. The review highlighted that staff can find the ESR/ e-Learning package to be difficult to use and this can prove to be a barrier for some staff. The Deputy Director of Finance and Company

Secretary confirmed that the update to ESR planned for the autumn should address this The other major barriers cited were service pressures with staff finding it difficult to set aside the time to undertake the training. It was noted that the Trust has implemented an 'appraisal season' – a three month period when all appraisals should be completed. As part of the appraisal process mandatory training is discussed. In addition, completion of mandatory training is now linked to pay progression.

The audit reviewed the basis on which issues are classed as mandatory, in order to understand the risk of failing to train in that subject. Internal Audit also reviewed the level of provision of classroom training when it was required to deliver the subject matter. Reviewing the training sessions for Fire Safety, there were insufficient training sessions throughout the year, based on the number of people who ought to be attending. This is being addressed by Estates and Facilities.

The Committee asked where the main areas of concern were relating to the tendering processes audit. It was noted that while the audit received an opinion of significant assurance, there was a lack of evidence in some key processes. This included the use of medical judgement as part of the assessment process and the need to ensure that this is better explained and quantified. There also needed to be a better file structure in place. It was recognised that there is a new Head of Procurement in post who had brought new ideas and challenges and who was making significant changes including tightening up procedures.

The Committee recommended that the Head of Procurement be invited to Finance and Performance Committee to do a presentation on procurement processes and Carter efficiencies, and the outcome of that presentation be reported to the Audit and Risk Committee.

ACTION: Finance and Performance Committee and feedback to ARC

OUTCOME: The Committee **RECEIVED** the Internal Audit Progress Report and **NOTED** the limited assurance opinion for mandatory training.

46/17 (3) Internal Audit Annual Report

The Internal Audit Manager presented the annual report setting out the work during the year. He explained that in future the report should be presented alongside the opinion

ACTION: Add to the work plan

The Committee discussed the number of overdue actions and recommendations that have not been implemented. It was agreed that the Executive Board be asked to consider this further.

ACTION: WEB agenda item on internal audit recommendations

Discussion took place about the efficiency and effectiveness of the Trust's use of taxi firms in relation to patient transport and it was agreed that Internal Audit would look at this further.

ACTION: Internal Audit review of the efficiency and effectiveness of taxi usage

OUTCOME: The Committee **RECEIVED** the Internal Audit Annual Report.

47/17 LOCAL COUNTER FRAUD SERVICE

47/17 (1) Progress Report

The report set out the progress against the approved Local Counter Fraud Service work plan. The Local Counter Fraud Officer explained that the main focus had been on agency workers including invoicing, who is turning up for work, qualifications, costs etc. A successful crime awareness day had been held in the Trust and agency workers had

come up as part of discussions during that day.

It was noted that the number of days allocated have been reduced as part of the overall reduction in audit based on benchmarking and brought in line with other local trusts on a risk-based approach.

The Local Counter Fraud Officer highlighted a risk relating to false invoicing and that the first line of defence is to follow the right procedures as laid out in the SFIs. This would include all possible spend going through the ordering system and then any invoice should match to this purchase order. The Executive Director of Finance reported that there is an ongoing programme of communications on heightened grip and awareness.

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

47/17 (2) Annual Report

The Local Counter Fraud Officer presented the Annual Report which describes the proactive and reactive activities undertaken during the year.

OUTCOME: The Committee **RECEIVED** the Annual Report.

47/17 (3) Investigations

The Local Counter Fraud Officer informed the Committee of the ongoing investigations and any action taken.

OUTCOME: The Committee **NOTED** the progress with ongoing investigations.

48/17 EXTERNAL AUDIT

The External Auditor presented the technical update and highlighted the following points:

- Naylor review - The Naylor Review examines how the NHS can make the best use of its estate to support NHS England's Five Year Forward View and identifies properties which are not being used efficiently. It was noted that any loss on property will go against the Trust's control total.
- Compliance with the standard around sugary drinks whereby the NHS has announced that sugary drinks will be banned in hospital shops beginning from next year unless suppliers voluntarily take decisive action to cut their sales over the next 12 months. It was noted that the Trust was doing a lot of work around this and that it linked to one of the CQUINS.
- Fitness tracking and Fitbit technology – scale of capital investment is challenging.

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

49/17 REPORT ON WHISTLEBLOWING AND OTHER EXPRESSIONS OF INTEREST

The Company Secretary explained that there was no information to report. It was agreed to review the process for bringing whistleblowing updates to the Committee.
ACTION: Executive Director of Workforce & OD / Company Secretary

50/17 INFORMATION TO RECEIVE

The following information was received and noted:-

1. Quality Committee Minutes – 31.5.17
2. Risk & Compliance Group Minutes – 11.4.17
3. THIS Executive Meeting Summary Notes – 20.3.17, 22.5.17
4. Information Governance & Records Strategy Committee Minutes - 26.6.17

56/17 ANY OTHER BUSINESS

The Deputy Director of Finance explained that there is a need for a protocol for financial forecast changes which will need to be signed by the Chief Executive, Chair, Chair of Audit and Risk Committee and the Chair of Finance and Performance Committee.

57/17 MATTERS TO CASCADE TO BOARD

- BAF and Risk Management Policy
- Waiving of SOs – Cymbio and Bluespier
- Mandatory training
- Naylor review

DATE AND TIME OF NEXT MEETING

Wednesday 18 October 2017 at 10.45am – 3rd Floor, Acre Mills Outpatient Building.

REVIEW OF MEETING

All present were content with the issues covered and the depth of discussion.
It was noted that Prof Peter Roberts would cease his term as a Non-Executive Director in September and therefore this was his last meeting. Richard Hopkins would take over as Chair of the Committee from October. The Committee thanked Peter for his hard work as Chair over the previous three years.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD ON THURSDAY 6 JULY 2017 IN DISCUSSION ROOM 1, LEARNING CENTRE, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Chair
Rosemary Hedges	Public elected – Constituency 1
Veronica Maher	Public elected – Constituency 2
Peter Middleton	Public elected – Constituency 3
George Richardson	Public elected – Constituency 5
Annette Bell	Public elected – Constituency 6
Kate Wileman	Public elected – Constituency 7
Lynn Moore	Public elected – Constituency 7
Brian Moore	Public elected – Constituency 8
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
Graham Ormrod	Nominated Stakeholder – University of Huddersfield
Dawn Stephenson	Nominated Stakeholder – South West Yorkshire Partnership FT

IN ATTENDANCE:

Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
David Birkenhead	Executive Medical Director
Kathy Bray	Board Secretary
Anna Basford	Director of Transformation and Partnerships
Gary Boothby	Executive Director of Finance
Brendan Brown	Executive Director of Nursing/Deputy Chief Executive
Mandy Griffin	Director of the Health Informatics Service
Ruth Mason	Associate Director of Engagement & Inclusion
Victoria Pickles	Company Secretary
Owen Williams	Chief Executive

34/17 APOLOGIES:

Apologies for absence were received from:

Di Wharmby	Public elected – Constituency 1
Dianne Hughes	Public elected – Constituency 3
Katy Reiter	Public elected – Constituency 2
Grenville Horsfall	Public elected – Constituency 4 (Reserve Register)
Nasim Banu Esmail	Public elected – Constituency 4
Stephen Baines	Public elected – Constituency 5
Brian Richardson	Public elected – Constituency 6
Michelle Rich	Public elected – Constituency 8
Mary Kiely	Staff-elected – Constituency 9
Nicola Sheehan	Staff-elected – Constituency 10
Charlie Crabtree	Staff-elected – Constituency 13
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
Sharon Lowrie	Nominated Stakeholder – Locala
Lesley Hill	Executive Director of Planning, Estates & Facilities
Ian Warren	Executive Director of Workforce & OD

The Chair welcomed everyone to the meeting. It was noted that the meeting was not quorate:- *Ten Governors (including not less than six Public, not less than two Staff Council Members and not less than two Appointed,)* but that any decisions required would be made subject to confirmation from those absent.

35/17 DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

36/17 MINUTES OF THE LAST MEETING – 5 APRIL 2017

The minutes of the last meeting held on 5 April 2017 were approved as an accurate record.

37/17 MATTERS ARISING

72/16 – Declaration of Interest - It was noted that the Board Secretary had sent a further reminder to return completed Declaration of Interests forms and these were awaited.

23/17 – Reserve Register – It was noted that eligible Governors had been contacted to express interest on the Council of Governors' reserve register and this would be confirmed once the election results have been received.

23/17- Review of Boundaries – The Company Secretary advised that this would be reviewed at an appropriate time following the Government's review on electoral wards.

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the matters arising.

38/17 CHAIRMAN'S REPORT

a. UPDATE FROM CHAIRS INFORMATION EXCHANGE MEETING – 3.7.17

The Chairman gave a brief update following the discussions at the Chairs Information Exchange held on Monday 3 July 2017. The key issues included:-

- Communication between clinicians and patients
- Levels of Staffing – concerns regarding turnover in Medicine
- Levels of 4th Perinatal tears

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the Chairs Information Exchange Minutes – 21.3.17

b. TRUST RESPONSE TO IMPROVING LIAISON WITH OUR VOLUNTEERS

The Chairman reported that Rachael Pierce, Recruitment Manager had now been allocated the management of the Volunteers Services. Details of the actions undertaken to date were received which included:-

- Contact with 395 volunteers to cleanse data
- Meeting with HRI 'Meet and Greet' volunteers
- Appointment of new Voluntary Co-ordinator Lead at CRH
- Walkarounds to introduce volunteers
- League of Friends (CRH) Meeting scheduled for August
- DBS checks being completed following Saville Enquiry
- Safeguarding Training – on going

Uniforms – It was noted that the volunteers had asked for more investment in uniforms and this would be fedback to Rachael.

Volunteers Accreditation – Dawn Stephenson reported that SWYPFT would be happy to get involved with the Trust Volunteers to learn from each other.

It was agreed that the Company Secretary would contact Rachael accordingly.

ACTION: Company Secretary

OUTCOME: The Council of Governors **SUPPORTED** the Trust's response to improving liaison with Volunteers.

c. TRUST PROPOSALS FOR THE NEW WORKING RELATIONSHIP WITH THE COG AND MEMBERSHIP OFFICE

As reported at the last meeting it was noted that the Associate Director of Engagement and Inclusion, Ruth Mason had taken up the post of Associate Director of OD with effect from 1 June 2017. Arrangements had been made for the Company Secretary, Victoria Pickles to take over the management of the Council of Governors and the administration work would continue to be supported by Vanessa Henderson and Kathy Bray. It was noted that Ruth would continue to have some involvement with the Council of Governors in her new role around training.

OUTCOME: The Council of Governors **NOTED** the new working relationship with the CoG and Membership Office.

d. WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS (WYAAT) Update

The Chairman advised the meeting that he had been appointed Chair of the WYAAT Committee in Common, a position he would hold until February 2018.

It was noted that work continues in the areas of Information Technology and Estates with a view to collaboration across the patch and the creation of a company/organization.

Other areas being developed within the West Yorkshire area included collaboration on the following services, Pharmacy, Vascular, Head and Neck, Finance, Nursing. This was hoped would achieve the expectancies of WYAAT in order to meet the STP ambitions and work was underway around governance arrangements.

PERFORMANCE AND STRATEGY

39/17a FINANCIAL POSITION AND FORECAST

The Executive Director of Finance presented the Month 2 position as at 31 May 2017.

The key issues were:-

- Reported year to date Deficit position in line with agreed control total of £6.14m,
- Capital expenditure is below plan,
- Cash position is in line with plan at £1.90m.
- Delivery of CIP is behind the planned level at £1.31m against a planned level of £1.43m.
- A Use of Resources score of level 3, in line with the plan.

The year to data position was:-

- The year to date deficit is £6.15m versus a planned deficit of £6.12m. This includes £0.02m net benefit excluded for Control Total purposes:
- The I&E impact of Donated Assets (£0.02m).
- The year to date position assumes receipt of the full allocation of Sustainability and Transformation Funding (STF) of £1.01m.
- Activity continued to be behind plan in Month 2, driven by lower than planned Outpatient and Elective activity. In addition to this underlying underperformance, £2.6m of clinical income has been included as an estimate to reflect coding and capture issues linked to EPR implementation.
- Capital expenditure year to date is behind plan at £3.08m against a planned £3.66. plans.
- Cash balance is as planned at £1.90m.
- Trust borrowing in month was slightly below the planned level. Year to date the Trust has borrowed £10.74m to support the deficit and delayed STF funding.
- CIP schemes delivered £1.31m, £0.11m less than the year to date target of £1.43m.
- The revised NHS Improvement performance metric Use of Resource (UOR) stands at 3 against a planned level of 3. Of the five metrics that make up the UOR, all are as planned except the I&E Margin Variance which shows an unfavourable variance - rated as a 2 (planned as 1).

It was noted that:

- The Trust is forecasting to achieve the planned year end Control Total deficit of £15.94m. This excludes a planned £14m impairment and the I&E impact of Donated Assets which are excluded from the deficit for Control Total purposes and therefore have no impact on our STF allocation or UOR metric.
- The forecast assumes full receipt of the allocated £10.1m STF Funding, recovery of £2.6m estimated clinical income and a return to planned activity levels from Month 3.
- The forecast assumes full delivery of the £20m CIP target, of which £5.54m is currently unidentified.
- The Trust cash position is forecast as planned at £1.90m. The total borrowing requirement is £28.76m in this financial year to support both Capital and Revenue plans. The total loan balance by year end is forecast to be £87.62m as planned.
- Capital expenditure is forecast for the full year as planned at £14.39m, supported by the final £8m instalment of an existing Capital Loan facility.

40/17b PERFORMANCE & QUALITY (Including Good News Stories)

The Chief Operating Officer presented the quality and performance report. The key issues from the report included:-

- May's performance score has fallen to 61% for the Trust.
- The SAFE domain remains GREEN although the position for harm free care and pressure ulcers had deteriorated.
- The RESPONSIVE domain remains Amber due to failing to meet the Emergency Care Standard and the two week wait target which was missed for the first time in over 12 months. An improvement was now being seen.
- CARING had deteriorated to RED due to a number of Friends and Family Targets being missed.
- EPR had impacted on the achievement of several indicators this month including 18 weeks admitted and non-admitted, VTE, coding and day case rates. Work was underway with an external data company to develop a recovery plan regarding clinical codings.
- A small increase in C.Diff and MRSA cases had been seen and work was being undertaken to reduce this.

- Green Cross Patients – work continued with social care to reduce the number of patients within the Trust who are medically fit for discharge. Currently 96 patients were on the transfer to care list.
- Mortality rates had fallen.
- The contents of the 'Performance Achievements' report (good news stories) was noted and thanks given to staff for preparing this for the Governors.

41/17 STRATEGIC PLAN AND QUALITY PRIORITIES UPDATE

The Company Secretary reported that the Strategic Plan and Priorities for 2017-18 would be discussed in detail at the BoD/CoG to be held on the 18 July 2017 and this had been circulated in advance to give opportunity for the Governors to review.

42/17 EPR UPDATE

The Director of THIS presented a detail paper following the implementation of the EPR system in May. The key points from the paper included:-

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

- With regard to the overall view of the cutover, go-live and early live support both Cerner and our external Cutover management team have been very complimentary stating that this had been one of the best 'go-lives' in Europe. It was noted that lessons learned would be shared with Bradford prior to their go-live on the 24 September 2017.

- Current work was in progress on data quality and outpatient arrangements to improve appointment bookings.

- The Council of Governors wished to thank all staff for their resilience during this challenging time.

43/17 FULL BUSINESS CASE UPDATE

The Director of Transformation and Partnerships presented an update to the Council of Governors on the development of the full business case (FBC). It was noted that the key benefits of the FBC remained the same but it had been refreshed and reviewed and included:-

- Activity modelling
- Workforce Modelling
- Estate costs
- Funding options
- Commercial/procurement options
- Trust financial model/impact on deficit
- System affordability

The next steps, timetable and sharing of information was discussed. It was noted that the Joint Health Overview and Scrutiny Committee was scheduled to meet on Friday 21 July and discussions with NHS Improvement at the Quarterly Review Meeting would be held on 25 July.

It was noted that this item would be discussed in more detail at the BoD/CoG Workshop to be held on the 18 July 2017.

GOVERNANCE

44/17 CONSTITUTIONAL AMENDMENTS

It was noted that the amended Constitution discussed and agreed at the last meeting had now been approved by the Board of Directors, along with the change of name to 'Council of Governors'.

45/17 COUNCIL OF GOVERNORS CHARTER

The Company Secretary reported that the Charter had been updated in line with the Constitution. She confirmed that there had been no material changes and the revised copy would be circulated to the newly elected Governors.

OUTCOME: The Council of Governors present approved the revised Charter.

46/17 APPOINTMENT OF EXTERNAL AUDITORS

The Company Secretary reported that the contract with the External Auditors was due to complete and arrangements were being made re-tender for the service. A small group of Governors would possibly be required to help with the procurement process which would likely to be during October.

ACTION: Company Secretary

47/17 COUNCIL OF GOVERNORS REGISTER

The updated register of members as at 6 July was received for information. It was noted that this included the governors elected unopposed. The Chairman reported that discussions were taking place with Locala and the CCG regarding attendance of representatives.

OUTCOME: The Council of Governors **NOTED** the updated Register.

48/17 REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The Chairman requested that any amendments be notified to the Board Secretary as soon as possible.

OUTCOME: The Council of Governors **APPROVED** the Register of Interests

49/17 FUTURE COUNCIL OF GOVERNOR MEETING DATES

The future meeting dates for the Council of Governors for 2017/18 was approved.

OUTCOME: The Council of Governors **APPROVED** the CoG future meeting dates

50/17 APPOINTMENT OF LEAD GOVERNOR

It was noted that only one candidate had applied for the post of Lead Governor and therefore Brian Moore had been appointed unopposed with effect from 15 September 2017.

OUTCOME: The Council of Governors **APPROVED** the appointment of Brian Moore as Lead Governor.

51/17 NON-EXECUTIVE DIRECTOR APPRAISAL FEEDBACK

The Chairman presented a paper reporting on the appraisals of the Non-Executive Directors (NEDs) carried out between January and March 2017 by the Chair with input from the Executive team. It was noted that all the Non-Executive Directors were assessed to be carrying out their duties to a satisfactory standard and fulfilling their time commitment to the Trust.

OUTCOME: The Council of Governors **APPROVED** the Chairman's Appraisal of the Non-Executive Directors.

52/17 CHAIR APPRAISAL FEEDBACK

Dr David Anderson, Senior Independent Non-Executive Director/Non-Executive Director gave feedback on the Chair Appraisal Process. It was noted that this was

Andrew's sixth appraisal and was to be his final year in office, but due to the crucial stage of some of the transformation agendas, the Council of Governors had approved an extra year to ensure that a change of Leadership would not disrupt progress.

Overall the appraisal had identified positive feedback:

- He works well with the Chief Executive, the Board and Council of Governors.
- He provides strategic insight and steerage through challenging times.
- The Governors felt engaged and to have status within the Trust which is not necessarily experienced in other Trusts.
- The NEDs felt Andrew was performing strongly and making significant contributions to performance of the Trust in a difficult challenging environment. The board meetings seemed to be more focused, prioritised and strategy more prominent, but a consistent feedback was there still needed to be more concise Board meetings.
- The challenges going forward were noted with new appointments and a challenging strategic agenda

OUTCOME: The Council of Governors **APPROVED** the Chair Appraisal

UPDATE FROM BOARD SUB COMMITTEES

53/17 AUDIT AND RISK COMMITTEE

It was noted that the Annual Report and Accounts were now available on the Trust Website.

54/17 FINANCE AND PERFORMANCE COMMITTEE

It was noted that the next meeting was scheduled for 1 August 2017. The contents of the Finance Report given earlier in the meeting were noted.

55/17 QUALITY COMMITTEE

It was noted that the next meeting was scheduled for 31 July 2017 and the agenda was very inclusive and detailed.

56/17 CHARITABLE FUNDS COMMITTEE

The Chairman reported that arrangements were being made to increase activity with the help of students from Huddersfield University.

57/17 WORKFORCE WELL-LED COMMITTEE

In Rosemary's absence the Company Secretary gave a brief overview of the issues discussed at the last meeting held on the 8 June 2017:-

- Progress with EPR
- E-Rostering "Allocate" system now being used
- Response to 2016 Staff Survey and action plan developed.

58/17 PATIENT EXPERIENCE AND CARING GROUP

Lynn Moore updated the Council of Governors on the issues discussed at the last meeting which included:-

- Communications between clinicians and patients
- Clinical treatment
- Patient care
- Task and finish group to be established
- The 'End of Life' video would be shared with the CoG at the Development Day on the 24 July 2017.

59/17 ORGAN DONATION COMMITTEE

The Chairman reported that the Committee was in the process of appointing a new Medical Lead and work continued with Healthwatch to encourage members of the public to join the register.

OUTCOME: The Council of Governors **RECEIVED** the updates from Sub Committees/Groups.

60/17 INFORMATION TO RECEIVE

The following information was received and noted:

a. Updated Council Calendar – updated calendar received and the contents were noted.

b. Extract from Quarter 4 Quality Report re Complaints and PALs
The Executive Director of Nursing reported that this information had been supplied to the Membership Council for information and offered an overall view of the Trust's management of the current position with regard to complaints and PALs contacts received during Quarter 4.

61/17 ANY OTHER BUSINESS

a. The Chief Operating Officer reported that the Health Visiting Team had transferred to Locala at the end of June.

b. Peter Middleton asked for assurance that the Trust had systems in place to avoid maverick surgeons/staff from committing criminal acts. The Executive Medical Director advised that all doctors go through revalidation and appraisal when complaints and other metrics are scrutinised. Any issues of concern would be brought to the attention of the Medical Director. Scrutiny of any issues would be highlighted through monthly clinical audits and external scrutiny is provided through MDTs.

c. The Chairman reported that as this would be the last formal meeting for a number of Governors including Peter, Grenville, George, Bob, Mary and Dawn he wished to formally place on record his thanks for their help and support.

62/17 DATE AND TIME OF NEXT MEETING

Thursday 26 October 2017 commencing at 4.00 pm in the Large Training Room, Learning Centre, CRH.

The Chair thanked everyone for their contribution and closed the meeting at 6.30 pm.