Calderdale and Huddersfield NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 7 December 2017 at 9.30 am (PLEASE NOTE AMENDED TIME)
Venue: Large Training Room, Learning Centre, CRH

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	Welcome and introductions: Charlie Crabtree - Staff Elected Governor Brian Moore – Lead Governor	Chair	**VERBAL**	**Note**
2	Apologies for absence: Phil Oldfield, Gary Boothby (Kirsty Archer attending), David Birkenhead	Chair	**VERBAL**	**Note**
3	Declaration of interests	All	**VERBAL**	**Receive**
4	Patient Story/Quality Report Deep-dive - Serious Incident Reporting – presentation by Juliette Cosgrove, Assistant Director of Quality and Safety and Andrea McCourt, Head of Governance and Risk		**Presentation**	**Receive**
Standing items				
5	Minutes of the previous meeting held on 2 November 2017	Chair	**APP A**	**Approve**
6	Action log and matters arising: a. Fractured Neck of Femur b. 160/17 - EPRRR Strategy & Core Standards Annual Submission	Chair Deputy Executive Medical Director Exec Director Planning, E&F	**APP B** **VERBAL** **VERBAL**	**Review** **Note** **Approve**
7	Chairman's Report a. Feedback from BOD/COG Workshop 15.11.17 b. Update from NHS Providers Chairs and Chief Executives' meeting	Chair	**APP C** **VERBAL**	**Note**
8	Chief Executive's Report: a. WYAAT update b. Staff survey / Flu c. Cardiology, respiratory and elderly medicine services update	Chief Executive	**VERBAL** **VERBAL** **VERBAL**	**Note**
Keeping the base safe				
9	Quarterly Quality Report	Executive	**APP D**	**Note**

		Director of Nursing		
10	Quarter 3 – Learning from Deaths Publication	Deputy Executive Medical Director	**APP E**	**Approve**
11	High Level Risk Register	Executive Director of Nursing	**APP F**	**Approve**
12	Governance Report a. Board Workplan b. Board Skills/Competencies c. Use of Trust Seal	Company Secretary	**APP G**	**Approve**
13	Safeguarding Update – Adults and Children	Executive Director of Nursing	**APP H**	**Approve**
14	Integrated Performance Report	Chief Operating Officer	**APP I**	**Approve**
Financial Sustainability				
15	Month 7 – 2017-2018 – Financial Narrative	Executive Director of Finance	**APP J**	**Approve**
16	Single Oversight Framework	Company Secretary	**APP K**	**Note**
A workforce for the future				
17	Safe Staffing Bi-Annual Report – (Hard Truths Requirement)	Executive Director of Nursing/Deputy CE	**APP L**	**Note**
Transforming and improving patient care – no items				
18	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 30.10.17 and verbal update from meeting 4.12.17 ▪ Finance and Performance Committee – minutes of 31.10.17 and verbal update from meeting 28.11.17 ▪ Audit and Risk Committee – minutes from meeting 18.10.17 ▪ Workforce Well Led Committee – minutes from meeting 9.11.17		**APP M**	**Receive**
Date and time of next meeting Thursday 4 January 2018 commencing at 9.00 am **Venue: Large Training Room, Learning Centre, CRH**				

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 December 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 2.11.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 2 November	
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 2 November

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 2 November

Appendix

Attachment:

draft BOD MINS - PUBLIC - 2.11.17.pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 2 November 2017 in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Andrew Haigh	Chairman
Owen Williams	Chief Executive
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Brendan Brown	Executive Director of Nursing and Deputy Chief Executive
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
Jan Wilson	Non-Executive Director

IN ATTENDANCE

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
Chris Lord-Tyrer	Matron (present for item 4)
Maureen Overton	General Manager (present for item 4)

OBSERVER

Brian Moore	Publicly Elected Governor – Lead Governor
Lynn Moore	Public Elected Governor
Nasim Esmail	Public Elected Governor
Cllr Megan Swift	Nominated Governor
Jayne Robinson	Shadowing the Chief Executive

165/17 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

166/17 APOLOGIES FOR ABSENCE

Apologies were received from:
Andy Nelson, Non-Executive Director

167/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

168/17 PATIENT STORY/QUALITY REPORT: STROKE SERVICES

Maureen Overton and Chris Lord-Tyrer attended the meeting to update the Board on Stroke Services. During 2016 the department had a peer review undertaken. The review identified that the services had received a national SSNAP audit rating of D, high crude mortality, high length of stay, high number of nursing vacancies and not all patients were being seen by therapy staff within the required timescale.

An action plan in response to the recommendations was developed and worked through

2016 to October 2017and the results achieved by Novembe
were noted:

- Assessed as and maintained SSNAP at B for the last 12 months
- Increased high dependency beds from 4 – 6
- Decreased number of rehabilitation beds – focus on getting patients back into their own environment
- Therapist input increased - so now achieving an A in SSNAP
- Skill mix review resulting in increase of senior leadership and vacancies filled by 40%
- More collaborative multi-disciplinary team working
- Reduced mortality results from 1.24 to 1.08

The next steps for the future included:

- Negotiating an area for 2 assessment beds
- Increasing Speech and Language Therapy availability
- Working with radiology to maintain consistent scanning times
- Educating all staff about the need for stroke patients to be transferred to the Stroke Unit as soon as possible.

The Board congratulated the team on their performance and the Chief Executive reported that this improved position would be helpful to the Trust in future conversations about stroke service delivery across West Yorkshire. The Board confirmed their support of the team in providing 7 day consultant coverage in the future.

The benefits for patients having reduced lengths of stay were discussed and it was emphasised that the right place for rehabilitation was in patients' own homes. It was noted that discussions were on going with the CCGs to ensure that sufficient therapists are available for home visits, noting that more than one therapist could be required for any one patient.

OUTCOME: The Board RECEIVED and NOTED the work of the Stroke Team.

169/17 MINUTES OF THE MEETING HELD ON 5 SEPTEMBER 2017

The minutes of the previous meeting were approved.

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

170/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG

153/17 – PATIENT STORY – MULTIDISCIPLINARY CLIENT CASE STUDY – LOAN STORE

The Chief Executive gave feedback on the issues regarding Loan stores that were flagged by the Support and Independence Team at the last meeting. One of the core reasons identified was that there had been a new manager and quite a number of new staff in the Loans store team who were learning systems which had led to a drop in performance. A meeting had been arranged between the manager of the Community Therapy Team and the new manager of the loan stores for 1 November 2017 so they can work together to address the issues.

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

It was noted that amendments had been made to the submission and it was agreed that this would be circulated to the Board.

ACTION: Executive Director of Planning, Estates & Facilities.

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

a. Annual Review of Non Executive Director (NED) Roles/Appointment of Deputy Chair

The Chairman reported that the annual review of NED roles had been undertaken and the following had been agreed:
Deputy Chair – Phil Oldfield
Senior Independent NED – Dr David Anderson
Chair - Audit and Risk Committee – Richard Hopkin
Chair – Finance and Performance Committee – Phil Oldfield
Chair - Quality Committee – Dr Linda Patterson
Chair - Workforce Well-Led Committee – Karen Heaton

It was noted that there were two areas requiring NED input, 'Research' and 'Security' and these would be confirmed in due course.

The Chairman wished to thank Jan Wilson both on behalf of the Board and himself for her hard work and commitment in her role of Non-Executive Director since November 2011 and Deputy Chair since 2013. It was noted that Jan's tenure would cease on the 30 November 2017 and that Alastair Graham would join the Trust as Non-Executive Director.

It was noted that the Nomination and Remuneration Committee (CoG) were due to meet on the 18 December 2017 to discuss the appointment process for the Chair position.

b. Executive Board Appointments

The Chairman reported that following the interviews held on 19 October 2017, the following had been offered and accepted substantive appointments:
Gary Boothby, Executive Director of Finance – with immediate effect
Suzanne Dunkley, Executive Director of Workforce and OD – to commence in the New Year.

OUTCOME: The Board NOTED the Chairman's report

172/17 CHIEF EXECUTIVE'S REPORT

a. **LGBT Event** – The Chief Executive advised that a regional event had been held the previous evening with attendees both from within and outside the organisation. The event had highlighted a number of areas including: same sex visibility, clinical interaction,and importance of safe space for discussion. It was agreed that a LGBT patient story would be presented to the Board in the future. The Board noted that networks would be set up and Karen Heaton offered learning from Manchester University to progress this.

b. **Ted Baker, Chief Inspector CQC – Regional Event** - The Deputy Chief Executive reported that the Trust was hosting a regional event on Friday 3 November 2017 to which Ted Baker, Chief Inspector, Care Quality Commission was the key note speaker. This would give a two way learning opportunity about the work of the Trust and the future CQC inspection regime.

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

173/17 HIGH LEVEL RISK REGISTER

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

These were:-
6967 (25): Non-delivery of 2017/18 financial plan
7062 (20): Capital programme

[illegible] risk, HRI
7049 (20): EPR financial risk
5806 (20): Urgent estates schemes not undertaken
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
6658 (20): Patient flow
6441 (20): Divisional income Surgery and Anaesthetics

It was noted that the staffing risk had been separated into three risks (nursing, medical and therapy) to ensure the risk controls and mitigation is clearer for each risk. Nurse staffing remained at risk reference 6345, with medical staffing now being captured under risk 7078. Therapy staffing is now reference 7077.

Risks with increased score
Risk 6441, regarding divisional income within the surgical and anaesthetics division had increased from a risk score of 16 to 20 following a detailed review of the year end forecast position.

Risks with reduced scores
Risk 7077, Therapy staffing – this risk was previously scored at 20 as part of the wider staffing risk. A re-assessment of the risk score by the risk owner and review at the Risk and Compliance Group had led to a reduction in this risk score from 20 to 8 due to progress with recruitment.

New risks
There are no new risks added to the risk register this month**.**

Closed risks
The Board were reminded of their discussions at the Board meeting on 5th October 2017 to remove Risk 6131 'service reconfiguration', and their agreement that it should be removed as currently written. It was agreed that a new risk should be identified in relation to the short-term service reconfiguration risks which was being developed with Anna Basford and will be presented to a future meeting for consideration.

Karen Heaton, Non-Executive Director requested further information on the reason for the reduction of Risk 7077 (Therapy Staffing) reducing from 20 – 8. The Executive Director of Nursing agreed to investigate this and respond directly to Karen.

ACTION: Executive Director of Nursing

Richard Hopkin noticed that the risks were not identified on the heat map. The Executive Director of Nursing agreed to update and recirculate the information.

ACTION: Executive Director of Nursing

OUTCOME: The Board APPROVED the High Level Risk Register

174/17 GOVERNANCE REPORT

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

a. Board Assurance Framework (BAF)
The Company Secretary reminded the Board of the difference between the Risk Register and Board Assurance Framework. She reported that the Board Assurance Framework sets out the key strategic risks facing the Trust. The BAF is reviewed regularly by the Board and its assurance committees. To ensure that the BAF and the high level risk register are dynamic and reflect all significant risks to Trust objectives the review of the high level risk register, the BAF and the 5 year strategy and one year plan had been undertaken. This work highlighted three areas for new risks to be

sideration on the high level risk register (leadership, health a safety action plan and development of bank and workforce models) as these were not currently reflected. Two areas of new risks were identified for the BAF (strategic partnership work and patient and public involvement) and for the others to be re-written to better reflect the risks we are facing.

The Chief Executive had requested that the Managing Director – Digital Health and the Company Secretary undertake some work around identifying IMT dependency/resilience and this would be included when the BAF was next update.

ACTION: MANAGING DIRECTOR-DIGITAL & COMPANY SECRETARY

Richard Hopkin noted that the cash flow required removing as the risk had now been downgraded from 20. It was also noted that the two new risks required amending.

ACTION: COMPANY SECRETARY

Discussion took place regarding the Hard Truths Update paper which would be brought back to the next meeting, along with next steps going forward. It was noted that ideally this paper should include all staff and not just nurses and midwives. The Executive Medical Director agreed with this opinion.

Discussion took place regarding the Board's risk appetite specifically around estates and staffing and the Chair asked if there was more that should be being done.

The Executive Director of Planning, Estates and Facilities agreed to discuss with the Executive Director of Finance the balancing of works and a paper would be brought to a future meeting. The Chief Executive suggested that this should be validated using an external lens before it goes to Board.

ACTION: FUTURE BOD AGENDA ITEM

OUTCOME: The Board APPROVED the Board Assurance Framework

b. Review of progress against the Strategy

It was noted that each quarter the Board receives an update on the progress made against the four goals described in the Trust's 1 year plan 2017/18. The latest update will also be discussed with the Council of Governors at the Joint Workshop to be held on Wednesday 15 November 2017.

OUTCOME: The Board APPROVED the progress against the Strategy

c. Scheme of Delegation

It was noted that the Scheme of Delegation has been overdue for review. The Deputy Director of Finance and Company Secretary had met to agree proposed changes and these had been updated in the document. There was however an ongoing piece of work relating to the Board's responsibilities under the Mental Health Act due to be concluded in November which will require further amendment to the Scheme of Delegation. It was therefore proposed that the briefing in relation to this work is brought with the revised Scheme of Delegation to the Board in December. For clarification, the current Scheme of Delegation and the authorisation limits set out in the Standing Financial Instructions remains in place and relevant until a new document has been approved by the Board.

OUTCOME: The Board NOTED the position in relation to the Scheme of Delegation and agreed that it is presented to the Board in December

ACTION: BoD Agenda Item – December 2017

d. Constitutional Amendments

The Company Secretary reminded the Board that the Trust's Constitution, along with the standing orders for the Council of Governors and the Board of Directors, sets the rules for the governance of the Trust and should be periodically reviewed for any changes or updates in legislation. Following the last significant review in April 2017, a

nendments have been identified:

- Removal of the Clinical Commissioning Groups' Stakeholder Governor place and replacing this with HealthWatch Calderdale and Kirklees;
- Amendment to quoracy to not specify make up of attendance, purely the need for 10 governors;
- Clarification of what happens when an elected governor moves constituencies during their term;
- Re-reviewed to ensure all references to Membership Council have been updated to Council of Governors.

It was noted that these proposed amendments were presented and approved at the Council of Governors meeting on 26 October 2017.

OUTCOME: The Board RATIFIED the amended Constitution

ACTION: Upload to public website

e. Declaration of Interest Policy

It was noted that the revised policy had been discussed and approved at Audit and Risk Committee subject to clarification on the system to be used. Discussions were required by the Company Secretary with Workforce & OD and THIS staff.

175/17 DIRECTOR OF INFECTION, PREVENTION AND CONTROL QUARTERLY REPORT

The Executive Medical Director presented the quarterly report as at 30 September 2017. The key points from the report were noted:

MRSA bacteraemia:
There have been 3 MRSA cases attributed to the organisation; 1 post case and 2 pre cases.

MSSA bacteraemia: there have been 15 post-admission MSSA bacteraemia cases at the end of quarter 2, against the internal objective of 9. All cases are subject to a case note review to identify themes.

MRSA - Hospital-Acquired Infections (HAIs): There have been 7 acquisitions this year compared to 17 for the same time period last year.

Clostridium difficile: the ceiling for 2016/17 is for no more than 21 post-admission cases. As at 30 September there had been 12 cases; this was an improved position compared to the same time last year when there had been 17.

Escherichia-coli (E-coli) bacteraemia: There have been 18 post-admission E-coli bacteraemia cases against the internal objective of 43; there is both a Trust and health economy wide reduction plan which had been developed and will be monitored through ICC and the HCAI Health Economy Meeting.

Handwashing – work continues and cases of staff with sore hands had increased.

Dr David Anderson asked about the effectiveness of the audit work. It was noted that this was helpful but wearing of rings and false nails continued. It was acknowledged that this was an important area and support from management was available if required. Lynn Moore stressed that this should also include long hair being tied up.

OUTCOME: The Board APPROVED the quarterly DIPC report

176/17 CARE OF THE ACUTELY ILL PATIENT REPORT

The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report and reminded the Board of the overall aim of the programme to reduce mortality. It was noted that this is divided into six themes:
1) Investigating causes of mortality and learning from findings
2) Reliability in clinical care

3) Timely initial treatment of deteriorating patients.
4) End of life care
5) Caring for frail patients
6) Clinical coding

The Medical Director highlighted the key points from the report:

- SHMI - Data released in September showed the SHMI for April 2016 to March 2017 = 105.4 (categorised as Band 2 – as expected)
- HSMR - Data released in Oct 17 showed the HSMR for Sept 16 – Aug 17 is at 91.08
- Learning from Deaths - The process to allocate ISRs (initial screening reviews) nearly complete. A trust-wide email to all non-training grade doctors who will perform these as part of their Supporting Professional Activities (SPA) time will be sent out by 3 November 2017. The plan will be to implement the process in full for all deaths from December 2017.
- 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 has been refreshed there is strong clinical engagement. A number of actions have commenced to move the improvement work forward.
- 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.
- End of Life Care – work continues to improve the end of care experiences for both patients and families.

Dr Linda Patterson reported that this report had been discussed in detail at the Quality Committee.

Dr David Anderson asked about the Trust's position on 7 day services. The Executive Medical Director reported that data was submitted 6 monthly to compare with peers. He reported that it would be a challenge to know what else the Trust could do with the current configuration of services and having services consolidated would help with clinical rotas to move forward.

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

177/17 INTEGRATED PERFORMANCE REPORT

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

- September's Performance Score stands at 60% for the Trust.
- The EFFECTIVE domain has improved to GREEN with all Maternity Mortality indicators achieving target.
- The RESPONSIVE domain has maintained AMBER, although Breast Symptomatic and 62 day screening for cancer have missed target.
- FINANCE domain has deteriorated to RED with variance from plan moving to Amber in-month.
- WORKFORCE has improved in-month with better performance in sickness absence.

Discussion took place regarding the recruitment and retention rates. It was noted that work was on going to develop different national packages particularly for newly qualified nurses.

Concern was expressed that Fractured Neck Of Femur remained an issue in the Trust and had been for the past 4 years. Although it was noted that this had not caused harm to any patient the Board asked for the reasons for the breach. It was agreed that further information would be brought back to the next meeting. It was noted that this issue had been discussed with NHSI.

ACTION: BOD AGENDA ITEM – DECEMBER 2017

OUTCOME: The Board RECEIVED the Integrated Board Report and NOTED the key areas of performance for September 2017 and agreed a paper should be brought to December 2017 BOD.

178/17 MONTH 6 – 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance presented the Month 6 Financial Narrative which had been submitted to NHS Improvement and had been discussed in detail at the last Finance and Performance Committee.
The Month 6 position is a deficit of £16.81m on a control total basis, in line with plan. This excludes year to date Sustainability and Transformation funding (STF) of £3.31m.
The final planning submission made to NHSI on 30th March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had a number of concerns regarding the scale of this challenge. Whilst appreciating the overall NHS Provider sector position, it was hoped that a revised control total could be considered. The key risks to delivery were outlined as the abnormal costs of implementation or short term loss of income as a result of EPR implementation and the scale of the CIP challenge at £20m, 5.3%. The original implementation of EPR was planned for 2016/17 and a revenue challenge was recognised by regulators during the planning round. Whilst this was not reflected in the control total, an original challenge of up to £7m (subsequently reduced to £5m), was recognised. Whilst this was again not recognised in agreeing control totals for 2017/18, the additional abnormal risk of implementing such large scale clinical change was highlighted at every opportunity. For 2017/18, the impact of EPR was estimated to be up to £5m, whilst only £17m of the required £20m CIP was believed to be achievable, leaving the Trust with a total risk initially assessed at £8m plus any subsequent loss of STF funding.

As at Month 6 these concerns have increased as the underlying financial position has continued to deteriorate. As such the underlying operational performance would drive an adverse financial variance of £9.2m to the year to date planned position. Whilst the Trust is able to report delivery of the financial plan, the underlying adverse variance from plan in month was over £2m in month and 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 of almost £6m year to date. The year to date position is reliant upon a number of non-recurrent income and expenditure benefits totalling £7.2m which cannot be replicated going forwards plus the use of the full £2m contingency reserve available for this financial year.

There is now a very high risk that the Trust will not be able to achieve the 17/18 control total due to a combination of: slower than expected recovery of clinical activity levels and therefore income following EPR implementation; reduced operational capacity whilst resolving implementation issues; and remaining unidentified CIP of £3m. The Trust has undertaken a detailed forecast review of both activity and income which indicates that that activity levels are unlikely to recover to planned levels during this financial year. A recovery action plan has been implemented which aims to tackle: the recovery of clinical income at risk due to issues with capture and coding in EPR; the development of Divisional financial recovery plans; a Trust wide establishment review and further tightening of budgetary controls. In addition, an EPR stabilisation plan has been put into action to regain activity performance levels to the maximum achievable. This in itself drives additional cost requirements. Every effort will be made to deliver the financial plan, including pursuing innovative technical accounting benefits, but in this context full recovery may not be possible. Work continues to explore other opportunities to reduce the current forecast. Delivery of the financial plan remains the highest risk on the Trust risk register scoring the maximum of 25.

OUTCOME: The Board NOTED the contents of the report.

179/17 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 30 October 2017 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- Quality Impact Assessment of Medical Services Reconfiguration Business Case discussed and approved and Committee satisfied that this should go forward to the CCG and Scrutiny.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 2 October 2017 and the verbal update of the meeting held on 30 October 2017.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 31 October 2017 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- Month 6 position discussed in detail and reflected in Risk Register
- Activity – rehabilitation and move into Community with impact on contracting and risk sharing discussed. Work continues with the CCGs on an approach to this which was a health economy wide issue.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 3 October 2017 and verbal update from 31 October 2017 meeting.

c. Workforce Well-Led Committee

The minutes from the meeting held on the 18 October were received. Karen Heaton, Chair of the Workforce Well-Led Committee reported on the key items discussed at the meeting held on the 18 October which included:

- Presentation on recruitment aspects
- Workforce performance report – focus on benchmarking to be discussed at next meeting.

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

d. Audit and Risk Committee

Richard Hopkin, Chair of the Audit and Risk Committee reported on the items discussed at the meeting held on 18 October 2017 which had not been previously covered on the Board agenda. The main areas discussed included:

- Risk Management – Further work on benchmarking of BAF and Risk Register – increased assurance received
- Internal Audit – Overdue position improved. Positive Audits except Income from Overseas Visitors
- Declaration of Interest System – New policy and system to be implemented by January 2018

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

DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 7 December 2017 commencing at 9.00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair closed the public meeting at 11:05am

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th December 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 December 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 1 December 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 **2.11.17** Updated BAF received. MD-Digital Health and Co-Sec undertaking work around identifying IMT dependency/resilience and this would be	Jan 2018		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			included when the BAF was next updated in January 2018			
175/16 3.11.16	**UPDATE FROM SUB-COMMITTEES** **Audit and Risk Committee – DECLARATIONS OF INTEREST** The Company Secretary explained that there would be a change to the declarations of interest policy as new guidance was due to be published in December. An update would be brought to a future Board meeting.	VP	**2.2.17** The Company Secretary advised that Guidance was still awaited. It was requested that this remain open on the Action Log for a report to come back in March 2017. **3.2.17** It was noted that this item would be taken to the Audit and Risk Committee in April with a proposed solution. **1.6.17** New guidance to be discussed at WEB in ?June and taken to the Oct ARC. It was agreed that the revised policy would be brought to the BOD. **2.11.17** Revised policy approved by ARC subject to clarification on the system to be used. Discussions were required by the Co. Sec, WOD and THIS staff.			ARC – 18.10.17
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	GB		Early in New Year 2018		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	summer.					
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		26.10.17
7.9.17 141/17	**HIGH LEVEL RISK REGISTER** The Executive Director of Nursing reported that work was on going to broaden the number of investigators available to undertake SI investigations. It was agreed that a deep-dive report would be brought to the December 2017 BOD Meeting.	BB/JC		7.12.17		
5.10.17 162/17	**IPR – GREEN X PATIENTS** The Board agreed that the IPR did not accurately record the number of Green X Patients to reflect the improvement journey. The Chief Operating Officer agreed to review this at the December 2017 Board Meeting.	HB		7.12.17		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) Position as at: 1 December 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
5.10.17 162/17	**IPR – SAFER PATIENT PROGRAMME** Arrangements had been made for 'Discharge Lounge' to be included on the Council of Governors agenda in October. It was noted that the Safer Patient Programme would be brought to the Board in January 2018.	HB		4.1.18		
2.11.17 147/17a.	**ESTATES – CAP FUNDING REDUCTION** Exec Director Planning, E&F agreed to discuss with Exec DoF the balancing of works and a paper would be brought to a future meeting.	LH/GB		TBC		
2.11.17 177/17	**IPR – FRACTURED NECK OF FEMUR** Concern was expressed that FNOF remained an issue. Although it was noted that this had not caused harm to any patient the Board asked for the reasons for the breach. It was agreed that something would be brought back to the next meeting.	DB		7.12.17		
5.10.17 160/17	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRRR) & CORE STANDARDS ANNUAL SUBMISSION** The Board requested that further work be undertaken on the submission to ensure an audit trail before submission to the Yorkshire and Humber Local Health	LH	**2.11.17** It was noted that amendments had been made to the submission and it was agreed that this would be circulated to the Board.	7.12.17		

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
	Resilience Partnership.					
2.11.17 174/17	**BOARD ASSURANCE FRAMEWORK – HEATMAP – CASH FLOW** Richard Hopkin noted that the cash flow required removing as the risk had now been downgraded from 20. It was also noted that the two new risks required amending.	VP		7.12.17		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th December 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: CHAIRMAN'S REPORT - The Board is asked to receive and note: a. Feedback from BOD/COG Workshop 15.11.17 - attached b. Update from NHS Providers Chairs and Chief Executives Meeting - verbal	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note:
a. Feedback from BOD/COG Workshop 15.11.17 - attached
b. Update from NHS Providers Chairs and Chief Executives Meeting - verbal

Main Body

Purpose:

The Board is asked to receive and note:
a. Feedback from BOD/COG Workshop 15.11.17 - attached
b. Update from NHS Providers Chairs and Chief Executives Meeting - verbal

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The Board is asked to receive and note:
a. Feedback from BOD/COG Workshop 15.11.17 - attached
b. Update from NHS Providers Chairs and Chief Executives Meeting - verbal

Appendix

Attachment:

typed flipcharts - BOD-MC WORKSHOP - 15.11.17.pdf

BOARD OF DIRECTORS/COUNCIL OF GOVERNORS WORKSHOP
WEDNESDAY 15 NOVEMBER 2017
BOARDROOM, HRI

1. TRANSFORMING AND IMPROVING

- Timing of judicial review
- Reconfiguration of actual services is the driver for improvement and transformation – COMMUNICATING TO PUBLIC!
- Ambulatory handover time

2. KEEPING THE BASE SAFE

EPR

- Need to understand the timeline and associated impact of remaining EPR stabilisation.

ENGAGEMENT

- How do we integrate urgent care services and educate public to access GP related services in a timely manner?
- How do we learn from the patients' experience in primary care and how this may be driving attendance at AED? 'With a critical eye' are we listening and acting appropriately?

HEALTH & SAFETY

- Do we have sufficient assurance that our Business Continuity Plans are robust in a digitally dependent organisation?

CQC

- What were the key messages from Ted Baker and what is our current position in relation to these?
- Do we need to plan/review our Q4 flow arrangements reflecting that inspection will be at a time of peak pressure?
- What are our plans to prep Board and other leadership groups for a Well Led Review?
- Do we know our hotspots/weaknesses as well as strengths/successes?
- Need to reflect on improvements from last visits – we have done a lot.
- Real emphasis needed on EPR stabilisation/optimisation as this is currently a high risk for a CQC inspection.

QUALITY IMPROVEMENT

- How can we accelerate our Quality Improvement Strategy?
- Are we satisfied that our quality assurance process is robust and there won't be any significant surprises?

3. FINANCIAL SUSTAINABILITY

CIP

- Forecast £17m – but £3m+ non-recurrent – some areas difficult – especially clinical variation/change. More recurrent schemes.

SAVINGS PROGRAMMES

- Devolved to directorates – but not to individual clinicians – need further clinical engagement and ownership.

WYAAT

- Agreement for procurement – if three organisations use something, it's OK for everyone.

IMPLEMENT MODEL HOSPITAL

- Use to see where we are an outlier on costs – but needs engagement with clinicians.

ACTIVITY

- Doing less activity than previously – so need to take costs out in areas where activity is reducing.

DELIVERING CLINICAL ACTIVITY DIFFERENTLY

- E.g. Telephone follow-up, ambulatory care, etc.
- Need to take full costs out when services are stopped / moved elsewhere.

4. WORKFORCE FIT FOR THE FUTURE

- Recruitment of overseas nurses, is the problem as big as media suggests?
- In terms of Mandatory Training is there protected time for staff to undertake it?
- Equality, diversity and inclusion – how do you make it part of the core business?
- Appraisals – focus on quality moving forward. Focus on benefit to colleagues and Trust.
- Report on good news stories like consultant recruitment, BAME Network.
- Celebrating Success – recognise everyone who puts in an application, personal thank you from CEO.
- Essential management development framework session. Equip colleagues with skills, knowledge and experience to be good managers.
- How do we management the dynamic of engaging people in challenging times bearing in mind CQC?

P:BOD17-WORKSHOP
BOD-COG 15.11.17

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 December 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Quarterly Quality Report - Q2 2017/18 - The paper summarises progress on quality for the period April 2017 to September 2017.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The attached quality report was presented to the Quality Committee on 30 October 2017.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper, together with a presentation at the meeting, provides an update on quality as at the end of September 2017, quarter 2 of 2017/18.

Main Body

Purpose:

To provide an assurance to Board members regarding work to improve quality of services and present quality data relating to Q2 2017/18.

Background/Overview:

A quarterly quality report is provided to the Board to share data regarding progress with quality improvement priorities and the 2017/18 quality account priorities.

The Issue:

A presentation on the key quality data as at Q2 2017/18 will be provided at the Board meeting.

The enclosed report has been previously discussed at the Quality Committee. The report summarises the information shared with the Board on quality over the last six months, which included three deep dives on progress with CQC actions in maternity services, critical care and paediatrics. It also details information shared with the Board on Learning Disabilities, via a patient story, naso-gastric tube feeding and falls.

The deep-dive on serious incidents earlier on the Board agenda forms part of the quality reporting to Board members also.

Information on the 2017/18 quality account priorities of sepsis screening for in patients, discharge planning and learning from complaints is also included within the enclosed quality report.

Next Steps:

The Board will continue to receive updates on quality on a quarterly basis.

Recommendations:

The Board is asked to note the quality reporting for the first six months of 2017/18, quality data as at quarter 2 2017/18 and the update on the three quality account priorities.

Appendix

Attachment:

App L - Quality Report.pdf

QUALITY COMMITTEE	
PAPER TITLE: QUALITY REPORT INCLUDING QUALITY ACCOUNT 2017/18	**REPORTING AUTHORS:** Juliette Cosgrove, Associate Director Quality and Safety Andrea McCourt, head of Governance and Risk
DATE OF MEETING: Monday, 30th October 2017	**SPONSORING DIRECTOR:** Brendan Brown - Chief Nurse / Executive Director of Quality
STRATEGIC DIRECTION – AREA: • Keeping the base safe	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUMS: None	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	

EXECUTIVE SUMMARY

This paper summarises assurances on quality that were provided directly to the Board for 2017/18 as agreed in the revised quality reporting arrangements in January 2017 and an update on the three quality account priorities for 2017/18.

1. Quality reports to the Board:

During the last six months three deep dives on progress with CQC actions were presented to the Board on maternity services, critical care and paediatrics. A patient story on Learning Disabilities was shared as well as quality reports on naso-gastric tubes and falls. Information on each of this is given below.

1.1 Maternity services

At the Board meeting on 1 June 2017 a CQC update on the maternity services action plan following the CQC inspection and report was presented to the Board by the Divisional Director as Head of Midwifery / Associate Director of Nursing. The Board heard about the good progress that had been made over the previous 12 months and confirmed that an open and positive culture had been established with a focus on learning and improvement that had led to improvements in the patient experience.

1.2 Critical Care

At the Board meeting on 6 July 2017 the Divisional Director presented an update to the Board on progress with the CQC action on critical care services, noting that good progress had been made, experienced nursing staff in critical care had now been recruited, high standards were being maintained in relation to infection control performance and there had been a low number of complaints.

A mock CQC inspection was subsequently undertaken in quarter 2 which demonstrated some significant improvements and identification of a small number of further actions that are being managed within the directorate. A CQC relationship team management visit to the department in August was positive and the CQC was pleased with the progress made.

1.3 Paediatrics

The senior management team for the Family and Specialist services division gave an update on progress with CQC actions to ensure that children are seen in appropriate environment by staff that are suitably skilled, qualified and experienced. This described work underway across the Emergency Department, Outpatients and the Paediatric Assessment Unit on workforce, embedding the escalation policy with "nurse in charge training", the environments in the neo-natal intensive care unit and the Emergency Department, reviews and updates of guidelines and protocols, with refreshed education and training to support this, enhanced supervision and sharing of learning from incidents and complaints.

The Board noted the progress and that the model of care was reliant on the reconfiguration of services.

1.4 Learning Disabilities

On 7 September 2017 the Board received a patient story on Learning Disabilities via a video, presented by the matron for Complex Care. This raised awareness of issues relating to caring for patients with a learning disability, DNA-CPR (do not attempt cardiac pulmonary resuscitation) and communication with the family regarding this and the Mental Health Capacity Act.

1.5 Naso- gastric tube feeding

On 3 August 2017 the Deputy Director of Nursing presented to the Board work being undertaken to embed key messages about the safe management of naso gastric tubes, including work on training and compliance, the nutritional policy, procurement and completion of the self-assessment against the National Patient Safety Alert. Work continues in this area during the next six months.

1.6 Falls

On 3 August 2017 the Falls clinical lead together with Assistant Director of Quality and Safety presented the work within the Trust to reduce falls, including work on prevention, individualised care, integration, learning from incidents and culture of safety, sharing specific work within the Acute Medicine Unit which takes an improvement science approach to improving quality, Haelo.

There has been a sustained reduction in the total number of falls and also a reduction in harm falls. Strong clinical leadership for this area of quality improvement continues.

2. Update on 2017/18 Quality Priorities

An update on the three quality account priorities for 2017/18, sepsis screening for in patients, discharge planning and learning from complaints is given below. Sepsis and discharge planning are CQUINs for 2017/18.

2.1 Sepsis Screening for in patients

Sepsis is an infection which starts in one part of the body but spreads via the blood and can prove fatal for some patients. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are thought to contribute to a number of preventable deaths.

The Trust is looking to improve the recognition of potential sepsis through a number of interventions. One key intervention centres on ensuring appropriate screening of patients with suspected sepsis. This screening will enable patients to commence treatments sooner and improve their overall outcomes. This is important for patients both arriving with us with sepsis and those that develop sepsis whilst under our care.

The aim is to achieve improvements in the identification of patients who are at risk of developing sepsis during their inpatient stay.

In June 2017 a risk was added to the high level risk register, risk 6990, scored at 16, of not meeting the 2017/18 CQUIN for sepsis.

The current position is that the timely treatment of sepsis in emergency departments and acute inpatient settings has seen a gradual improvement throughout the year, however timely identification

of patients with sepsis in emergency departments and acute inpatient settings has seen a significant deterioration since EPR.

Timely treatment of sepsis in emergency departments and acute inpatient settings	**% Patients with severe red flag/ septic shock that received Iv antibiotics < 1hr in Emergency Admissions**	75.0%	85.7%	83.3%	**82.5%**
	% Patients with severe red flag/ septic shock that received Iv antibiotics < 1hr in Inpatients (LOS >0)	55.6%	75.0%	84.6%	**73.3%**
Timely identification (screening) of patients with sepsis in emergency departments and acute inpatient settings	% Eligible patients screened for Sepsis in Emergency Admissions	84.0%	14.0%	28.0%	**42.0%**
	% Eligible patients screened for Sepsis in Inpatients (LOS >0)	34.0%	20.0%	28.0%	**27.3%**

Work is ongoing to assess the possibility of hitting the treatment target of 90% in late Q3 or early Q4; however the identification target is not likely to be met this financial year.

An improvement plan has been developed, together with a resource to support the delivery of this plan. Clinical leadership has also been engaged, with the Sepsis Improvement Group refreshed during October.

A deep dive report on all CQUINs is being presented at the Executive Board on 27 October 2017.

2.2 Discharge Planning

Safe and timely discharge planning is an important part of the inpatient stay. It is estimated that over 20% of discharges require some complex planning and coordination. In order to ensure that these patients have a safe and appropriate environment to return to after their stay, the Trust will be working to enhance and develop the role of the discharge co-ordinator so that these roles continue to be effective and work collaboratively with our partners

The last year has seen the work that the discharge team have implemented in collaboration with partners leading to a real reduction in the length of stay for our most complex patients. This has a positive impact on patient's wellbeing and supports reduction in risks associated with being in hospital when you are medically fit for discharge. The discharge team continue their commitment to changing an existing culture of only discharge planning when medically fit, to a system that plans for discharge on admission with the next step of a full clinical engagement and implementation of the SAFER bundle.

In early 2017 we implemented an acute frailty model and team at HRI and in September have rolled this out to CRH. We will continue to work closely with CCG and community colleagues in the development of a whole system frailty model. A report to the Board on frailty is planned for early 2018.

Further work also includes the introduction of a new screening tools are now in place to facilitate timely and accurate information gathering on day 3 of admission, identifying patients with complex needs. We are completing joint working events with not only external partners, Age UK, CCG, Local authority but also internally between different professions to improve ward discharge processes to make them more efficient and more patient focused.

Working with partners, the use of one trusted assessment is being trialled.

A number of small tests of change are being rolled out across wards to support improvements in patient discharge transport, discharge information, TTOs.

We are starting to see benefits with the introduction of the EPR and the use of the transfer of care database for information sharing and monitoring progress in the patients clinical and discharge pathways, we anticipate this will continue to have an important role to play.

The work in 2017/18 is a continuation of a transformational piece of work started by the Trust in 2016/17 and has robust metrics attached. Targets to measure improvements include zero tolerance of patients over 100 days length of stay, 30 patients over 50 days length of stay, a reduction in the length of stay for patients who are deemed frail, a reduction in the re-admission rate for frail patients and the % patients who have had a comprehensive geriatric assessment.

The metrics for this work, which include an acute frailty dashboard and a Safer Programme dashboard, are reviewed monthly by the Safer Patient Flow Programme Board.

3. Learning from Complaints

Why we chose this
We receive a lot of positive feedback on our services throughout the year. However, when our patients are dissatisfied with the service they receive and make a formal complaint, we act on it. It is critical that we learn from patients' experiences of our services and make improvements. We plan to improve the quality of the response to complaints and increase learning from complaints.

Improvement work
The Parliamentary Health Service Ombudsman's report, Learning from Mistakes, July 2016, reiterated that training and accrediting sufficient investigators is crucial to improve learning from investigations. Therefore a new training package was devised to support staff in their investigative approach to patient complaints.

Increase in number of staff trained in complaints management
The Complaints Development have rolled out and undertaken a complaints investigations training course. The complaints training is a full day course looking at the legislation behind NHS complaints, tools and techniques for investigating a complaint, how to identify and disseminate learning.

Since the commencement of the course 62 members of staff have been trained in complaints management.

Positive feedback has been received from the evaluation, with attendees feeling more confident in managing complaints, understanding the need to plan and structure the investigation and increased awareness of the requirements for complaints responses and legislative requirements.

On reviewing of feedback forms and staff attending the course, we are looking to review the complaints training package to make it modular based instead of a full day, we hope that we will be able to target more staff this way.

Improving learning from complaints.
Following on from the internal audit report on complaints the complaints team together with maternity services staff undertook a "go see" visit to University Hospitals of Morecambe Bay NHS Foundation Trust to see how they demonstrated learning from the complaints they reached. We were re-assured to find that they took a similar approach to us, in that they reported their learning through their quarterly complaints report.

During October the complaints manager has met with FSS and agreed improvement actions based on best practice from the go see visit, including meeting with complainants to review responses to seek feedback.

A proposal to take forward improvement actions following the Morecambe Bay visit is being taken to the Patient Experience Group in November.

Also work is planned on improving customer service in the Emergency Departments, in 2018, following complaints relating to staff attitude and communication.

Section 5 of our quarterly complaints report details Divisional and Parliamentary and Health Service Ombudsman learning from complaints. To this section we have also added a feature on learning, where we take one piece of learning and provide more of a story around the complaint and learning.

An example of this featured learning from the Q1 complaints report is given below:

A patient was admitted and diagnosed with a brain haemorrhage; this progressed well for 48 hours. However, on the third day the treatment was withdrawn. The family were worried that, due to implementation of EPR, the patient was mistaken with another patient of same first name. Upon speaking with the consultant the family were told there was no further bleeding and full care was reinstated.

The withdrawal of treatment had lasted for 20 hours, which family believe led to the early death of the patient. Another scan was ordered but the patient was not well enough to have it. The hospital was deemed to be in a state of chaos and confusion due to the new EPR computer system.

The Trust apologised that we did not provide the family with the necessary information to ensure you they fully aware of the decisions being made about the patient and that this meant they were not fully appreciative of how unwell she was and left the family with doubts about the care provided.

As a result of this complaint, a Consultant is to discuss with the Clinical Director of Radiology, the feasibility of Radiologists incorporating further information in their reports, for example, to include an explanation for the reason or cause of deterioration in a patient's condition, to assist when communicating the findings with patients and their family.

Other areas of learning
The Q1 and Q2 complaints report is presented at the patient Experience Group and shared with governors.

We have introduced a number of improve and learning initiatives with focus on a subject of learning instead of the source (examples Bite Sized Learning, Sharing Learning – Improving Care Newsletter, Improve@CHFT - social media group). Learning from complaints feeds into this wider learning.

FINANCIAL IMPLICATIONS OF THIS REPORT:
None

RECOMMENDATION
The Quality Committee is asked to note the quality reporting for the first six months of the year and the update on the three quality account priorities.

APPENDIX ATTACHED
No

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Senior Nurse Clinical Governance
Date: Thursday, 7th December 2017	**Sponsoring Director:** Cornelle Parker, Deputy Medical Director
Title and brief summary: Learning from Death Report - This is the first Learning from Death report provided to the Board of Directors	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This is the first Learning from Death report presented to the Board of Directors and outlines our review process.

Main Body

Purpose:

To note the content

Background/Overview:

See attached report

The Issue:

See attached report

Next Steps:

See attached report

Recommendations:

The Board is asked to note the contents

Appendix

Attachment:

Learning from Deaths Report - amended.pdf

Background

It is estimated that approximately 3% of in-hospital deaths are preventable. In September 2017 the trust published its revised Learning from Death (LfD) Policy both on the Trust's intranet and internet. It outlines the process by which we, as an organisation, will learn from those who die in hospital. It builds on the previous mortality review process which had been in place for a number of years. In accordance with the National Quality Board (NQB) March 2017 framework it outlines how we will identify, investigate, report on and demonstrate learning from deaths that occur at Calderdale and Huddersfield NHS Foundation Trust. The ambition is that all deaths will have an Initial Screening Review (ISR). The ISR is intended to be a high level overview of the patients care whilst in hospital to identify any obvious concerns in the quality of care given. ISRs will be allocated across the consultant body from a centrally coordinated process. Consultants will be encouraged to complete the ISR within a 2 week period by completing an online ISR tool. Specialty specific ISRs will continue in Gastroenterology, Critical Care, Emergency Medicine, General Surgery, Orthopaedics and Stroke Medicine. Cases that score 1 (very poor care) or 2 (poor care) will trigger a more in depth Structured Judgement Review (SJR).

SJR process to review deaths is outlined in the LfD policy and is based on a retrospective review of the patient's record. In addition to cases escalated from the ISR process SJRs will also be performed on certain cohorts of patients. These include Serious Incidents (where there has been a death), patients with a learning disability or serious mental health concerns, patients who have died following an elective admission or in conditions that are alerting on the Hospital Standardised Mortality Ratio/Summary Hospital-level Mortality Indicator (HSMR/SHMI). The SJR will be performed by a consultant specifically trained to make a judgement on whether the death was avoidable using the following score:

1. Definitely avoidable
2. Strong evidence for avoidability
3. Probably avoidable, more than 50-50
4. Possibly avoidable, less than 50-50
5. Slight evidence of avoidability
6. Definitely not avoidable.

The policy also outlines how deaths in Maternity and Children are investigated and reported through the Mortality Surveillance Group.

The team of nine structured judgement reviewers are expected to complete their reviews within a 2 week period. Data is collected not only to record the avoidable score but also key themes where things have been done well and also where there could be areas for improvement. The LfD panel chaired by Dr Sal Uka, Associate Medical Director and attended by the structured judgement reviewers with senior nursing representation will meet every two months to discuss all SJRs. The first LfD panel is scheduled for Friday 22nd December. The role of the LfD panel is to review the findings of the SJR and agree the opportunities to share the learning through junior doctors training sessions, clinical governance meetings, senior nurses meetings and Patient Safety and Quality Boards.

The NQB framework outlines that the trust should publish quarterly data on deaths through a paper as an agenda item at a public Board meeting from Quarter 3 onwards.

Dr Sal Uka, Associate Medical Director

This is the first LfD quarterly update to the Trust's Board of Directors.

LfD Mortality Data

The LfD mortality data is presented on the LfD dashboard using the NQB template (appendix 1). It should be born in mind that:

- Data will be presented one quarter in arrears e.g. Q3 report will be up to and including Q2. Hence this report is data for deaths that have occurred up to the end of September 2017. Data for deaths in Q3 will be reported in Q4 and so on.
- The revised LfD Policy was agreed in August with plans to implement it from September 2017. Although there are now 9 structured judgement reviewers in post these were not in place until mid- October or indeed fully trained to perform all SJRs needed prior to September 2017. However certain SJRs have been prioritised especially where there were concerns regarding care and/or where subject to a Serious Incident (SI) investigation.
- Although ISRs were being performed prior to September 2017, the numbers being completed remained low. The process to allocate all deaths for an ISR (with the exception of those where a SJR is indicated directly) will commence from 1 December 2017.

The total number of deaths in Q2 was 386. Of these 24 deaths referred for a SJR. The reason for escalation included:

- 3 patients with learning disabilities
- 14 cases following ISR
- 1 case as part of a complaint
- 3 cases as part of ongoing SI investigation
- 3 cases admitted for elective procedures

20 of the 24 deaths have had a SRJ completed with the following assessment of avoidability:

- Score 1 = zero
- Score 2 = zero
- Score 3 = two cases
- Score 4 = zero
- Score 5 = one case
- Score 6 = seventeen cases

The remaining 4 cases referred for SJR will be reported in Q4. Of the two cases that were deemed to be 'probably avoidable', both are being investigated under the Trust's Incident Management Policy. The two themes that have emerged from these cases are escalation to senior medical staff and decisions about ceilings of care.

Summary

This is the first quarterly board report presenting data from the new LfD process. Some early themes such as escalation to senior medical staff are already being strengthened through the Deterioration Programme. However, as time progresses more themes will emerge and require strategies to improve the quality and ultimately outcomes for patients at CHFT. Consideration is being given on

how to best disseminate learning to those involved and wider through the trust. It is anticipated that future quarterly board reports including an annual report will continue to build on this picture.

Dr Sal Uka, Associate Medical Director

Appendix 1

Learning from Death Dashboard

NHS Calderdale and Huddersfield NHS Foundation Trust: Learning from Deaths Dashboard - November 2017-18

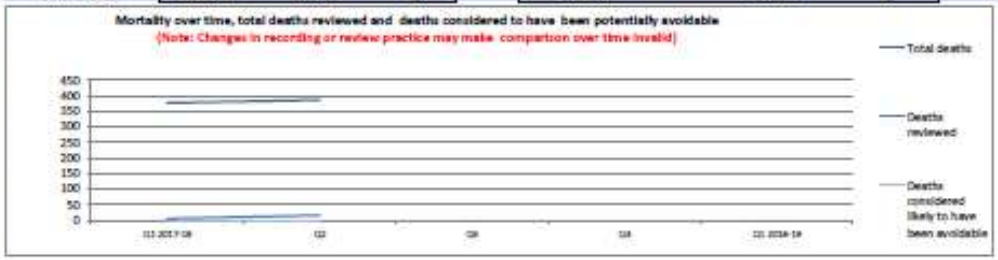
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Potentially Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP=<3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	186	0	17	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
763	0	23	0	2	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Total Deaths Reviewed by RCP Methodology Score

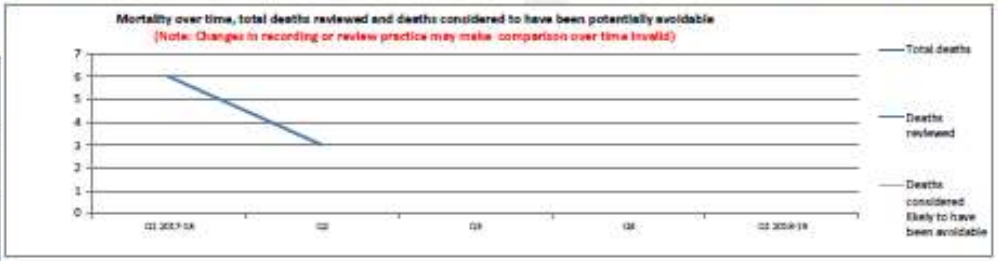
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	4.3%	This Year (YTD)	1	4.3%	This Year (YTD)	3	13.0%	This Year (YTD)	18	78.3%

Summary of total number of deaths in patients with a learning disability and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Potentially Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	3	0	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	0	3	0	1	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Dr Sal Uka, Associate Medical Director

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 December 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: High Level Risk Register - To present the high level risks on the Trust risk register as at 25 September 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: RIsk and Compliance Group 21 November 2017	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The high level risk register is presented on a monthly basis to ensure that the Board of Directors is aware of key risks facing the 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 be deemed a high level risk, 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 27 November 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.

There are no new risks that have been added to the high level risk register during November.

Risk 6971, endoscopy is being revised to incorporate issued identified in risk 6857 currently on the Surgery and Anaesthetics divisional risk register regarding loss of accreditation for endoscopy units following discussion at the Risk and Compliance Group on 21 November 2017. This will be shared in the December high level risk register report.

To note that, as advised previously, a risk around bank and workforce model has been developed by the Workforce and Organisational Development team which has a risk score of 12 and is therefore not triggering a score of 15+ for the high level risk register.

A specific risk regarding the health and safety action plan is not now being developed as it has been confirmed that risks are captured through the current risk register entries within Estates and Facilities.

Next Steps:

The EPR risk panel continues to review risks arising from the EPR programme. This work will be completed during December, with any risks scoring over 15 featuring on next month's high level risk register report.

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. Advice on any further risk treatment required.

Appendix

Attachment:

Risk Register Summary - November 2017.pdf

HIGH LEVEL RISK REGISTER SUMMARY OF CHANGES

Risks as at 27th November 2017

TOP RISKS

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

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

The Trust risk appetite is included below.

RISKS WITH INCREASED SCORE

None

RISKS WITH REDUCED SCORE

None

NEW RISKS

None.

Risk 6971, endoscopy is being revised to include issued identified in risk 6857 currently on the Surgery and Anaesthetics divisional risk register regarding loss of accreditation for endoscopy units following discussion at the Risk and Compliance Group on 21 November 2017. This will be shared in the December high level risk register report.

CLOSED RISKS

None

NOVEMBER 2017 – BOARD - SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 27.11.17

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Jun 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17
Safety and Quality Risks										
007	4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=16	=16	=16	=16	=16	=16
012	2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
007	6990	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/18	Medical Director (DB)	=16	=16	=16	=16	=16	=16
007	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	=16	=15	=15	=15	↑16	=16
007	6829	Keeping the Base Safe	Aseptic Pharmacy Unit production	Director of Nursing	=15	=15	=15	=15	=15	=15
011	5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
014	6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD (JE)	=16	=16	=16	=16	=16	=16
014	6977	Keeping the base safe	Mandatory training 2017/18	Director of Workforce and OD (JE)	! 16	=16	=16	=16	=16	=16
011	6903	Keeping the base safe	ICU/Estates joint risk	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	6924	Keeping the base safe	Misplaced naso gastric tube for feeding	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
007	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
007	6971	Keeping the base safe	Endoscopy provision	Divisional Director of Surgery and Anaesthetics (J O'R)	= 15	=15	=15	=15	=15	=15
020	7046	Keeping the base safe	EPR Quality and safety risks	Exec Medical Director (DB)			!16	=16	=16	=16
007	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (MdB)			!15	=15	=15	=15
007	6011	Keeping the base safe	Blood transfusion process	Divisional Director of FSS (MdB)			!15	=15	=15	=15

Finance Risks										
021	6967	Financial sustainability	Non delivery of 2017/18 financial plan	Director of Finance (GB)	=20	↑25	=25	=25	=25	=25
021 & 022	7049	Financial sustainability	EPR financial risk due to increased costs and decreased income	Director of Finance (GB)			!20	=20	=20	=20
022	7062	Financial sustainability	Capital programme 2018/19	Director of Finance (GB)				!20	=20	=20
021	6441	2017/18 income	Divisional income surgery and anaesthetics	Divisional Director of Surgery and Anaesthetics (JO)				!16	↑20	=20
Performance and Regulation Risks										
007	6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (BB)	=16	=16	=16	↑20	=20	=20
007	6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
009	7047	Keeping the base safe	EPR Performance – failed regulatory standards, contractual KPIs, patient / staff performance	Chief Operating Officer (HB)			!16	=16	=16	=16
People Risks										
012	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce	=20	=20	=20	=20	=20	=20
012	7078	Keeping the base safe	Medical Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce	=20	=20	=20	=20	=20	=20

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

TRUST RISK PROFILE AS AT 27/11/2017

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	**Minor**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Highly Likely (5)			= 6715 Poor quality / incomplete documentation	= 6345 Nurse Staffing = 7049 Financial risk arising from EPR = 6658 Inefficient patient flow = 7078 Medical Staffing	= 6967 Not delivering 2017/18 financial plan
Likely (4)				= 4783 Outlier on mortality levels = 6300 CQC improvement actions = 6596 Serious Incident investigations = 6598 Essential Skills Training Data ! 5862 Falls risk = 6990 CQUIN sepsis = 6977 mandatory training = 7046 EPR quality and safety risks = 7047 EPR Performance /regulatory/KPI risk arisisng from EPR	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6903 ICU/ resus estates risk = 7062 Capital programme 2018/19 =6441 Divisional income 2017/18 surgery and anaesthetics
Possible (3)					= 6829 Pharmacy Aseptic Unit = 6924 Misplaced naso gastric tube = 6971 Endoscopy provision = 6011 Blood transfusion process = 5747 Vascular /interventional radiology service
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE NOVEMBER 2016

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

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

Risks Scoring 15+

Risk No	Div	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6967 (BAF ref 021)	Trustwide	Apr-2017	Financial sustainability	The Trust is planning to deliver a £15.9m deficit in 2017/18. There is a high risk that the Trust fails to achieve its financial plans for 2017/18 due to: - £20m (5.3% efficiency) Cost Improvement Plan challenge is not fully delivered - loss of productivity during EPR implementation phase and unplanned revenue costs - inability to reduce costs should commissioner QIPP plans deliver as per their 17/18 plans - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level - Risk overlaps that referred to in Ref. 6441 (Surgical Division).	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach Financial recovery actions were agreed by Turnaround Executive on 13th June. Controls around use of agency staffing have been strengthened. For 2017/18 the Trust has been given a £16.86m ceiling level for agency expenditure by NHS Improvement. Agency spend is planned to reduce considerably from the level of expenditure seen in 16/17 if the Trust is to deliver the financial plan, and not exceed the ceiling. Year to date this planned reduction in expenditure has been achieved.	Lack of direct consequence to budget holders for poor budgetary management. Difficulty in identifying EPR benefits to offset additional committed resource. Nursing Agency spend above planned level. Not all Agency shifts booked through flexible workforce team.	20 5 x 4	25 5 x 5	15 5 x 3	Whilst the Trust agreed the 17/18 Control Total of £15.9m, serious concerns about the achievability of this target have been raised with the regulator. It leaves the Trust with a planning gap of £3m that has been added to the £17m CIP target. At 5.3% efficiency this will be extremely challenging to deliver. The organisation currently has plans for £17m of the £17m CIP target, but £3.73m of this forecast saving is currently considered at a high risk of non delivery. The year to date position has continued to deteriorate, with activity and income well below the planned level. EPR implementation has had a significant impact on the capture and coding of activity and £1.56m 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 in Month 7 the Trust reported a position that is £2.48m away from Control Total. In previous months achievement of the Control Total relied on the release of our entire Contingency Reserve and a number of non recurrent benefits that were one off in nature and cannot be repeated. Achieving the full year 17/18 Control Total currently relies on identifying additional recovery plans of the magnitude of £13m in the final five months of the year. Failure to achieve the Control Total in future months would also impact on Sustainability & Transformation funding.	Dec-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell

6903 (BAF ref 011)	Estates & Facilities	Dec-2[illegible]5	Keepin[illegible] the base safe	Collective ICU & Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to inadequate access [illegible] to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.This incluides: ICU - Air Handling Unit (AHU) RESUS - Ventilation RESUS – Electrical Resilience ICU & RESUS - Flooring ICU & RESUS - Electrical Infrastructure RESUS - Plumbing infrastructure ICU & RESUS - Life Support Beams/Pendant ICU - Building Fabric ICU - Nurse Call System RESUS - Medical Engineering Risk - 4 Dameca Anaesthetic Machines RESUS - Operational Safety f RESUS – Compliance / Statute Law All of the above does not meet the minimum requirement as stipulated in the Health	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	**November 17 Update** - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Estates have re-developed the old plaster room into a Rapid Assessment Area. October 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. Resus has completed a small refresh i.e. removal of X-Ray equipment. September 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. Resus is currently undergoing a small works refresh i.e. removal of X-Ray equipment and installation of additional curtains	Dec-2017	Dec-2017	RC	Lesley [illegible] / David McGarrigan	Chris D[illegible]es
7049 (BAF ref 021)	Trustwide	Aug-2017	Financial sustainability	EPR Financial risk with increased costs and decreased income. Due to: Reduction in activity arising from increased time per patient in Outpatients leading to reduced templates, errors with booking process related to migration and build leading to DNAs etc, pre-assessment build impacting on elective activity & mapping issues impacting on overall income capture. Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff Increased costs to ensure timely and appropriate response to clinical & operational risks.	Developing financial recovery plans. Weekly activity and income meeting chaired by Director of Transformation and partnership, weekly Theatre scheduling now attended by an Executive. systems to capture activity. Weekly performance monitoring. Targeted improvement for those in greatest need. Activity coding issues being addressed. Continuing to shadow monitor activity using existing systems. Cymbio dashboard deployed from Day 1 of EPR, weekly Data Quality Board, validation expertise deployed and extended, retaining senior analytical support until post Bradford Go-live, increased Booking staff to maximise appointment booking. Stabilisation plan developed.	Adequate system build BAU Team capacity. Staff training.	20 4 x 5	20 4 x 5	0 0 x 0	Identification of staff training needs. Specialty delivery of recovery plans. System build changes identified and prioritised, BAU team capacity review. Education and training for clinical staff. Placing Coders in clinical areas **November Update** Weekly data quality meeting reviews data capture and system issues with Divisional, Finance and THIS representation - ongoing. Divisional financial recovery plans to address activity maximisation. Negotiations with commissioners progressing to secure estimated income at risk in Months 1-6. Additional costs incurred being monitored with approvals to be taken through Commercial Investment Strategy Group.	Dec-2017	Mar-2018	FC	Gary Boothby	Kirsty Archer

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

7078 (BAF ref 012)	Corpo	Oct-20	Keepi	the base safe	Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing) Risk of not being able to deliver safe effective and high quality care with a positive experience for patients due to: - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record) "	Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	**November 2017** New Guardian of Safe Working in post 1 October 2017, working with consultant colleagues to tackle areas where there have been a number of exception reports raised. The BMJ advert for consultant posts closed 30 October. There are two applicants to consider and the Clinical teams are currently in the process of shortlisting. Interview dates have been identified for mid November 2017. A rolling programme of recruitment and retention meetings focusing on medical and dental staff has commenced. These meetings are chaired by the Deputy Medical Director and are intended to support Divisional colleagues to review vacancies and the costs associated with them, such as agency costs, bank costs and waiting list initiatives. An open evening for our SAS doctors has been arranged for 27 November 2017. External speakers are attending, along with our own employees who have been through the CESR process and who are now working at consultant level. There is an opportunity for the Trust to be a national Pilot site for CESR programmes in a number of specialties. If we are successful, we will have access to some funding from Health Education England to promote the scheme. October 2017 The final cohort of doctors in training moving to the 2016 contract commenced in post. All our doctors in training are now employed on the 2016 terms and conditions. The new Guardian of Safe Working presented to the October cohort of junior doctors in training. The Trust wide BMJ advert for consultant posts was published . Specialty Doctor has been appointed to commence in a Gastro CESR position. Plans are in place to hold a Trust open evening for SAS doctors to learn more about CESR opportunities at CHFT.	Dec-2017	Jan-2018	WF	David E enhead	Pauline rth

2827 (DMF ref 012)	Medic	Apr-20	Devel ng our workforce	The inability to recruit sufficient middle grade and consultant emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Development of CESR programme ACP development Continued recruitment drive for Consultant and Middle Grade doctors Weekly meeting attended by flexible workforce department, finance, CD for ED and GM	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level CESR training will extended time to reach Consultant level with no guarantee of retention	20 4 x 5	20 5 x 4	12 4 x 3	**November 2017** CESR applications being progressed. 2 MTI doctors recruited.. applications being progressed. Currently aware of significant shortfalls in night provision for Christmas week. Alternative strategies being explored Oct 2017 2 doctors appointed to CESR post, Recruitment in process.6 ACPs in post at varying stages of training Sept 2017: No change from last month. CESR interview did not occur due to IT problems. Further interview being arranged	Dec-2017	Aug-2018	WEB	David E enhead	Dr Mari avies/Mrs Caroline Smith

6345 (CRF ref 011)	Corpo	Jul-20	Keepir the base safe	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment		16 4 x 4	20 4 x 5	9 3 x 3	**November 2017** Applicants from the recruitment campaign in the Philippines are progressing steadily. 120 offers were made in country. Since March 2017; 7 candidates have withdrawn, 84 are completing their training for the International English Language Test System (IELTS), including 31 who are due to sit their IELTS exam before the end of November. We have 12 candidates that have passed their IELTS and are progressing with their NMC application, 3 of which have been successful and are due to start with the Trust on 27 November 2017. Nursing recruitment event held 14 October 2017 was well attended. There were 65 candidates, 55 of whom were interviewed and all were successful and offered employment upon attaining their exam results. It is anticipated that they will commence in post September 2018. In the meantime they will be able to undertake bank work within the organisation as a Health Care Assistant. An additional event is scheduled for March 2018. Following the successful recruitment of Physician Associates (PAs) in October 2017 a further cohort is being planned for early 2018. **October 2017 Update:** - 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, 85 are completing their training for the International English Language Test System (IELTS), 6 have their IELTS exam booked before the end of October. We have 13 candidates have passed their IELTS and are progressing with their NMC application, 3 of which has been successful with their NMC application and are due to start with the Trust 30 October 2017. - We are now using 2 generic adverts, 1 for Medical division and the other 1 for Surgical division 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 advertised and managed within departments as required.	Dec-2017	Jan-2018	WF	Brenda rown, Jason Eddleston	Rachae ierce

6441 (CR-F ref 021)	Surgery & Anaesthetics	May-2017	Finance sustainability	Risk of income being below planned levels for Division due to failure to delivery contract activity / income plan, inability to recover lost activity during EPR go live or planned level of activity in an appropriate case mix and inability to remove the equivalent total cost base to recognise this non delivery Resulting in non achievement of the Divisional planned contribution impacting on the Trusts ability to deliver its 17/18 I & E plan and remain a viable sustainable organisation	* Division Weekly activity / scheduling meeting attended by Executive lead " "Weekly Operational Performance meeting with Director of Operations * Monthly Business Meeting incorporating performance management' 'Revised activity forecast as at month 5 clinically owned and monitored weekly" 'Ongoing review of recovery plans with a need to consider cost out equivalent to income loss' 'Data Quality Group meeting weekly to ensure data quality in place and all activity captured and income generated appropriately'	Not all specialties job plans linked to activity volumes * individual surgeon performance management to activity plans	12 4 x 3	20 5 x 4	12 4 x 3	Attendance of Executive Director at weekly scheduling meeting. Division focus on Daycase & Elective. Trust wide including Division on Outpatient utilisation post EPR. EPR Stabilisation paper being prepared by COO. Directorate specific focus on aspects of planned care. Review of all surgery workforce against speciality in which activity captured. Recognition that income being captured at trust level but may be now within other Divisions with no change to control totals to recognise this. Revised activity forecast prepared within month 5 re fresh and monitored monthly with executive team through PRM's October 2017 Update Detailed work reviewing year end forecast position led to re-assessment of risk score with impact score increased from 4 to 5 using 5x5 risk matrix. Increased risk score of 20 agreed at SAS divisional board meeting on 23.10.17. November 2017 update Risk score remains at 20 with Division forecast remaining as per month 5 re forecast. Weekly Theatre scheduling meeting has been reviewed and agenda and approach amended to incorporate additional KPI's in order to drive out the in efficiencies. Month 7 reported financial position is inline with reforecast plan.	Dec-2017	Mar-2018	DB	Surgery and Anaesthetics Dvisional Director	Joanne Purdcastle

6658 (BAF ref 007)	Corpo	Mar-2(	Keepir	the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and [illegible] This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20 4 x 5	20 4 x 5	9 3 x 3	**November 2017** Work initiated to meet the discharge CQUIN will have a positive impact on this risk by reducing the LOS for complex patients, improve clinical pathway management. Implementation of the SAFER Bundle across the clinical divisions starts this month. October 2017 Delay in the additional cubicle space being created - should be in place by November Introduction of Urgent Care Action Cards- to aid good flow, prevent exit block- work on-going with the divisions to embed. Discharge Improvement week took place in September. Introduction of a whole system partner working group to improve transfer of care (medically fit patients waiting for discharge) September 2017 All initiatives introduced continue to be imbedded. Trackers start in post in ED from 11th September 2017 Extending cubicle space in the ED at HRI should be complete by the end of September which will aid time to initial assessment.	Dec-2017	Dec-2017	BOD	COO H	n Barker	Bev W	r

5806 (BAF ref 011)	Estates & Facilities	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. Details of specific risks listed in full on risk register.	Each of the risks above has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.	16 4 x 4	20 5 x 4	6 3 x 2	**November Update** - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. The Capital Plan continues to progress on track. Estates have recently completed a rapid assessment area within ED. September Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. Resus is currently undergoing a small works refresh i.e. removal of X-Ray equipment and installation of additional curtains. The Capital Plan continues to progress on this financial years projects within budget. October Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime and annual audit. The Capital Plan continues to progress on track.	Dec-2017	Mar-2018	RC	Lesley / David McGarrigan	Paul Gi / Chris Davies
5862 (BAF ref 007)	Medical	Aug-2013	Keeping the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls. Butterfly scheme. Delirium assessment	Insufficient uptake of education and training of nursing staff, particularly in equipment. Staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12 4 x 3	16 4 x 4	9 3 x 3	**November update** Work continues as plan however further engagement is required for implementing consistently safety huddles on clinical areas . Falls incidents are reducing in numbers in the last 2 months (N=137). ESR falls prevention now available as mandatory clinical training. October update Work continues as per plan, continued input from clinical leaders and engagement with clinical teams. September update Slips ,trips and falls policy redrafted for update at Falls Collaborative EPR falls awareness training being finalised. Equipment training on-going with ward based trainers. Falls awareness boards now being initiated on each ward. Falls incident numbers remain static for the previous 3 months (N=152) Reviewed data and metrics on risk, focussed work on MAU and ward 5 ad, with risks on local risk register.	Dec-2017	Jan-2018	PSQB	Brendan Brown	Janette Cockroft

6300 (BAF ref 007)	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 the inspection we will be judged as inadequate in some services. Additionally the CQC has announced a programme of Well Led Inspections which the Trust will be subjected to prior to Autumn 2018 ,there is a risk that we may not meet the required standard resulting in a judgement of "requires improvement".	Follow Up Inspection Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection Action plans progressed for all must and should do actions Separate action plans in place for each core service Reports to the Trust Board on those core services requiring improvement CQC compliance reported in Divisional Board reports to the Quality Committee Mock inspections for core services System for regular assessment of Divisional and Corporate compliance Routine policies and procedures Quality Governance Assurance structure The Risk and Compliance Group has oversight of	The March 16 inspection report placed us in the has shown us to be in the "requires improvement" category. We do not know the date of the next inspection We do not yet have the Insight Report from the CQC which details the data that they hold regarding our services. We do not know when core service inspections will take place as these are unannounced visits	16	4 x 4	16	4 x 4	8	4 x 2	**November 2017:** Trust wide CQC group reviewing responses from the self assessments commenced with well led domain, next will be safe domain. Populating plan with issues identified. Trust wide Regional Leadership Event delivered by Ted Baker, Chief Inspector of Hospitals October 2017: Meetings re-established for the Trust-wide CQC group with an initial focus on reviewing outputs from the mock well led PIR and core service self-assessments. Plan being established for key lines of enquiries (KLOEs) identified. September 2017 Divisions are setting up groups to prepare for the next inspection phase. Work continues on the Well Led PIR	Dec-2017	Dec-2017	WEB	Brenda rown	Juliette sgrove
6596 (BAF ref 007)	Corporate	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16	4 x 4	16	4 x 4	8	4 x 2	**November 2017** Continued focus on meeting with appointed investigators to support completion of report and / or timely investigation and scheduling within divisional panels prior to SI panel. October 2017 Significant assurance from internal auditors confirming a good system is in place for learning lessons from incidents. Continued focus on improving quality of serious incident reports. September 2017 New Senior Risk Manager in post, tighter monitoring of investigations timescales, greater scrutiny of reports as drafted and support for investigators to increase the likelihood of reports and action plans being agreed at SI panel.	Dec-17	Dec-2017	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove

6598 (CR-F ref 007)	Corpo	Jan-2(	Keepir 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 being 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. There are currently 30 agreed essential skills in total. Compliance measurement will be enabled as a target audience (TA) for each essential skill is set. Brendan Brown/Lindsay Rudge are restricting additions to the list to keep it to a manageable number. Improved functionality within ESR has enabled a more efficient identification of target audiences and of training completion. It is planned that all essential skills will have a target audience set in ESR by December 2017.	1/ Essential skills training data held has historically been inconsistent and patchy. 2/ Target audiences setting to allow compliance monitoring against a target has historically been inconsistent and patchy. 3/ Heavy focus on EPR training and implementation had an impact on staff being able to complete essential skills training due to time and resource implications. 4/ Now all clinical staff have been issued a bank contract there are some discrepancies with competencies assigned to bank position but not their substantive post. These are small in number. 5/ recent focus on mandatory training and appraisal has had an impact on staff completing essential skills training.	16 4 x 4	16 4 x 4	12 4 x 3	**November 2017** Target audiences set for falls, food hygiene level 2 and NGT placement. Athena training removed from the maternity essential skills list. Data captured in line with EPR training data. A plan is being developed to work collaboratively with subject matter experts and HR BPs to drive up compliance across the suite of essential skills. October 2017 Safeguarding Level 3 inc. MCA/DoLs package is uploaded and live on the system. The target audiences for the few remaining essential skills are being set. Following this, managers will be targeted by email to request compliance information for their team members and to confirm dates for planned activity. September 2017 MCA/DoLS level 1 now complete and uploaded to the e-learning platform. TA to be assigned the competence on 11.09.17 then this will appear in compliance matrix for staff to complete. Safeguarding level 2 inc MCA/DoLS - package ready but technical difficulties are preventing successful upload to the e-learning platform. Problem escalated for solving. Once this is resolved the revised package will replace the original safeguarding L2 for colleagues renewing with immediate effect. Falls prevention - package ready, final analysis on TA required, planned completion and roll out date 15.09.17 PREVENT WRAP - Complete and set up on ESR Driver essential skills - discrepancies with position codes identified. Unable to clarify due to staff sickness. Escalated for progress with a deadline date for completion of 29.09.17.	Dec-2017	Dec-2017	WF	Jason E leston	Ruth M n

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

6977 (BAF ref 014)	Corpo g	May-2 7	Devel(ng our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period. It was agreed at 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. A pay progression policy approach including mandatory training compliance is now in place.	Computer settings across the Trust have proved inconsistent. This can inhibit access to mandatory training and cause delays in compliance. This issue has been prioritised and a solution has been sourced. October 2017 - update: technical issues now resolved. Computer settings now consistent across the Trust.	16 4 x 4	16 4 x 4	4 4 x 1	**November 17** A 'deep dive' into the reasons for non-compliance is being undertaken by the mandatory training lead. Areas of high levels of non-compliance are being contacted to discover what the reasons are and to offer support in achieving compliance. This is an on-going action as colleagues can drop out of compliance for any of the 5 key subjects at any point in the year, this is dependent on when their previous learning expires. October 17 Mandatory training completed by Junior Doctors at induction to CHFT had not been recognised and therefore left unrecorded. This indicates low compliance from this staff group. This will be rectified December 17 September 17 A mandatory training lead has been identified in Workforce & OD who is providing additional overview and scrutiny..	Nov-2017	Mar-2018	WF	Jason E leston	Ruth M n
6990 (BAF ref 021)	Corporate	Jun-2017	Transforming and improving patient care	CQUIN target at risk of not being met for 2017/18 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non - compliance with NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also financial penalties.	Awareness and new controls for ward areas Divisional plan, medical leads identified in all divisions -improvement action plan in place, improvements seen in data for 2016/17 -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign was launched introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards -sepsis prompt in EPR	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of communication and joined up working between nursing and medical colleagues Information on patients not receiving the sepsis bundle in a timely manner. Clarity on use of EPR prompts required	16 4 x 4	16 4 x 4	4 4 x 1	Assess impact of EPR sepsis prompt Improve safety huddles to include sespis Coordinate activity with the Deteriorating Patient Group Strengthen divisional leadership **November update** In-depth analysis of sepsis prompts being undertaken to prepare guidance for staff. Policy review underway Focussed work with ED teams to take place over the coming weeks October update Training for Health Care Assistants in recording clinical observations taking place Performance reports to clinical teams September update Analysis work continues focused on admission areas at both acute sites Weekly performance data shared with directorate teams Continued engament with staff as to barriers to detecting and responding to deteriorating patients	Dec-2017	Dec-2017	SC	David Birkenhead	Juliette Cosgrove

7046 (DAF ref 020)	Trustwide	Aug-2017	Keeping the base safe	EPR Clinical risk of patients receiving delayed access to care due to migration issues which placed incorrect location codes to activity, access issues for several members of staff resulting in delays. RTT build issue which does not place patients correctly onto the pathway. Electronic Discharge summary process not adhered to resulting in delayed information to GP. Lack of understanding on use of 'Encounters' leading to activity being connected with the incorrect episode. A 45 day purge of all activity within the Message Centre including correspondence unknown to users resulting in delayed distribution of correspondence. Reductions in outpatient activity & issues with appointment correspondence delaying access to review. Lack of familiarity with the system leading to an increased potential for clinical risk	Remedy on Demand for escalation of all system related issues for resolution. Stabilisation plan. Issues log populated by specialties, clinical and non-clinical staff to ensure all issues, risk, concerns were known and prioritised. All Divisions have own risk register and included in PSQB & Digital Modernisation Boards; high risks and risk changes reviewed at PRMs. Two weekly Operations Board with clear process for escalation. Datix reporting encouraged and all Red Datix received by Medical Director, Chief Nurse & Chief Operating Officer. Clinical Risk Panel established and Stabilisation plan in place SWAT team deployed to undertake Deep Dives/RCAs. DT meeting undertaken as required Visible leadership and feedback. Manual workarounds. Targeted support and training. On going training requirements identified and developed. Additional expert support deployed for Junior Doctor Change. Training & Access process for new and agency staff agreed. Access rights provided for all staff to undertake role as delivered pre-EPR	Response of external partner slow leading to delayed resolution. BAU team capacity & focus on 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	**November Update** EPR risk panel reviewing risks derived from EPR clinical hazards log. Each specialty to meet with EPR Team and a Director to ensure all concerns identified and plans agreed. Quality Directorate to attend each Digitial Modernisation Board for assurance of appropriate escalation and mitigations. BAU team capacity and operational capability being reviewed. Change Board TORs reviewed to ensure operational/clinical led prioritisation. Further formal escalation to EPR partner regarding speed of resolution. Introduce thematic review of incidents, complaints, PALS etc. Submit change requests for system build. Formal review of roles and development of these on EPR to refine access rights. Identify training needs. Work with clinical leads to develop information and support tools. September Update EPR risk panel established in September 2017, will report on risks routinely to Risk and Compliance Group October Update Migrated appointment data issues mostly resolved Access / Roles – current work on cleaning up access / roles – majority have access to perform job but often excess or dual roles Electronic Discharge Summary process tracked on a daily basis with improving performance BTHFT now live and EPR Back Office team now able to focus on stabilisation activities 45 days Additional EPR project team contracts extended to resolve issues	Dec-2017	Mar-2018	QC	David Benhead	Alistair Harris

7047 (CAF ref 009)	Trustwide	Aug-2017	Keeping the base safe	EPR Performance risk of failed regulatory standards, contractual key performance indicators or other patient/staff focussed performance due to: Issues with data migration impacting on RTT pathways. Build/Configuration impacting on reporting data and pathway tracking. Delayed access for patient as a result of migration, build and staff familiarity. Patient satisfaction and reputational issues due to the perceived impact of the system as staff familiarise themselves. Staff satisfaction as they learn the new system or there are delays in resolving issues pertaining to patient care, flow and efficiency. Data Quality issues, duplications, incorrect pathways, coding all impacting on ability to report. Management capacity & capability to resolve issues with the new system and maintain sufficient focus on all KPIs. Management reports inaccurate and requiring additional validation before deployed delaying responsiveness. Management reports timeliness to comply with local and national reporting deadlines	Weekly Performance meetings, Weekly Data Quality Board, Additional Data Quality expertise and capacity, weekly activity review. ...odelling of data to identify potential performance risks. Recruitment of additional staff into AED & Booking office. Shadow monitoring of activity using existing systems. Task and finish groups to address activity dips. Investigating areas of most concern. Manual recovery where poor recording is identified. Micromanagement of pathways. Working with IT to design appropriate reports. Use of Cymbio reports. Manual recording and collection of data. Stabilisation plan developed. Management capacity increases prioritised. All regulatory bodies kept informed proactively	Adequate system build. Availability of additional management capacity with correct skill set. Vacancies remain across all staff groups BAU capacity to support resolution of outstanding issues. Partner responsiveness & ability to find solutions. Several very large scale priorities to be managed. Communication and engagement	16 4 x 4	16 4 x 4	0 0 x 0	**November Update** Cymbio expertise reintroduced. Data Quality Board Terms of Reference completed Data Quality Structure completed October RTT return saw “Admitted completed” sent for first time since April submission. Incomplete RTT has been returned every month since go live. Non Admitted completed for the last 3 months. Monthly Activity Return (MAR) was sent in full for first time since April submission as a result of process to remove A&E Clinical Decision Unit chair only (results and awaiting transport) admissions continues to be issued. Quarterly Activity Return was issued for Quarter 2 17/18 after not issuing a Quarter 1 statement. Diagnostic Monthly Return (DM01) – still not reported waits or activity for Endoscopy diagnostic procedures. Validation processes fell just short of required quality for October to be returned. Much progress made in November so is full intention that return will be possible for 3 of 4 scope types in November position statement due mid-December. Aim for Cystoscopy waits to be reported for end December position. October 2017 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.. A number of KPIs reintroduced into IPR. August RTT return saw “non-admitted completed” sent for first time since April submission. August Monthly Activity Return (MAR) was sent in full for first time since April submission.	Dec-2017	Mar-2018	QC	Helen Ever	Division Directors

6924 (DATIX ref 007)	Corpo	Feb-2(	Keepir the base safe	Risk of mis-placed nasogastric tube for feeding due to lack of of knowledge and training in insertion and ongoing care and management of NG feeding tubes from nursing and medical staff resulting in patients fed into the respiratory tract or pleura and possible death or severe harm	Risk overseen by Nutritional Steering Group Task and finish group established by director of nursing to address elements of NPSA alert 22.7.16 on nasogastric tube misplacement Training package available Nursing staff have been encouraged to undertake self assessment and declaration of competency Check X rays are performed where aspirate is not obtained, or greater than pH5.5 Radiology team flag when sighted if tube is in the lung following xray Training and competency package in place for nursing staff identified from high use areas	Initial X Rays are reviewed by medical staff - currently have no record of training or competency assessment for medical staff working at CHFT Daily process for checking is dependent on individuals competency to be performed accurately Training data base is only available through medical device data base and is not monitored for compliance No assurance that all medical and nursing staff who are inserting and managing NG tubes have the competency required to do this No policy in place at CHFT to support guidelines	15 5 x 3	15 5 x 3	8 4 x 2	NPSA self -assessment has been completed and action plan is in development High use areas identified and training plan in place to ensure all nursing staff are trained and assessed as competent by 1st April 2017 Training figures monitored weekly for compliance from these areas Task and finish group – next steps will be a focus on training of medical staff Draft nutrition policy has been developed – plan to sign off through task and finish group. Currently with medical staff for comments. **November 2017 Update** Training package sourced by essential skills team from Preston and is currently being reviewed to ensure content suitable for target audience. When this has been done Dr Uka will work through Comms plan and THIS will lease with Preston team to transfer onto CHFT e learning. Package is aimed at any staff member who is responsible for initial placement check through interpretation of Xray. Support from radiology to identify target audience has been sourced. Class room sessions continue for nursing staff. Uptake remains variable as not mandatory however Comms plan has been rolled out regarding ' No training , No touching ' in terms of access of NG tubes. High use areas all have a key trainer identified who is responsible for ensuring that nursing staff are trained as per NPSA guidelines. 2 further areas have been identified as increased use since original areas were identified – these are ward 10 and 15. Nursing staff booking onto training however areas have been asked to identify key trainers. October Update Meetings re-established for the Trust-wide CQC group with an initial focus on reviewing outputs from the mock well led PIR and core service self-assessments. Plan being established for key lines of enquiries (KLOEs) identified.	Nov-2017	Nov-2017	QC	Brenda rown,	Jo Midc on

6971 (BAF ref 011)	Surgery & Anaesthetics	Apr-20	Keeping the base safe	Business continuity risk relating to reduced endoscopy provision / capacity and hysteroscopy capacity (risk 6993) due to increased demand on the Alternate 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. Due to data quality it is impossible to assess a accurate back log position this is impacting on the ability to outsource patients to identified providers. There is currently a risk to patient receiving timely care due to reduced hysteroscopy	Machines checked and monitored daily by endoscopy technicians whilst in use and all cycles are now conducted under physical supervision. The trust fire officer has ensured that there is adequate fire fighting equipment and decontamination staff are compliant in their use. Increased estates support and improved access to gettinge (HRI) Cantel (CRH) (maintenance contractor) technicians in place for all AER's A full downtime 36 hour period for maintenance schedules to be completed and all relevant tests to ensure all compliance is met. In sourced provider (medinet) is continuing to support service delivery through 2 CRH theatres on Saturdays, meetings with providers with a view to out source patient back log have commenced (Living Care/Yorkshire Clinic) these providers have offered capacity that will clear the back log by November. Continued support through medinet and in house weekend support will enable 3 theatres at CRH to deliver service lists and reduce the current back log. Discussions (meeting 29/09/17) with Living Care for the delivery of BoSs lists that run parallel to in house delivery increasing to a potential 9 lists per week. CRH decontamination now have replacement AER's in place, commissioned and operational For the next 9 weeks we will be running additional hysteroscopy weekend sessions (mixture or consultant and nurse-led sessions) which will start to reduce the waiting list (the first of these is this coming Saturday) Now the women's health unit is up and running we are planning to run additional sessions during the week the limiting factor here is staff to run additional lists but we're working to resolve this.	Data Quality	20	5 x 4	15	5 x 3	4	4 x 1	**Update November 2017** Plan in place for unit manager Increased Medinet use will have back log cleared by Dec 17 (plan with Chief Operating Officer). To replace all AER's as part of the endoscopy decontamination replacement scheme, by expediting the scheme the risk will be mitigated. Risk 6857 being merged with this risk to reflect risk of loss of accreditation status for both endoscopy units. October Update 2017 Refurbishment plan is on track. risk regarding backlog / outsourcing - patients have been identified for repatriation to outsourced provider. Staffing - resignation of Endoscopy Unit Manager Band 7 at CRH. Plan to review staffing structure. September, supporting decontamination unit to be built at HRI that will support the decontamination replacement on both sites. In front of plan Reintroduction of BCSP Cleansing of data to establish a accurate access to services and back log position	Dec-2017	Dec-2017	DB	TBC	Jason Ashby
5747 (BAF ref 012)	Family & Specialist Services	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of failing to provide an interventional vascular service due to challenges recruiting substantively to vacant posts at consultant interventional radiologist level resulting in our inability to meet the 6 week referral to treatment target; inability to deliver an appropriate service at CHFT and our inability to provide hot week cover on alternate in collaboration with Bradford Teaching Hospitals FT.	1wte substantive consultant Part-time short term Locums supporting the service	Failure to appoint to vacant post substantively due to limited availability. Failure to secure long term locum support.	16	4 x 4	15	5 x 3	6	2 x 3	**November 2017** No update 1. Continue to seek long term locum cover; 2. Continue to try to recruit to the vacant post; 3. Progressing a regional approach to attract candidates to work regionally; 4. Progressing approach to further contingency using regional-wide approach.	Dec-2017	Apr-2018	DB	Rob Aitchison	Sarah Clenton

6011 (BAF ref 007)	Family Specialist Services	May-2014	Keeping the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBH) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust).	Lack of electronic systems Lack of duplicate sampling Training compliance not at 100%	15	5 x 3	15	5 x 3	3 3 x 1	**November 2017** Apex upgrade postponed - will not impact on planned go-live of phase 1 of project (April 18). Overall project progressing to timescales. October 2017 Project continues. Apex upgrade has commenced and should conclude early November allowing project to progress to next stage of implementation. September 2017 Implementation group met for first time in August. Project continuing and timescales to be signed off in Sep. Intention to implement Apex upgrade in October	Jan-2018	Mar-2019	PSQB	Julie O'Jordan	Sarah Fensden
6715 (BAF ref 007)	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.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs.	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy / Alistair Morris, via back office team, December 2018 Establish a joint CHFT / BTHFT clinical documentation group.- lead Jackie Murphy and Alistair Morris timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group	20	4 x 5	15	3 x 5	6 3 x 2	Establish clinical documentation group N**ovember 2017** No change to existing controls	Dec-2018	Dec-2018	WEB	Brendan Brown	Jackie Murphy

6829 (CR-F ref 007)	Family Specialist Services	Aug-2[illegible]5	Keepin 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 [illegible]icrobial 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	The procurement of manufactured ready to administer injectable medicines when available from commercial suppliers. The first phase will be the procurement of dose- banded chemotherapy as soon as regional procurement contracts have been approved. This will create some capacity. The business case for the future provision of Aseptic Dispensing Services to be produced in July 2017 following the results of the feasibility study at the CRH unit with a view to consideration and approval by the Commercial Investment Strategy Group taking into account commercial procurement of some products. **November 2017** Re-audit 15/11/17 - still high risk with some actions taken to mitigate short term. still pursuing BC and possible use of PMU as an alternative. October 2017 The business case was taken to The Commercial Investment and Strategy Committee and was approved in principal with the need to find the best financial solution. The possible use of the PMU as part of the business case is to be considered. September Business case finalisation not yet complete. Will be completed for consideration by end of September	Dec-2017	Jan-2018	DB	Brenda rown	Fiona Sh

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

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

Executive Summary

Summary:

This report brings together governance items for review and approval by the Board:
a. Board Workplan
b. Board Skills/Competencies
c. Use of Trust Seal

Main Body

Purpose:

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

b. Board Skills/Competencies
The Board of Directors are asked to undertake a self-assessment of their skills and competencies as part of an annual review. A copy of the form to be completed is attached at appendix 1. This will be used to help identify any required development and also the assessment of what skills are required when consideration is given to future board vacancies. A composite of the assessment will be brought back to the Board in March.

c. Use of Trust Seal
Two documents have been sealed since the last report to the Board. These were in relation to Deeds of Variation for
St Luke's, Section 73, Planning Application and Elmdale and Ashdale anti-ligature shower installation.
The Board is asked to NOTE the use of the Trust Seal.

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to NOTE and COMMENT on the above items.

Appendix

Attachment:

COMBINED GOVERNANCE REPORT.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 - WYAAT Update	✓	✓	✓	✓	✓	✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework (Quarterly)	-	✓	-	-	✓	-	-	✓	-	-	✓	-
DIPC report	-	✓	-	Annual Report	✓	-	-	✓	-	-	✓	-
High Level Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Care of the acutely ill patient report	✓			✓		✓		✓		TBC		TBC
CQC Assessment Update on Action Plan			✓ Deepdrive Maternity	✓ Deepdrive Critical Care	✓ Deepdrive Paeds					✓		
Learning from Deaths – Quarterly Report									✓Q3			
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				✓ SI reporting			✓
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	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes				✓		✓			✓			✓
Performance Management Framework – update on work from sub-committee workplans		✓										
Guardian of Safe Working Quarterly Report (? Anu Rajgopal to attend if avail)							✓			✓		
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	✓											

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
- Board meeting dates			✓									
- Committee review and annual report												✓
- Annual review of NED roles								✓				
- Use of Trust Seal			✓			✓			✓			✓
- Quarterly Feedback from NHSI			✓			✓						✓
- Declaration of Interests - BOD (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		✓										

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
HPS Business Plan											✓	
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)								✓				
Winter Plan						✓						
ONE-OFF ITEMS												
Membership Council Elections				✓							✓	
Single Oversight Framework (VP/GB)									✓			
Hospital Pharmacy Transformation Plan (AB/Mike Culshaw)										? later summe r 2017		
Risk Management Strategy										✓		
Workforce Strategy											✓	
LHRP Core Standards (LH/Ian Kilroy)							✓					
Performance management update								✓				
Assisted Conception Service										✓		

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	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Minutes of the WYAAT CiC meeting							✓		✓			✓
ADDITIONAL PRIVATE ITEMS												
Reforecast financial plan							✓					
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)		✓	✓	✓			✓	✓		✓	✓	✓
Committee in Common - Minutes									✓	✓	✓	✓
Committee in Common – Programme Directors' Report	-	-	-	-	-	-	-	-	-	✓	✓	✓

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
CIC - PID											✓	

Calderdale and Huddersfield NHS Foundation Trust

BOARD SKILLS AND COMPETENCIES SELF-ASSESSMENT 2017-2018
Template – November 2017

The proposition for this assessment is that the Board can regard itself as competent if there is a good spread of in depth and working knowledge for each domain across the Executive Directors and Non-Executive Directors. This assessment is used to satisfy the Board that it is fit for purpose and to inform recruitment processes to ensure that any gaps that arise at short notice, or can be predicted through turnover, are filled.

The domains are determined by the Board, having regard to the provisions set out in the Code of Governance for Foundation Trusts by the Foundation Trust Regulator.

KEY:
E – denotes Essential domain
D – denotes Desirable domain
✓ - Area of sufficiency or strength – considers self competent
★ - Area requiring some development – moderate experience or skill
△ - No or little experience/skill – development required

		EXECUTIVE DIRECTORS	NON EXECUTIVE DIRECTORS
DOMAIN		**✓ - Area of sufficiency or strength – considers self competent** **★ - Area requiring some development – moderate experience or skill** **△ - No or little experience/skill – development required**	**✓ - Area of sufficiency or strength – considers self competent** **★ - Area requiring some development – moderate experience or skill** **△ - No or little experience/skill – development required**
Strategic risk & governance management	**E**		

Financial expertise	**E**		
DOMAIN		✓ - **Area of sufficiency or strength – considers self competent** ★ - **Area requiring some development – moderate experience or skill** △ - **No or little experience/skill – development required**	✓ - **Area of sufficiency or strength – considers self competent** ★ - **Area requiring some development – moderate experience or skill** △ - **No or little experience/skill – development required**
Audit expertise	**E**		
THIS expertise	**E**		
Strategic thinking and practice	**E**		
System management and system thinking to include customer relationship management and partnership working	**E**		
Current and future policy environment	**E**		
Leadership and organisational development	**E**		
Improvement and change management	**E**		
Performance management	**E**		
Health and Social Care experience	**E**		

		EXECUTIVE DIRECTORS	NON EXECUTIVE DIRECTORS
DOMAIN		✓ - Area of sufficiency or strength – considers self competent ★ - Area requiring some development – moderate experience or skill △ - No or little experience/skill – development required	✓ - Area of sufficiency or strength – considers self competent ★ - Area requiring some development – moderate experience or skill △ - No or little experience/skill – development required
Clinical quality & interdependencies	**E**		
Commercial focus & entrepreneurial skills	**E**		
Human resources management	**E**		
Legal awareness	D		
Health & Safety	D		
Corporate communication/media	D		
Community Development experience	D		
Ambassadorial skills to develop networks that complement the development of the Trust	D		
Equality & Diversity experience	D		

		EXECUTIVE DIRECTORS	NON EXECUTIVE DIRECTORS
DOMAIN		✓ - Area of sufficiency or strength – considers self competent ★ - Area requiring some development – moderate experience or skill △ - No or little experience/skill – development required	✓ - Area of sufficiency or strength – considers self competent ★ - Area requiring some development – moderate experience or skill △ - No or little experience/skill – development required
Knowledge as a Corporate Trustee	D		
Formal Qualifications & Training – please specify field(s)			
Fit and Proper Person Declaration:- • The person is not an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged; • The person is not the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland; • The person is not a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40); • The person has not made a composition or arrangement with, or	**E**	**Please sign to confirm:** ……	**Please sign to confirm:** ……..

granted a trust deed for, creditors and not been discharged in respect of it: • The person is not included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland; • The person is not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment; • The person has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.			

Board Directors are also required to have an awareness of their personal impact in terms of Board working and behaviours. This will be continually assessed using both formal and informal evaluation tools.

NAME: …… DATE: …….

NAME ([PRINTED] ……..

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
253	27.9.17	27.9.17	Deed of Variation – St Luke's Section 73 Planning Application – Replacement definition to principal agreement – cost to owner £220.00	NAME: VICTORIA PICKLES V Pickles. TITLE: COMPANY SECRETARY. NAME: DAVID BIRKENHEAD TITLE: MEDICAL DIRECTOR.

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
254	2.10.17	2.10.17	Deed of Variation – confirmed works variation relating to Elmdale and Ashdale Anti-ligature Shower Installation	NAME: VICTORIA PICKLES TITLE: COMPANY SECRETARY NAME: BRENDAN BROWN TITLE: CHIEF NURSE | DEPUTY CHIEF EXECUTIVE

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th December 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: SAFEGUARDING ADULTS AND CHILDREN - The Board is asked to receive and approve the Safeguarding update.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Safeguarding Committee and Quality Committee Meeting	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

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

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

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

To receive and approve the contents of the report

Appendix

Attachment:

Safeguarding Adults and Childrens Report for Trust Board 28.11.17.pdf

TRUST BOARD	
PAPER TITLE: SAFEGUARDING ADULTS AND CHILDREN	**REPORTING AUTHOR:** Victoria Thersby, Head of Safeguarding Lindsay Rudge, Deputy Chief Nurse
DATE OF MEETING: 7th December 2017	**SPONSORING DIRECTOR:** Brendan Brown, Chief Nurse, Deputy Chief Executive
STRATEGIC DIRECTION – AREA: • Keeping the base safe	**ACTIONS REQUESTED:** • To approve
PREVIOUS FORUMS: Safeguarding Committee and Quality Committee Meeting	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	

EXECUTIVE SUMMARY:

This report is the Safeguarding Adults and Children update for the Board of Directors.

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

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

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

FINANCIAL IMPLICATIONS OF THIS REPORT:
None

RECOMMENDATION:
To receive and approve the contents of the report

APPENDIX ATTACHED:
- Schedule of Actions from the CQC Calderdale Safeguarding and Looked After Children Review Action Plan:

This report is the Safeguarding Adults and Children update for the Board of Directors.

The update provides information from April 2017 to September 2017. The report provides an overview of activity and outlines key achievements and developments on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009), Safeguarding Training Compliance, Mandatory Children's Safeguarding Supervision requirements and actions; recent CQC inspections and any potential inspections, and the Children Looked After service specification. The report provides and update since the introduction of the new EPR and how this has developed and challenged the safeguarding agenda.

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

This report provides overview and assurance that CHFT is fulfilling its statutory safeguarding responsibilities and working in partnership across both Calderdale and Kirklees footprint.

2. MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY SAFEGUARDS

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and the Deprivation of Liberty Safeguards (DoLS, 2009).The legal framework provided by the MCA 2005 is supported by the MCA Code of Practice, which provides guidance and information about how the Act works in practice. The Code has statutory force which means staff who work with and/or care for adults who may lack capacity to make particular decisions have a legal duty to have regard to relevant guidance in the Code.

The DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the European Convention on Human Rights (ECHR) in a hospital or care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where a deprivation of liberty appears to be unavoidable, in a person's own best interests.

The specific aims for the work are to:

- To ensure all patients who are deprived of their liberty have in place a legal Safeguard that authorises CHFT to detain the patient, whether it be under the DoLS, the Mental Health Act 1983 (amended 2007), or the Mental Capacity Act 2005.
- Provide assurance that CHFT are compliant with all aspects of the MCA (2005) and DoLS (2009).

2.1 DoLS Data

Year	Number of Urgent DoLS	Number Standard DoLS	Number Declined	Average p/month
2014	11	5		0.9
2015	194	33	11	16
2016 – 2017	369	50	212	31

Data around DoLS is now captured monthly and reports are shared at the Safeguarding Committee meeting. The CQC are notified of all DoLS authorisations and outcomes in line with the requirements of the legislation. All patients who are subject to an urgent or standard authorisation are monitored by the Safeguarding Team, and this is shared weekly with the Matrons and ward sisters.

2017	Number of Urgent DoLS	Number Standard DoLS	Number Declined	Average p/month
Quarter 1	84	10	31	28
Quarter 2	82	5	29	27

From April to June 2017 there have been 166 urgent and standard authorisations in total made to both Kirklees and Calderdale Metropolitan Councils regarding patients who are deprived of their liberty whilst being cared for as inpatients. CHFT can grant itself an urgent authorisation for up to a period of 14 days whilst the Local Authority determines whether or not to authorise the deprivation of liberty.

A small number of the urgent authorisations lapse. This occurs when the Local Authority do not complete all their assessments within 14 days of the urgent authorisation being applied. In these cases the Safeguarding Team continue to monitor the patient to ensure that the deprivation is still valid, the patient still lacks capacity, all restrictions in place remain least restrictive whilst ensuring the patient remains safe on the wards, and that there are no objections to the DoL.

3. TRAINING

A recommendation was made to Weekly Executive Board (WEB) that Trust mandatory training be reduced from 100% to 95% compliance to be achieved by March 2018. To facilitate this trajectory the safeguarding team have identified the numbers of staff required to train on a month by month basis up to March 2018 and are facilitating training sessions to meet outstanding numbers of staff who require training.

The number of sessions planned for Safeguarding Children will meet the training trajectory of 95% by March 2018 if all places available are filled and there will be a surplus of 55 spaces.

There are 257 staff who require level 3 adult safeguarding training and there are 7 sessions planned until the end of March 2018. Bookings of 30 places are taken. This would leave a shortfall of 47 places required to meet this target up to the end of March 18. This will be met by facilitating an additional 2 sessions up to March.

3.1 Training compliance

Trust overall compliance is 85.29% from the Knowledge Portal.

This data is the overall compliance against the annual target.

Safeguarding Training	Delivery method	Target 2018	Quarter 1-2 (2016-17)	Quarter 1-2 (2017-18)	Increase
Level 1	eLearning	95%	81%	91%	10%
Level 2	eLearning	95%	66%	80%	14%
Level 3 children	Classroom	95%	50%	74%	24%
Level 3 Adults	Classroom	95%	28%	50.5%	22.5%
FGM	eLearning	95%	Jan 17- 35%	62%	62%
Prevent Level 1	eLearning	95%	81%	91%	10%
Prevent Health Wrap	Classroom	95%	67%	74%	7%

Separate MCA and DoLS training has been implemented in September 2017 and is now delivered as an essential skill at level 1 for the nominated target audience via eLearning. Level 2 adult safeguarding training has had this element enhanced and Level 3 Safeguarding has a separate MCA/DOLS session which is a classroom based to further enhance this element of training as recommended.

Work has been completed in line with the Prevent Competencies Framework and particular groups of staff that do not require Health Wrap training. This is now reported as level 1 (eLearning) and Level 2 (Health Wrap – face to face).

Further work has started to utilise the ESR systems and assign all staff who require mandatory safeguarding children's supervision compliance on ESR to ensure staff are reminded to access supervision and this will then be recorded on individual staff records.

4. INSPECTIONS/ SECTION 11 AUDITS

4.1 Section 11 Audits

Section 11 of the Children Act 2004 places a statutory duty on organisations, and individuals, to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children and all agencies are required to submit an annual self-assessment to the Safeguarding Children Board. The Safeguarding Team submitted the Section 11 self-assessment to Calderdale Safeguarding Children Board and in June 2017 and attended a challenge event in September. A request has been made by Kirklees Safeguarding Children's Board for submission in December 2017.

The Trust is compliant in 26 out of 27 actions. The amber action is detailed below.

- Further CSE work relating to risk assessment is being developed for use in the emergency care department

4.2 CQC Inspection 2016

The Care Quality Commission (CQC) Trust wide inspection in March 2016 has resulted in 4 must do actions for the safeguarding team to lead on.

a) The Trust must strengthen its knowledge and training in relation to the MCA and DoLS.
b) The service must ensure staff have an understanding of Gillick Competence.
c) The Trust must ensure that staff have undertaken safeguarding training at the appropriate level for their role.
d) The service must ensure all relevant staff are aware of Female Genital Mutilation (FGM) and the reporting processes for this.

All these actions are rated completed and sustained with ongoing recognition and requirement for continued development and embedding. Work continues to ensure that these 'Must Do's' remain embedded.

4.3. Children's and Children Looked After CQC Inspection (Calderdale).

The review took place on 25 - 29 April 2016 and was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups. The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. The focus was on the experiences of looked after children and children and their families who receive safeguarding services. Individual action plans are monitored by the CCG through the Safeguarding

Committee meeting attended by the CCG Designated Nurse for Safeguarding Children. Assurance and progress on action plans through clinical audit, review of training needs analysis and the impact of the effectiveness of training (appendix).

CHFT amber actions:

- Maternity are investigating the possibility for the safeguarding team to be informed of referrals to children's social care via automatic cc when referral sent to local authority. A report is able to be captured of children's social care referrals and how to attach these referrals to the Athena record. This action will turn green.
- To ensure effective safeguarding practice is provided by frontline staff across the continuum of need including referrals to children's social care, a comprehensive action plan ensures delivery of the key actions relating to improving safeguarding compliance, embedding safeguarding supervision, and assessing and recognising risk through bespoke risk assessments.
- The Children Looked After team were asked to improve the timeliness of review health assessments to align with statutory requirements, ensure that care leavers receive timely health passports, review the service specification to develop and improve health services for children looked-after, and review the staffing in the children looked-after team to ensure resources are in place to deliver the commissioned service. All above recommendations are interdependent with commissioning and contracting of the service. Meetings have taken place between LA & CCG commissioners and CHFT contracting to progress the issues and reach resolution for the resourcing of the service in order to meet the service delivery requirements in line with statutory guidance.

4.4 Kirklees Ofsted Inspection update

Ofsted Inspection of Kirklees Children's services in September and October 2016 focused on local services for children in need of help and protection, looked after children and care leavers and an inspection of the Independent Safeguarding Children's Board. The resulting overall outcome was inadequate.

CHFT continues to support the Safeguarding Board by attending both the Board and the sub-groups of the Board, providing any data requested by the Board to support in identifying vulnerable children, providing challenge at Board and sub-groups and its participation in Serious Case review panels and delivering SMART action plans through scrutiny at the Safeguarding Committee meeting.

CHFT has contributed to the MASH (Multi-agency Safeguarding Hub) live audit that took place on behalf of the Children's Board. The aim of the audit was to see what is happening in real time with live cases rather than looking at hypothetical situations. This was presented at the Safeguarding Children's Board meeting in May 2017.

Kirklees Safeguarding Children's Board are working closely with Kirklees Children's Social Care in their improvement journey and have strong links and liaison to the Leeds Safeguarding Children's Board. The Leeds Safeguarding Children's Board were rated good within their last Ofsted Inspection in 2015.

At a recent monitoring visit by Ofsted in June; CHFT were asked to provide chronologies of information and contact of children and families. CHFT received positive verbal feedback regarding the quality and content of information and joint working.

4.5 Potential Joint Targeted Area Inspection (JTAI)

A series of joint targeted area inspections (JTAI) involving Ofsted, the Care Quality Commission (CQC), HMI Constabulary and HMI Probation has begun. This JTAI will examine how local agencies work together to protect children living with, or at risk of, neglect. In particular, the inspections will focus on the

between 7 and 15 years old, who may be at higher risk of going being exploited, or who exhibit challenging behaviours in adolescence.

CSCB has held a briefing session in May which included the guidance and the expectations of partners, including; pre-inspection self-assessments, details of data and records to be provided to inspectors, multi-agency audit information and inspection preparation. The Council will be leading the collection of data and making sure that focus groups of key staff in agencies are briefed. Previous inspection programmes have focused on domestic abuse and child sexual exploitation. CHFT developed an associated action plan and information was disseminated to staff through 7 minute briefings and circulation of the virtual noticeboard dedicated to neglect.

5. ELECTRONIC PATIENT RECORD AND SAFEGUARDING FLAGS

Following the successful implementation of the new EPR system, the flags for safeguarding children and adults at risk previously on EDIS have been migrated manually onto the patient's records on Cerner. In 2015 CHFT went live with the introduction of the Child Protection information Sharing System (CP-IS) by Calderdale Social Care for Calderdale Children and Young People. CP-IS is a national system led by NHS England introduced to identify children subject to Child Protection Plans and those who are Looked After Children who attend unscheduled care settings. On the initial 'Go live' of the new EPR the interface for the CP-IS between CHFT and Social care was not functioning, however this has now been remedied. The introduction for CP-IS by Kirklees Social Care is planned for December 2017 with full national rollout anticipated in 2018.

The safeguarding team are adding and removing additional flags for MARAC, Child Protection, Looked After Children and Child Sexual Exploitation upon receipt of this information from multi-agency partners. These are being monitored by the safeguarding team and all flags are current and up to date.

CHFT is the first Trust in the Country to have a safeguarding build within its EPR. There is further work to review the safeguarding documentation for recording child protection medicals, and paper documentation continues to be used until this is finalised. The clear benefits of the EPR means there is a more visible and clearer flag for staff to view in all parts of the record that can highlight potential risk.

6. LEARNING FROM SERIOUS CASE REVIEWS/ SERIOUS ADULT REVIEWS AND DOMESTIC HOMICIDE REVIEWS.

Under Regulation 5 of The Children Act (2004), The Care Act (2014), and under Section 9 of the Domestic Violence and Victims Act (2004), statutory duties apply in cases of Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews.

The purposes of reviews enable Local Safeguarding Boards and Community Partnerships to fulfil their obligations under each of these Acts and for us as a partner agency to contribute to the carrying out of a review, identify any lessons to be learned and apply these lessons to future practice. Each Act defines a slightly different obligation and review of a case in relation to adults, children and domestic homicides.

Key themes in each review enable services to look at establishing what lessons to be learned about how professionals/ agencies (individually and together), work to safeguard children and/or adults at risk; review the effectiveness of local safeguarding procedures (multi-agency and single agency) and inform and improve local inter-agency practice.

The Safeguarding Team have fulfilled partnership requests for information and contributed to a number of reviews that have been published and are ongoing.

views with one new request for information; 2 serious adu
and one new request for information and 4 Domestic Homicide Reviews and one new request for information.

Learning from reviews are shared with Divisions and at the learning and audit subgroup of the safeguarding committee meeting.

- In one review there was a missed opportunity to routinely enquire about domestic abuse during pregnancy; this question has now been incorporated into the maternity electronic records where this is now asked at each attendance where it is appropriate and safe to do so.
- There was a missed opportunity to identify early support in pregnancy where there are concerns and early referral to Early Intervention for parents who have a learning disability; there is collaborative work ongoing to develop a pathway for support for parents with a learning disability.

7. REVIEW OF DOMESTIC ABUSE HUB

CHFT hosts a Domestic Abuse Lead and a Domestic Abuse Practitioner who are based in the Calderdale Domestic Abuse Hub at Halifax Police Station. This service is commissioned by Calderdale Clinical Commissioning Group and has been operational since January 2016.

The service provides health information from all multi-agency partners in order to manage high and medium risk incidents in cases of Domestic Abuse. The health information is on behalf of all health agencies in Calderdale and actions are then shared out to the appropriate health professionals involved in order to reduce duplication, allow a more coordinated approach and early identification of any unmet health needs.

The DA health service attends both the Kirklees Domestic Violence Strategic and Operational groups ensuring that there is regular representation from CHFT. There is also attendance to the fortnightly Kirklees MARAC on behalf of CHFT to feed into multi-agency risk assessment and appropriate information sharing for victims who are likely to use our health services. There is a dedicated worker (an Independent Domestic Violence Advocate) from Pennine Domestic Violence Group who works into HRI Emergency Department providing twice weekly drop in sessions to collect referrals, support staff and raise the awareness of CHFT DA pathway and referral system.

The DA lead provides support and management to the Hospital IDVA role, a specific evidence based role facilitated by Pennine Domestic Violence Group. The IDVA is based at HRI and provides specialist support and risk assessment to patients and staff who are currently experiencing domestic abuse. The Hospital IDVA also contributes to CHFT training of staff around identifying and responding to domestic abuse.

Since the DA Hub commenced in January 2016, Calderdale has been able to establish a lot more about the presentation of health needs for the victims and perpetrators who access services. From this, it has identified where within our services opportunities are missed and areas for improvement including training, closer working with partner agencies and improving processes and pathways.

The DA Health service has established a service that is effective, feeding significant health information into multi-agency risk management causing no extra time or tasks for health professionals. On average, the DA Health service receives between 7-9 phone calls a day from different health professional from various organisations, for advice or further information. There has been a reduction in duplication of information resulting in less wasted time and a health workforce who are better informed of the risks posed to patients they are treating. The DA Health service works across all health agencies and in 2016 has made an estimated saving of £315,000 due to the health referrals trebling to MARAC. Department and ward staff are being trained to respond to a suspicion and disclosure of domestic abuse as part of routine clinical consideration or enquiry

The partnership in Calderdale is a reduction in repeat victimisation of domestic abuse – health is seen as a significant partner in driving this as health would inevitably make the most savings if repeat victimisation is reduced.

Commissioning of this service in 2017/18 is at risk; discussions with CCG and local authority are in place to agree next steps.

8. IMPROVEMENT PLANS FOR 2017/18

Improvement Plans for 2017/18	Progress Q1 & Q2
Implementation of a joint working protocol with SWYPFT and CHFT and improved data collection of sections used	This is in draft format and currently being reviewed
To re-launch the training for Duty Matrons and Site Commanders on the receipt and scrutiny of Mental Health Act papers, and understanding the role of security and use of restrictive interventions to enable appropriate detention of patients under the Act.	Training need has been identified with co-ordination to training to roll out as part of a training plan
To continue work embedding knowledge and skills in all areas regarding MCA and DoLS	Planned event on the 21st November. Hempson's are delivering Mental Health in the Acute Healthcare Setting- An interactive education event. The session will cover: • legal frameworks and options for holding powers and treating patients and advice on applying these in practice
Ensuring scrutiny of all referrals made by CHFT staff to Children's Social Care	Work continues to raise awareness in training/supervision sessions
Continued work and challenge to ensure robust Children and Adults data collection	Audit undertaken of all datix referrals for children's
Development and implementation of a CSE risk assessment in the Emergency Department and work towards roll out throughout the trust.	Progress in Q3/4
Further work and embedding of monitoring of training for junior medical staff	Progress in Q3/4
Further work is ongoing to embed Safeguarding Supervision Trust wide. This work is planned for completion in Q1 (2017-18) to coincide with an updated Supervision Policy.	Progress and completion of this in Q3. The safeguarding Team are working alongside the safeguarding champions who will take an active part in ensuring wards & departments are developing processes to enable safeguarding supervision to take place.
To continue increasing the capture of adult safeguarding referrals and concerns via the Datix reporting system when these relate to other providers	Continued
To achieve more timely outcomes relating to referrals through closer collaboration with Social Services colleagues, both referrals relating to CHFT care to ensure that learning is shared as widely as possible and development needs can be followed up through the safeguarding subgroups and referrals relating to the care of other providers to obtain feedback on the appropriateness of our referrals	Discussed and reviewed at the Learning and Audit Subgroup

local agreement between CHFT internal processes for orange / red incidents and formal adult safeguarding processes as led by Calderdale and Kirklees Social Care.	Meeting is planned with Calderdale Social ca this
Safeguarding Champions have been identified throughout the organisation and part of this role will require them to be trained to facilitate safeguarding supervision in line with their staff requirements to help improve compliance. Training has been delivered in January and March and 42 Champions are trained to date with a further date arranged for 23.5.17.	This is ongoing. The Supervision Policy has been reviewed and updated
Update of the Adult Safeguarding Policy in Quarter 1 and development of a separate MCA DoLS Policy	Adult Policy and MCA DoLS policy approved subject to comments
Development of a Safeguarding Dashboard that is aligned to the Safeguarding Strategy	Dashboard has been developed
Further audits planned are the Adult Safeguarding Policy audit and another MCA DoLS Trust wide audit in relation to Adults.	A further Trust wide audit had taken place on MCA and DoLS. This is awaiting analysis and dissemination
Further planned involvement in Safeguarding Week in October 2017	Involvement of the team in Safeguarding Week 9th October 2017 with delivery of events and support to all four local safeguarding boards. Stalls at HRI and CRH for the week
The FGM guideline is being reviewed and updated to include Department of Health recommendations regarding risk assessments.	Work to progress Q3/4
Development of a CSE Risk Assessment for the Emergency Department and completion of the CSE action plan	Work progressing Q3/4
Active support to Kirklees children's services improvement plan	Continued attendance and support at Board meetings and Subgroups
To ensure that following go live with EPR the system continues to support statutory and regulatory compliance.	Progress Q3
To review the risk associated if the DV Hub funding is not continued.	Funding has been approved until March 2018. Awaiting confirmation if there are recurrent monies for continued funding April 2018 onwards. The Domestic Abuse Policy has been updated and reviewed this quarter.

- Schedule of Actions from the CQC Calderdale Safeguarding and Looked After Children Review Action Plan:

						Due date									
	Senior manager	Operational lead	CQC review	Recommendation	Governance	Actions	Embedded	As at 1.12.16	As at 8.2.17	As at 8.3.17	As at 12.4.17	As at 10.5.17	As at 14.6.17	As at 12.7.17	As at 9.8.17	As at 13.9.17
1.1	AM Henshaw	J Ayre	Maternity	Record keeping ***systems*** in maternity and neo-natal	FSS PSQB	31.10.16		**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**	**1.1**
1.2	A Mooraby	J Youd / G Berriman	ED	ED documentation - hidden harm to children	Emergency Care Directorate / Medicine PSQB	30.4.17 EPR May 17		**1.2** **1.2**	**1.2** **1.2**	**1.2** **1.2**	**1.2** **1.2**	**1.2** **1.2**	**1.2** **1.2**	**1.2** **1.2**	**1.2** **1.2**	**1.2** **1.2**
1.3	A Mooraby	J Youd / G Berriman	ED	ED recording accompanying adult and who has parental responsibility.	Emergency Care Directorate / Medicine PSQB	31.12.16 EPR May 17		**1.3** **1.3**	**1.3** **1.3**	**1.3** **1.3**	**1.3** **1.3**	**1.3** **1.3**	**1.3** **1.3**	**1.3** **1.3**	**1.3** **1.3**	**1.3** **1.3**
1.4	A Mooraby	J Youd / G Berriman	ED	Risk assessment / alert prompts	Emergency Care Directorate / Medicine PSQB	30.4.17		**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**
1.4	AM Henshaw	G Bristow / G Harries	CASH	Risk assessment / alert prompts	FSS PSQB	30.11.16		**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**
1.4	D Catlow	J Ghee	HV	Risk assessment / alert prompts	Community PSQB	31.1.17		**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**
1.4	L Rudge	V Thersby	Safeguarding	Risk assessment / alert prompts	Trust Sfgdg Committee	~~31.12.16~~ 31.3.17	12.5.17	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**
1.4	AM Henshaw	J Ayre	Maternity	Risk assessment / alert prompts	FSS PSQB	30.4.17		**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**	**1.4**
1.5	A Mooraby	J Youd / G Berriman	ED	Safeguarding governance arrangements	Emergency Care Directorate	30.4.17		**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**

	Senior manager	Operational lead	CQC review	Recommendation	Governance	Due date: Actions	Due date: Embedded	As at 1.12.16	As at 8.2.17	As at 8.3.17	As at 12.4.17	As at 10.5.17	As at 14.6.17	As at 12.7.17	As at 9.8.17	As at 13.9.17
					/ Medicine PSQB											
1.5	AM Henshaw	G Bristow / G Harries	CASH	Safeguarding governance arrangements	FSS PSQB	Complete		1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	
1.5	L Rudge	V Thersby	Safeguarding	Safeguarding governance arrangements	Trust Sfgdg Committee	~~30.4.17~~ 31.7.17	~~14.6.17~~ 31.8.17	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**
1.5	AM Henshaw	J Ayre	Maternity	Safeguarding governance arrangements	FSS PSQB	30.11.16		**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**
1.6	AM Henshaw	J Ayre	Maternity	Record keeping ***standards***	FSS PSQB	31.7.16		**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**
1.7	L Rudge	V Thersby / J Ayre	Maternity / Safeguarding / CCG	Multi-agency plans for expectant women	Trust Sfgdg Committee	~~31.3.17~~ ~~30.4.17~~ 30.6.17	~~14.6.17~~ 31.7.17	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**
1.8	V Thersby	H Smith	CLA	Timeliness of review health assessments (statutory requirements)	Head of Sfgdg monthly meet with Des. Lead	31.3.17	**31.12.17**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**
1.9	V Thersby	H Smith	CLA	Part A documentation	Head of Sfgdg monthly meet with Des. Lead	31.10.16	complete	**1.9**	**1.9**	**1.9**	**1.9**	**1.9**	**1.9**	**1.9**	**1.9**	**1.9**
1.10	V Thersby	H Smith	CLA	Quality of health action plans	Head of Sfgdg monthly meet with Des. Lead	31.3.17	**30.4.17**	**1.10**	**1.10**	**1.10**	**1.10**	**1.10**	**1.10**	**1.10**	**1.10**	**1.10**
1.11	V Thersby	H Smith	CLA	Sharing of SDQs	Head of Sfgdg monthly meet with	~~30.9.16~~ 31.1.17	30.6.17	**1.11**	**1.11**	**1.11**	**1.11**	**1.11**	**1.11**	**1.11**	**1.11**	**1.11**

	Senior manager	Operational lead	CQC review	Recommendation	Governance	Due date: Actions	Due date: Embedded	As at 1.12.16	As at 8.2.17	As at 8.3.17	As at 12.4.17	As at 10.5.17	As at 14.6.17	As at 12.7.17	As at 9.8.17	As at 13.9.17
					Des. Lead											
1.12	V Thersby	H Smith	CLA	Timely health passports / info for care leavers	Head of Sfgdg monthly meet with Des. Lead	31.3.17	**30.9.17**	**1.12**	**1.12**	**1.12**	**1.12**	**1.12**	**1.12**	**1.12**	**1.12**	**1.12**
1.13	AM Henshaw	G Bristow / G Harries	CASH	Child safeguarding and children looked after training	FSS PSQB	Complete		**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**
1.13	A Mooraby	J Youd / G Berriman	ED	Child safeguarding and children looked after training	Emergency Care Directorate / Medicine PSQB	30.4.17		**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**
1.13	L Rudge	V Thersby	Safeguarding	Child safeguarding and children looked after training	Trust Sfgdg Committee	~~31.3.17~~ ~~30.4.17~~ 14.7.17	~~14.6.17~~ 31.8.17	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**
1.13	D Catlow	J Ghee	HV	Child safeguarding and children looked after training	Community PSQB	31.3.17		**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**	**1.13**
1.14	AM Henshaw	G Bristow / G Harries	CASH	Embed safeguarding supervision	FSS PSQB	31.8.16		**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**
1.14	L Rudge	V Thersby	Safeguarding	Embed safeguarding supervision	Trust Sfgdg Committee	31.3.17	12.4.17	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**
1.14	A Mooraby	J Youd / G Berriman	ED	Embed safeguarding supervision	Medicine PSQB	30.4.17	31.12.17	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**
1.14	AM Henshaw /	J Ayre / V Thersby	Maternity / safeguarding	Embed safeguarding supervision	FSS PSQB	Complete		**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**	**1.14**

	Senior manager	Operational lead	CQC review	Recommendation	Governance	Due date: Actions	Due date: Embedded	As at 1.12.16	As at 8.2.17	As at 8.3.17	As at 12.4.17	As at 10.5.17	As at 14.6.17	As at 12.7.17	As at 9.8.17	As at 13.9.17
	L Rudge															
1.15	V Thersby	H Smith	CLA	Engagement of GP's in health assessments	Head of Sfgdg monthly meet with Des. Lead	31.12.16	Complete	**1.15**	**1.15**	**1.15**	**1.15**	**1.15**	**1.15**	**1.15**	**1.15**	**1.15**
1.16	L Rudge	V Thersby	Safeguarding (paeds liaison)	Effective and timely information sharing	Trust Sfgdg Committee	~~31.12.16~~ ~~28.2.17~~ ~~30.4.17~~ 31.7.17	~~14.6.17~~ 31.8.17	**1.16**	**1.16**	**1.16**	**1.16**	**1.16**	**1.16**	**1.16**	**1.16**	**1.14**
1.17	G Poyser Young	H Smith	CCG / CLA	Involvement of children looked after professionals in commissioning and strategic decisions	Head of Sfgdg monthly meet with Des. Lead	31.1.17	30.4.17	**1.17**	**1.17**	**1.17**	**1.17**	**1.17**	**1.17**	**1.17**	**1.17**	**1.14**
1.18	L Rudge	V Thersby	Safeguarding	Performance reporting of child safeguarding practice	Trust Sfgdg Committee	~~31.1.17~~ ~~31.3.17~~ ~~31.5.17~~ 30.6.17	~~14.6.17~~ 31.7.17	**1.18**	**1.18**	**1.18**	**1.18**	**1.18**	**1.18**	**1.18**	**1.18**	**1.18**
1.19	G Poyser Young	H Smith	CCG / CLA	Staffing - children looked-after team in line with commissioned service	Head of Sfgdg monthly meet with Des. Lead	31.1.17	**30.4.17**	**1.19**	**1.19**	**1.19**	**1.19**	**1.19**	**1.19**	**1.19**	**1.19**	**1.19**
1.20	AM Henshaw	G Bristow / G Harries	CASH	Recording name and relationship of accompanying adults	FSS PSQB	30.9.16		**1.20**	**1.20**	**1.20**	**1.20**	**1.20**	**1.20**	**1.20**	**1.20**	**1.20**
1.20	L Rudge	V Thersby	Safeguarding	Recording name and relationship of accompanying adults	Trust Sfgdg Committee	31.3.17 EPR May 17	10.5.17	**1.20** **1.20**	**1.20** **1.20**	**1.20** **1.20**	**1.20** **1.20**	**1.20** **1.20**	**1.20** **1.20**	**1.20** **1.20**	**1.20** **1.20**	**1.20** **1.20**
1.20	D Catlow	J Ghee	HV	Recording name and	Community PSQB	31.3.17		**1.20**	**1.20**	**1.20**	**1.20**	**1.20**	**1.20**	**1.20**	**1.20**	**1.20**

	Senior manager	Operational lead	CQC review	Recommendation	Governance	Due date: Actions	Due date: Embedded	As at 1.12.16	As at 8.2.17	As at 8.3.17	As at 12.4.17	As at 10.5.17	As at 14.6.17	As at 12.7.17	As at 9.8.17	As at 13.9.17
				relationship of accompanying adults												
1.20	AM Henshaw	G Harries / J Mellor	Paediatrics	Recording name and relationship of accompanying adults	FSS PSQB	31.12.16 EPR May 17		1.20 1.20	1.20 1.20	1.20 1.20	1.20 1.20	1.20 1.20	1.20 1.20	1.20 1.20	1.20 1.20	1.20 1.20
1.20	AM Henshaw	J Ayre	Maternity	Recording name and relationship of accompanying adults	FSS PSQB	30.11.16		1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20
1.21	A Mooraby	J Youd / G Berriman	ED	ED facilities view / oversight of children waiting to be seen	Emergency Care Directorate / Medicine PSQB	31.7.17		1.21	1.21	1.21	1.21	1.21 – outside the range of safeguarding				
1.22	A Mooraby	J Youd / G Berriman	ED	Use of age appropriate paediatric documentation	Emergency Care Directorate / Medicine PSQB	Complete EPR May 17		1.22 1.22	1.22 1.22	1.22 1.22	1.22 1.22	1.22 1.22	1.22 1.22	1.22 1.22	1.22 1.22	1.22 1.22
1.23	A Mooraby	J Youd / G Berriman	ED	ED documentation supports effective safeguarding triage and assessment (previous attendances)	Emergency Care Directorate / Medicine PSQB	Complete		1.23	1.23	1.23	1.23	1.23	1.23	1.23	1.23	1.23
1.24	AM Henshaw	J Ayre	Maternity	Midwifery routine enquiries about domestic abuse	FSS PSQB	31.3.17		1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24
1.25	V Thersby	H Smith	CLA	Robust arrangements and IT for review health	Head of Sfgdg monthly	Complete	Complete	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25

	Senior manager	Operational lead	CQC review	Recommendation	Governance	Due date: Actions	Due date: Embedded	As at 1.12.16	As at 8.2.17	As at 8.3.17	As at 12.4.17	As at 10.5.17	As at 14.6.17	As at 12.7.17	As at 9.8.17	As at 13.9.17
				assessments	meet with Des. Lead											
1.26	D Catlow	J Ghee	**HV**	Health visitors and school nurses records are linked	Community PSQB	31.5.16		**1.26**	**1.26**	**1.26**	**1.26**	**1.26**	**1.26**	**1.26**	**1.26**	**1.26**
4.1	G Poyser Young / D Catlow	G Poyser Young / J Ghee	CCG lead / HV	MAST and Hub teams - access to complete health records	Community PSQB	31.1.17		**4.1**	**4.1**	**4.1**	**4.1**	**4.1**	**4.1**	**4.1**	**4.1**	**4.1**
4.2	G Poyser Young	G Poyser Young / V Thersby	CCG lead / safeguarding	Sharing developments in safeguarding practice (multi-agency bruising, burns and scalding protocol for non-mobile babies)	Trust Sfgdg Committee	~~31.1.17~~ ~~28.2.17~~ 30.4.17	12.4.17	**4.2**	**4.2**	**4.2**	**4.2**	**4.2**	**4.2**	**4.2**	**4.2**	**4.2**
4.3	AM Henshaw / G Poyser Young	J Ayre	CCG / maternity	Multi-disciplinary perinatal mental health pathway	FSS PSQB	31.3.17		**4.3**	**4.3**	**4.3**	**4.3**	**4.3**	**4.3**	**4.3**	**4.3**	**4.3**
4.4	G Poyser Young	G Poyser Young	CCG / Paeds / safeguarding	Access to local tier four mental health beds	Trust Sfgdg Committee	30.4.17		**4.4**	**4.4**	**4.4**	**4.4**					
4.4	AM Henshaw	G Harries / J Mellor	**Paediatrics**	Access to local tier four mental health beds	FSS PSQB	31.3.17		**4.4**	**4.4**	**4.4**	**4.4**	**Delivery of recommendation is not within our gift – escalate to GPY**			**4.4**	**4.4**
7.1	AM Henshaw	G Bristow / G Harries	**CASH**	DNA policy and guidance - under 18 who miss CASH appointments	FSS PSQB	30.11.16		**7.1**	**7.1**	**7.1**	**7.1**	**7.1**	**7.1**	**7.1**	**7.1**	**7.1**

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 December 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report - The Board is asked to receive and approve the Integrated Board Report for October 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board (30.11.17) and Quality Committee (4.12.17)	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

October's Performance Score has fallen to 59% for the Trust. The SAFE domain is now RED due to a reported Never Event. The EFFECTIVE domain has maintained its GREEN rating. The RESPONSIVE domain has maintained AMBER, although cancer 62 day GP referral to treatment missed its target. FINANCE remains RED with variance from plan moving to Red in-month. WORKFORCE has deteriorated to RED due to higher short-term sickness absence.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

IPR Board Report - October 2017.pdf

Board Report

October 2017

Report Produced by : The Health Informatics Service

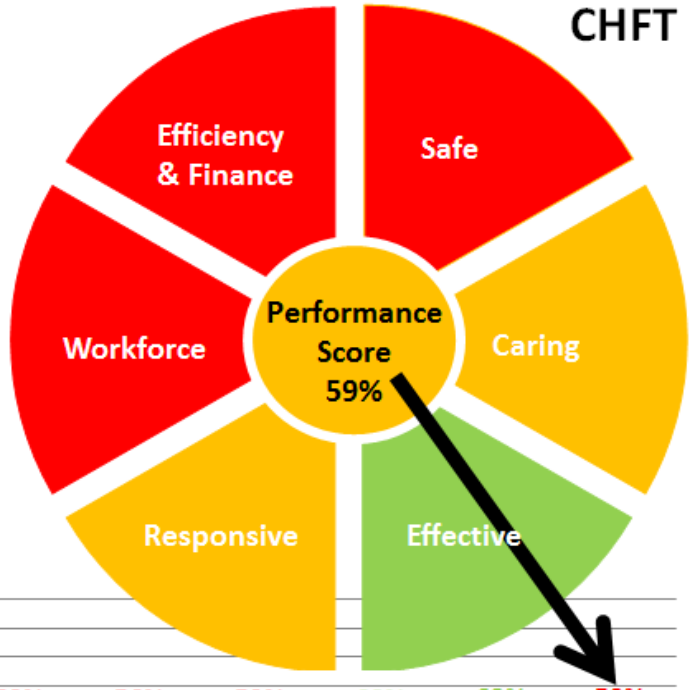
Data Source : various data sources syndication by VISTA

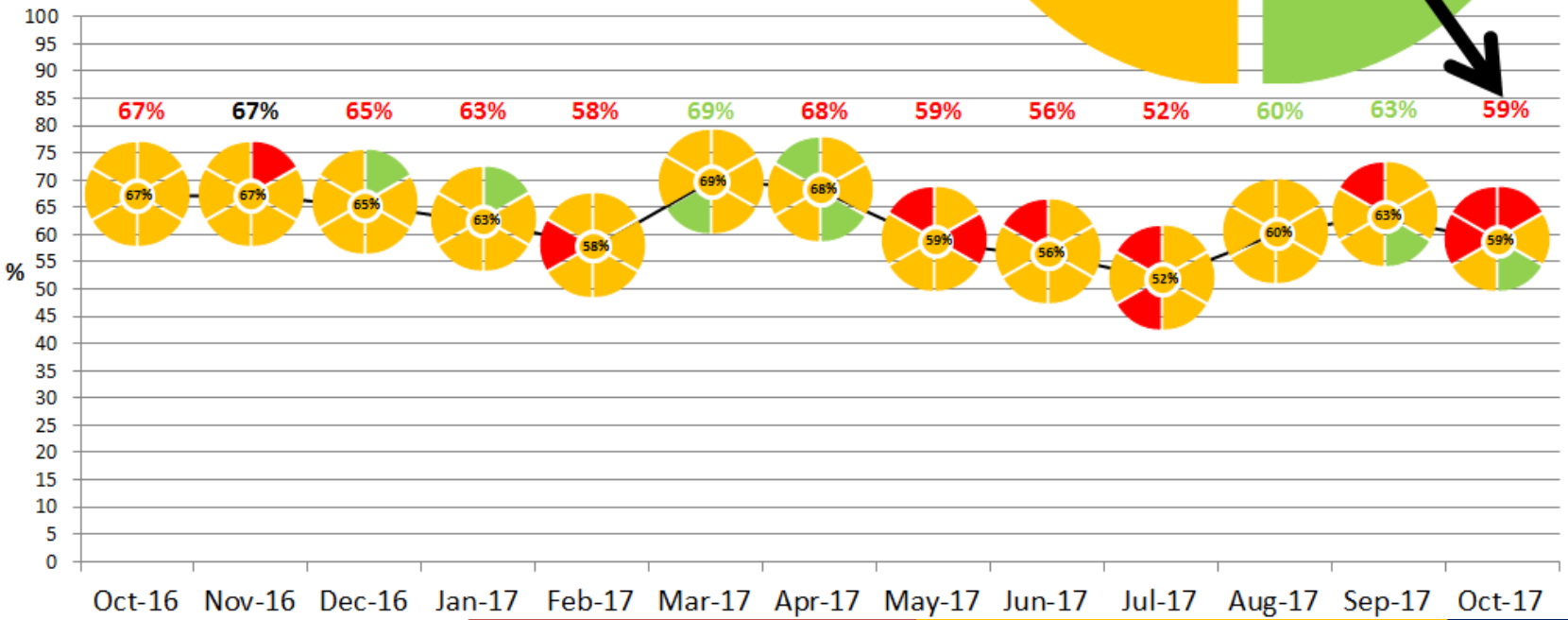
Performance Summary

October

RAG Movement

October's Performance Score has fallen to 59% for the Trust. The SAFE domain is now RED due to a reported Never Event. The EFFECTIVE domain has maintained its GREEN rating. The RESPONSIVE domain has maintained AMBER although cancer 62 day GP referral to treatment missed its target. FINANCE remains RED with variance from plan moving to Red in-month. WORKFORCE has deteriorated to RED due to higher short-term sickness absence.





SINGLE OVERSIGHT FRAMEWORK

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

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

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	97.1%	96.7%	↑	96.3%
	Inpatient Complaints per 1000 bed days	2.4	2.3	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	4.39	4.57	↑	5.17
	Delayed Transfers of Care	3.51%	2.00%	↓	3.5%
	Green Cross Patients (Snapshot at month end)	90	120	↑	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	91.08	92.86	↑	100
	Theatre Utilisation (TT) - Trust	82.3%	82.5%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.89%	1.21%	↑	0.6%
	Emergency Care Standard 4 hours	94.17%	91.22%	↑	95%
	% Incomplete Pathways <18 Weeks	92.08%	92.42%	↓	92%
	62 Day GP Referral to Treatment	81.8%	91.9%	↓	85%
SAFE	% Harm Free Care	93.90%	94.82%	↓	95.0%
	Number of Outliers (Bed Days)	516	534	↑	495
	Number of Serious Incidents	5	2	↓	0
	Never Events	1	0	↓	0

MOST IMPROVED

Improved: Friends and Family Test Community Survey - % would recommend the Service has improved by 8.5 percentage points to 97.5% and is now achieving target for the first time.

Improved: Emergency Care Standard 4 hours at 94.2% best performance since April. Almost 10 percentage points above the England position.

Improved: Appraisal (Year To Date) managed to achieve 96.3%.

MOST DETERIORATED

Deteriorated: Short Term Sickness Absence rate is highest level since February.

Deteriorated: % Complaints closed within target timeframe has deteriorated to lowest performance since January following last month's peak.

Deteriorated: % Stroke patients spending 90% of their stay on a stroke unit/% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival - worst performance in over 12 months.

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

ACTIONS

Action: HR Business Partners and HR Advisers continue to work closely with line managers on a one to one basis where hotspot areas are identified to offer focussed advice. Weekly 'Confirm and Challenge' meetings, led by Director of Operations or Assistant Director of Nursing continue to take place within Divisions to performance manage wards and Departments against workforce targets and Key Performance Indicators. The first attendance management training session was held 26th October. Monthly training sessions will be held until March 2018.

Action: Work with the Divisions to continue to improve the complaints handling process. Complaint scales are monitored weekly which highlights all breaches and potential breaches to the Complaint leads for each Division. Each breached complaint is investigated weekly as to the reason for the delay. There is a focus on recovery at divisional PRMs.

Action: Work continues on the Stroke ISR action plan through the Stroke Action Team and the Stroke Clinical Governance meeting and this is reviewed via the monthly Directorate PRM. The stroke team continue to explore the opportunity to create an assessment area in ED to improve the overall management of stroke patients.

Arrow direction count ↔ 1 ↑ 8 ↓ 10

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.5	7.5	↔	
Sickness Absence Rate	3.87%	3.85%	↓	4.0%
Turnover rate (%) (Rolling 12m)	12.95%	12.75%	↓	12.3%
Vacancy	333.55	341.47	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	79.0%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q1	57.0%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£8.70	-£6.00	🔴
Expenditure vs Plan var (£m)	£4.50	£5.90	🟢
Liquidity (Days)	-28.52	-25.15	🔴
I&E: Surplus / (Deficit) var - Control Total basis (£m)	-£2.48	£0.01	🔴
CIP var (£m)	£0.75	-£1.94	🟢
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	14.52%	12.77%	🔴

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care** - Performance deteriorated slightly in-month to 93.9%. Within the Medical division a number of initiatives continue to be strengthened (changes to the format of the pressure ulcer panel, progress with the falls action plan) to impact on improving the position. • **Never Event -** A serious incident investigation is underway and will be completed within 60 days.
Caring	• **Complaints closed within timeframe** - Of the 36 complaints closed in October, 44.4% of these were closed within target timeframe which is the worst performance since January following last month's good performance. CHFT aims to have backlog of complaints closed by 6th January. With complaint panels and aid from corporate staff aiming to close 15 complaints per week. With senior divisional support, this model will sustain an effective complaints procedure. Assurance provided from Divisions that contact is being made with complainants within 7 days. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance is still not achieving target. The task and finish group established by the ADN has identified 2 clinical specialty areas to work with and test improvements and is also undertaking Go-See reviews. Healthwatch have been invited to undertake a more detailed study which has been scoped by the Chief Nurse. • **Friends and Family Test A & E Survey -** Response Rate has remained at 11% in-month whilst % would recommend has fallen just below target. The new rapid assessment area which opened this month should help to improve waiting times for assessment. • **Friends and Family Test Community Survey** - Although the % of patients that would recommend the service has achieved the target for the first time which is great news, the response rate has fallen below target to 2.1%. Data is collected one day a month for FFT via the web form or paper forms. As national reporting requires caseloads to be reported as the denominator therefore the response rate has fallen significantly from 10% but it provides a more realistic view of FFT "would recommend" as it directly relates to the community service experience rather than hospital or primary care which the previous system captured.
Effective	• **E-Coli - Post 48 hours** - There were 6 cases in-month, highest number since March, with 5 within Medicine. The Trust level task and finish group for E.Coli has now commenced and a Trust and Health Economy wide reduction plan has just been developed. • **Mortality Reviews** - The new Learning from Deaths policy was approved in August which describes the ambition to perform initial screening reviews on all deaths plus Structured Judgment Reviews (SJR) on selected cases from September. Expect improvements to be visible in the data from October, an additional measure will appear to record the % of applicable cases undergoing SJR. • **% Sign and Symptom as a Primary Diagnosis** - Since EPR go live the % Sign and Symptom has increased. This is due to documentation within Power Chart and the admitting primary diagnosis not being updated to the diagnosis at discharge. There was a deterioration in-month and a further reminder was sent out in the EPR fortnightly updates. The audit work continues within specialties and specific S&S groups to identify common issues. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge** - October's performance improved to 74%. As noted in the previous month, CHFT 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. November looks set to achieve 85%.

Background Context

EPR stabilisation continues with several elements progressing well including the establishment of a Risk panel bringing together all elements of clinical risk. Divisional and corporate teams have good risk registers and to date no incidents of harm have been identified.

Data Quality monitoring continues with volumes contained which is positive. Some early backlogs continue and options to accelerate clearance are being discussed.

Several sessions have been held with clinical teams on system enhancements and diagnostics have taken place on booking administration in conjunction with increased booking capacity which has reduced call centre waiting times.

Plans for the reconfiguration of Elderly, Cardiology and Respiratory services continued in month with staff 1:1s, workforce modelling and move planning at the peak of activity. Preparations for presentation to Scrutiny and QIA were advanced and successful.

Stroke services reconfigured internally on the CRH site with a reduction in Rehabilitation beds and a single floor for stroke delivered which will have a positive impact on patients and flow however further work is required with partners to maximise the opportunity for out of hospital stroke care.

Clinical escalation plans for non-elective patients were developed, agreed and implemented however some concerns were raised by individual specialties around impact and communication. 1:1 discussions have continued and the plans refined for a relaunch in November.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** improved further to 94.2% for October, best performance since April - The ECS recovery and sustainability Plan actions continue to be worked through and implemented. • **% Stroke patients Thrombolysed within 1 hour -** with the exception of this indicator, all stroke indicators are below target in-month. Work continues on the Stroke ISR action plan through the Stroke Action Team and the Stroke Clinical Governance meeting and this is reviewed via the monthly Directorate PRM. The stroke team continue to explore the opportunity to create an assessment area in ED to improve the overall management of stroke patients. • **62 Day GP Referral to Treatment -** performance fell to its lowest position in the last 12 months at 81.8% due to a number of complex cases. Weekly meetings in place between GMs and trackers with COO escalation. • **38 Day Referral to Tertiary** - deteriorated to 40% following its peak in September.
Workforce	• **Short term sickness absence** has deteriorated in-month to its highest position since February at 1.6%. The first attendance management training session was held 26th October. Monthly sessions will be held until March 2018. • **Mandatory Training** is now behind on all 5 agreed topics with Fire Safety moving to Amber. Following a paper to WEB 26th October, a 'deep dive' into the reasons for mandatory training non-compliance was conducted. The 'deep dive' has identified a number colleagues who have yet to complete any of their mandatory training, these are being targeted individually.
Finance	• **Finance**: Reported year to date deficit position of £15.96m, an adverse variance of £2.48m compared with the control total of £13.48m; • Delivery of CIP is above the planned level at £9.04m against a planned level of £8.29m; • Capital expenditure is £5.1m below plan due to revised timescales; • Cash position is £1.9m, in line with the planned level; • A Use of Resources score of level 3, in line with the plan. The Month 7 reported position is a deficit of £15.96m on a control total basis. The financial position has continued to deteriorate with activity and income significantly below the original planned level and growing cost pressures. This has been offset by the release of all of the Trust's contingency reserves for the year alongside a number of non-recurrent benefits. The Trust continues to report a forecast in line with the Control Total deficit of £15.94m, however the deteriorating position leaves the Trust with the requirement to deliver recovery plans of the magnitude of £13m, to cover the growing underlying gap between the planned deficit and operating position. The size of this gap is unlikely to be resolved quickly enough to achieve the control total over the next 5 months and the Trust is now forecasting an adverse variance from plan during Months 7-11. STF funding of £6.57m for Quarters 3 and 4 remains at risk and will only be made available if the Trust can deliver full recovery back to plan.

Background Context

The Radiology team has undertaken significant work in the past month to improve compliance with 14 day fast-track reporting timescales. Request to Report times across the service will be reported in this document from next month.

Last month the Outpatient team welcomed colleagues from Bradford who came to learn about the improvement work carried out at the Trust.

This month the Radiology leadership programme will begin where senior leaders from the service will undertake a 6 week development programme focussing on areas including governance, performance and safety.

This month the Trust signed a contract with AGFA to become the Trust's new PACS provider from March 2019. This is part of the Regional collaborative work taking place across West Yorkshire.

The mobilisation of the new Harrogate Lymphoedema service has commenced with first clinics now organised for the first week in December.

The Community division submitted a bid to continue providing the Childhood Flu Immunisation within Calderdale from October 2018 onwards. This was a national tender process conducted by NHS England. Award of contract will be made in January 2018.

A new Frailty Pilot commenced in October which supports people who attend Accident and Emergency or have been admitted for short stay interventions and could return home with some short term support.

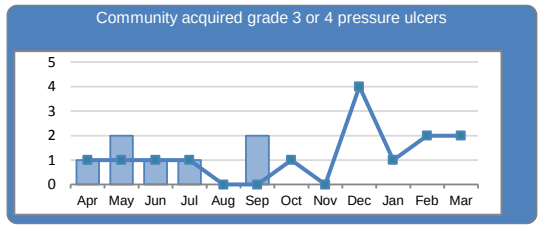
Safe, Effective, Caring, Responsive - Community Key messages

Area	Reality	Response	Result
Safe	Grade 3/4 pressure ulcers Maintaining a low prevalence of grade 3/4 pressure ulcers with two grade 3s being reported in September.	Grade 3/4 pressure ulcers Continued work is progressing with tissue viability. Community division has released one senior nurse to focus more dedicated time on wound care and pressure ulcers . Orange panel continues to review all grade 3 and 4 pressure ulcers.	Grade 3/4 pressure ulcers Continue to maintain and improve performance in this area. By when: Review December 2017 Accountable: ADN
Effective	Admission Avoidance The new frailty service, established early October from existing community teams, has been in-reaching into A&E and the short stay bed base to support people to return home without being admitted, or reduce length of stay where they need a short spell in acute care.	Admission Avoidance The frailty team identifies patients in A&E and on short stay or assessment wards. They meet together for a daily MDT to ensure patients have the right level of MDT input and follow up. This is proving to be a very successful pilot and it is hoped that sufficient evidence is available to continue after the 12 week pilot.	Admission Avoidance 59 patients were seen in October with 20 admissions avoided. A dashboard is being developed to capture results and KPIs to share with the team and commissioners. By when: November 2017 Accountable: Matron Intermediate Tier Services
Caring	FFT The new method of recording FFT was implemented in October. Reported a 2% response rate and a much improved 97.5% would recommend performance with the new reporting methodology.	FFT The division has chosen one day a month for staff to collect FFT via the web form or paper forms that are then inputted onto web forms for reporting. As national reporting requires to report caseloads as the denominator the response rate has fallen significantly to 2% from 10% but it provides a more realistic view of FFT "would recommend" as it directly relates to the community service experience rather than hospital or primary care which the previous system captured.	FFT Will continue to monitor the response rate and would recommend and drill down into comments so responses can be developed for improvement. By when: Review March 2018 Accountable: Director of Operations
Responsiveness	Waiting Time for Children's services Orthotics waiting time, particularly for children continues to cause some concern - this currently stands at 146 days for Huddersfield and 121 days for Calderdale. Children's Therapies waiting times are long due to the increased demand and static capacity available in the teams. There are particular issues in SALT in Calderdale due to the current commissioning arrangements and OT in Huddersfield for similar reasons.	Waiting Time for Children's services Additional orthotics clinics have been put on and some adult clinics have been converted to children's clinics to improve the situation. Commissioner dialogue continues to occur to get to a point where a model of delivery can be agreed that supports the level of demand experienced. Terms of reference for an external review are being developed.	Waiting Time for Children's services An improved position in Orthotics is hoped to be available by January. An external review is hoped to be commissioned by Christmas to commence in early 2018. By when: January 2018 Accountable: Head of Therapies

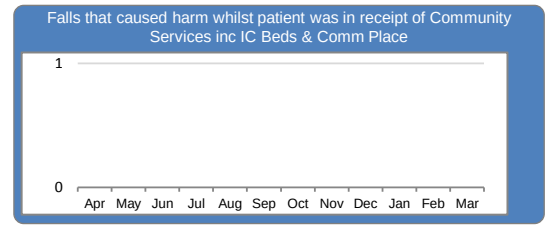
Dashboard - Community

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

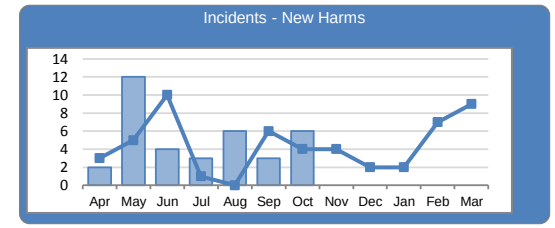
Safe

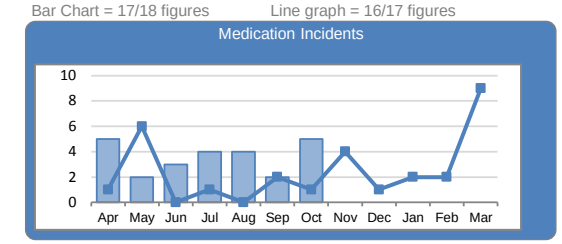


One month in arrears



One month in arrears





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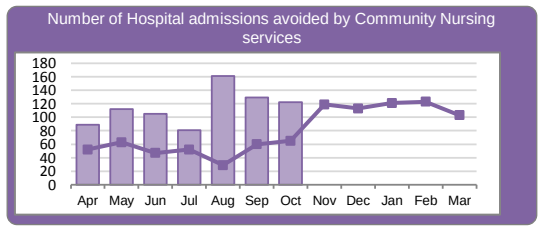
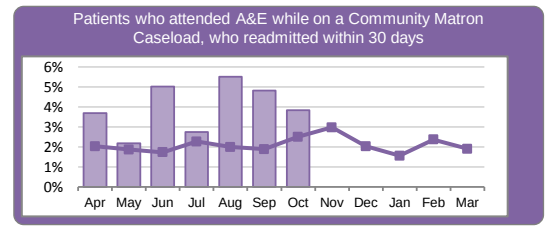
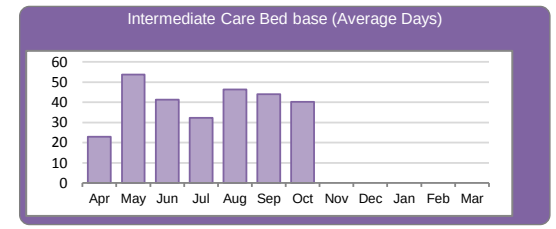
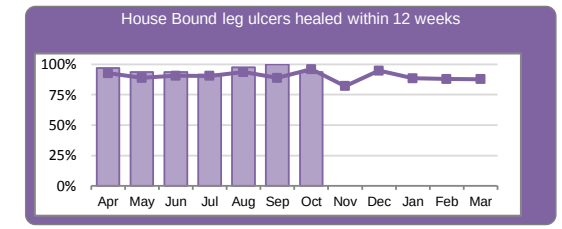
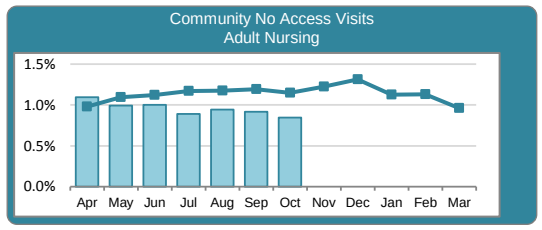


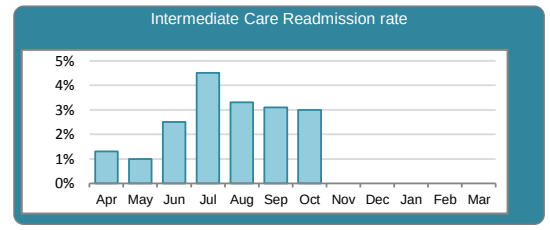


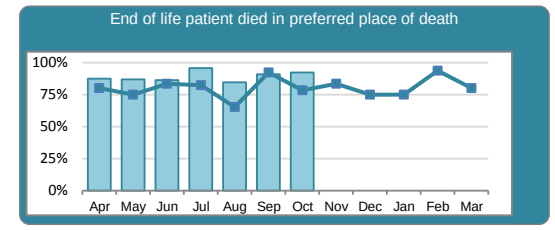


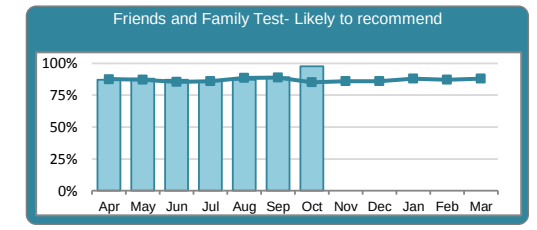


Caring

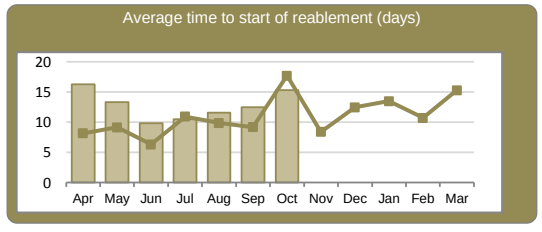


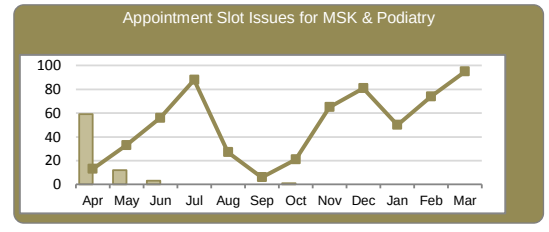


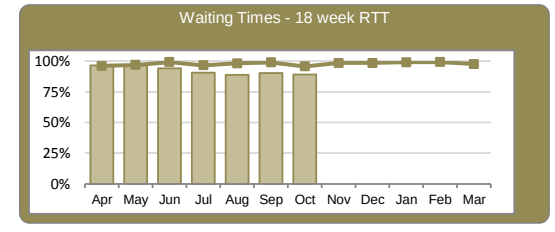


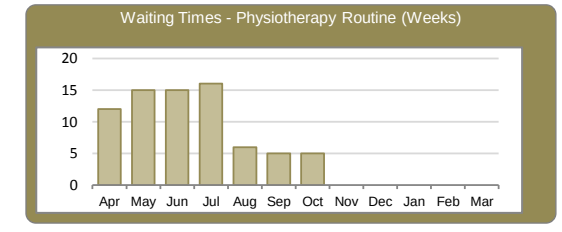


Responsive

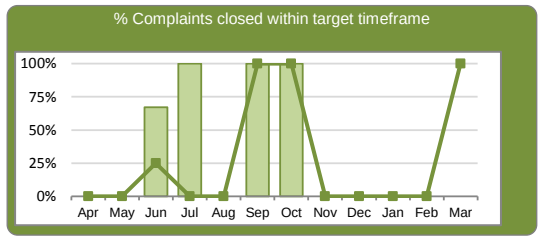


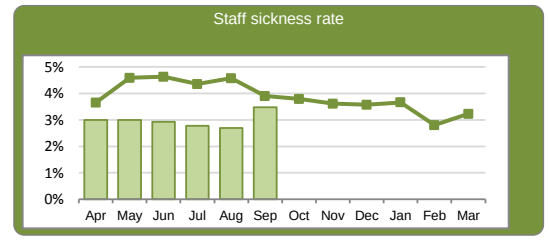




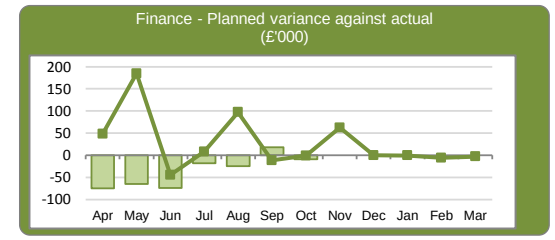


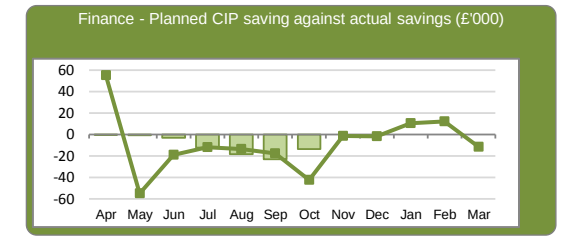
Well Led



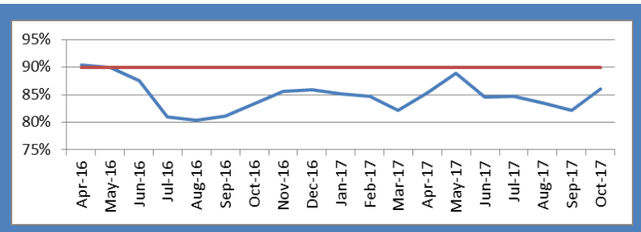
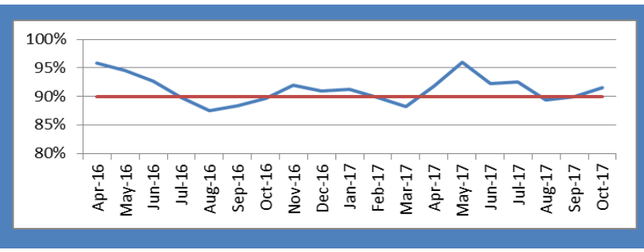
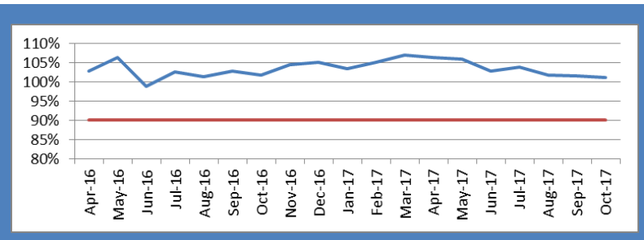
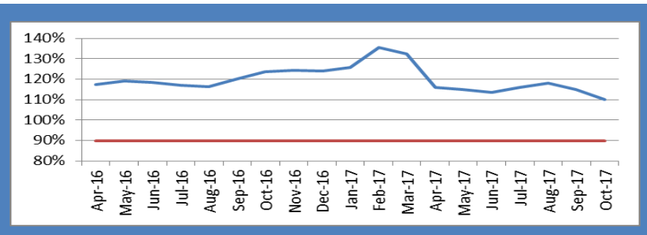


One month in arrears





Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation	Result
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	86.08% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% -WARD 6D : 73.6% -WARD 7BC : 64.8% - WARD 12: 72.3% - WARD 21: 67.2%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team to ensure safe staffing against patient acuity and dependency is achieved. The low fill rates reported in October are attributed to a level of vacancy & teams not achieving their WFM. The low fill rate on 7b/c is due to bed reduction
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	91.59 % of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% -WARD 12 : 74.2% -WARD ICU : 70.4% -WARD 8AB : 64.2% -WARD 8D : 74.2%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team to ensure safe staffing against patient acuity and dependency is achieved. The low fill rates reported in October are attributed to a level of vacancy & teams not achieving WFM. The low fill rate on 7b/c is due to bed reduction.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	101.2% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at day <75% -WARD 7BC : 69.1% - WARD 8AB: 64.3% - WARD NICU : 58.8% - WARD 3ABCD : 58.3%	The low HCA fill rates in October are attributed to fluctuating bed capacity and a level of HCA vacancy within the FSS division. This is managed on a daily basis against the acuity of the work load. Recruitment plans are in place for all vacant shifts. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; realisation of supervisory time for band 7 registered nurses and for care staff supporting reduced fill rate of registered nurse hours.
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	110.15 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% -WARD 7BC: 49.5%	The low HCA fill rates in October are attributed to reduced bed capacity on 7bc. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; and for care staff supporting reduced fill rate of registered nurse hours

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

	Ward	Main Specialty on Each Ward	DAY						NIGHT					
			Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)
			Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual		
CRH2CD	CRH MAU	GENERAL MEDICINE	2046	1888	1209	1373.5	92.3%	113.6%	1364	1481.5	1023	851	108.6%	83.2%
HRI1	HRI MAU	GENERAL MEDICINE	2046	1948	2139	1986.5	95.2%	92.9%	1705	1683	1364	1375	98.7%	100.8%
CRH 2AB	WARD 2AB	GENERAL MEDICINE	1906.5	1533.5	1209	1602.5	80.4%	132.5%	1364	1353	682	792	99.2%	116.1%
HRI5	HRI Ward 5 (previously ward 4)	GERIATRIC MEDICINE	1674	1415.5	1209	1500.5	84.6%	124.1%	1023	1012	1023	1298	98.9%	126.9%
HRI11	HRI Ward 11 (previously Ward 5)	CARDIOLOGY	2076	1901	1006.5	1018	91.6%	101.1%	1320	1309	660	649	99.2%	98.3%
CRH5AD	WARD 5AD	GERIATRIC MEDICINE	2139	1672.5	1581	1910.5	78.2%	120.8%	1364	1279	1364	1317	93.8%	96.6%
CRH5C	WARD 5C	GENERAL MEDICINE	1069.5	1029.5	837	825	96.3%	98.6%	682	682	341	341	100.0%	100.0%
HRI6	WARD 6	GENERAL MEDICINE	1674	1576	1209	1124.5	94.1%	93.0%	1023	1023	682	682	100.0%	100.0%
CRH6BC	WARD 6BC	GENERAL MEDICINE	1674	1647.5	1209	1434.5	98.4%	118.7%	1364	1353	682	880	99.2%	129.0%
CRH5B	WARD 5B	GENERAL MEDICINE	1209	935.5	744	1136	77.4%	152.7%	682	660	682	917.5	96.8%	134.5%
CRH6A	WARD 6A	GENERAL MEDICINE	976.5	801	976.5	741	82.0%	75.9%	682	682	341	451	100.0%	132.3%
	WARD 8C	GENERAL MEDICINE					-	-					-	-
CCU	WARD CCU	GENERAL MEDICINE	1674	1385	372	379.5	82.7%	102.0%	1023	996.5	0	34	97.4%	-
ASU	WARD 6D	GENERAL MEDICINE	1674	1232.5	837	835	73.6%	99.8%	1023	990	682	662	96.8%	97.1%
CRH 7AD	WARD 7AD	GENERAL MEDICINE	1674	1454	1581	1746	86.9%	110.4%	1023	1045	1023	1023	102.2%	100.0%
CRH7BC	WARD 7BC	GENERAL MEDICINE	1674	1084.5	1581	1092.5	64.8%	69.1%	1023	814	1023	506	79.6%	49.5%
HRI8	WARD 8	GERIATRIC MEDICINE	1441.5	1224.3	1209	1917.45	84.9%	158.6%	1023	880	1023	1507	86.0%	147.3%
HRI12	WARD 12	MEDICAL ONCOLOGY	1674	1210.5	837	981	72.3%	117.2%	1023	759	341	605	74.2%	177.4%
HRI17	WARD 17	GASTROENTEROLOGY	2046	1594.3	1209	1097.5	77.9%	90.8%	1023	992	682	682	97.0%	100.0%
HRI21	WARD 21	REHABILITATION	1209	812.5	976.5	1255.2	67.2%	128.5%	682	682	682	693	100.0%	101.6%
	ICU	CRITICAL CARE	3770	2954.5	768.5	634	78.4%	82.5%	4278	3011	0	0	70.4%	-
HRI3	WARD 3	GENERAL SURGERY	945.5	943	754	699	99.7%	92.7%	713	713	356.5	356.5	100.0%	100.0%
CRH8AB	WARD 8AB	TRAUMA & ORTHOPAEDICS	1053	847	934	600.5	80.4%	64.3%	966	620.5	253	356.5	64.2%	140.9%
CRH8D	WARD 8D	ENT	821.5	819.5	821.5	749	99.8%	91.2%	713	529	0	230	74.2%	-
HRI10	WARD 10	GENERAL SURGERY	1302	1178	754	926.5	90.5%	122.9%	1069.5	713	356.5	724.5	66.7%	203.2%
HRI15	WARD 15	GENERAL SURGERY	1562.5	1651.2	1248.5	1205.5	105.7%	96.6%	1069.5	1081	356.5	850.5	101.1%	238.6%
HRI19	WARD 19	TRAUMA & ORTHOPAEDICS	1643	1426.5	1178	1520	86.8%	129.0%	1069.5	1046.4	1069.5	1426	97.8%	133.3%
HRI20	WARD 20	TRAUMA & ORTHOPAEDICS	1999.5	1546.5	1410.5	1308	77.3%	92.7%	1069.5	1069.5	1069.5	1069.5	100.0%	100.0%
HRI22	WARD 22	UROLOGY	1178	1136	1178	1103	96.4%	93.6%	713	713	713	713	100.0%	100.0%
SAU	SAU HRI	GENERAL SURGERY	1891	1579.5	966	834.5	83.5%	86.4%	1426	1426	356.5	356.5	100.0%	100.0%
LDRP	WARD LDRP	OBSTETRICS	4278	3751	945.5	752	87.7%	79.5%	4140	3519.25	690	570.5	85.0%	82.7%
NICU	WARD NICU	PAEDIATRICS	2247.5	2106	930	546.5	93.7%	58.8%	2139	1989.5	713	540.5	93.0%	75.8%
CRH1D	WARD 1D	OBSTETRICS	1234.5	1121	356.5	356.5	90.8%	100.0%	713	713	356.5	356.5	100.0%	100.0%
CRH3	WARD 3ABCD	PAEDIATRICS	3110.5	2841	1208	704	91.3%	58.3%	2495.5	2405.5	356.5	365	96.4%	102.4%
CRH4C	WARD 4C	GYNAECOLOGY	713	713	465	397.5	100.0%	85.5%	713	701.5	356.5	345	98.4%	96.8%
CRH9	WARD 9	OBSTETRICS	1069.5	968.5	356.5	378.8	90.6%	106.3%	713	713	356.5	333	100.0%	93.4%
HRI18	WARD 18	PAEDIATRICS	790	723.5	132	100.5	91.6%	76.1%	713	695.5	0	0	97.5%	-
	Trust		**61166**	**52651.3**	**36338**	**36772.5**	**86.08%**	**101.20%**	**45129.5**	**41335.7**	**21660**	**23859**	**91.59%**	**110.15%**

Hard Truths: Safe Staffing Levels (3)

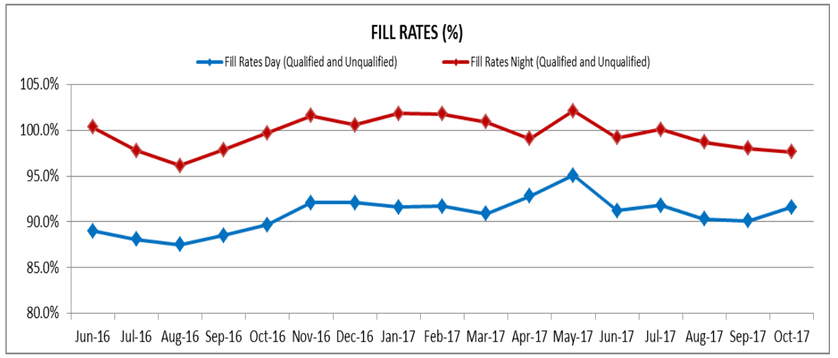
Care Hours per Patient Day

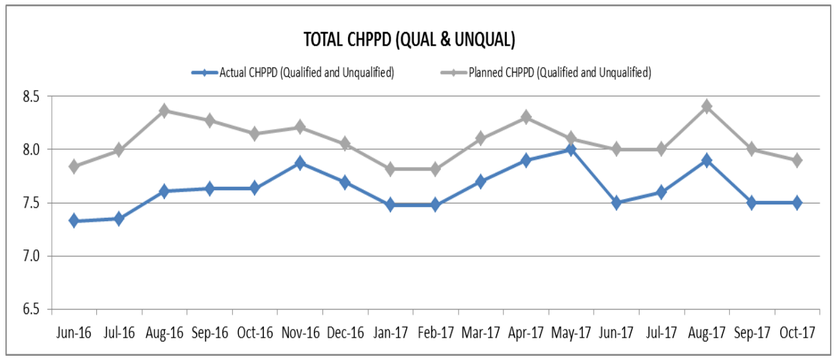
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Aug-17	Sep-17	Oct-17
Fill Rates Day (Qualified and Unqualified)	90.30%	90.10%	91.60%
Fill Rates Night (Qualified and Unqualified)	98.70%	98.00%	97.60%

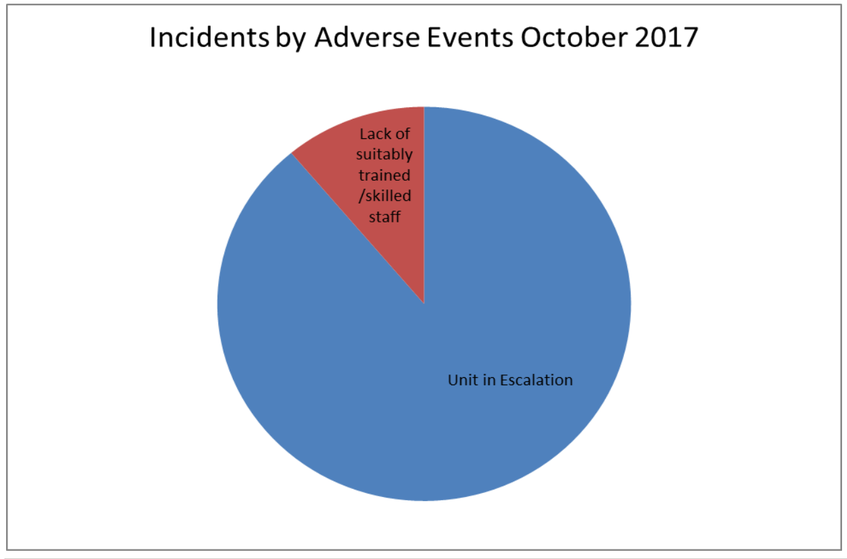
Planned CHPPD (Qualified and Unqualified)	8.4	8.0	7.9
Actual CHPPD (Qualified and Unqualified)	7.8	7.5	7.5

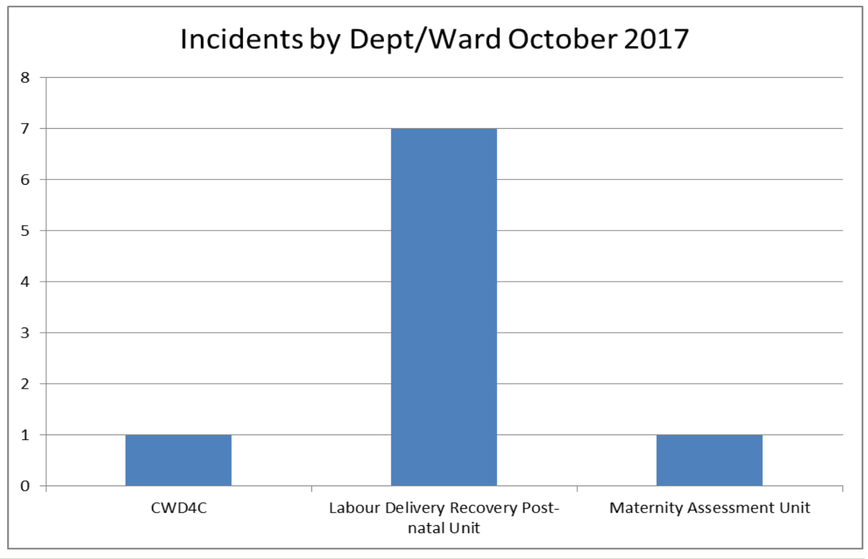
A review of October CHPPD data indicates that the combined (RN and carer staff) metric resulted in 27 clinical areas of the 37 reviewed had CHPPD less than planned. 2 areas reported CHPPD as planned. 8 areas reported CHPPD slightly in excess of those planned. Areas with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). In total there were **9 Trust Wide Red shifts** declared in **October**. The Red flagged shifts were resolved within the Divisions and support for areas where staffing levels had fallen below planned levels was provided across the floor and by the duty night sister/site co-ordinator. No harm was reported to patient.

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

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

On-going activity:

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

2. Further recruitment event planned for March 2018.

2. Applications from international recruitment projects are progressing well and the first nurses are expected in Trust November 2017.

3. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NA who started in post in April 2017. A proposal is being developed to up-scale the project in line with the national & regional workforce plans.

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

5. 4 Additional clinical educators have been recruited to the medical division. They will have a real focus on supporting new graduates & overseas nurses to the workforce.

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 7th December 2017	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Financial Commentary for NHS Improvement - Month 7 - The attached commentary was submitted to NHS Improvement on the 15th of Nov 2017 alongside the Month 7 Monthly Monitoring financial return.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

For information - see attached

Main Body

Purpose:

See attached

Background/Overview:

See attached

The Issue:

See attached

Next Steps:

-

Recommendations:

To note

Appendix

Attachment:

NHSI Financial Commentary Month 7 Final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 7 OCTOBER 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 October 2017.

The report is structured into three sections to describe:

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

1. Key Messages

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

The final planning submission made to NHSI on 30th March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had a number of concerns regarding the scale of this challenge. . For 2017/18, the impact associated with the abnormal risk of EPR implementation was estimated at £5m, whilst only £17m of the required £20m CIP was believed to be achievable, leaving the Trust with a total risk initially assessed at £8m plus any subsequent loss of STF funding.

As at Month 7 these concerns have increased as the underlying financial position has continued to deteriorate. The underlying operational performance would drive an adverse financial variance of £11.7m to the year to date planned position and in the first 6 months of the year the planned position was only achieved through a number of non-recurrent income and expenditure benefits totalling £7.2m, including a £3.5m negotiated settlement with the PFI facilities management provider in support of CIP delivery. This is in addition to the release in the year to date of the full £2m contingency reserve available for this financial year. In Month 7 the Trust is unable to report delivery of the financial plan due to a further adverse variance from plan in month of £2.5m. The implementation of EPR continues to have a significant impact on both productivity and the capture of activity data and is significantly contributing to a material clinical income variance of almost £7m year to date.

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

financial plan remains the highest risk on the Trust risk register scoring the maximum of 25. Financial recovery plans are being implemented details of which are shown below in section 4.

Month 7, October 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	217.93	209.22	(8.70)
Expenditure	(216.82)	(212.32)	4.50
EBITDA	**1.11**	**(3.09)**	**(4.20)**
Non operating items	(28.54)	(14.75)	13.79
Surplus / (Deficit)	**(27.42)**	**(17.84)**	**9.58**
Less: Items excluded from Control Total	13.94	0.04	(13.91)
Less: Loss of STF funding	0.00	1.84	1.84
Surplus / (Deficit) Control Total basis	**(13.48)**	**(15.96)**	**(2.48)**

- Delivery of CIP of £9.04m against the planned level of £8.29m.
- Contingency reserves of £2.00m have been released against pressures.
- Capital expenditure of £6.94m, this is below the planned level of £12.04m.
- Cash balance of £1.90m against a plan of £1.91m.
- Use of Resources score of level 3, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

Operating Income

Operating Income is £8.70m below plan year to date.

NHS Clinical Income

The year to date NHS Clinical income position is £185.07m, £9.18m below the planned level.

The underlying Clinical Contract income position for Month 7 based upon activity coded and captured within EPR is £8.44m below plan. There remain a number of areas where activity is either not captured within EPR or a change to patient data is required in order to accurately price the activity. £1.56m of income has been calculated as an estimate of the value of this missing data. This income is included within the reported position 'at risk' pending formal agreement. Discussions are in progress with Commissioners with regards agreement to the Month 1-6 position. The year to date position also assumes receipt of the full 2.5% of CQUIN including the STP and Risk Reserve elements, with the exception of £0.15m linked to Sepsis and 'Preventing ill health by risky behaviours' targets.

Following these adjustments, NHS Clinical contract income is still below plan by £6.88m and this is largely driven by both case mix and activity volumes due to a reduction in productivity following the implementation of EPR, in particular impacting on Outpatient, Daycase and Elective activity. The impact of HRG4+ Tariff changes is assessed to be in the region of £0.6m year to date and is also

contributing to this under-recovery of income. Maternity pathway and NICU income which naturally fluctuate are both below plan with a combined impact of £0.25m.

In addition, there is an adverse variance of £2.30m on NHS Clinical income that is outside of contract, off which £1.84m relates to the loss of Sustainability and Transformation funding with the remaining variance due to lower than planned Cancer Drugs and Hep C drugs income of £1.4m (offset within High Cost Drugs expenditure) and a number of other smaller variances, , offset by non-recurrent Accelerator zone funding of £0.77m and a non recurrent benefit of £0.95m following a comprehensive review of all prior year accruals.

The year to date reported position includes loss of the £1.0m Month 7 planned STF funding due to failure to achieve the planned financial performance plus £0.84m for Quarters 1 and 2 linked to the A&E 4 hour performance target. Performance in Quarter 2 improved significantly; at Trust level 92.7% of patients were seen within the 4 hour target and at Delivery Board level performance was 94.33%, just below the 94.56% target. This is a change to that reported in Month 6 due to an external mapping error for Delivery Board data that has resulted in a reduction in STF funding of £0.61m. This mapping was challenged at month 6 but the Trust was advised that this was correct. The Quarter 1 deterioration compared to the very high levels reported in 16/17 were as a direct result of both the implementation of EPR and the adherence to IR35 guidance, and as such should be considered to be exceptional.

Other income

Overall other income is above plan by £0.48m year to date. Increased sales activity within our commercial operations has been offset to some extent by slippage in recovery of the Apprentice Levy of £0.3m compared to plan and lower than planned Car Parking income.

Operating expenditure

There is a cumulative £4.50m favourable variance from plan within operating expenditure across the following areas:

Pay costs	£0.34m favourable variance
Drugs costs	£0.03m favourable variance
Clinical supply and other costs	£4.13m favourable variance

The year to date position included the benefit of releasing unspent all of our £2.00m Contingency Reserve and a number of non-recurrent benefits including: a £3.5m credit relating to a negotiated non-recurrent refund of PFI facilities management costs, non-recurrent benefits of £0.82m relating to prior year creditors, £1.52m of prior year benefits following a full review of accruals, (£0.95m income and £0.57m expenditure), the release of £0.38m of Provisions and non-recurrent income of £0.97m. The total of non-recurrent benefits in the year to date position is £7.19m.

Employee benefits expenses (Pay costs)

Pay costs are £0.34m lower than the planned level in the year to date, although this underspend includes the release of Contingency Reserves of £2.00m. The underlying pressure on pay expenditure is therefore £1.66m and relates to an overspend of £2.3m on nursing staff and some higher than planned costs linked to EPR of £0.47m, offset to some extent by an underspend on Medical Staffing. 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 £10.11m year to date, with total Agency expenditure of £9.41m.

Drug costs

Expenditure year to date on drugs is £0.03m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £1.52m below plan. Underlying drug budgets are therefore overspent by £1.49m, largely due to additional activity in the Pharmacy Manufacturing Unit which is a commercial operation.

Clinical supply and other costs

Clinical Support costs are £1.91m lower than planned. This underspend reflects some activity related underspend in clinical supplies, as well as a non-recurrent benefit of £0.82m relating to prior year creditors as described above.

Other costs are £2.22m lower than planned due to the £3.5m non recurrent benefit mentioned above and the release of £0.38m of provisions. Net of some profiling differences on CIP, the underlying cost pressure is £0.80m linked to diagnostic pressures, RPI inflationary pressures and higher than planned equipment maintenance costs.

Non-operating Items and Restructuring Costs

Non-operating expenditure is £13.79m 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 £0.25m 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.

£9.04m of CIP has been delivered this year against a plan of £8.29m, an over performance of £0.75m. This position includes non-recurrent CIP of £3.5m relating to the refund of PFI facilities management costs mentioned above. The Trust has identified £17.0m of savings and continues to push hard for full delivery. The forecast assumes that this will be achieved, but this remains extremely challenging with a number of schemes currently flagged as very high risk. Should these very high risk schemes fail to deliver; further mitigation of around £3.2m will have to be found in addition to the £3m currently unidentified.

Statement of Financial Position and Cash Flow

At the end of October 2017 the Trust had a cash balance of £1.90m in line with the planned level.

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

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	9.58
	Non cash flows in operating deficit	(13.67)
	Other working capital movements	2.26
	Sub Total	**(1.82)**
Investing activities	Capital expenditure	5.13
	Movement in capital creditors / Other	(1.76)
	Sub Total	**3.37**
Financing activities	Net drawdown of external DoH cash support	(0.95)
	Other financing activities	(0.64)
	Sub Total	**(1.59)**
	Grand Total	**(0.05)**

Operating activities

Operating activities show an adverse £1.82m variance against the plan. The impact of the I&E variance due to the October operational adverse variance of £2.48m and loss of £1.84m STF funding, (Quarter 1 &2 A&E 4 hour performance and all of Month 7's allocation), is offset by the favourable cash impact of £2.26m working capital variances and the cash benefit of higher than planned Depreciation charges of £0.25m. Both the deficit and non-cash flows figures should be considered net of a £14m planned impairment which will now take place later in the year. Whilst the overall working capital variance is not massive, it masks some significant working capital issues. The favourable working capital variance is driven by a number of factors: Trade and other Creditors are currently £4.1m above the planned level due the requirement to manage payments to creditors in order to retain sufficient cash to ensure that key payments are made. Deferred income is also higher than the planned level due in part to the £1.5m impact of the under-trade against Commissioner contracts as invoiced. These variances are partially offset by an increase in receivables due to the accounting of the £3.5m PFI credit described above. The cash benefit of the PFI credit is likely to fall at least in part into the next financial year and this combined with rapidly increasing levels of Creditors and the fact that much of the mitigation used to support the year to date position has not been cash backed are now significantly impacting our ability to pay suppliers in a timely manner.

The Trust's request to Department of Health for working capital cash support has been confirmed and the additional loan facility is due to be received in November, at which point the Trust will be in a position to settle most of the long term outstanding liabilities that have been on hold.

Investing activities (Capital)

Capital expenditure year to date is £5.13m lower than planned and the resulting cash benefit has offset some of the pressure on working capital described above. However, this cash benefit has been offset by a reduction in Capital creditors due to the payment of EPR related invoices that were accounted for in the 16/17 capital programme. The requirement for cash support to cover these liabilities was included within the 17/18 cash plan.

Financing activities

Borrowing to support capital expenditure is £8.00m in the year to date in line with plan. In addition the Trust has received £16.81m of Revenue Support linked to deficit and STF funding requirements. This is £0.91m less than planned and reflects planned working capital loan support that has not been received in the year to date.

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 STF allocation funding of £9.26m. However, the risk of failing to achieve our target deficit of £26.04m (excluding STF funding) continues to increase, despite the Trust taking action to improve the financial position. The deteriorating position leaves the Trust with the requirement to deliver recovery plans of the magnitude of £14m, in addition to the ongoing CIP challenge, to cover the growing underlying gap between the planned deficit and operating position.

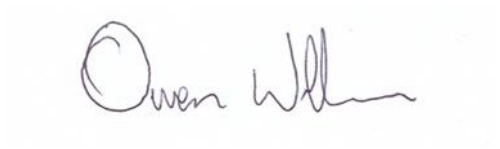
The submitted forecast is an indicator of the Trust's ambition to close the gap to plan and assumes:

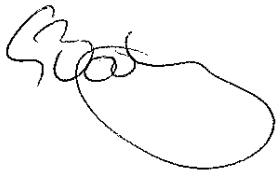
- That recovery plans of up to £14m are identified and delivered by year end (see table below).
- That the Trust is able to secure from commissioners the £1.56m of estimated income that is in the year to date position.
- Full delivery of the £17m Cost Improvement programme including £1.6m that is currently flagged as extremely high risk.
- Full receipt of CQUIN funding, including the 0.5% STP and 0.5% Risk Reserve elements.
- Securing STF income in full for Quarters 3 and 4 by achieving the control total in Month 12.
- That a programme of additional budgetary grip and control is successfully maintained as planned.
- Delivery of further recovery plans which are in development as below:

Recovery Plans		Potential scale £m
Pay Expenditure	Enhanced Vacancy Control – heightened challenge for all non-medical, non-frontline nursing.	0.50
	Review deployment of nursing workforce & Establishment	
	Maternity – review skill mix/cover hours/ midwife : birth ratios	
	Multi-Professional Staffing Model Review	
Non Pay Expenditure	Cease expenditure on discretionary categories	2.00
	Course Fees – cease all not Apprentice Levy funded	
	Estates Special Purpose Vehicle	
Activity / Income	Pursue contract negotiation with NHSE to support exceptional underperformance (gain share)	2.00
	Pursue tariff agreement (gain share) with commissioners for MSK	
	Further challenge to divisions to increase activity throughput	
	Day case – consolidation of provision	
	Ward 18 closure or temporary use	
	Cease Gynae ward provision	
	Limit provision against Community block contract to funded levels	
Technical Accounting adjustments	Prepay Apprentice Levy expenditure	0.30

These internal actions sit alongside a programme of system wide recovery that is being developed in partnership with commissioners with a view to minimising the overall local health system gap to plans. The mobilisation time required to implement a number of these wider health economy plans as well as the transformational internal schemes means that delivery is most likely to span the two year planning timeframe of 2017-2019.

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 minimise the deficit in 2017/18 and create the best conditions for delivery in 2018/19 and beyond.





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 December 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: SINGLE OVERSIGHT FRAMEWORK UPDATE - The Board is asked to note the changes to Single Oversight Framework	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the Single Oversight Framework

Main Body

Purpose:

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

Background/Overview:

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

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

The Issue:

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

Following consultation, NHS I have amended the SOF as follows:

What has changed

- Improved structure and presentation – clarified processes /definitions; corrected discrepancies
- A few changes to the information/metrics used to assess providers' performance under each theme
- A few changes to the indicators that trigger consideration of a potential support need.

Key SOF clarifications

- The relationship between triggers and segmentation – a trigger indicates a potential support need; further investigation is needed to determine whether there is an actual support need
- Operational performance standards – NHS I will only use absolute performance against the national standard as a trigger; not trajectories
- Use of Resources (UoR) assessments provided an overview of the new UoR assessments which aim to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients
- NHS I's support offer – provide an overview of support offer
- SOF metrics – updated the SOF appendices to detail which metrics NHS Improvement uses to assess provider performance; how these metrics are defined and calculated; the frequency of data publication; and a link to the data source.
- Future updates to the SOF – align future updates of the SOF with the national planning cycle; the next scheduled refresh will therefore be for 2019/20

Quality

+ Added

E. coli bacteraemia bloodstream infection (BSI)

Meticillin-sensitive staphylococcus aureus (MSSA)

Removed
Aggressive cost reduction plans metric
Hospital Standardised Mortality Ratio – Weekend (DFI)

Finance and use of resources
+ Added
Reference to new Use of Resources (UoR) framework, with explanation of how UoR assessments will be used under the SOF;
NHSI will use the UoR report/rating alongside the finance score to inform our consideration of the provider's support needs

~ Amended
Replaced the existing term SOF 'finance and use of resources score' with 'finance score' to make a clear distinction between this and the new UoR ratings; no change to any of the metrics or underlying calculations

Operational Performance
+ Added
Dementia assessment and referral standards

- Removed
Emergency readmissions

~ Amended
Data Quality Maturity Index (DQMI) - Mental Health Services Data Set Data Score – replaces previous standards for submitting 'priority' and 'identifier' metrics to MHSDS
For operational performance standards, NHSI will use performance against the absolute national standards as a trigger, not performance against STF trajectories.

Strategic Change
+ Added
NHSI will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme.

Leadership
+ Added
Reference to NHS Improvement and CQC's new, fully joint well-led framework and guidance on how providers should carry out developmental reviews of their leadership and governance as part of their own continuous improvement

Next Steps:

The Integrated Performance Report will incorporate the updated SOF reporting requirements.
More information is available at NHS Improvement: https://improvement.nhs.uk/resources/single-oversight-framework/

Recommendations:

The Board is asked to receive and note the Single Oversight Framework

Appendix

Attachment:

NHS Providers on the day briefing - NHSI Single Oversight Framework (November 2017).pdf

on the day BRIEFING

NHS Providers

NHS IMPROVEMENT SINGLE OVERSIGHT FRAMEWORK UPDATE RESPONSE – ON THE DAY BRIEFING

Today NHS Improvement (NHSI) has published the updated Single Oversight Framework (SOF) and its response to a recent feedback exercise on updates to the SOF. NHS Providers submitted a response to the exercise, which was informed by feedback from members and can be found on our website. This briefing summarises the specific metric changes under each SOF theme, followed by a summary of the feedback from respondents and NHSI's response, where this has been provided.

If you have any questions about this briefing or our work on regulation more generally please contact Ella Jackson, policy advisor (regulation), Ella.Jackson@nhsproviders.org

SUMMARY OF CHANGES TO THE SINGLE OVERSIGHT FRAMEWORK

The first version of the single oversight framework (SOF) was published in September 2016. In light of recent developments and to reflect learning from the framework's first year of operation, NHSI conducted this feedback exercise on making some changes to the SOF, including:

- Changes to improve the structure and presentation of the document, updating the introductory sections and summarising key information more succinctly
- Introducing a separate section outlining the five key themes of the SOF and summarising under each theme what would trigger consideration of a support need
- Changes to some of the metrics that NHSI uses to assess providers' performance under the SOF themes and the indications that trigger consideration of a potential support need (including removing some metrics and adding new ones). Of note is the addition of a new standard on the reduction of inappropriate adult mental health out-of-area placements as standard for mental health providers
- Making clear under all themes that in addition to specific triggers, other material concerns arising from intelligence gathered by or provided to NHSI could trigger consideration of a support need
- Making explicit that providers are expected to notify NHSI of significant actual or prospective changes in performance or risk outside routine monitoring.

NHSI did not propose any changes to the underlying framework itself – i.e. there will be no changes to the five themes, NHSI's approach to monitoring, how support needs are identified, and how providers are segmented.

During NHSI's feedback exercise we welcomed the changes to improve the structure, format and presentation of the SOF document which is now clearer and easier to read. However we have highlighted

the need for further clarity and detail around NHSI's support offer and the decision-making process around segmentation. We also highlighted concerns around some of the additional metrics being proposed, particularly around the mental health out of area placements. Although we support the ambition to reduce inappropriate adult mental health out of area placements, which is in line with the policy priorities of the Five year forward view for mental health, this new metric is likely to be a cause for concern and contention for providers that are not yet part of a new mental health care model which gives them control over the commissioning budget.

Overall we are pleased to see that NHSI is delivering on its commitment to review the SOF, but would encourage NHSI to establish a regular review of the SOF and to evaluate its impact, in the same way that Monitor undertook a yearly consultation on its risk assessment framework. We also note more broadly that it continues to be difficult to separate the framework from the wider policy context, continued financial pressure and the reality of greater grip and control from the centre. In addition to this, given the current direction of travel of Sustainability and Transformation Partnerships (STPs) and Accountable Care Systems (ACSs), NHSI will need to continue to work closely with providers and other national bodies to ensure the new framework develops alongside STPs and ACSs, as well as the development of new models of care, and the emerging organisational structures needed to support these new approaches.

CHANGES BY THEME

Please find below an overview of the metric changes under each SOF theme.

Quality of care		
Added	*Removed*	*Amended*
E.coli bacteraemia bloodstream infection (BSI) rates to quality indicators	Aggressive cost reduction plans metric from list of quality indicators	
Medticillin-sensitive Staphylococcus aureus (MSSA) rates to quality indicators	Hospital standardised mortality ratio-weekend (DFI) from list of quality indicators for acute providers	
	Emergency readmission rates from list of quality indicators for acute providers	
		Change to triggers of potential support needs regarding quality of care: CQC rating of 'inadequate' or 'requires improvement' in overall rating, or against any of the safe, effective, caring or responsive key questions.
Finance and use of resources		
Added	*Removed*	*Amended*
Reference to the new Use of Resources (UoR) framework, with		

explanation of how UoR assessments will be used under the SOF		
'Finance and use of resources score' is re-labelled as 'finance score'		
Operational performance		
Added	*Removed*	*Amended*
Dementia assessment and referral standards for acute providers	Patients requiring acute care who received a gatekeeping assessment as standard for mental health providers	Where relevant, NHSI will use performance against the national standard rather than the Sustainability and Transformation Fund (STF) trajectories as the trigger of potential support needs in relation to operational performance standards
Reduction of inappropriate adult mental health out-of-area placements as standard for mental health providers		Ambulance response time standards (updated to reflect the new standards, indicators and measures that have been introduced for ambulance providers through the Ambulance Response Programme)
Data Quality Maturity Index (DQMI) – Mental Health Services Data Set (MHSDS) Data score replaces previous standards for submitting 'priority' and 'identifier' metrics to MHSDS		
Strategic change		
Added	*Removed*	*Amended*
NHSI will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme.		
Leadership and improvement capability		
Added	*Removed*	*Amended*
Reference to NHS Improvement and CQC's new, fully joint well-led framework and guidance on developmental reviews		

SUMMARY OF FEEDBACK AND NHSI RESPONSE

Quality of care

Feedback: Concerns were raised in response to the original proposal to move to using only the overall CQC rating as the main trigger to consider potential support needs under the quality of care theme. We recognised the rationale behind the proposed change to the CQC rating trigger under the quality of care theme from an 'inadequate' or 'requires improvement' rating against any of the safe, effective, caring or responsive key questions to a rating of 'inadequate' or 'requires improvement' in an overall rating. However, we urged NHSI to ensure there is a clear understanding of what sits underneath the overall rating so that support is tailored appropriately to individual providers

NHSI response: The SOF has reverted to listing ratings of 'inadequate' or 'requires improvement' in both the overall CQC rating and those for the individual themes acting as triggers to consider a potential support need under the quality of care theme.

Finances and use of resources

Feedback: Respondents to the feedback exercise felt NHSI's proposals clearly explained how the new UoR assessments will inform SOF monitoring and its assessment of providers' support needs under the finance and use of resources theme. We welcomed the re-labelling of the previous 'finance and use of resources score' as 'finance score' to reduce potential for confusion with the Use of resources assessment ratings. Requests for clarity on the UoR assessment process were made by respondents and some also suggested that the UoR key lines of enquiry (KLOE) would require further development for mental health services. We believe that NHSI should have revisited how UoR aligns with the financial special measures regime.

NHSI response: NHSI and CQC have now published the UoR assessment framework, summary of responses to the consultation on the assessment framework, and a brief guide for acute non-specialist trusts on UoR assessments. Currently, the availability and quality of productivity metrics for non-acute trusts are not sufficient to support a robust UoR assessment. NHSI is undertaking a programme of work to understand the productivity of community, mental health and ambulance trusts. The emerging metrics and benchmarking in these areas will be available to providers via the Model Hospital portal, in due course.

Operational performance

Feedback: We raised concerns that including both the STF trajectories and absolute performance as triggers around A&E performance was confusing. Respondents also suggested that reporting against STF trajectories should apply to other relevant operational performance indicators, in addition to A&E. There was a request for clarity on when formal monitoring of performance under the new ambulance response targets will start, and around how delayed transfers of care (DToCs) will be measured.

Some respondents noted that only a few metrics apply to community trusts and that the SOF could better reflect the requirements on mental health, community and ambulance sectors. Specific concerns were raised about the indicators and standards use to measure the performance of mental health providers,

including data quality; the requirement for local interpretation within the national definition; urban/rural population differences; the extent to which reducing out-of-area placements is within the control of providers, and how locally agreed trajectories for this metric will be agreed.

NHSI response: Consideration of support needs should be based on absolute performance. Failure to meet any of the absolute national standards - including A&E waiting times - for more than two months will trigger consideration of a provider's support needs. Where providers have an agreed trajectory for improvement toward any national standard, progress against this will be taken into account when determining whether they have an actual underlying support need. However, as all providers are expected to meet national standards, it is appropriate to consider what support may be required if performance consistently falls below this level.

There will be a transition period until April 2018 to allow all providers to implement the new ambulance response targets requirements. During this period providers will be expected to demonstrate progress towards full implementation of the new standards, following an agreed plan and trajectory. From April 2018, failure to meet the standards will trigger consideration of a provider's support needs in this area. NHSI will consider introducing DToCs as an indicator or standard in future updates of the SOF.

The out-of-area indicator is already a key indicator for clinical commissioning groups (CCGs) and addressing this issue requires a joined-up approach. The Department of Health has published guidance on what counts as an adult acute out-of-area placement. STP mental health leads, supported by NHS England and NHSI regional teams, are developing STP and provider-level baselines and trajectories for eliminating out-of-area placements.

Strategic change

While NHSI is developing its work on the governance and oversight of STPs and accountable care systems, we believe further work is necessary to clarify how NHSI intends to measure the contribution of individual providers to local systems as currently the strategic change theme is underdeveloped.

Use of information beyond routine monitoring

Feedback: Respondents made requests for clarity on what may be considered 'other material concerns' arising from intelligence gathered by or made available to NHSI. Clarity was also sought on when providers are expected to notify NHSI of significant actual or prospective changes in performance or risk outside routine monitoring. We also urged NHSI to adopt a formal consultation approach where any changes to the SOF are proposed, in a similar way to Monitor's approach when it proposed changes to its risk assessment framework.

NHSI response: It is not possible to specify what would suggest new, material concerns in each case, as such information would be considered in the context of NHSI's wider knowledge of the provider and its circumstances. However any such information should be discussed openly with the provider to determine its relevance and significance. Examples of the types of circumstances where NHSI would expect providers to notify it of significant actual or prospective changes in performance or risk outside routine monitoring have been provided in the updated SOF.

Contact: Ella Jackson, Policy Advisor (Regulation) ella.jackson@nhsproviders.org

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 December 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Safe Staffing Bi-Annual Report (Hard Truths) - The Board is asked to approve the safe staffing bi-annual report.	
Action required: Approve	
Strategic Direction area supported by this paper: A Workforce for the Future	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Workforce/Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Patient safety is a key priority for CHFT. The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England has continued to issue guidance from November 2013 onwards, building upon the ten key recommendations made to optimise nursing, midwifery and care staffing capacity and capability. This report is to assure the Trust Board of Directors that robust mechanisms are in place to set and monitor nursing and midwifery staffing levels, and work is underway to meet the expectations set out in the NQB national recommendations.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

To receive this report as assurance of the continued management of the Nursing and Midwifery workforce agenda.

Appendix

Attachment:

Safe Staffing Nursing and Midwifey BOD Report November 2017 working version (3).pdf

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS	
PAPER TITLE: Safe Staffing Bi-Annual Report (Hard Truths)	**REPORTING AUTHOR:** Brendan Brown – Chief Nurse/Deputy Chief Executive L Rudge , Deputy Chief Nurse M Bamforth, Head Nurse
DATE OF MEETING: 7th December 2018	**SPONSORING DIRECTOR:** B Brown, Deputy Chief Nurse and Deputy Chief Executive
STRATEGIC DIRECTION – AREA: • Keeping the base safe • A workforce for the future	**ACTIONS REQUESTED:** • To receive
PREVIOUS FORUMS: Not applicable	
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: Patient safety is a key priority for CHFT. The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England has continued to issue guidance from November 2013 onwards, building upon the ten key recommendations made to optimise nursing, midwifery and care staffing capacity and capability. This report is to assure the Trust Board of Directors that robust mechanisms are in place to set and monitor nursing and midwifery staffing levels, and work is underway to meet the expectations set out in the NQB national recommendations.	
FINANCIAL IMPLICATIONS OF THIS REPORT: Enclosed within report	
RECOMMENDATION: To receive this report as assurance of the continued management of the Nursing and Midwifery workforce agenda.	
APPENDIX ATTACHED: YES	

CONTENTS		

1.0 Introduction

NHS Trusts are responsible for ensuring the quality of care provided to patients. They are also responsible for ensuring that this care is provided appropriate to the need of patient and client groups, and within a restricted financial envelope. It is well known that the NHS faces challenges with constraints determined by financial imperatives whilst finding ways to counter the rising demand for services. At the forefront of this balancing act is the challenge of staffing wards and department safely in the face of a nationally recognised shortage of nursing and midwifery staff.
What is certain is that staff are an essential, if not vital link in maintaining that responsibility to patients. The Francis Report (Francis, 2013) found that lower staffing levels impacted adversely on patient outcomes and in the Keogh review (Keogh, 2013), an examination of the quality of care and treatment in fourteen Hospital Trusts in England highlighted the importance of nursing ratios upon quality and patient safety.
The National Quality Board (NQB) for England accepts that nurse staffing capacity and capability are the main determinants of the quality of care experienced by patients and has issued on-going guidance in this area (National Quality Board, 2013).
Patient safety and quality of care are paramount, with Trusts Board of Directors needing to ensure safer staffing levels are embedded within the organisation and that patient outcomes are not compromised. For this, NHS England and the Care Quality Commission have published joint guidance to NHS trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels. Building on this initial drive to improve reporting, management and delivery of the nursing and midwifery workforce, further guidance was issued in July 2016 supporting NHS Trusts to deliver the right staff, with the right skills, in the right place at the right time.

<table>
<tr><th colspan="3">Safe, Effective, Caring, Responsive and Well-Led Care</th></tr>
<tr><td colspan="3">Measure and Improve
- patient outcomes, people productivity and financial sustainability -
- report investigate and act on incidents (including red flags) -
- patient, carer and staff feedback -</td></tr>
<tr><td colspan="3">- Implementation Care Hours per Patient Day (CHPPD) -
- develop local quality dashboard for safe sustainable staffing -</td></tr>
<tr><th>Expectation 1</th><th>Expectation 2</th><th>Expectation 3</th></tr>
<tr><td>Right Staff
1.1 evidence-based workforce planning
1.2 professional judgement
1.3 compare staffing with peers</td><td>Right Skills
2.1 mandatory training, development and education
2.2 working as a multi-professional team
2.3 recruitment and retention</td><td>Right Place and Time
3.1 productive working and eliminating waste
3.2 efficient deployment and flexibility
3.3 efficient employment and minimising agency</td></tr>
</table>

The aim of this paper is to provide the Board of Directors with an overview on the nurse staffing position. The paper will provide assurances that Nursing and Midwifery staffing, capacity and capabilities are monitored, reviewed and established in line with national guidance.

2.0 Workforce measurement and data collection

Attention and analysis of the nursing workforce continues to take place at a national level. Particular focus is maintained on safe staffing level and there are a number of resources and tools to support this in place recommended by NHS England and NHS Improvement with close regulation from the Care Quality Committee and Nursing and Midwifery Council. Calderdale and Huddersfield Foundation Trust (CHFT) continue to deliver within this agenda, and manage the complexity of nurse staffing with a pro-active and considered approach.

Definition of staffing measurements:

UNITS OF STAFFING MEASUREMENT		
Type of Measure	Examples	How these can be used
Staff to patient rates/ratios	Care hours per patient day (CHPPD) reported as total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix Nursing hours per patient day (NHPPD)	CHPPD is a unit of measurement that can be applied to any aspect of staffing, registered staff and/or whole care team The Carter Report defines CHPPD as registered nurse hours plus healthcare support staff hours in a 24 hour period divided by the number of patients at midnight. NHPPD is a unit of measurement used in in-patient setting internationally. It is able to summarise variations in numbers of staff and numbers of patients over the course of a 24 hour period. It typically refers to the number of registered nursing hours available per patient
Patient to staff rates/ratios	X patients per registered nurse X service user on caseload X women per midwife per year One to one observation	Used as a snapshot of current responsibilities or as an average of responsibilities over a longer period. Actual numbers of staff and of patients/women/service users will tend to vary over the course of the day in inpatient settings and over days/weeks in community settings.
Whole time equivalents	Ward/unit/team has xx WTE in post Ward/unit/team is funded for xx WTE	Provides a unit of measurement for all contracted staff
Head Count	Ward/unit/team headcount is Xx Registered Nurses Xx Healthcare assistants Xx Ward support staff	Provides a unit of measurement that is important when counting activity every employed staff member has to undertake regardless of how many hours they work , e.g. mandatory training
Fill Rates	The ward/unit team had xx % of planned staff overall The ward/unit/team had xx% of planned registered nurse/midwifery staffing The Ward/unit team had xx	This was previously calculated by dividing actual staff by planned or required staff and multiplying by 100 to convert to a percentage. Difficult to interpret in isolation from other units of measurements as previous plans may not reflect patient acuity/dependency on the day and the % total cannot distinguish between aiming high but delivering

	%of required staff overall The ward/unit/team had xx% of required nurse/midwifery staffing	less or aiming low and delivering lower . Where registered nursing/ midwifery staffing gaps are covered by a higher number of healthcare assistants, or where fluctuating numbers of staff are required for special observation , overall fill rates become even more difficult to interpret
Weighted Activity Unit (WAU)	Model Hospital National dashboard	WAU measures the total units of activity in a Trust where one unit, one WAU, represents a quantity of clinical activity equivalent to the cost of the average elective in-patient stay (£ 3,500 per average)
Headroom and uplift	Xx% uplift Xx % headroom	Building in capacity to deal with planned and unplanned but predictable variations in staff available, such as annual leave, maternity and paternity leave, compassionate leave, jury service, sickness and study leave. If the headroom/uplift allowance is lower than actual requirements this can lead to greater use of temporary/agency staff.
NOTE: For all units of staffing measurement creating averages over days, weeks or months can potentially be misleading: a ward/unit/team that fluctuates markedly between too few of too many staff to meet patients' needs on different days of the week, or from week to week, will not be able to deliver the same quality of care as a ward/unit/team where staffing is more consistent.		

Taken from updated NQB publication July 2016

In addition to the complexity of workforce measurement tools, National guidance also strongly suggests the professional judgement of organisations senior Nursing teams is applied when implementing methodologies. Whilst difficult to measure this should not be underestimated.

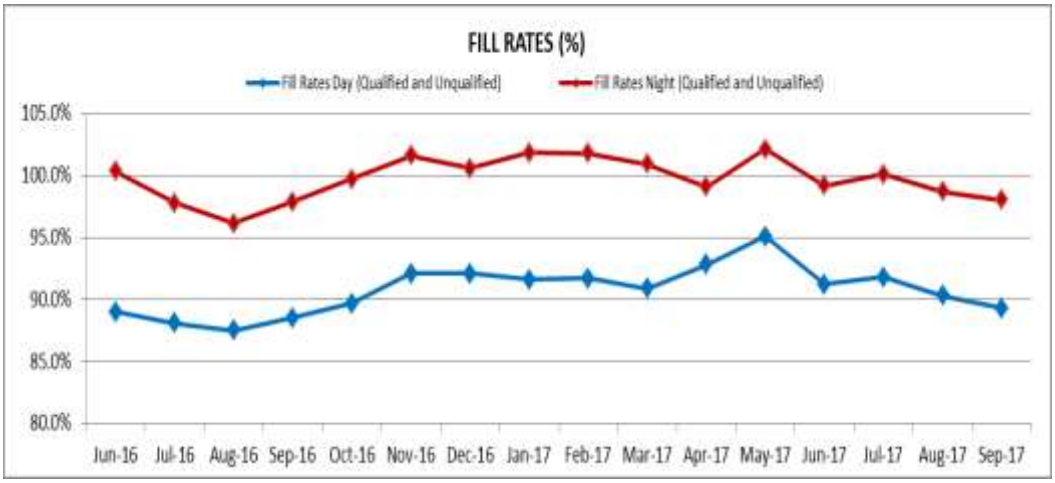
2.1 Fill Rates

Average shift fill rates identify the actual staffing levels in place against what was planned.
The fill rate is calculated by taking actual hours as a percentage of planning hours for all;

- Registered Nurses and Midwives on day shifts
- Registered Nurses and Midwives on night shifts
- Care Staff on day shifts
- Care staff on night shifts

Fill rates are monitored and interrogated on a monthly basis by the Nursing and Midwifery Workforce Steering Group and by the Associate Directors of Nursing within the clinical divisions.

As an example, the table below indicates that average fill rates have been maintained over the last four months. Whilst this enables assurance that safe staffing levels are being achieved, this has been achieved through a level of non-contracted bank/agency staff support.



Within CHFT staffing levels are reviewed and scrutinised at regular periods daily to ensure safe staffing levels are maintained at all times. This daily monitoring of nurse staffing levels ensures levels are operationally managed appropriately according to risk, taking into consideration the acuity and dependency of patients to ensure that all wards achieve safe staffing levels.

This process will be further enhanced following the implementation of the Allocate Health roster system and the introduction of the safe care module (see section 7.0).

A monthly compilation of this data for the entire Trusts wards is submitted on a monthly basis to NHS England.

Appendix 1 shows individual areas fill rates.

2.2 Care Hours per Patient Day (CHPPD)

In line with the updated NQB guidance, CHFT report monthly on CHPPD data. This metric has been created as a single means of measuring staff deployment and is a productivity tool considered by NHSI to be used by Trusts as one element of a multifaceted methodology for assessing safe staffing. This metric is included at Trust level in the monthly Integrated Performance Report Carter dashboard on a monthly basis to the Trust Board of Directors.

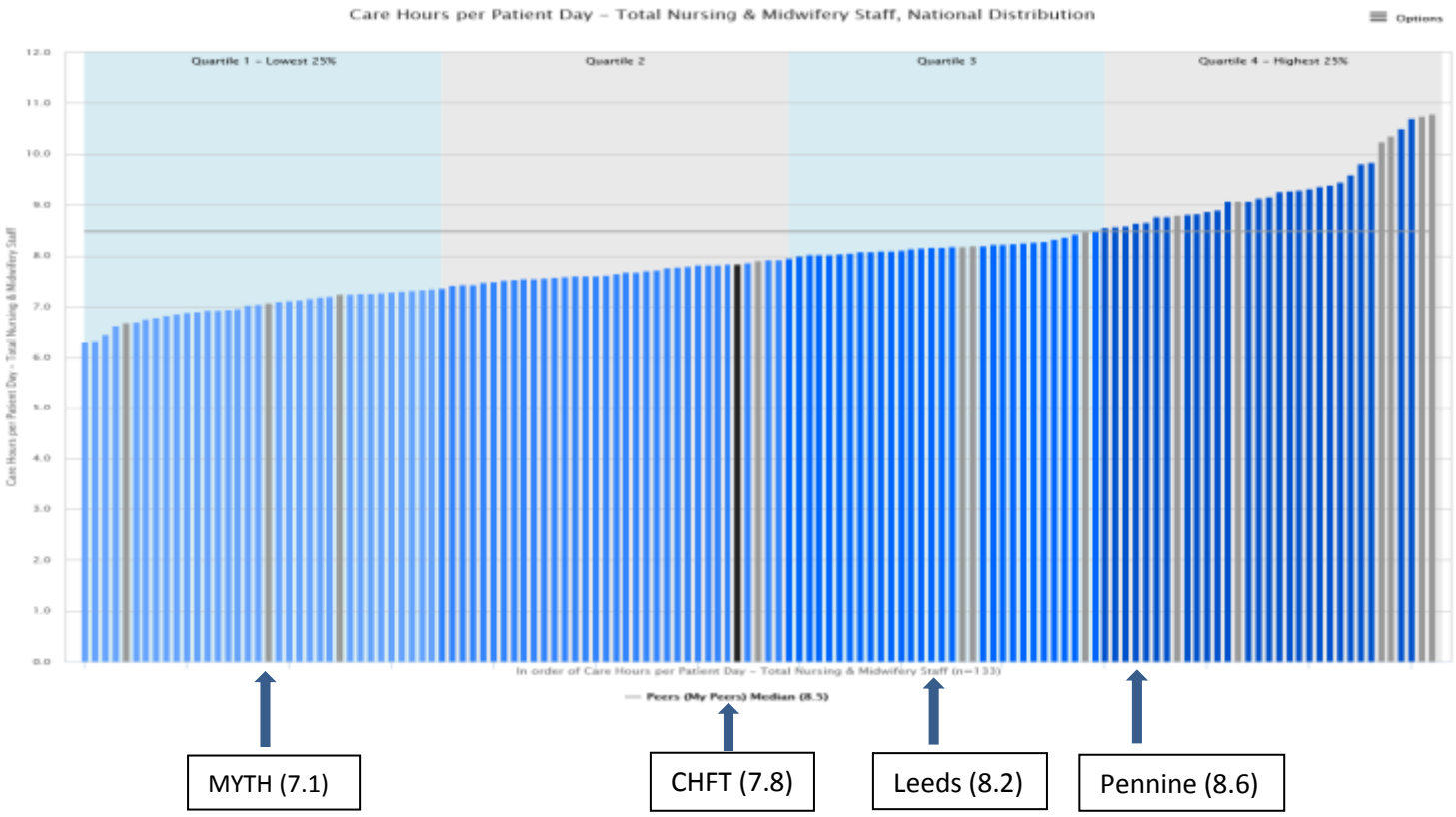
CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 hours by counts of patients at midnight)

Care Hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

Average CHPPD levels recorded at CHFT over the last four months have maintained between 7.5 and 7.9. CHPPD (see Appendix 1)

The table below details how CHFT's CHPPD levels compare with regional West Yorkshire Acute Trusts. CHFT currently sit on the median line, confirming that the staffing establishment is in line with national trends.

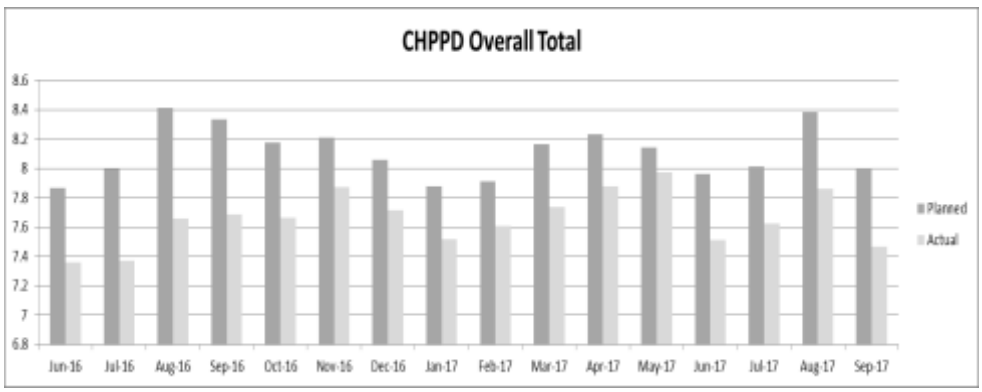
National CHPPD Data from the Model Hospital Portal October 2017



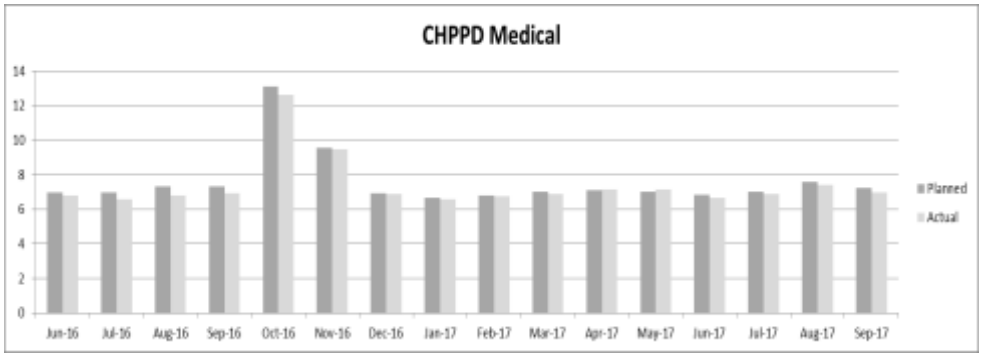
CHPPD data is reviewed and challenged monthly by the Nursing and Midwifery Workforce Steering Group and the divisional Associate Directors of Nursing. Data is not considered in isolation, but alongside local quality dashboards that include patient outcomes measured alongside workforce and financial indicators.

Overall the Trust has shown an improving picture in achieving planned CHPPD hours. The overall average is affected by an element of consistent over achievement within divisions. Interrogation of the data indicates that care hours greater than planned are due to increased patient acuity and dependency. The CHPPD Metric does not consider additional patient needs or workforce demands.

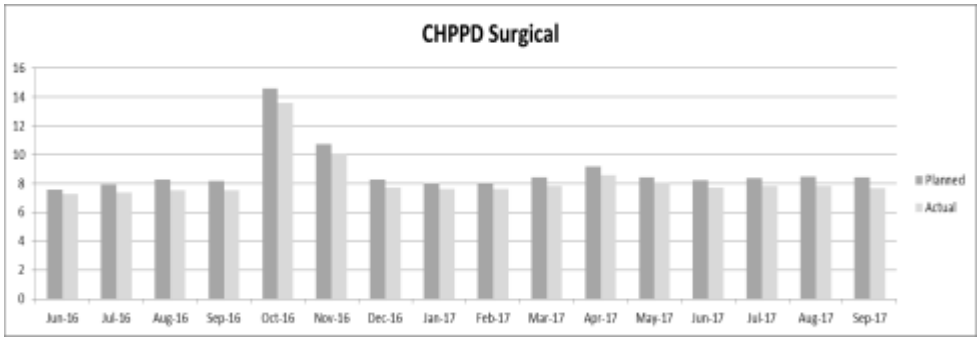
CHPPD Trust Level Data:



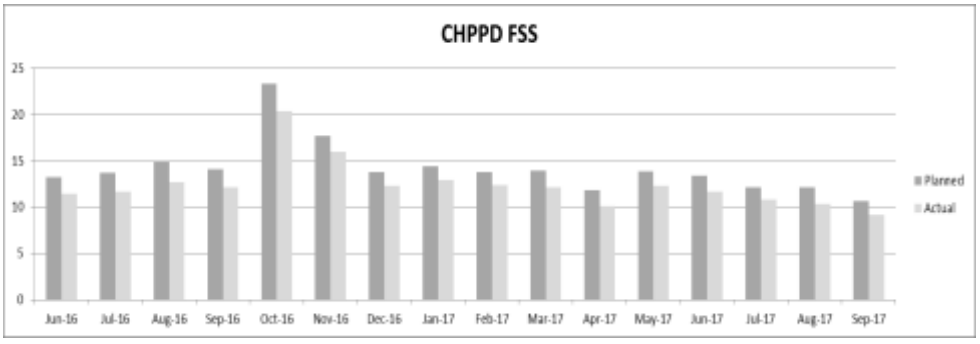
CHPPD Medical Division



CHPPD Surgical Division



CHPPD FSS Division



CHPPD methodology is applied to the nursing and midwifery workforce in three of the four clinical divisions. Nationally, CHPPD is not applied to community nursing provision. As the Trust transition into using the allocate and safe care soft wear the data and planned CHPPD requirement will be drawn factoring in acuity and dependency of patients as well as available staff on duty. This real time, sensitive data will allow the organisation to make informed staff deployment choices and improve workforce efficiencies.

2.3 Acuity and Dependency Studies

To support the recommended establishment reviews CHFT currently run bi-annual patient acuity and dependency studies. This data then influences discussions at the Safer Staffing Hard Truths review panels and enables divisions to factor in changing patient demand when setting establishment levels.

It is widely recognised that professional judgment should play a part in the process around safe staffing levels in conjunction with other methodologies. CHFT also consider the nurse-to-bed ratios, percentage skill mix, nurse quality indicators and take into account non-ward based activity.

Recognised and validated tools are used to review this measurement at CHFT. These includes the Safer Care Nursing Tool, Birth Rate Plus (Maternity Services), PANDA (Neonatal Services), Allocate Safe Care (based on the Safer Care Nursing Tool).

3.0 Nursing and Midwifery Workforce – Current Position

Vacancies

The Trust continues to seek to recruit to vacancies across the nursing establishments. Vacancies for Registered Nurses/Midwives have increased each month from May 2017, rising to 219 Whole Time Equivalent (WTE), confirmed from data reported via Electronic Staff Record (ESR) in August 2017. The vacancy rate for the Trust is currently 13.82%.

The Trust has undertaken a limited benchmarking exercise to ascertain its position in context and comparison to neighbouring organisations with regards to vacancy rates. Whilst limited this indicates a comparison against local and national Trusts facing similar challenges.

Vacancy rates in March 2017 – provided for comparison shared through AUKUH (Association of UK University Hospitals) network:

Trust	RN Vacancy Rate %
Central Manchester NHS FT	18.3
The Christie Hospital NHS FT	15.95
Great Ormond Street	20.64
Newcastle	11.8
Leeds Teaching Hospitals	13.4
MYTH	20
CHFT (November 2017 data)	13.82 (8.61% band 5)

Vacancy for non-registered nursing staff are reported from ESR (September 2017) as 39.42 WTE. Significant recruitment to the non-registered workforce has been completed. The development of a HCA “talent pool” has proved successful and coupled with the regular recruitment to clinical apprenticeships the Board of Directors can be assured of the timely recruitment of vacant HCA posts.

Absence rates have continued to reduce through focused attendance management across the clinical divisions. Turnover rates for both registered and unregistered nursing staff are improving. (See appendix 2)

3.1 Recruitment:

Recruitment to the nursing and Midwifery Workforce in 2017 is less than the levels achieved in 2016, although the retention of the workforce has slightly improved.

Oversees recruitment

As part of the strategy to increase stability in the nursing workforce and reduce the use of temporary workforce the Trust carried out an overseas recruitment project in March 2017. This has resulted in offers being made to 119 Philippine nurses, which will ensure we meet our target brief to recruit 75 nurses from this recruitment initiative.

The trajectory for the recruitment phase has been stalled by national policy around entry requirements. It is expected that 12 nurses will be in post by January 2018.

Recently recruitment within the European Economic Area (EEA) has become increasingly challenging due to the demand for nurses and the introduction of the International English Language Testing System (IELTS) requirement to obtain Nursing and Midwifery Council (NMC) registration. CHFT's planned level of Registered Nurse recruitment from the EEA has been lower than expected between January and September 2017 and noticeably less than 2016 – contributing to the lower recruitment level achieved overall.

The Trust is to meet with the current recruitment agent and Higher Education Institutes to determine if the recently released information from the NMC could strengthen its recruitment plans from the EU.

Domestic recruitment

Domestic recruitment of Registered Nurses remains a priority to the Trust. Two successful recruitment fairs have been hosted on site – resulting in the overall recruitment of 50 nurses. A further event took place in October 2017, and a further sixty offers of employment have been made to students qualifying in 2018.

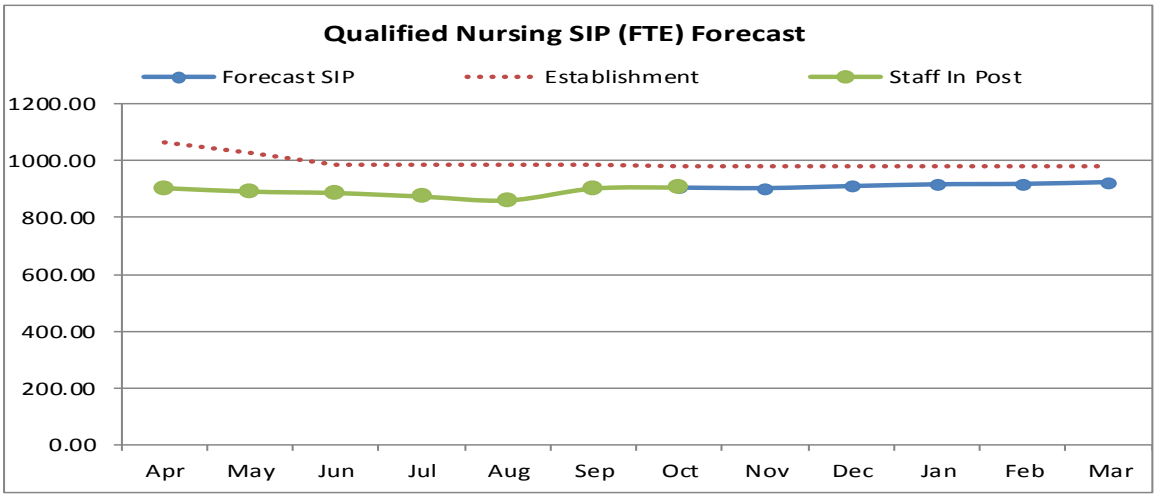
The Trust is also working closely with Huddersfield University to increase the capacity to host pre-registration nursing student within the organisation. This year on year sustainable increase will contribute to the number of local graduating nurses who can then be recruited by the organisation. The Trust is also working closely with the school of heath to increase the number of students recruited onto the nursing pre-registration 2 year MSC programme.

In addition, CHFT continues to work closely with Bradford University to facilitate the training of nurses wishing to return to Practice. Since September 2016 the Trust has offered candidates the opportunity to be employed as a Band 3 trainee whilst completing the programme of study at the university. Uptake for this programme remains low.

Future entry into the profession remains multifaceted in an attempt to meet the nationally recognised shortage of registered staff (Appendix 3)

The table below details the forecast of Band 5 Nursing staff expected in post supported by the recruitment trajectory from the listed initiatives:

Trajectory April 2017 – March 2018



3.2 Retention

To improve retention rates within the nursing workforce the clinical education team have developed a new preceptorship policy and document. This is in line with national frameworks and approved by Health Education England. The package is supported by a comprehensive induction to employment and an on-going year-long development programme. This is offered to all new registrants and staff new to the organisation.

Health Education England (HEE) recently reviewed best practice strategies for the retention of nurses within the current supply and demand challenges across England. Appendix 4 identifies key recommendations/best practice from this and maps CHFT's current position.

CHFT have contributed to NHSI's national retention programme. This focused programme of work assists provider Trusts with the development and implementation of improvement measures to support nurse retention, through the application of guidance and good practice. Further work on the retention of experienced and long service staff requires further development.

3.3 Workforce Modernisation

CHFT are also part of Health Education England's (HEE) national Nursing Associate (NAs) pilot scheme. The multi-site model is now operational with trainees having completed their first assessments. Recent government announcements support the continued investment in this role and the Nursing and Midwifery Council are in the process of applying regulation to this role.

Draft standards are currently out for public consultation. A proposal is being developed to up-scale the project in line with national and regional workforce plans. A future cohort could be in training by spring 2018.

Appendix 5 details the Nursing Associate role.

In addition, the Trust is working closely with Huddersfield University and HEE to appraise the apprenticeships route into nurse training. Ministerial approval of the pre-registration standards is due in November 2017. Once this is finalised, firm plans and a recruitment strategy can be put into place for September 2018 recruitment.

The Trust has also increased the number of Advanced Clinical Practitioners (ACP) roles to support innovations and modernisations of the clinical workforce.

4.0 Governance of the Nursing and Midwifery Workforce

In recognition of the current workforce challenge, the Nursing and Midwifery Workforce Steering group now works to a revised management structure.

The group which is led by the Chief Nurse will work to oversee a programme to deliver improved efficiencies and consistency of approach across Divisions. To develop this strategic work stream the Trust has secured the support of an external consultant, who has knowledge and experience in progressing this work with demonstrable impact and promoted as an exemplar by NHSI.

4.1 Revised structure of the Nursing Workforce Steering Group

Chief or Deputy Chief Nurse

QIA	Governance	Assurance
Risk management	Quality	Safety

Recruitment & Retention W/S Lead: C. North Clinical Lead: M.Bamforth	**Roster Management & Controls** W/S Lead: R. Hagreen Clinical Lead: J. Middleton	**Ward / Department Deep Dives** W/S Lead: R.Hagreen Clinical Lead: ADN's	**Safe Care (Health Roster)** W/S Lead: R. Hagreen/ A. Mooraby Clinical Lead: M. Bamforth	**Flexible workforce & Agency Management** W/S Lead: L. Cooper Clinical Lead: A.M. Henshaw

• RN 90 day plan
• Recruitment strategy
• Vacancy management
• Overseas strategy
• Apprenticeship
• Retention strategy
• Alternative recruitment and initiatives
• Marketing methods
• Trajectory reporting
• Bank recruitment
	• Roster Policy review and compliance
	• Dashboard performance reviews
	• Template lockdown and management
	• Standard Operating Procedures
	• Refresh training plan
	• Flexible working reporting
	• HCA – Virtual ward
	• Forward view planning
	• Night team
	• Overtime
		• Shift review
		• Establishment review
		• Roster template review
		• Flexible working review
		• Template lockdown
		• Ward action planning
		• Bespoke training requirements
		• Reporting
			• Roll-out plan
			• Training
			• Reporting
			• Communication
			  ○ Matrons
			  ○ Ward Sisters
			  ○ Charge Nurses
			• Night team / site co
			• Governance
				• Agency average hourly rate reduction
				• Bank fill rate increase
				• Agency tiering cascade standardised
				• Agency performance management
				• Revised bank rates
				• Revised agency standardised rates
				• Booking controls
				• NHSI & Trust reporting
				• Electronic invoicing

An overview of the key areas of immediate focus to reduce the reliance on nursing agency usage is as follows:

a) **Registered Nurse bank:** The delivery of an improved shift fill rate of CHFT substantive bank and bank only staff. Enhanced rates (incorporating weekly pay) have been implemented from the 1st of October 2017. *As of the 20th October an increase of 125 shifts worked is reported when compared to the whole of September 2017 demonstrating the impact of the change.*

b) **Agency Management and performance:** The delivery of a reduction of average hourly agency rates and NHSI cap breaches: The Trust is seeking to reduce the volume and value of nursing agency spends.

- Allocate bank system review of current working and improvements with cascade of shifts to improve fill rates
- A revised Flexible Workforce draft report has been completed for Nursing. This shortened more detailed report which will track progress across all elements of bank and agency performance includes NHSi breaches and variable pay spends.
- Implement innovative approaches to working with agencies to both improve fill rate at cap rates and to reduce hourly costs

c) **Roster management and controls - Ward/Department deep dives:**
To provide gap analysis and action planning for Trust wide consistent rostering management and controls

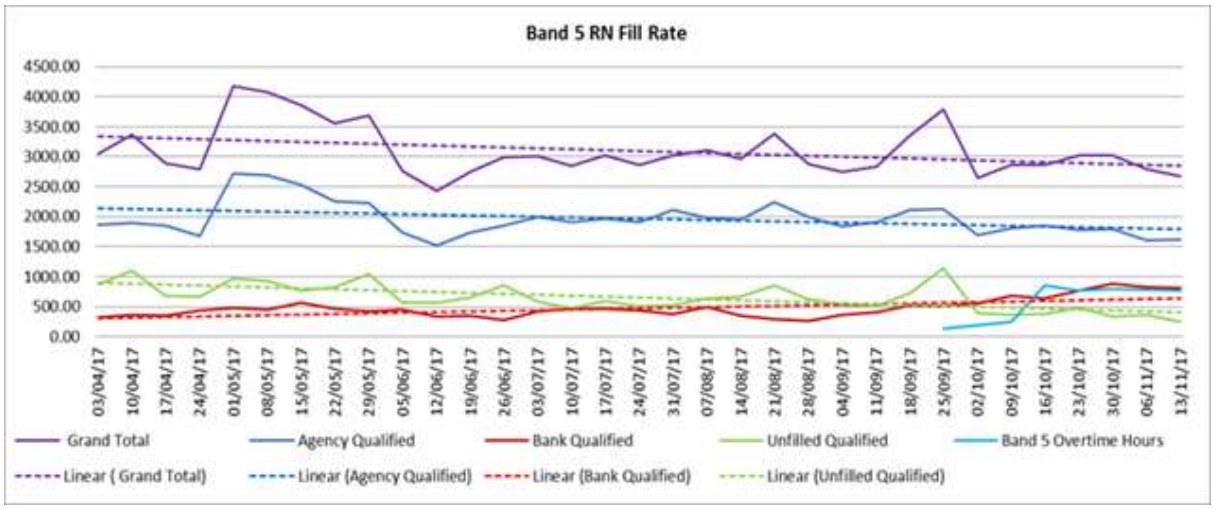
- A revised deep dive template which builds a profile of individual wards/departments has been completed
- An overall plan for Medicine has been approved with 14 deep dives completed to date, each having a comprehensive action log agreed between the Ward Manager and Health Roster lead
- The information creates ward based and generic actions which also identify training gaps for future refresh training plans
- Other Divisions and areas will be completed by priority.
- Roster policy review and compliance
- Refresh training plans
- Enhanced standard operating procedures

d) **Health Care Assistants – Enhanced care Team:**
As part of our dementia strategy and ambition to provide outstanding compassionate care we have introduced a new peripatetic team of Enhanced Care Assistants.

Improved enhanced care (sometimes called 1-1 or specialling) arrangements help deliver more consistent, patient-centred care and allow for greater involvement of patient's relatives and carers. Examples nationally have also seen reductions in the use of bank and agency spend and is now referenced within the Carter work stream. The steering group will review and identify key actions for further improvement and revised reporting

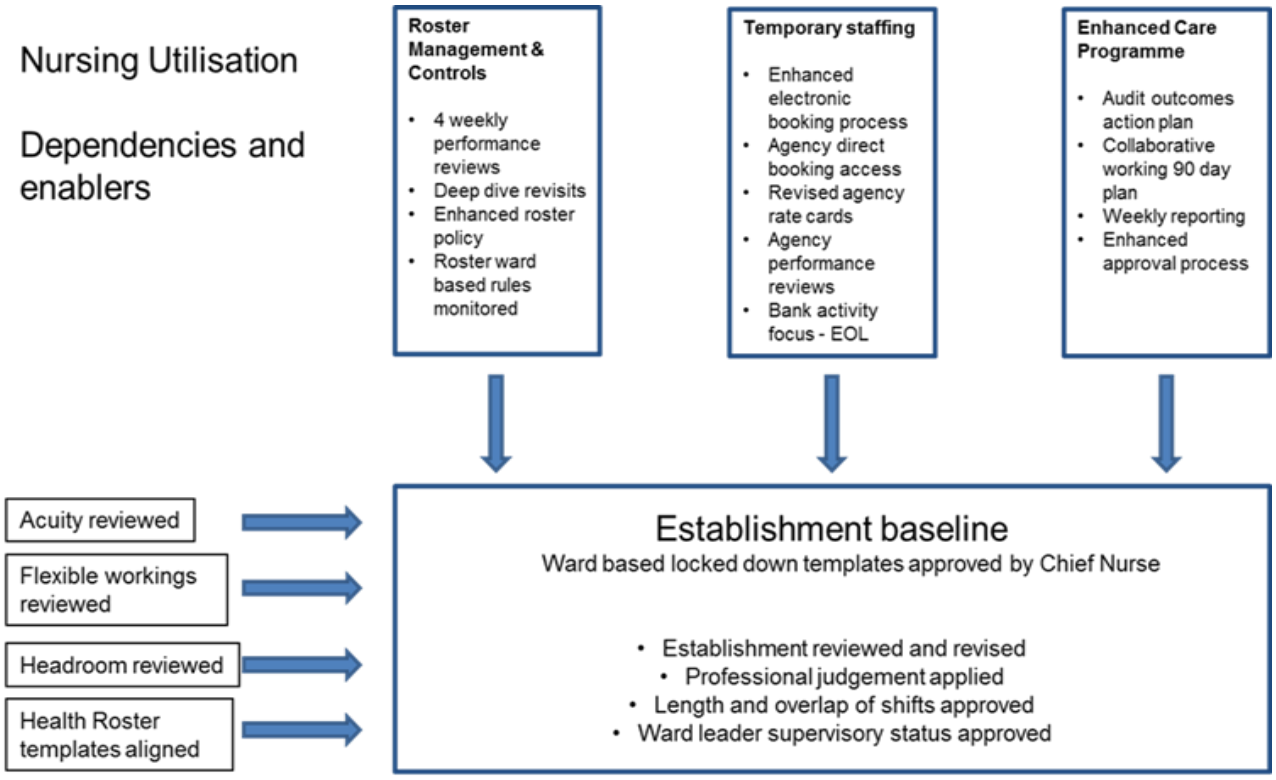
4.2 Impact

The following table indicates that through the above initiatives, Registered Nurse Band 5 bank fill hours are increasing and agency fill is reducing. At present the fluctuation in increased demand is being filled predominantly with bank. Current information suggests that the organisation is replacing Agency Fill with Bank and in general, additional demand requests and reduction in unfilled hours are also being filled predominantly by Bank staff.



This indicates how the combined processes will improve nursing utilisation and ultimately efficiencies.

4.3 Impact of Nursing Workforce work streams



5.0 Rostering

The Executive Board committed to the replacement of the e-rostering system with Allocate to continue to support effective roster management but with the added benefit of the safe care module.

The objectives of the implementation of Allocate Health Roster, Bank Staff and Safe Care include:

- Improved service delivery and clinical safety - right people, right place, right time
- Improved productivity and utilisation of substantive and temporary staff - significant financial saving on Bank and Agency spend
- Reduction in avoidable costs - the drive to control expenditure
- Improved payroll accuracy - reduction in unnecessary overtime payments and enhancement errors
- Improved leave management
- Reduced sickness levels
- Improved rostering practice and access to rosters - increased roster efficiency
- Reduction in administration tasks and functions
- Improved leave management
- Improved reporting
- Improved workforce planning.

Health Roster Safe Care functionality will allow CHFT to understand in further detail the wards staffing levels in relation to patient numbers and patient acuity and dependency.

The next phase of the project is to implement the “safe care module” across all clinical departments within the organisation. The Trust will then start to review data from Safe Care and use it operationally, in order to better understand trends in patient acuity, dependency and staffing level data. This will further inform the continued review and deployment of the workforce.

6.0 Nursing Workforce Review Panels

In February 2017 all nursing workforce models were reviewed using the nursing workforce model review panel which was introduced in October 2015. This ensured a consistent approach was utilised across each division to complete the reviews using standardised templates and guidance. The process will be repeated through the 2017/18 workforce review process and be aligned to strategic workforce and business planning.

Workforce review Updates

Medicine:
Interim WFM were developed and implemented within the division in March 2017.The interim models were developed to support care delivery whilst maintaining a focus on recruitment into vacant nurse posts across the division. It is intended that once recruitment into vacant posts are realised the interim models will discontinue.

The interim WFM recognise areas of pressure from activity and were supported by the findings from the November 2016 acuity & dependency studies. The models have improved the overall CHPPD and stability within the division.

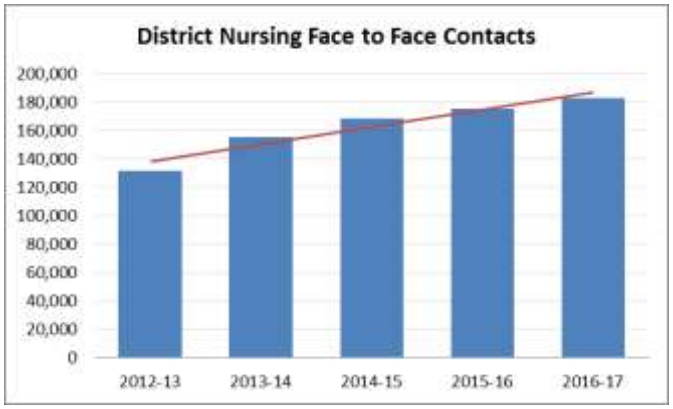
The proposal was supported by the development of x4 WTE Band 6 clinical educators. The clinical educators have a focus on training and clinical support for the new graduate workforce within the division and the expected overseas nurses from Q4.

Surgery:
Critical care – The panel support the investment of 3.37 WTE Band 5RN's into the department to meet D16 guidance. These shifts have been built into the current WFM. However due to a level of vacancy these are not always filled. The Team are actively recruiting to fill their vacancies and once this is achieved the prefer model will be worked to

The panel also supported the revised WFM within budget to enable a twilight shift on wards 3, 10 and 15. These posts have now been filled and the clinical teams report a positive impact on care provision. A further impact has been the reduction in the number of enhanced care shifts requested above WFM.

Community:
No investment/disinvestment was requested at the hard Truths staffing review in Feb 2017 for the Community Division.

However, in the context of care delivery the District Nursing service has demonstrated an annual upward trend in face to face patient contacts over the last five years. In spite of this the total clinical workforce has remained largely the same.



Despite the complexities of Community Nursing CHFT has begun to develop approaches to describe the elements of the service and its current demand. Based on the work already underway locally and drawing from the NQB guidance the community division is to:

1) Continue to work with the corporate nursing team to develop a workforce model for community services
2) Explore the options for a community focused eRostering tool.
3) Build on the current work stream demonstrating more objectively the impact of demand upon the service
4) Thread the nine characteristics of good quality care in district nursing to ensure that quality and patient experience are central to care delivery
5) Reappraise the locality approach
6) Review the care closer to home specification to "tease out" the detail of district nursing services
7) Systems leadership

8) Work closely with the corporate education team and local HEI to increase student capacity within the community sector and showcase the career opportunities of community nursing for the future workforce

This work will be presented in full as part of the 18/19 workforce planning Hard Truths process and will be reported on in the subsequent Board reports

FSS:
The panel supported the recommended realignment of maternity inpatient services. The proposed change would have resulted in the disinvestment of x1WTE band 6 and x1WTE MSW due to skill mix realisation. The proposed disinvestment was to be managed via vacancy and will be released in Q4.

Labour and Maternity Assessment Centre:

The role of the band 7 co-ordinator was to be monitored/reviewed to mitigate against the removal of the supervisor of midwifes role. There has been no reported impact since the changes came into effect. The two Band 7 coordinators have managed complex situations extremely well. There have been regular team meetings to review the situation.

NICU:

The panel supported the recommended disinvestment of x2WTE band 5 posts. The post were in cost centre but not needed to maintain badger shift fill on occupancy levels. These positions have now been released.

7.0 Non ward based reviews

The Trust has begun a systematic review of all non-ward based registered nurses across the four clinical divisions. The aim is to confirm funding, identify clinical synergies with operational and management structures alongside role titles and functions, and to ensure all registered nurses have updated, current job plans with clear roles and responsibilities aligned to effective management structures to support care delivery.

The initial reviews have indicated commonalities across the divisions. There was variable assurance across the services in regards to governance structures to support non ward based teams. This has been addressed and clearly defined processes put in place to ensure appropriate supervision and governance arrangements. The divisions have reported an upward trend in activity and caseload within some services. A resulting impact has been additional administration duties. This will be addressed through current work being undertaken by the HR team, mapping capacity and demand.

It is intended that once completed this work will inform future requirements for non-ward based registered nurses and ensure that there are succession planning process in place to support this.

8.0 Financial Position

The current position is projecting a year end forecast that is higher than planned. Agency demand for registered nurses needs to continually reduce; both from a patient safety and variable pay spend perspective. Whilst CHFT have observed an increase within the substantive Nursing

Workforce, we have remained reliant on agency nurses to meet safe staffing levels in the absence of sufficient substantive supply.

As at Month 7:	Year to Date							Forecast						
	Qualified nursing, midwifery and health visiting staff plus nursing support pay Expenditure							Qualified nursing, midwifery and health visiting staff plus nursing support pay Expenditure						
	M7 YTD Budget	M7 YTD Actual					M7 YTD Variance	17/18 Budget	17/18 Year End Forecast					Year End Forecast Variance
	Total Budget	Total Actual	Substantive Pay	Agency	Bank	Overtime /Add Basic Pay/Ext Sessions		Total Budget	Total Forecast	Substantive Pay	Agency	Bank	Overtime /Add Basic Pay/Ext Sessions	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
E_999935:MEDICAL DIVISION	19.67	21.94	17.19	3.00	1.16	0.58	2.27	33.11	35.47	28.01	4.44	2.12	0.91	2.36
E_999940:SURGERY & ANAESTHETICS	14.40	14.35	12.91	0.76	0.31	0.37	-0.05	24.57	24.68	22.14	1.28	0.65	0.60	0.11
E_999915:FAMILIES & SPECIALIST SERVICES	12.37	12.20	11.83	0.03	0.22	0.12	-0.17	21.17	20.93	20.27	0.06	0.43	0.16	-0.24
E_999945:COMMUNITY DIVISION	5.50	5.38	5.24	0.00	0.05	0.08	-0.12	8.96	8.81	8.55	0.02	0.10	0.14	-0.15
E_999925:ESTATES & FACILITIES	-0.06	0.00	0.00	0.00	0.00	0.00	0.06	-0.10	-0.02	-0.02	0.00	0.00		0.08
E_999910:CORPORATE SERVICES	2.64	2.67	2.53	0.09	0.03	0.02	0.03	4.54	4.42	4.21	0.09	0.07	0.04	-0.13
E_999904: CENTRAL INCOME	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00					0.00
E_999900:CENTRAL & TECHNICAL	0.00	0.07	0.02	0.04	0.01	0.00	0.07	0.00	0.07	0.02	0.04	0.01	0.00	0.07
E_999930:HEALTH INFORMATICS	0.00	0.03	0.03	0.00	0.00	0.00	0.03	0.00	0.06	0.06		0.00	0.00	0.07
E_999955:PMU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00					0.00
E_999906:RECHARGES	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00		0.00
E_999908:TRUST RESERVES	-0.16	0.02	0.02	0.00	0.00	0.00	0.18	-0.31	0.02	0.02				0.33
TRUST TOTAL	**54.37**	**56.66**	**49.78**	**3.93**	**1.78**	**1.18**	**2.30**	**91.94**	**94.43**	**83.27**	**5.93**	**3.37**	**1.86**	**2.49**
check		0.00	0.0						0.00	0.00				

8.1 Nursing Investment/Disinvestment:

The following table indicates the investments/disinvestments within the nursing workforce made by the clinical divisions through the "Hard Truths" process over the last three year. There has been minimal investment into ward establishment's levels over the last 2 years.

The Trusts cost per Weighted Activity Unit (WAU) for medical staffing are below the National median and may reflect the Trusts investment in specialist nursing roles, offsetting medical costs. The Trusts costs per WAU for combined medical and nursing staff are comparative to regional and national statistics (data sourced from the Model Hospital portal).

Division	Year	Investment (£000's)	Dis Investment (£000's)	Comment:
FSS	2015	0	0	• WFM's introduced. • No investment/Disinvestment. • Establishment changes made within current budget
Surgery	2015	70	166	• Investment of £70k to support additional band 2 on ward 15. • Introduction of the Head Nurse role. • The division re-modelled its long day to short day ratios – disinvesting £166k • Overall disinvestment of £96k
Medicine	2015	966	184	• Disinvested £184k due to long day/short day review of shift patterns • Invested £966k into the nursing establishment • Overall investment of £782k
FSS	2016	161	0	• Invested into the establishment on ward 3
Surgery	2016	0	0	• No investment/disinvestment made

Medicine	2016	527	0	• £527k invested into nursing (non-ward based roles)
FSS	2017	0	257	• Due to service re-modelling
Surgery	2017	5	0	• Other establishment changes made within current budget
Medicine	2017	0	0	• Interim WFM from April 2017

In recognising the Trust's reliance on nursing agency the Trust has made a number of investments to support and reduce the cost of the nursing workforce. The key areas of investment are:

- 2017/18 Peripatetic Nurses - £500k
- Enhancement to Bank pay by 20% (trial for 6 months) from 1 October 2017
- Investment in a replacement e-Rostering system (Allocate) - £370k (roll out to other staff groups planned)
- Overseas recruitment planned expenditure (planned expenditure in 2017/18) - £650k; however this has been stalled by national policy around entry requirements.
- Flexible Workforce Team investment to improve bank utilisation and reduce agency - £310k

9.0 Next Steps

External review of the nursing and midwifery workforce

To ensure quality assurance of staffing at CHFT, the Chief Nurse/ Deputy Chief Executive has commissioned an assurance review of its nursing and midwifery workforce, and requested NHS Improvement, Director of Nursing colleagues and representatives from neighbouring Trusts and commissioning services undertake a review of the organisations existing staffing establishments.

Methodology will include:

1. Review of work undertaken to date
2. Review of evidence submitted by CHFT
3. Site tour and ward visits
4. Focus group interviews with Nursing and Midwifery staff and leaders.

10. Conclusion

There remains significant risk to the workforce due to the national shortage of qualified staff and recent level of vacancies, therefore sustainable recruitment and retention to the nursing workforce remains a priority. The Board of Directors is asked to receive this paper as assurance of the continued and vigorous scrutiny and management of the Nursing and Midwifery workforce agenda in response to this growing challenge.

Over the coming months, the Trust will need to adopt any further guidance issued by NHS Improvement and continue to strive to make further efficiencies, whilst maintain safe staffing levels and high quality patient outcomes.

This 6 monthly review provides assurances to the Board of Directors that the Trust is sustaining the Nursing and Midwifery workforce and that workforce models have been reviewed, scrutinised and challenged. This will be further strengthened through the external review that has been commissioned, and reported through to the Board of Directors.

STAFFING - CHPPD & FILL RATES (QUALIFIED STAFF)

	Total CHPPD (Qual)				Fill Rates Day (Qual)		Fill Rates Night (Qual)		Current Vacancy Snapshot - Nov 17		Sep-17				Oct-17			
	Sep-17		Oct-17		Sep-17	Oct-17	Sep-17	Oct-17	RN Vacancy (Band 5)	HCA Vacancy (band 3&2)	Cdiff	MRSA	Pressure Ulcer (Month Behind)	Falls	Cdiff	MRSA	Pressure Ulcer (Month Behind)	Falls
	PLANNED	ACTUAL	PLANNED	ACTUAL														
CRH MAU	10.4	9.9	9.2	9.1	88.0%	92.3%	105.3%	108.6%	-4.55	-1.83				10				4
HRI MAU	5.7	5.8	6.7	6.4	90.9%	95.2%	116.4%	98.7%	-2.09	+3.99			1	2			1	11
WARD 2AB	3.9	3.5	4.0	3.5	80.7%	80.4%	98.9%	99.2%	-8.64	-1		1	3	2			1	11
HRI Ward 5	3.2	2.8	3.2	2.9	82.3%	84.6%	97.0%	98.9%	-2.99	0			1	6			0	5
HRI Ward 11	3.8	3.2	3.9	3.7	81.1%	91.6%	95.0%	99.2%	-1.86	0			1	6	1		5	4
WARD 5AD	3.7	3.0	3.2	2.7	76.6%	78.2%	89.2%	93.8%	-2.45	+1.69	1			3				8
WARD 5C	3.4	3.3	3.5	3.4	96.9%	96.3%	98.3%	100.0%	-4.28	+1.48			1	5			1	6
WARD 6	5.4	5.1	4.5	4.4	91.3%	94.1%	95.3%	100.0%	-1.86	-2				5				4
WARD 6BC	3.8	3.7	3.2	3.2	94.4%	98.4%	100.8%	99.2%	-4.62	+2.71				7				5
WARD 5B	3.3	2.7	3.3	2.8	74.9%	77.4%	96.7%	96.8%	-	-				4			2	4
WARD 6A	3.3	2.9	3.3	2.9	80.2%	82.0%	100.0%	100.0%	-3.7	-1.03				8				8
WARD CCU	9.9	8.6	10.0	8.9	82.4%	82.7%	95.6%	97.4%	-2.1	0				3				1
WARD 6D	7.3	5.8	20.9	17.2	72.2%	73.6%	90.0%	96.8%	-	-			1	3				5
WARD 7AD	3.5	3.2	3.7	3.4	85.8%	86.9%	100.0%	102.2%	+8	+10				3				5
WARD 7BC	7.5	4.4	4.8	3.4	53.6%	64.8%	67.8%	79.6%	-8.21	0				2			2	1
WARD 8	3.2	2.4	3.2	2.7	78.4%	84.9%	66.7%	86.0%	-3.11	+0.64			4	10			1	3
WARD 12	4.1	3.2	4.3	3.1	78.2%	72.3%	77.8%	74.2%	+0.7	0			1	2			1	3
WARD 17	3.6	2.8	3.7	3.2	69.5%	77.9%	92.4%	97.0%	-1.79	0				1			1	
WARD 21	2.6	2.1	3.0	2.4	69.4%	67.2%	100.0%	100.0%	-3.01	-2				7			2	3
ICU	45.2	36.6	46.3	34.3	84.7%	78.4%	77.4%	70.4%	+0.86	+0.22			1					
WARD 3	3.8	3.7	3.8	3.8	95.8%	99.7%	100.0%	100.0%	-0.46	0		1	2	9			2	5
WARD 8AB	6.0	4.4	7.1	5.2	80.9%	80.4%	65.4%	64.2%	-2.57	+0.19			1	2				3
WARD 8D	5.7	5.1	5.4	4.8	101.7%	99.8%	76.7%	74.2%	-2.87	+0.77				1				2
WARD 10	4.0	3.1	4.1	3.3	88.3%	90.5%	66.6%	66.7%	-6.59	+0.67				1				2
WARD 15	3.3	2.8	3.3	3.4	88.1%	105.7%	76.7%	101.1%	-1.66	0		1	2					1
WARD 19	4.7	3.9	4.2	3.9	76.7%	86.8%	95.4%	97.8%	-0.93	+3			1	5			3	11
WARD 20	3.7	3.1	3.7	3.1	76.1%	77.3%	98.9%	100.0%	-4.83	-3.8				8				13
WARD 22	2.9	2.8	2.8	2.7	94.9%	96.4%	100.0%	100.0%	+0.55	-2			1	6				
SAU HRI	6.0	5.3	7.5	6.8	80.2%	83.5%	99.5%	100.0%	-4.36	+1.3	1		2	1				2
WARD LDRP	16.3	13.8	15.5	13.4	84.8%	87.7%	85.3%	85.0%	+1.07	-3.56								
WARD NICU	10.2	8.8	7.6	7.1	87.8%	93.7%	85.0%	93.0%	-1.86 RN, -1.00RM	-1.30								
WARD 1D	3.0	2.8	3.1	3.0	90.5%	90.8%	100.0%	100.0%	-1.75	0								
WARD 3ABCD	9.4	7.9	7.3	6.8	77.3%	91.3%	92.2%	96.4%	0	-1.37								
WARD 4C	4.7	4.7	5.3	5.3	98.3%	100.0%	100.0%	98.4%	-1.65	0				3				
WARD 9	3.7	3.6	3.8	3.6	93.0%	90.6%	100.0%	100.0%	+1.79	+1.49								
WARD 18	22.4	20.8	18.6	17.5	91.0%	91.6%	95.0%	97.5%	0	-1.37								
Trust	**5.2**	**4.5**	**5.1**	**4.5**	**82.77%**	**86.08%**	**90.01%**	**91.59%**										

APPENDIX 2

Workforce Turnover and Absence Rates

Table 1& 2: Turnover

Qualified Nurse Turnover	2017 / 01	2017 / 02	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09
Turnover Rate (FTE)	0.44%	0.86%	0.70%	1.50%	1.10%	3.23%	1.13%	0.74%	0.44%
Turnover Rate FTE (12m)	13.21%	13.04%	11.92%	12.10%	12.02%	14.45%	14.13%	13.64%	13.10%

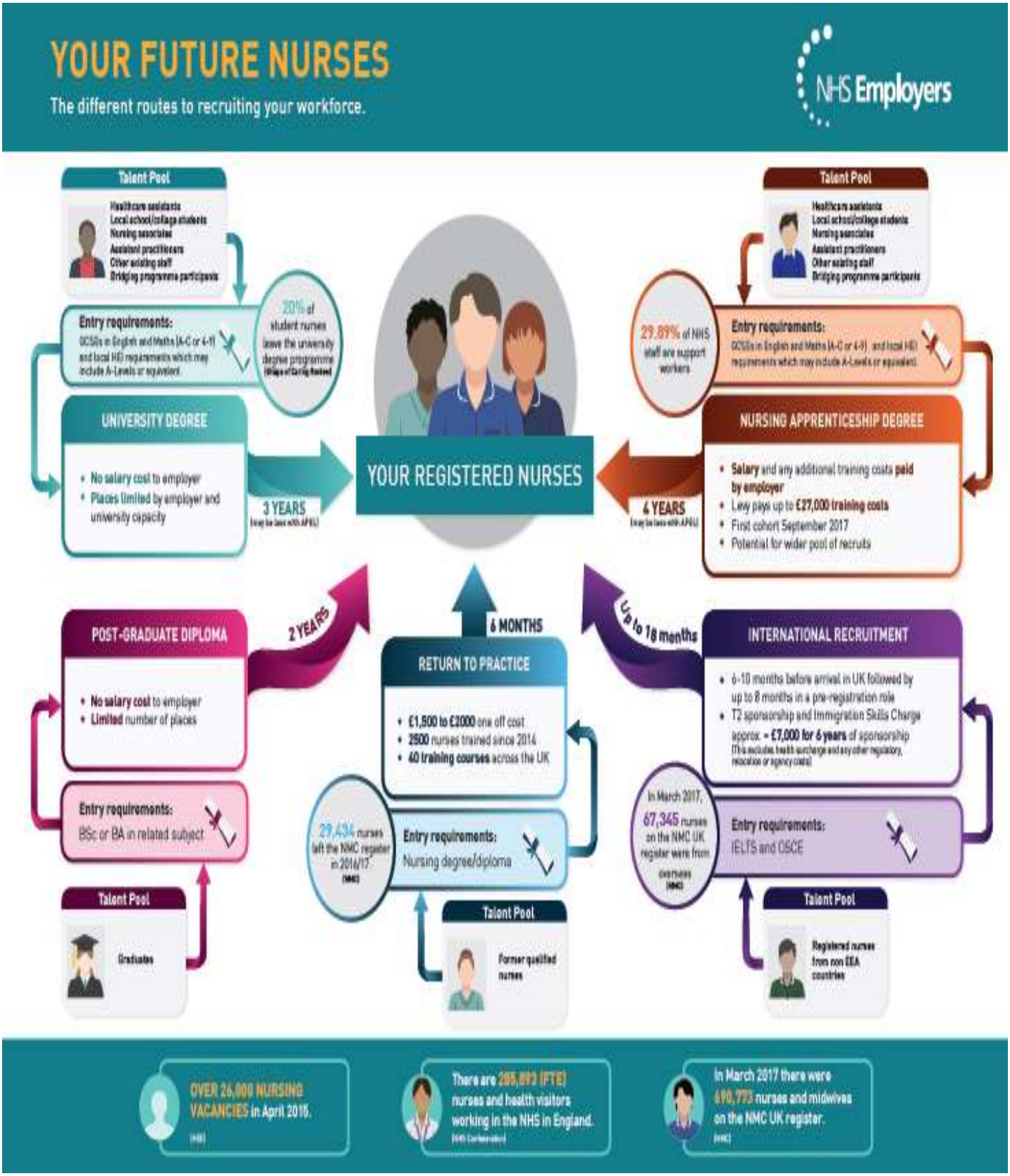
Unqualified Nurse Turnover	2017 / 01	2017 / 02	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09
Turnover Rate (FTE)	0.61%	0.90%	0.32%	1.31%	0.67%	3.16%	0.84%	0.58%	0.37%
Turnover Rate FTE (12m)	9.91%	9.96%	8.70%	9.65%	9.50%	11.99%	12.08%	12.06%	10.94%

Table 3 & 4: Absence levels

Nursing & Midwifery									
Division	2017 / 01	2017 / 02	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09
372 Community L3	3.11%	2.73%	3.66%	4.62%	3.88%	3.47%	2.67%	3.39%	1.91%
372 Corporate L3	3.57%	3.53%	5.76%	3.52%	2.42%	0.81%	0.98%	2.35%	1.09%
372 Families & Specialist Services L3	4.41%	4.05%	4.17%	3.49%	4.44%	4.62%	3.84%	3.90%	2.07%
372 Health Informatics L3									
372 Medical L3	5.18%	5.01%	3.84%	3.93%	3.63%	5.00%	5.05%	5.09%	3.59%
372 Surgery & Anaesthetics L3	5.40%	5.08%	3.35%	3.04%	3.25%	4.99%	5.07%	4.01%	3.53%
Grand Total	**4.68%**	**4.41%**	**3.86%**	**3.68%**	**3.71%**	**4.51%**	**4.28%**	**4.18%**	**2.89 %**

Unqualified									
Division	2017 / 01	2017 / 02	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09
372 Community L3	11.41%	7.95%	5.86%	3.57%	6.69%	7.18%	2.35%	2.18%	2.04%
372 Corporate L3	8.99%	6.08%	1.58%	1.05%	0.94%	4.41%		3.23%	
372 Families & Specialist Services L3	9.59%	7.44%	7.48%	3.65%	6.26%	4.68%	3.86%	2.80%	0.40%
372 Medical L3	6.99%	7.01%	6.66%	6.50%	6.01%	5.67%	6.16%	5.82%	4.22%
372 Surgery & Anaesthetics L3	5.86%	4.91%	5.61%	4.90%	4.92%	5.65%	3.86%	4.57%	2.68%
Grand Total	**7.41%**	**6.48%**	**6.37%**	**5.34%**	**5.66%**	**5.61%**	**4.86%**	**4.86%**	**3.30 %**

APPENDIX 3


YOUR FUTURE NURSES
The different routes to recruiting your workforce.
NHS Employers
Talent Pool
Healthcare assistants
Local school/college students
Nursing associates
Assistant practitioners
Other existing staff
Bridging programme participants
Entry requirements:
GCSEs in English and Maths (A-C or 4-9) and local HEI requirements which may include A-Levels or equivalent.
20% of student nurses leave the university degree programme
UNIVERSITY DEGREE
• No salary cost to employer
• Places limited by employer and university capacity
3 YEARS
YOUR REGISTERED NURSES
Talent Pool
Healthcare assistants
Local school/college students
Nursing associates
Assistant practitioners
Other existing staff
Bridging programme participants
29.89% of NHS staff are support workers
Entry requirements:
GCSEs in English and Maths (A-C or 4-9) and local HEI requirements which may include A-Levels or equivalent.
NURSING APPRENTICESHIP DEGREE
• Salary and any additional training costs paid by employer
• Levy pays up to £27,000 training costs
• First cohort September 2017
• Potential for wider pool of recruits
4 YEARS
POST-GRADUATE DIPLOMA
• No salary cost to employer
• Limited number of places
2 YEARS
Entry requirements:
BSc or BA in related subject
Talent Pool
Graduates
6 MONTHS
RETURN TO PRACTICE
• £1,500 to £2000 one off cost
• 2500 nurses trained since 2014
• 40 training courses across the UK
29,434 nurses left the NMC register in 2016/17
Entry requirements:
Nursing degree/diploma
Talent Pool
Former qualified nurses
Up to 18 months
INTERNATIONAL RECRUITMENT
• 6-10 months before arrival in UK followed by up to 8 months in a pre-registration role
• T2 sponsorship and Immigration Skills Charge approx. = £7,000 for 6 years of sponsorship
(This excludes health surcharge and any other regulatory, relocation or agency costs)
In March 2017, 67,345 nurses on the NMC UK register were from overseas
Entry requirements:
IELTS and OSCE
Talent Pool
Registered nurses from non EEA countries
OVER 26,000 NURSING VACANCIES in April 2016.
There are 285,893 (FTE) nurses and health visitors working in the NHS in England.
In March 2017 there were 690,773 nurses and midwives on the NMC UK register.

APPENDIX 4

Health Education England (HEE) recently reviewed best practice strategies for the retention of nurses within the current supply and demand challenges across England.

Table 1 Identifies key recommendations / Best Practice from HEE and current practice at CHFT. Proposed actions are also included.

Table 1: Gap Analysis: Best Practice / Current CHFT Practice

Best Practice	Current CHFT Practice	Proposed Action	Date to be Completed By
Development of clear career structure from Band 5 upwards, including advanced roles, with development opportunities to support.	Competency programme developed – not fully integrated	Review the competency programme & align it to the new pre-registration nursing standards	September 2018
Provision of robust preceptorship for new registrants to support their transition to practice.	Preceptorship programme (12 months commenced Sept 15) Preceptorship database commenced Dec 15 Web based preceptorship training available (minimal uptake)	Evaluate and recommend format for 16/17 Develop reports from database to utilise data and present updates at Nursing and midwifery committee Promotion of role of preceptor and training	Completed – new document in use Completed
Opportunity for flexible working including retire and return, phased retirement options and part time working options	Flexible working available including part time hours and variety of shifts Phased retire and return options in place	Promote and assist ward managers use flexible approach whilst maintaining safe base	Continuing work
Completion of in-depth exit interviews at an early stage following resignation to explore any potential solutions	Increased focus on exit interviews to by monitored closely by divisional teams	Consider education for ward managers in completing interviews and identifying solutions	July 18
Availability of “fast-track” pre-registration	Work with HEE & NMC on role developments:	Review development role and monitor progression	Monthly review

programmes for healthcare workers who have experience and previous academic qualifications	• Nursing Associate • Degree Apprenticeships	within nursing strategy group	
Development of leadership at all levels	Preceptorship programme Band 7 & 8 Leadership & development programmes	Review implementation against guidance	Programmes currently being delivered.
Introduction of Mentor / clinical supervision to support RN	Clinical supervision available in some areas of workforce. To review the guidance & implement into the full nursing workforce	Review implementation against guidance	Ongoing
Promotion of work / life balance, including health promotion, employee counselling and stress management	OH team have programme of events and resources addressing promotion of work life balance and providing counselling and stress management	Promotion of availability to be considered Inclusion of benefits at recruitment events to be considered	Ongoing Completed
Implementation of safe staffing levels in areas of high acuity to ensure RN do not have an unacceptable workload	Monitoring and review of safe staffing levels completed and reviewed by senior nurse x 3 per 24 hours as a minimum to ensure risks mitigated. Focused recruitment continues. Divisional review of areas of concern with divisional plan to mitigate risks completed	Promotion of acuity results. Feedback to nurses on the process and outcome of "hard truths" reviews Training for site co to ensure use of daily safe care module alongside rostering system Consider moving staff within defined areas to ensure expertise	Ongoing Ongoing Dec 2017 Ongoing

APPENDIX 5

Nursing Associate Partnership
Calderdale Kirklees Wakefield Pilot Group

1.0 Introduction

CHFT were successful in their bid to Health Education England (HEE) to be part of the national Nursing Associate Test site pilot scheme launched in April 2017. CHFT are lead partners in this multi-site model working towards modernisation of the nursing workforce.

The Nursing Associate role is a key part of the national workforce transformation required to build the nursing workforce for the future. The role will:

- ✓ **Create a defined title** and competence framework for a key section of the support workforce.
- ✓ **Build the capacity and capability of the health and social care workforce** to care for service users across different settings, particularly out of hospital
- ✓ **Facilitate the provision of care across health and social care** through the introduction of a role with a flexible and portable skill set
- ✓ **Provide a bridge between the unregulated care assistant and nursing workforce** through training and development - enhancing the quality of hands on care offered by the support workforce
- ✓ **Deliver direct and fundamental care** to patients, individuals and service users, releasing Registered Nurses to focus on higher care interventions, treatment, assessment and advancing their practice
- ✓ **Widen access and entry** into the nursing profession
- ✓ **Support career progression** of all care roles and enabling a greater skill mix in the care and nursing workforce to work flexibly and responsively

The aim is to adequately train and educate current HCA's/ CSW's already employed to a higher level and standard which would enable the right care to be given to the right person at the right time in line with the National Quality Boards (NQB) recommendations. At the end of the 2-year training programme, Nursing Associates will hold a nationally recognised training award.

2.0 Future plans

The Nursing and Midwifery Council (NMC) have agreed to regulate the Nursing Associate role. Following a public consultation they have just release the draft Nursing Associate standards for review. This is in line with the draft version of the pre-registration graduate nurse standards. Together, this provides a vision for what the future nursing workforce will look like.

HEE are about to release details on the future funding streams & associated tariff related to the provision to train Nursing Associates. CHFT, alongside its partners wants to be in a position to up-scale our current project and secure a place on the second wave of the national pilot scheme.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 7th December 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from the sub-committees.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from the sub-committees.
a. Quality Committee – minutes of 30.10.17 and verbal update from meeting 4.12.17
b. Finance and Performance Committee – minutes of 31.10.17 and verbal update from meeting 28.11.17
c. Workforce Well-Led Committee - minutes 9.11.17
d. Audit and Risk Committee – minutes from meeting 18.10.17

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, 30th October 2017

Discussion Room 2, Huddersfield Royal Infirmary

PRESENT

Dr David Anderson **(DA)**	Non-Executive Director
Michelle Augustine **(MA)**	Governance Administrator ***(Minute Taker)***
Helen Barker **(HB)**	Chief Operating Officer
Brendan Brown **(BB)**	Executive Director of Nursing – Corporate
Juliette Cosgrove **(JC)**	Assistant Director of Quality and Safety - Corporate
Lesley Hill **(LH)**	Director of Planning, Performance and Estates and Facilities
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Lynn Moore **(LM)**	Governor
Julie O'Riordan **(JOR)**	Divisional Director, Surgery and Anaesthetics Division
Dr Linda Patterson **(LP)**	Non-Executive Director ***(Chair)***
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Dr Sal Uka **(SU)**	Associate Medical Director
Jan Wilson **(JW)**	Non-Executive Director

IN ATTENDANCE

Sharon Appleby **(SA)**	Transformation Programme Manager, Estates and Facilities
Andrew Haigh **(AH)**	Chairman ***(Observing)***
Dr Rob Moisey **(RM)**	Clinical Director, Acute Medical Directorate, Medical Division
Catherine Riley **(CR)**	Assistant Director of Service Development, Estates and Facilities
Bev Walker **(BW)**	Associate Director of Urgent Care - Acute Medicine

185/17 WELCOME AND INTRODUCTIONS

The Chair welcomed members to the meeting.

186/17 APOLOGIES

Paul Butterworth	Governor

187/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

188/17 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 4th September 2017 was approved as a correct record.

189/17 ACTION LOG AND MATTERS ARISING

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

Surgery update from meeting on 4th September 2017
JOR gave an update on issues raised from the divisional Patient Safety and Quality Board (PSQB) report at the September 2017 meeting:

- Friends and Family responses for the division are very positive
- Harm free care has improved with no harm falls this year
- Fractured neck of femur performance / Best Practice Tariff (BPT) and time to theatre in

36 hours has seen some improvement in the last two months. There is a plan to provide extra trauma capacity and to finding a consistent way of covering for annual leave.
- Cancer pathways are improving and taking a lot of management to ensure patients are being closely followed. The two week wait has also improved.

JOR stated that more detail will be provided in the next divisional report.

Medical Devices and Procurement Group
LH reported that the suggestion of merging the above group into the Health and Safety Committee was not ideal, and recommended that the Medical Devices and Procurement Group meet separately. This is to be followed up by LH for meetings to be re-instated.

AMcC reported that the chairs of all sub-groups of the Patient Safety Group have been contacted to provide information to help understand the effectiveness of the subgroups and how they are fulfilling their terms of reference. Activity from the last 12 months has been requested and the findings will be compiled into a report.

Nasogastric tube training
Following last month's action to identify which areas were targeted for high risk nasogastric tube training, LH reported that work has been done on nasogastric tube insertion training for all high risk areas, however, issues concerning non-attendance of colleagues for training for lower risk areas is being looked into. Discussion ensued on assessments being in place to check skills and competencies of colleagues to perform nasogastric tube insertion. It was suggested that it would be helpful for Jo Middleton, Associate Director of Nursing for the Surgical Division to give an update on this subject.
ACTION: Jo Middleton to provide an update on nasogastric tube training at the meeting on Monday, 30th January 2018.

The order of the agenda was slightly amended at this point. The QIA on the reconfiguration of medical services (as stated as Any Other Business on the agenda) has been moved to this point.

190/17 QUALITY IMPACT ASSESSMENT FOR THE RECONFIGURTION OF MEDICAL SERVICES

Dr Rob Moisey and Sharon Appleby were in attendance to present the interim proposal for the reconfiguration of cardiology, respiratory and elderly medicine services (appendix M).

The current dual site model of hospital services provided by CHFT does not, and cannot, meet national guidance. The Full Business Case model has all acute medicine and emergency services co-located at Calderdale Royal Hospital. In 2016 the Trust's care of older people and respiratory medicine services were reviewed with recommendations that action should be taken to enable cardiology and respiratory services to be co-located on the same hospital site and for the care of older people to be located on a single hospital site. The medical division has been working to develop proposals for the interim reconfiguration of cardiology, respiratory and elderly care services across the two hospital sites. Since early 2017 there have been a number of discussions and meetings with the Clinical Commissioning Groups, Yorkshire Ambulance Service, Locala and Local Authorities to discuss development of these plans. CHFT aims to enable implementation by mid-December 2017. Whilst this timescale is challenging, the Division believes it is essential to strengthen the resilience of the hospitals and the wider system services for Winter 2017/18.

The report outlines staff and stakeholder involvement and engagement, patient engagement and feedback, the benefits of the proposed interim reconfiguration, key quality risks and next steps.

Discussion ensued on the risks and mitigations put in place for the proposal interim reconfiguration, and the Quality Committee were happy with the progress being made. Dr Moisey and Sharon Appleby were thanked for their presentation.

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

191/17 QUALITY IMPACT ASSESSMENT OF THE FULL BUSINESS CASE CLINICAL MODEL

Catherine Riley was in attendance to present the Quality Impact Assessment (QIA) for the clinical model in the Full Business Case (FBC) (appendix C).

The report included the background, changes to the clinical model and quality impacts identified across the Trust. Discussion ensued on the quality impacts identified, namely, travel and parking for patients and relatives. It was recognised that a robust support group is needed for this and it was stated that a sub-group is currently in place to review transport. Discussion also ensued on system issues with capacity issues and the challenges for both the acute and community services to deliver the plan.

The Quality Committee were satisfied with the QIA undertaken and the plans in place to mitigate. This will be an ongoing process, and if there are any significant changes, the QIA will need to be reviewed. Thanks were conveyed to divisions, departments, staff groups and patient groups that were involved in this piece of work.

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

192/17 HIGH LEVEL RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

AMcC presented the high level risk register (appendix D1) detailing the movement of risks scored at 20 and above as at 25th September 2017. No new risks were added to the high level risk register this month.

The Board Assurance Framework (BAF) (appendix D3) has undergone a significant review to ensure that the BAF and the high level risk register are dynamic and reflect all significant risks to Trust objectives. The work highlighted three areas for new risks to be developed for consideration on the high level risk register (leadership, health and safety action plan and development of bank and workforce models) as these are not currently reflected.

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

193/17 SERIOUS INCIDENT REPORT

AMcC presented the above report (appendix E) summarising new serious incidents reported to commissioners in September 2017, of which there were three and completed serious incident reports submitted to commissioners in September 2017, of which there were six.

The three serious incidents comprised of two incidents relating to treatment delay and one relating to thrombosis, the detail of which was outlined in the paper. The six completed incident reports submitted to commissioners comprised of two slips, trips and falls cases, two pressure ulcers cases, one disruptive/aggressive/violent behaviour case and one treatment delay. All case summaries were included in the report.

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

194/17 PATIENT SAFETY GROUP REPORT

AMcC reported on the above report (appendix F) which highlights issues raised at the last Patient Safety Group meeting on Thursday, 5th October 2017:

- Sub-group report received from the Point of Care Testing (POCT) Group highlighted issues of the frequency of meetings and concerns as to where risks regarding equipment are discussed. It was agreed that the issue of the frequency of meetings should be raised at the Diagnostic and Therapeutic Services (DaTS) Patient Safety and Quality Board (PSQB) meeting for assurance of the need for the formal POCT group to be re-instated. It was also agreed that issues relating to equipment risks will be raised with the Families and Specialist Services (FSS) division in order for them to be placed on a risk register. It was suggested that concerns should also be raised with the medical division, as issues with equipment will also have an impact on those from the division.

- Sub-group report received from the Medication Safety Group highlighted the membership and terms of reference of the group, inconsistent attendance at meetings and an update of the perfect week for medicine management which was undertaken on ward 20 HRI in July 2017 and ward 2ab CRH in October 2017. The Patient Safety Group requested a copy of the revised terms of reference from the Medication Safety Group for the next meeting.

- Sub-group report received from the Hospital Transfusion Group highlighting poor attendance and inadequate representation at the Hospital Transfusion Group from all specialties. This has a major impact on the ability to make adequate progress on transfusion issues. It was also reported that from 1st November 2017, there will be an added uncertainty as the chair will be stepping down as transfusion lead. An action from the Patient Safety Group was for the chair to escalate individuals' non-attendance to the Group with their appropriate line managers. An update on this will be given at the next Patient Safety Group meeting.

Discussion ensued on issues raised from the Patient Safety Group and HB reported that a review of terms of reference and membership of all meetings is due to be carried out regarding availability to attend and the capacity of meetings. It was also stated that it would be helpful to know what the risks from the POCT group were. This will be provided for the next meeting.

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

195/17 SAFEGUARDING ADULTS AND CHILDREN'S REPORT

LR presented the above report (appendix G) updating on information from April 2017 to September 2017, giving an overview of activity and outlining key achievements and developments on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009), Safeguarding Training Compliance, Mandatory Children's Safeguarding Supervision requirements and actions; recent CQC inspections and any potential inspections, and the Children Looked After Service Specification update. The report also provided an update since the introduction of the new Electronic Patient Record (EPR) and how this has impacted upon the safeguarding agenda. The report also outlined innovative developments and further plans and arrangements for safeguarding adults and children.

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

196/17 HEALTH AND SAFETY COMMITTEE REPORT

LH presented the above report (appendix H) summarising key points from the Health and Safety Committee meeting held on 18th October 2017:

- Concerns regarding the move from Ward 15 to Ward 11 and issues relating to shortage of sockets for electrics, damaged flooring, inadequate oxygen ports and oxygen flow.
- Results being awaited following audit of transfer of patients needing medical gases.
- Medical Devices Management and Procurement group not met since December 2016.
- Moving and Handling – plan to be in place to mitigate risk for training.

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

197/17 CLINICAL OUTCOMES GROUP

SU presented the above report (appendix I) summarising key points from the last Clinical Outcomes Group meeting held on 18th September 2017:

- Update received from the Clinical Effectiveness and Audit Group (CEAG) on costs relating to national clinical audits and a major update relating to National Safety Standards for Invasive Procedures, with the intention of introducing safety checklists in areas that don't currently have one in place.

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

198/17 MORTALITY SURVEILLANCE GROUP REPORT

SU presented the above report (appendix J) summarising key points from the last Mortality Surveillance Group meeting held on 13th October 2017:

- Hospital Standardised Mortality Ratio (HSMR) score is 92.32, which is a significant improvement from the 98.71.
- Summary Hospital-level Mortality Indicator score is 105.47. This is a decline from the position of 104.73
- Structured Judgement Reviews (SJRs) have replaced the former second-level reviews and are now in place. A team of nine consultants have been appointed to support the process and will be available to commence reviews from week commencing 16th October 2017.
- A copy of the learning from death shared learning – improving care newsletter was attached.

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

199/17 QUALITY AND PERFORMANCE REPORT

HB presented the above report (appendix K) highlighting September's performance score which stands at 60% for the Trust. The effective domain has improved to green with all Maternity Mortality indicators achieving target. The responsive domain has maintained amber, although Breast Symptomatic and 62 day screening for cancer have missed target. Finance domain has deteriorated to red with variance from plan moving to amber in-month. Workforce has improved in-month with better performance in sickness absence.

Key points to note from the report are:

- Safe – Venous Thromboembolism (VTE) Risk assessments have dropped in compliance following the Electronic Patient Record (EPR) go-live as new systems and processes embed. Cohort areas are expected to be better understood by the end of October 2017 when a truer reflection of performance will be known
- Caring – of the 41 complaints closed in September, 64.4% of these were closed within the target timeframe. Improvement in response times remains challenging and performance is expected to be back on track from quarter 4, 2017.
- Responsive – the target for the two week wait from referral to date first seen: breast symptoms cancer missed; the Emergency Care Standard 4 hours is now stabilising. There will now be capacity for a walk-in minor injury unit and privacy and dignity for ambulatory at HRI.
- Feedback on a deep dive report on all CQUINS will be brought to the next meeting.

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

200/17 QUALITY REPORT INCLUDING QUALITY ACCOUNT

AMcC presented the quality report (appendix L) which summarises assurances on quality reports provided directly to the Board for 2017/2018 as agreed in the revised quality reporting arrangements in January 2017, and an update on the three quality account priorities for 2017/2018 (Sepsis screening for inpatients, discharge planning and learning from complaints).

BW was in attendance to present discharge planning and reported on work that the discharge team have implemented leading to a real reduction in the length of stay for complex patients.

An acute frailty model and team have also been implemented on both sites, and work will continue with Clinical Commissioning Groups and community colleagues in the development of a whole system frailty model. A report to the Board on frailty is planned for early 2018.

The work in 2017/18 is a continuation of a transformational piece of work started by the Trust in 2016/17 and has robust metrics attached. Targets to measure improvements include zero tolerance of patients over 100 days length of stay, 30 patients over 50 days length of stay, a reduction in the length of stay for patients who are deemed frail, a reduction in the re-admission rate for frail patients and the % patients who have had a comprehensive geriatric assessment. The metrics for this work, which include an acute frailty dashboard and a Safer Programme dashboard, are reviewed monthly by the Safer Patient Flow Programme Board.

Discussions ensued on planned admissions, the fantastic work with community colleagues and work ongoing to facilitate early discharge.

The Quality Committee thanked BW for her input into the report.

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

201/17 ANY OTHER BUSINESS

CQC Event
An invitation was extended to the Quality Committee to attend a regional leadership event on Friday, 3rd November 2017 in the Lecture Theatre at CRH from 10:00 am to 2:00 pm.
Ted Baker, the recently appointed Chief Inspector of Hospitals will be in attendance and is keen to engage directly with key leaders, discuss in more detail plans for assessing Well-led reviews, and to consider examples where clinical leadership has led to demonstrable benefits for patients.

Facebook Page
The Quality Committee are encouraged to join the Improve @ CHFT Facebook page.

202/17 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- That the reports on the Quality Impact Assessment for the reconfiguration of medical services and the Quality Impact Assessment of the Full Business Case clinical model were received. Both reports will be further discussed at the upcoming Board meeting on Thursday.

203/17 QUALITY COMMITTEE WORK PLAN

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

204/17 EVALUATION OF MEETING

The effectiveness and evaluation of the meeting were acknowledged as:

- The meeting finishing on time
- Positives coming through regarding the performance of the Trust
- A lot of assurance received from reports and updates
- Extra contributions to the meeting were very good

NEXT MEETING

Monday, 4th December 2017
3:00 – 5:30 pm
Discussion Room 3, Learning Centre, Huddersfield Royal Infirmary

This meeting will focus on divisional Patient Safety and Quality Board (PSQB) reports, and divisional representation is expected at the meeting.

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Tuesday 31 October 2017 at 9.00am Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

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

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Andrew Haigh	Chair of the Trust
Vicky Pickles	Company Secretary
Betty Sewell	PA (Minutes)

ITEM

165/17 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

166/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Stuart Baron – Associate Director of Finance
Brian Moore – Lead Governor
Andrew Nelson – Non-Executive Director

167/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

168/17 MINUTES OF THE MEETING HELD 1 SEPTEMBER 2017

The Minutes of the meeting held 3 October 2017 were approved as an accurate record following a minor amend on page 4 – 'signs and systems' should read 'signs and symptoms'.

169/17 MATTERS ARISING AND ACTION LOG

To be covered as part of the agenda.

170/17 MONTH 6 FINANCE REPORT

The Deputy Director of Finance reported that the year to date position is £13.28m deficit in line with the plan. However, there is an underlying adverse variance from plan and £9.3m of non-recurrent benefits have been released to bring the position back to the control total. In terms of the Sustainability and Transformation funding (STF) the finance element has been secured for the first 6 months and the A&E element has been secured for Qtr. 2. This was achieved with contribution from system wide performance. It was noted that in terms of CIP we are below where we

need to be, discussions took place at the QRM with our regulators as to whether the use of non-recurrent benefits should be used as CIP and further discussions will take place prior to reporting Month 7.

It was also noted that Capital Expenditure for Month 6 is lower than planned but continues to forecast to be on plan by year end. The resulting cash benefit has offset some of the pressure on working capital. At the end of September the Trust had a cash balance of £3.18m, £1.28m above the planned level. This reflects the payment of Q1 STF that was received in September but it will be required to be repaid. A new metric was highlighted on the Cash schedule which shows the scale of the invoices that we were not able to pay and at the end of September £6.36m of invoices approved for payment had not been paid, which relates to 6700 invoices. The Public Sector Payment matrix was explained and it was noted that whilst this may not be the best indicator of liquidity, NHSI are still looking at this metric when deciding on cash support for working capital.

With regard to the Forecast, following the detailed presentation last month attention was drawn to a new graph which shows the organisation getting back to planned deficit by year end based on a significant level of recovery. Recovery plans remain under development.

It was noted that every aspect of our position was shared fully with NHSI at the QRM which took place 24 November 2017.

Discussions turned to the Activity where a number of areas were reported below plan in month. The Chief Operating Officer commented that Outpatients are still struggling, however, within October there is an improving picture, it was noted that we continue to have issues with Elective Daycase and Inpatients and following discussions at the Surgical Divisional Performance Review meeting they have been asked to review Theatre scheduling. In terms of Rehab, it was reported that this has been a planned change which has resulted in a ward closure. Further discussions took place with regard to our contract with Commissioners and services provided by the Community. A question was asked with regard to our capacity to absorb the extra work, it was noted that re-admissions is an area where we are struggling but in the main we are managing. It was also noted that Community benchmarking is led by Karen Barnett, Director of Operations for Community and a model hospital portal is due to be launched. It was acknowledged that the challenge for Community is the different interventions needed by individuals. The home visit policy is being reviewed and the 'Allocate' staff roster system for Community is being considered by the Director of Nursing.

It was noted that discussions around cost out need to be more prevalent and that the reduction in activity is not unique to ourselves but is part of a national picture. It was also noted that there is an adverse variance against plan for nursing pay and it was confirmed that the Director of Nursing and wider nursing colleagues would attend the next F&P Committee to present to ensure we are sighted. Following the QRM it was noted that we remain an agency outlier and there is a piece of work being carried out to benchmark our medical pay rates.

ACTION: The Director of Nursing to attend the next F&P Committee to present a

paper with regard to Nursing costs – **BB, 28/11/17**

UNCOMMITTED INTERIM REVENUE SUPPORT FACILITY

The Deputy Director of Finance reminded the Committee that a Board Resolution had been made in March 2017 which covered revenue loan funding up to £20.2m, this now needs to be extended as detailed in the paper. Following discussions with our regulator, approval has been granted against the request up to the value of £5.7m for working capital and for the extended deficit funding in Months 7 to 11.

The Committee recommended the Board Resolution to the Board required to increase the value of the Uncommitted Interim Revenue Support Facility.

171/17 FINANCIAL POSITION & FORECAST RECOVERY PLAN

The Director of Finance provided a presentation which detailed the 2017/18 YTD I&E position giving an understanding of the drivers of the underlying financial position and the Forecast Recovery update and recovery actions.

The YTD position is supported by £9.3m of non-recurrent measures. The YTD challenge is made up of £7m income shortfall and £2.3m of expenditure pressure. Of the £7m income challenge, elements relate directly to EPR but other elements also relate to non-elective readmissions in NICU, A&E and Maternity HRG4+ tariff changes and Apprentice Levy challenges.

EPR is estimated to have had a £3.07m direct impact to date on I&E with a further £1.4m capitalised above plan.

Divisions continue to forecast a £14m adverse variance from plan prior to recovery actions. Recovery actions were discussed and these will form the recovery plan to be shared with regulators. Many of the actions are still to be quantified and they will remain a challenge even after the regulator meeting.

Discussions took place with regard to how we can challenge the organisation further, it was noted that we would not re-forecast at present, we will continue to push CIP and review again at Month 7.

ACTION: To receive a further update next month – **GB, 28/11/17**

172/17 ALIGNED INCENTIVE CONTRACTS

The Director of Finance referenced the paper which described a model which is now in place across the Bolton healthcare system. The paper also highlighted some of the benefits and it was noted that our Commissioners strongly believe this model could be adopted and would support the objective to reduce overall costs.

The Committee received and noted the contents of the presentation and following discussions it was agreed that we would not support moving to the model of present but would continue to monitor closely how this develops in Leeds.

The Director of Transformation and Partnerships recognised that there are benefits but at the moment it would not be in our interests to move to a block contract. It was also noted that there is a heightened need to have a credible system recovery plan

in place for the gap in our full business case to share with NHSI / NHSE, conversations have taken place with a further meeting to take place tomorrow.

The Committee also agreed to focus on developing a System Recovery Plan to come back to this forum at the end of November to go to the December Board.

ACTION: To develop a System Recovery Plan for the next F&P Committee meeting – **AB, 28/11/17**

173/17 CIP UPDATE

The Chief Executive highlighted that work needed to continue to develop more CIP and replace with alternatives where necessary.

The YTD delivery of £4.7m was noted as being £1.94m behind plan. The forecast at Month 6 was an in year shortfall of £6.17m, there also remains a number of high risk schemes within the forecast.

174/17 INTEGRATED PERFORMANCE REPORT AUGUST 2017

The Chief Operating Officer reported that the Trust's performance score for September had remained at 60%. The Efficiency & Finance domain has moved into RED and the Effective domain has improved to GREEN. The following areas were highlighted:-

- 6 week diagnostics has been missed which will have contractual penalties. Endoscopy has not been reported since EPR implementation and validation is in the final stages
- Emergency Care Standard is an improving position for October
- Carter Dashboard – cancelled ops is a deteriorating picture
- #NoF still not on plan which has a best practice tariff implication and a more structured report has been requested by NHSI
- Signs and symptoms as a primary diagnosis is improving, which will impact on our income and Summary Hospital-level Mortality Indicator (SHMI)
- There is particular focus on ambulance turnaround, a new facility is opening in Huddersfield
- Sickness is better than plan but is not translating into less spend
- Recruitment of nurses from the Philippines, only 3 nurses out of 85 have joined the organisation
- A&E have had 20 new starters last month, the 6 week induction has proved successful
- Efficiency - length of stay is better
- Theatre Utilisation is negative

The Committee received and noted the report.

175/17 MONTH 06 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee were asked to note the contents of the paper for information.

176/17 MINUTES FROM SUB-COMMITTEES

The Committee received and noted the minutes from the following Sub-

Committees:-
Cash Committee held 13 October 2017
Commercial Investment & Strategy Committee held 21 September 2017
Capital Management Group held 22 September and 20 October 2017

177/17 WORK PLAN

The Work Plan was received by the Committee, it was agreed to give the Performance Report a deep-dive at the next meeting. It was also agreed to include a summary paper with regard to Model Hospital and Benchmarking to the Work Plan for the next meeting.

ACTION: To include Model Hospital and benchmarking work for Community to the Work Plan – **AB, 28/11/17**

178/17 MATTERS TO CASCADE TO THE BOARD

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

- Financial position year to date and the underlying variance to plan
- Forecast position / re-forecast decision
- Activity reduction – local/national
- Cash – decision to support the Board Resolution for extra working capital
- Performance – generally an upward trajectory
- Aligned Incentive Contract was discussed – support the direction but the current forecast is to work on the system recovery plan

179/17 REVIEW OF MEETING

The forum agreed that discussions had been open and helpful.

180/17 ANY OTHER BUSINESS

The Committee received and noted the schedule of dates for the 2018 Finance & Performance Committee which reflected the recent amends.

DATE AND TIME OF NEXT MEETING
Tuesday 28 November, 9.00am – 12.00noon
Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Audit and Risk Committee Meeting held on Wednesday 18 October 2017 in Room 4, Acre Mill, Huddersfield Royal Infirmary commencing at 10:45am

Richard Hopkin	Chair, Non-Executive Director
Phil Oldfield	Non-Executive Director

IN ATTENDANCE

Zoe Quarmby	Assistant Director of Finance
Leanne Sobratree	Internal Audit Manager
Helen Kemp-Taylor	Head of Internal Audit for Audit Yorkshire
Andrea McCourt	Head of Governance and Risk
Clare Partridge	Engagement Lead, KPMG
Victoria Pickles	Company Secretary (from item 62/17 onwards)
Kathy Bray	Board Secretary (minutes)

Item

58/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Andy Nelson, Non-Executive Director
Gary Boothby, Executive Director of Finance
Adele Jowett, Local Counter Fraud Specialist
Alastair Newall, External Auditor (KPMG)

The Chair welcomed Leanne Sobratree, Internal Audit Manager to her first meeting of the Audit and Risk Committee (ARC) and it was noted that this too was the first meeting for Richard Hopkin as Chair of ARC.

59/17 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

60/17 MINUTES OF THE MEETING HELD ON 19 JULY 2017

The minutes were approved as a true record.

61/17 ACTION LOG AND MATTERS ARISING

46/16 PAYROLL UPDATE

Unfortunately neither the Executive Director of Finance or the Executive Director of Workforce and OD were available to attend the meeting. It was noted that it had been agreed that an update would be circulated to the Committee within the next few weeks.

ACTION: GB/JE

b. 46/17(2) PROCUREMENT PROCESSES/CARTER

The Chair reported that the newly appointed Head of Procurement had given a presentation to the Finance and Performance Committee on procurement processes and Carter efficiencies. An overview of the new procurement strategy was received focussing on spend and demand levels, a more commercial approach generally and other initiatives including management of representatives on site. It was noted that Level 1 accreditation had been received by the Procurement Team. Phil Oldfield, Chair of Finance and Performance Committee reported that this was a good insight into the work and opportunities of the Team and an update report would be given to the Finance and Performance Committee in 6 months' time.

c. 44/16 REVIEW OF SCHEME OF DELEGATION

It was noted that work was still underway and an update would be brought to the next meeting. Claire Partridge, Engagement Lead - KPMG acknowledged that it would be timely to review the SFO/SFI/SoD following the appointment of the Executive Director of Finance later that week.

62/17 ANNUAL REVIEW OF RISK MANAGEMENT SYSTEM

ANNUAL REVIEW OF RISK MANAGEMENT SYSTEM

The Head of Governance and Risk reported that this item had been brought to the Committee to gain assurance on the processes in place. It was noted that work was underway to align the Risk Register and Board Assurance Framework and Internal Audit were to investigate whether benchmarking data from other Trusts would be available to check any gaps in reporting.

The work of the Risk and Compliance Group was discussed and it was agreed that an example of the Compliance Register would be circulated to the Non-Executive Directors' for information.

ACTION: AM

Overall the Committee agreed that robust systems were in place and were assured that additional work was to be undertaken by Internal Audit, but suggested that once benchmarking information was available the Committee should review the receipt of minutes from the sub committees to ensure that these added benefit and sufficient assurance to the Committee and/or whether the Committee should request periodic reports/attendances from representatives of the Quality Committee and Risk and Compliance Group.

ACTION: Future ARC Agenda Item

It was noted that a review of the clinical audit plan would be undertaken for the forthcoming year.

63/17 (1) COMPANY SECRETARY'S BUSINESS

ARC Meeting Dates 2018 – Amended Venues

The Company Secretary reported that the meeting venues had been altered and were brought to the Committee to approve and amend in diaries. It was noted that this had been agreed partly to accommodate one of the Governors who has clinical commitments on the Calderdale Royal site.

OUTCOME: The Committee **AGREED** the amended meeting dates schedule 2018

63/17 (1) Declaration of Interest Policy

The Company Secretary reminded the Committee that the guidance for Managing Conflicts of Interest in the NHS had been received earlier this year and an overview of the main changes was included in the presentation contained within the papers. The policy template was published by NHS England in June and the Trust's policy had been updated in line with that template. The process for collation of an annual nil return for all staff at Band 7 or above (circa 1500 staff) was due to be discussed at a future Executive Board meeting as it would require the implementation of a system linked to the Trust's HR system in order to manage the volume of returns and therefore sign-up from Divisions was required.

It was agreed that a Communications Strategy would be prepared and brought back to the ARC on the 24.1.18

ACTION: VP

OUTCOME: The Committee **APPROVED** the draft policy.

64/17 (2) Declaration of Interest Registers

The current registers of interests were attached for information. Following on from the discussions regarding the policy, it was clear that this did not represent a true picture and the Committee supported the intent that wide communication of the policy and a system to support returns and reminders would improve this position within the Trust.

OUTCOME: The Committee **NOTED** the contents of the registers.

65/17 EXECUTIVE DIRECTOR OF FINANCE BUSINESS

66/17 (1) Waiving of standing orders

The Assistant Director of Finance reported that during the second financial quarter of 2017/2018 3 orders were placed as a result of standing orders being waived, at a total cost of £105,337.78. It was noted that 2 amendments to earlier single sources had been made this quarter at a value of £35,350.00.

It was noted that some items repeatedly come to ARC for approval under the Waving of Standing Orders. Zoe Quarmby agreed to question the contracting arrangements with Procurement and request that going forward a column be included in the report to identify the number of amendments/number of years the contract has been running for.

ACTION: ZQ

OUTCOME: The Committee **APPROVED** the waivers of standing orders.

66/17 (2) Losses and Special Payments

The Executive Director of Finance reported that losses and special payments over the quarter totalled £35,200. It was noted that the total value of losses and special payments to quarter 2 2017/18 is 3% lower than the value at the same quarter 2016/17.

The key areas were noted as being:
Pharmacy expired stock £11.9k
NHS Litigation - Public/employer liability claims – damages/costs £17.5k

Discussion took place regarding the total claims and it was agreed that a breakdown of the claims would be prepared and circulated to Divisions.

ACTION: ZQ

OUTCOME: The Committee **NOTED** the losses and special payments report.

67/17 INTERNAL AUDIT

67/17 (1) Internal Audit Follow-up Report

The Head of Internal Audit provided an overview of the outstanding internal audit recommendations. It was noted that the report had been considered by the Executive Team and updated as far as possible. She reported that a new process for follow-ups had been agreed with management going forward and it was expected that more of the outstanding items would be actioned.

The Audit and Risk Committee agreed that this was a positive trajectory and there were no areas requiring the intervention of the Audit and Risk Committee at this stage.

OUTCOME: The Committee **RECEIVED** the Internal Audit follow-up report.

67/17 (2) Internal Audit Progress Report

The Head of Internal Audit presented the report setting out that since the last Audit and Risk Committee, six reports have been finalised with one further report in draft and work

underway on six other audits.

Of the six completed reports, one received full assurance (Winter Planning Follow-up); four gave significant assurance (Cyber Security, Freedom of Information, Learning Lessons from Incidents and Divisional Governance Structures); and one limited assurance (Income from Overseas Visitors).

Discussion took place regarding Income from Overseas Visitors. The review considered the effectiveness of the system for identifying and raising income from overseas visitors. It confirmed that the approach to identifying overseas visitors was working well and that the numbers of overseas visitors being identified each month had risen substantially over the last 18 months.

However the review noted that the Trust still struggles to ensure that those who should pay for their treatment ultimately do pay for their treatment. For example in 2016/2017 only 46% of overseas visitors who were billed actually paid in full. The current system is therefore not delivering on its key objective.

It was noted that the regulations are due to change in October 2017 and Trusts will be expected to estimate the costs of treatment and to collect monies from the patient prior to treatment. This will require significant changes to the operational approach to billing patients. It was noted that the Trust had taken a number of very positive steps to accommodate these changes and was in the process of implementing further changes.

With the implementation of a new process the overall 'limited opinion' on this system will hopefully move to 'significant assurance' once the new system is in place and is delivering improvements in the proportion of monies actually collected.

The challenge to the organisation and particularly staff in identifying overseas patients was discussed.

Brief discussion took place regarding the other reports received and Phil Oldfield requested information regarding the number of Cyber Attacks/near misses which had been recorded. Helen Kemp-Taylor reported that this was available within the Internal Audit information and agreed that this would be brought to the next meeting.

ACTION: HKT – ARC AGENDA ITEM 24.1.18

The Committee only discussed the Internal Audit report on Reconfiguration. It was noted that this audit report was still in draft. Helen Kemp-Taylor agreed to check the status of this and email progress back to the ARC.

ACTION: HKT – ARC AGENDA ITEM 24.1.18

OUTCOME: The Committee **RECEIVED** the Internal Audit Progress Report and **NOTED** the limited assurance opinion for Income from Overseas Visitors.

68/17 LOCAL COUNTER FRAUD SERVICE

68/17 (1) Progress Report

In the absence of the Local Counter Fraud Officer the Head of Internal Audit presented the LCFS progress report The report set out the progress against the approved work plan. Changes to the name, status and operations of NHS Protect were also reported.

The Committee noted the positive work of local counter fraud officer and overall the trust had a positive proactive approach to fraud. It was felt that the controls would be strengthened going forward with the introduction of the new declaration of interests process which may prove challenging to clinical staff and the culture and tone from the

top was essential.

OUTCOME: The Committee **RECEIVED** the progress report.

68/17 (2) Investigations

OUTCOME: The Committee **NOTED** the progress with ongoing investigations.

69/17 EXTERNAL AUDIT

The External Auditor presented the technical update and specifically highlighted the following points:

- **GENERAL DATA PROTECTION REGULATION (GDPD)**

New EU law had been passed on the 27.4.17 and comes into force in May 2018. A briefing had been included within the technical update. It was noted that the Board would include discussion on this as well as Well Led Review and Board Risk Appetite at the next BOD Workshop on the 15 November 2017.

It was agreed that the Technical Update would be circulated to the remaining Board members for information.

ACTION: KB

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

70/17 REGULATORY COMPLIANCE

The Company Secretary reported that two meetings were due to take place with NHSI on the 24 October 2017 – the Quarterly Review Meeting and Business Case Meeting.

The Company Secretary also updated on a recent conference she had attended regarding CQC Well Led Reviews. No further information had been received regarding the next CQC Inspection.

There were no other regulatory compliance issues to bring to the attention of the Committee.

71/17 INFORMATION TO RECEIVE

The following information was received and noted:-

1. Quality Committee Minutes – 31.7.17 and 4.9.17
2. Risk & Compliance Group Minutes – 18.7.17
3. THIS Executive Meeting Summary Notes – 19.7.17 and 23.8.17
4. Information Governance & Records Strategy Committee Minutes – 21.8.17

Discussion took place regarding having a summary of information from sub-committees, particularly from Committees which have no Non-Executive Director input.
The value of receiving the THIS Executive Meeting notes was discussed and it was agreed that this item would be revisited in the future.

ACTION: FUTURE ARC AGENDA

72/17 ANY OTHER BUSINESS

There was no other business to note.

73/17 MATTERS TO CASCADE TO BOARD

The Committee noted the following items to be brought to the attention of the Board at its

next meeting:

- Risk Management – Further work on benchmarking of BAF and Risk Register – increased assurance received
- Internal Audit – Overdue position improved. Positive Audits except Income from Overseas Visitors
- Declaration of Interest System – New policy and system to be implemented by January 2018

DATE AND TIME OF NEXT MEETING
Wednesday 24 January 2018 at 10.45am – Boardroom, Trust Offices, Calderdale Royal Hospital.

REVIEW OF MEETING
All present were content with the issues covered and the depth of discussion.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 9 November 2017, 1.30pm – 3.30pm in the Board Room, Calderdale Royal Hospital

PRESENT:

David Anderson	Non-Executive Director
Brendan Brown	Chief Nurse
Jason Eddleston	Director of Workforce and Organisational Development
Karen Heaton	Non-Executive Director (Chair)
Vicky Pickles	Company Secretary

IN ATTENDANCE:

Stephen Baines	Council of Governors
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development
Claire Wilson	Assistant Director of HR (for agenda item 148/17)

141/17 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

142/17 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
Jan Wilson, Non-Executive Director

143/17 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

144/17 **MINUTES OF MEETING HELD ON 18 OCTOBER 2017:**

The minutes of the meeting held on 18 October 2017 were approved as a correct record.

145/17 **ACTION LOG (items due this month)**

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

Staff Side Attendance

This action was deferred to the December Committee meeting in the absence of Chris Burton.

MAIN AGENDA ITEMS

FOR ASSURANCE

146/17 **WORKING EFFECTIVELY – SKILL MIX AND ROLE REVIEW**

JE provided an update of the Working Effectively – Skill Mix and Role Review programme.

Sixteen service areas have been identified for the introduction of the Calderdale Framework methodology. Phase 1 will include Cardiology, Respiratory Medicine, General Surgery and Community Paediatrics. Detailed project plans for these areas will be

developed during the Calderdale Framework facilitator training scheduled for 28, 29 and 30 November 2017. It is anticipated it will take 6 months to complete the service reviews. Phase 2 is planned to commence April 2018 and is to include MAU, Elderly Medicine, Radiology, Community Nursing and Gynaecology.

KH queried the engagement of colleagues during the service reviews. JE confirmed that engagement is a core theme of the Calderdale Framework

JE agreed to provide to Committee members the presentation which was shared with Turnaround Executive on 6 November 2017.

ACTION: JE to circulate presentation shared with Turnaround Executive on 6 November 2017 and to provide regular updates to the Committee.

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

147/17 **STAFF HEALTH AND WELLBEING CQUIN**

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

JE provided an overview of the current position and projection to Q4 for the Staff Health and Wellbeing CQUIN.

The CQUIN is divided into 3 parts with each part having a value of c£213k.

Part 1 relates to the general improvement of health and wellbeing of colleagues. Local improvement plans are in place however it was noted that there was dependence of achievement on the 2017 staff survey responses. The Trust's needs to see a 5% improvement in 2 of the 3 related questions. The Trust has a view that only 50% of this CQUIN value will be delivered. An early indication of staff survey response results should be available in December 2017 with the detailed results being published February or March 2018.

Part 2 relates to healthy food options to staff, visitors and patients. The full CQUIN was delivered last year and there is an expectation it will be achieved this year.

Part 3 relates to flu immunisation. The target for 2017/2018 is 70%. Last year's target was 75% and will return to this target for 2018/2019. Currently, 51% of colleagues have received the flu vaccine. Last year 76% of colleagues received the flu vaccine and the Committee was advised that there was a high degree of confidence that the 70% CQUIN target will be delivered this year.

ACTION: JE to provide regular updates to the Committee.

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

PERFORMANCE

148/17 **WORKFORCE PERFORMANCE REPORT (OCTOBER 2017)**

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

In addition to the monthly report, CW presented a detailed analysis of workforce metrics in relation to:-

Sickness absence

Benchmark data comparing June 2016 to June 2017 was provided as below.

	June 2016			June 2017		
Benchmarking Group	**CHFT rate**	**Group Average**	**Benchmark Position**	**CHFT rate**	**Group Average**	**Benchmark Position**
All Acute	4.60%	3.97%	126 of 151	4.18%	3.95%	93 of 151
All Large Acute	4.60%	4.20%	28 of 33	4.18%	4.15%	15 of 33
All Y&H Acute Trusts	4.60%	4.33%	11 of 14	4.18%	4.36%	5 of 14
All Y&H	4.60%	4.49%	11 of 20	4.18%	4.53%	5 of 20
Wigan, Wrightington & Leigh	n/a	4.08%	82 of 151	n/a	4.23%	103 of 151

	June 2016		June 2017	
Benchmarking Group	**Lowest**	**Highest**	**Lowest**	**Highest**
All Acute	2.43%	5.80%	2.25%	5.38%
All Large Acute	2.98%	4.99%	3.01%	5.20%
All Y&H Acute Trusts	3.72%	5.16%	3.85%	5.20%
All Y&H	3.72%	5.91%	3.85%	5.88%

The Committee noted the downward trend. CW reported that two years ago the Trust's sickness absence was above 5%.

An analysis of departments with the highest absence rates (top 10) over a rolling 12 month period from October 2016 to September 2017 was also provided. This data identified an absence range of 7.28% to 12.94%. It was noted that this analysis showed that the Medical and Dental staff group has the lowest sickness absence rate of 1.43% although it was acknowledged that this could be supported by under reporting of sickness for this staff group. CP confirmed the Allocate e-rostering system will act as an enabler to improvements in data capture and sickness management in this group of staff.

CW confirmed the focussed activity initiated by the Attendance Management team continues with the support of the HR Business Partners within each Division. HR Business Partners are provided with sickness hotspot information. All absences have a case management action plan. Focus is being given to Return to Work interviews with an aim to reach a target of 100%.

Turnover

The data provided is a 12 month rolling turnover rate for the period August 2016 to July 2017.

	July 2017				
Benchmarking Group	**CHFT rate**	**Group Average**	**Benchmark Position**	**Lowest**	**Highest**
All Acute	12.09%	9.54%	70 of 151	8.32%	45.04%
All Large Acute	12.09%	10.64%	18 of 33	8.51%	17.48%
All Y&H Acute Trusts	12.09%	9.40%	12 of 14	8.32%	12.41%
All Y&H	12.09	9.02%	12 of 20	8.32%	30.65%

At October 2017 the Trust's turnover rate was noted at 12.74%. This figure had been as low as 11.8% in March 2017.

CW confirmed that Healthcare Scientists saw the highest turnover in the Trust, this being due to various reasons such as retirement, career development and recruitment difficulties.

Recruitment to Consultant posts has significantly increased over the last 12 months.

CW highlighted the work being undertaken by the Divisions to address recruitment and retention of colleagues.

Appraisal

CW reported that at 26 October 2017 appraisal compliance was 88.64%, against a planned position of 100% by 31 October 2017.

Today's rolling compliance (over the last 12 months) was noted at 97.54%.

The Committee noted the top 10 hotspots (by department) across the Trust.

It was noted there was no data available to compare with other Trusts.

JE advised there is focus on the quality of appraisals as well as compliance rate. Discussions are taking place to consider a process to test the quality of appraisals.

Mandatory training

The Committee noted the compliance rates below as at 26 October 2017.

Mandatory Training	Compliance
Fire Safety	84.96%
Information Governance	78.86%
Infection Control	80.60%
Moving & Handling	78.79%
Safeguarding	82.45%

CW advised that percentages were increasing for most of the training elements. The target aim is to achieve 95% compliance.

The Trust's pay progression policy was established to ensure colleagues are compliant with both appraisal and mandatory training. CW confirmed the policy is being reviewed followed by a communication across the Trust

It was noted that a national pilot is underway to streamline junior doctors' mandatory training allowing their mandatory training history to transfer with them between employers. A similar piece of work is being undertaken regarding the portability of mandatory training for other NHS colleagues.

The Committee agreed this deep dive analysis had been very informative. A summary of the actions are detailed below.

ACTIONS:

CW:-

Sickness Absence:
Nursing – establish if absence figures spiked from transition from Kronos to E-Roster.

Provide comparator data for independent hospital sector.

Appraisal:
Provide appraisal rates from other Trusts.

Update on progress in relation to assuring quality of appraisals.

Deep Dive
Add deep dive of workforce metrics data to 2018 workplan (updates to be provided quarterly).

TR:-

Add to the December meeting an agenda item to review the Committee's work using the structure set out in the slide deck from the Ted Baker, CQC Chief Inspector of Hospitals, presentation.

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

INFORMATION

149/17 **WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS (WYAAT) ESTATES AND FACILITIES FULL BUSINESS CASE**

LH attended the meeting to brief the Committee on the work of the WYAAT Estates and Facilities Sub Group.

As part of the West Yorkshire and Harrogate Strategic Transformation Partnership (STP) work a project has been established under the governance of the West Yorkshire Association of Acute Trusts (WYAAT) Estates and Facilities Sub Group to look at options for the creation of 'wholly owned subsidiaries' (limited companies owned by the NHS) for some services including estates and facilities functions.

From this work a 'case for change' to develop a Full Business Case was approved. The four trusts within the WYAAT group - Bradford Teaching Hospitals NHS Foundation Trust,

Calderdale and Huddersfield NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and Mid Yorkshire NHS Trust are in the process of developing their Full Business Case.

Briefings to staff and trade union colleagues across the four trusts have commenced. LH reported the briefings have gone well. There is a commitment to ensure every member of staff has a face to face briefing. LH has invited colleagues to get in touch at any time.

The four Trust Boards are expected to have assessed their respective business cases by the end of December 2017. A full consultation period will then follow.

The briefing note will be shared with the Committee.

ACTION: TR to email briefing note to Committee members.

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

150/17 **2017 STAFF SURVEY UPDATE**

JE provided a verbal update in relation to the staff survey response rate. JE advised that two touchpoints occur each week to monitor the participation rate. Today 33.1% (just under 1,800 people) colleagues completed and submitted a staff survey. The survey closes on 1 December 2017.

Colleagues are encouraged at every opportunity to complete the survey.

ACTION: JE to provide update at December Committee meeting.

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

ITEMS TO RECEIVE AND NOTE

151/17 **ANY OTHER BUSINESS:**

No other business was raised.

152/17 **MATTERS FOR ESCALATION:**

There were no matters for escalation.

DATE AND TIME OF NEXT MEETING:

Wednesday 13 December 2017, 9.30am – 11.30am, Discussion Room 2, Learning and Development Centre, Huddersfield Royal Infirmary