Calderdale and Huddersfield NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 6 July 2017 at 9.00 am

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

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	Welcome and introductions: Di Wharmby	Chair	**VERBAL**	Note
2	Apologies for absence: Phil Oldfield	Chair	**VERBAL**	Note
3	Declaration of interests	All	**VERBAL**	Receive
4	Minutes of the previous meeting held on 1 June 2017	Chair	**APP A**	Approve
5	Action log and matters arising:	Chair	**APP B**	Review
6	CQC Update on Action Plan (Deep-dive) – Critical Care presented by:- Dr Julie O'Riordan, Divisional Director Mary Hytch, Matron	Executive Director of Nursing	**APP C** Presentation **to follow**	**Approve**
7	Chairman's Report a. NHS Confederation Conference	Chair	**VERBAL**	Note
8	Chief Executive's Report: a. CQC 'Driving Improvement – Case studies from eight NHS Trusts'	Chief Executive	**APP D**	Note
Keeping the base safe				
10	High Level Risk Register	Executive Director of Nursing	**APP E**	**Approve**
11	Board Assurance Framework	Company Secretary	**APP F**	**Approve**
12	Plan on a Page Q1 Update – Year Ending 2018	Company Secretary	**APP G**	**Approve**
13	Care of the Acutely Ill Patient Report	Executive Medical Director	***APP H TO FOLLOW***	**Approve**

14	DIPC Annual Report	Executive Medical Director	**APP I**	**Approve**
15	Guardian of Safe Working Hours Quarterly Report	Deputy Medical Director/Miss Tamsyn Grey	**APP J**	**Approve**
16	Integrated Performance Report	Chief Operating Officer	**APP K**	**Approve**
Financial Sustainability				
17	Month 2 – 2017-2018 – Financial Narrative	Executive Director of Finance	**APP L**	**Approve**
A workforce for the future				
18	2016 Staff Survey Action Plan	Executive Director of Workforce & OD	**APP M**	**Approve**
Transforming and improving patient care – no items				
19	Elderly Care Strategy	Chief Operating Officer	**APP N**	**Approve**
20	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 31.5.17 and verbal update from meeting 3.7.17 ▪ Finance and Performance Committee – minutes of 30.5.17 and verbal update from meeting 4.7.17 ▪ Workforce Well Led Committee - minutes 8.6.17		**APP O**	**Receive**
Date and time of next meeting Thursday 3 August 2017 commencing at 9.00 am **Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital**				

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, 6th July 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 1.6.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 1.6.17.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 1.6.17.

Main Body

Purpose:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 1.6.17.

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 1.6.17.

Appendix

Attachment:

draft BOD MINS - PUBLIC - 1.6.17(2).pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 1 June 2017 in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

PRESENT

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

OBSERVER

Lynn Moore	Publicly Elected Membership Councillor
Kate Wileman	Publicly Elected Membership Councillor

73/17 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

747/17 APOLOGIES FOR ABSENCE

Apologies were received from:
Dr David Birkenhead, Medical Director

75/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

76/17 MINUTES OF THE MEETING HELD ON 2 MARCH 2017

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

OUTCOME: The minutes of the meeting were approved.

77/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG

There were no matters arising which had not been included on the agenda. It was noted that the Board Assurance Framework would be brought to the July meeting.

ACTION: BOD Agenda – July 2017.

78/17 CHAIRMAN'S REPORT

The Chairman reported that he had no items to discuss which had not already been included on the agenda.

79/17 CHIEF EXECUTIVE'S REPORT

a. Electronic Patient Record (EPR) Update

The Trust, in partnership with Bradford Teaching Hospitals NHS Trust (BTHFT) and Cerner commenced the work to build and implement an Electronic Patient Record in May 2015. It was agreed that CHFT would be the first Trust to go live with a cutover commencement date of the 28 April 2017. The Chief Executive presented a report updating the Board on the implementation highlights and lessons learned.

CHFT delivered against this plan and were able to confirm that they were fully live in all areas by 7am Tuesday 2 May 2017. The cutover plan was to go live in stages, starting in A&E and inpatient areas followed by outpatient areas. The cutover progressed well and by Tuesday 2 May all clinical and administration staff were using the system.
The Trust put in place support and mitigation plans to manage issues as they emerged during go-live and early live support.

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

Discussion took place regarding the details of the implementation and lessons learnt which would be shared with Bradford Trust. The Chief Executive stated that now was the time for the Trust to continue on the journey towards "Compassionate Care" rather than "EPR".

The Board noted the progress made in the implementation of EPR and acknowledged the significance of what had been achieved and the issues still to be addressed. All present, including the Membership Councillors wished to thank colleagues and volunteers for their help and resilience in achieving a successful cutover, with particular thanks to Mandy Griffin, Director of THIS and Helen Barker, Chief Operating Officer.

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

80/17 CQC UPDATE ON ACTION – MATERNITY SERVICES

As agreed at the previous meeting Martin Debono, Consultant Gynaecologist/Obstetrician, Anne-Marie Henshaw, Associate Director of Nursing/Head of Midwifery and Rob Aitchison, Director of Operations attended the meeting to update the Board on the progress with the CQC Action Plan around Maternity Services.

The key highlights of the presentation titled "Compliance and Beyond" centred around the recommendations of the inspection, what the department did to address these and actions for the future around the five CQC domains:-

- Well-led : Governance and Risk Management
- Caring: Patient Experience and Engagement
- Safe: Post Partum Haemorrhage
- Responsive: Operative Births and Procedures
- Effective: Obstetric Anal Sphincter Injuries

The discussions concluded that:-

- Good progress had been made over the last 12 months
- A culture which is open to external review and learning had been established

- Work continued to strengthen the service to deliver consistently good outcomes
- The refreshed culture continued to attract talented recruits to the department
- The department had a positive, improvement focused outlook to future provision.

The Board thanked the team for attending and felt assured that the work undertaken to date had improved the patient experience and that a culture which treated scrutiny as normal business would ensure further improvements in the future.

The Board was reminded that as agreed at the last meeting it would receive a deep-dive into progress of the CQC Action plan in the areas of CDU and ICU.

OUTCOME: The Board RECEIVED and NOTED the progress with the Maternity Services CQC Action Plan and welcomed further updates from CDU and ICU in the future.

ACTION: Future BOD Agenda Items

81/17 CQC YEAR END REPORT

The Executive Director of Nursing explained that the report provided an end of year review of the Trust's response to the CQC inspection report published in August 2016, and to the concerns raised at the time of the inspection in March 2016.

The report set out a year-end position against all of the must and should do actions. It also described and how the plan had been managed, including the role of the CQC Response Group and ongoing discussions with the CQC management team. The report also provided information regarding the expected re-inspection, detailing changes to the inspection regime and how the Trust had started to prepare for this.

The Chief Executive suggested that the Board should discuss 'Well-Led' at the workshop on 18 July 2017. The Chief Executive asked the Executive Director of Nursing to ascertain whether it would be possible to invite another Trust to help facilitate this session .

OUTCOME: The Board NOTED the progress being made with regard to the CQC Year End Report and agreed that 'Well-Led' should be a topic for discussion at the Board Workshop on the afternoon of the 18 July 2017.

ACTION: BOD Workshop Agenda – 18.7.17

82/17 HIGH LEVEL RISKS REGISTER

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

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

Risks with increased score
6969 (was 6723) (20): Capital programme risk had an increased risk score from 15 to 20.

Risks with reduced scores
6503 (15): Delivery of Electronic Patient Record Program. Following completion of "Go live" this risk had been reduced to 15.

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

Finance risks:
3 finance risks have been re-freshed for the financial year 2017/18 with new reference numbers. All had a risk score of 20:
6967 - non delivery of 2017/18 financial plan
6968 - cash flow risk
6969 - capital programme - the risk score has increased from 15 to 20.

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

As discussed at the previous meeting, it was noted that further work was being undertaken and the Board would receive a position statement on the nasogastric tube risk at either the July or August 2017 Meeting.

Prof. Roberts highlighted the issue of calibration of risks following his attendance at a Treasury Conference. It was agreed that Prof Roberts would meet with Executive Director of Nursing to discuss this further.

OUTCOME: The Board **APPROVED** the High Level Risk Register.
ACTION: BOD Agenda Item – July/August 2017
ACTION: Executive Director of Nursing/Prof. Roberts

83/17 GOVERNANCE REPORT
The Company Secretary presented the Governance Report which brought together a number of governance items for review and approval by the Board:

a. Board Workplan
The Board work plan had been updated and was presented to the Board for review. The Board was asked to consider whether there are any other items they would like to add for the forthcoming year.
OUTCOME: The Board **APPROVED** the work plan.

b. Declaration of Single Sex accommodation compliance
All providers of NHS funded care are required to confirm whether they are compliant with the national definition 'to eliminate mixed sex accommodation except where it is in the overall best interests of the patient, or reflects their patient choice'. It was noted that Trust Boards must approve the declaration and ensure that it is clearly visible on the Trust website.
OUTCOME: The Board **APPROVED** the declaration for publication on the Trust Website.

c. Use of Trust Seal
One document had been sealed since the last report to the Board in December. This was in relation to the agreed overage deed with Locala for the sale of Princess Royal Community Health Centre which took place on 30.11.16
OUTCOME: The Board **NOTED** the use of the Trust Seal.

d. Constitutional Changes
The Trust's Constitution had been reviewed and updated by the Membership Council in April 2017. The key amendments were listed in the report.

It was noted that the format of the Constitution has changed to match that of the model constitution provided by NHS Improvement.

The main issue of change was that the Membership Council had agreed to change their name to 'Council of Governors' which was consistent with almost all other councils and all of the documentation released from NHS Improvement referred to Council of Governors.

It was also noted that the catchment area for the appointment of Non-Executive Directors had been extended to cover the West Yorkshire and Harrogate Association of Acute Trust areas.

Prof Peter Roberts mentioned that constituency boundaries had not been reviewed to equalise the membership. The Company Secretary reported that when boundary changes occur in the future this would be reviewed.

OUTCOME: The Board **AGREED** the amendments set out in the draft Constitution which had been approved by the Membership Council.

e. Board Meeting Dates

The proposed meeting dates for the Board of Directors from January to December 2018 were circulated.

OUTCOME: The Board **APPROVED** the meeting dates for 2018.

f. Declaration of Interests

The Company Secretary advised that the new guidance becomes effective from 1 June 2017 although currently the Trust was compliant. In order that a new policy could be issued the Trust needed to determine the level of decision making influence in the organisation.

This would be discussed at WEB in June prior to to the Audit and Risk Committee in July. It was noted that significant work was required once a decision had been made as there was no process in place to record large numbers of declarations. It was agreed that the revised policy would be brought to the August BOD Meeting.

OUTCOME: The Board **NOTED** the progress

ACTION: BOD Agenda Item 3.8.17

g. Board to Ward Visits

The Company Secretary advised that reports were being obtained from the Executive Team following the visits undertaken during March-May and a formal report would be brought back to the Board

ACTION: Future BOD Agenda Item

84/17 INTEGRATED PERFORMANCE REPORT

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

- April's Performance Score is 69% for the Trust.
- The SAFE domain has once again gone back to a Green rating following improvements in Harm Free Care, Category 4 Pressure Ulcers and % post-partum haemorrage.
- The RESPONSIVE domain had returned to an Amber rating due to missing the 62 day GP Referral to Treatment target for the first time in over 12 months and continuing to underperform in the diagnostics 6 week target.
- CARING has deteriorated due to FFT Maternity and FFT A&E would recommend but remains Amber.
- Methodology for scoring has changed for FINANCE and WORKFORCE to reflect emphasis on indicators considered more important and this methodology has been applied to previous months for comparison purposes. This formed part of a review of

weighting of indicators across all domains where the weighting for Diagnostics and Readmission Rates has reduced but further debate is necessary for FFT (response rates) Within the Caring Domain where a wider discussion around the need for additional indicators is also required.

The Chief Operating Officer reported that changes to the ratings would be reviewed on an annual basis in liaison with the Non-Executive Directors.

The Executive Director of Finance advised that a narrative for Month 1 had not been required by NHSI and the finance information contained within the IBR was noted. This highlighted the challenges in Month 1 due to delivery of performance/activity. An analysis of the activity was being undertaken and initially this was showing that although the volume of patients had not changed it was felt that the case mix may have. This was not related to the implementation of EPR or GP referrals.

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

85/17 DIRECTOR OF INFECTION, PREVENTION AND CONTROL (DIPC) REPORT

In the absence of the Executive Medical Director, Dr Cornelle Parker, Deputy Medical Director presented the quarterly DIPC report for the period January to April 2017.

It was noted that there had been a number of challenges during the year and the highlights were:-

MRSA bacteraemia - At year end 2 cases reported against a planned target of 0
C.Diff – 32 cases identified against a planned target of 21 (7 avoidable and 25 unavoidable cases)
MSSA (post admission) – 13 cases against a planned local target of 12
E.coli bacteraemia (post admission) – 48 cases against a planned local target of 29
MRSA Screening – 95.2% compliance against a target of 95%

Discussion took place regarding the valuable opportunities afforded by the implementation of EPR to give clinicians alert prompts.

OUTCOME: The Boar**d RECEIVED** and **NOTED** the DIPC Report

86/17 SAFEGUARDING ADULTS AND CHILDREN UPDATE AND ANNUAL REPORT

The Executive Director of Nursing presented the Safeguarding update and Annual Report. The report covered the period April 2016 to March 2017 and confirmed the Trust's commitment and pledge to ensure the Safeguarding of Adults and Children remains a key organisational priority. The report had been written by the Head of Safeguarding in conjunction with the Named Nurses for Safeguarding Children and Adults, the Named Midwife, the Designated Nurse for Looked After Children (Calderdale) and the Domestic Abuse Lead.

The report described further plans and development for 2017/18, together with forthcoming legislation relating to the Deprivation of Liberty Safeguards (DOLS). Safeguarding Children and Adults is an integral aspect of patient care within CHFT; and ensure systems and processes effectively support patients and staff.

The report emphasized the key element to safeguarding was partnership working and as such the safeguarding team continued to progress with CHFTs contribution to multi-agency working with its partners.

Discussion took place on how the Trust knew it was making progress. It was noted that a

quarterly report would be presented to the Quality Committee along with a deep-dive.

It was agreed that the Executive Director of Nursing and Dr Linda Patterson would meet outside the meeting to discuss how this information can be made 'real' for the Board in order to give them assurance on the progress/improvements being made

OUTCOME: The Board NOTED the contents of the report.

ACTION: DoN and LP to meet outside the meeting.

87/17 HOSPITAL PHARMACY SPECIALS (HPS) ANNUAL REPORT

The Executive Director of Finance presented the Hospital Pharmacy Specials Annual Report and the contents were noted and approved.

The Executive Director of Finance reported that in order for the service to undertake large scale products, significant investment was required and a Business Strategy would be brought to the Board later in the summer,.

OUTCOME: The Board APPROVED the HPS Annual Report and agreed that a Business Strategy be presented to the Board later in the summer 2017.

88/17 TREASURY MANAGEMENT POLICY

The Executive Director of Finance presented the Treasury Management Policy which had been supported by the Audit and Risk Committee at its meeting in April 2017.
It was noted that Foundation Trusts have discretion to invest and borrow money for the purposes of or in connection with their functions. The Treasury Management Policy sets out a governance framework for the management of operating cash within an acceptable risk profile and in accordance with their duty to safeguard and properly account for the use of public money.

OUTCOME: The Board APPROVED the Treasury Management Policy

89/17 BUDGET BOOK 2017-18

The Executive Director of Finance presented the Budget Book 2017-18. He outlined the 2017/18 Financial Plan Overview, highlighting detailed information and assumptions regarding:-

- I&E position
- Capital Summary
- Strategic Plan

OUTCOME: The Board APPROVED the Budget Book 2017-18

90/17 NURSING AND MIDWIFERY STAFFING – HARD TRUTHS

The Executive Director of Nursing advised that the paper followed on from the detailed safe staffing report provided to the Trust Board in May 2016, and the follow up report from November 2016. It provided assurance to the Trust Board that nursing and midwifery staffing capacity and capability were monitored, reviewed and established in line with the recommendations of the Hard Truths (2014) document;

The paper set out the evidence base underpinning the staffing reviews completed in January 2017 as well as an analysis of the review findings and provided an overview of the size and shape of the nursing and midwifery workforce. Current and potential workforce risks were highlighted and recommendations made for investment, disinvestment or change to the workforce models.

It was noted that there remains significant risk to the workforce due to the national shortage of qualified staff and the recent level of vacancies, therefore sustainable recruitment & retention to the nursing workforce is a priority alongside

workforce modernisation.

The Board of Directors were reassured that the Trust was reviewing the capabilities of the newly introduced E-rostering and Safe Care systems and how these can be utilised to support our work in achieving the recommendations set out in Lord Carter's report.

It was noted that the Trust will continue to embed the National Quality Board guidance to inform strategic workforce planning for the Nursing and Midwifery Workforce to ensure the right staff with the right skills are available at the right time and place to provide compassionate care to people who access our services.

As part of the Hard Truths paper, discussion took place regarding the new discharge processes which had recently been introduced with the help of Age Concern. It was agreed that once the service had been evaluated, the Chief Operating Officer would provide and update to the October Council of Governors Meeting. At this point in the meeting Richard Hopkin, Non-Executive Director declared an interest due to his connections with Age Concern.

OUTCOME: The Board APPROVED the Hard Truths Report
ACTION: COO to attend Council of Governors Meeting 26.10.17

91/17 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

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

a. Quality Committee

Dr Linda Patterson, Chair of the Quality Committee reported on the items discussed at the meeting held on 31 May 2017 which had not been previously covered on the Board's agenda:

- Divisional Reports received
- Good news story – Cleaning Industry Management Standard awarded with honours to the Trust. The Trust was the only one in the country with honours. The Board asked that congratulations be passed to all staff.

OUTCOME: The Board **RECEIVED** the verbal update of the meeting held on 31.5.17.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 30 May 2017:-

- CIP risk – to be discussed in more detail at next meeting – meeting with NHS Improvement the following week.
- EPR – Successful implementation noted. The Committee will review the next stage of benefits to be realized.
- Financial implications of Bradford EPR Go-Live discussed.
- Employment of External Consultancy discussed and questioned whether these delivered best value for money. A list of criteria to benchmark against in the future would be drawn up by the Chief Executive and Executive Director of Finance.

OUTCOME: The Board **RECEIVED** the verbal update and the minutes of the meeting held on 4.4.17 and 2.5.17.

c. Audit and Risk Committee

Prof. Peter Roberts, Chair of the Audit and Risk Committee reported on the items discussed at the meeting held 25 May 2017. It was noted that these had been discussed in detail at the Extra-ordinary Private Board of Directors Meeting held on 25 May 2017.

OUTCOME: The Board **RECEIVED** the minutes of the meeting held on 19.4.17.

92/17 DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 6 July 2017 commencing at 9.00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital. (Please note amended venue)

The Chair closed the public meeting at 11:30 am.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 6th July 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 July 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 July 2017.

Main Body

Purpose:

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

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

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

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
165/16 3.11.16	**BOARD ASSURANCE FRAMEWORK** It was agreed to bring the Board Assurance Framework to the Board in February and for the Company Secretary to review other organisations' BAFs to assess the types of risks included	VP	**1.12.16** It was agreed that the Company Secretary would undertake a deep dive of the top themes and bring back to the Board anything which would benefit changing on the BAF in February 2017. **2.2.17** Compliance with NHSI was discussed and the Board questioned whether this was still relevant. It was agreed that this would be further discussed through the Finance and Performance Committee. **2.3.17** Presented to the Finance & Performance Committee prior to Board in June. 1.6.17 It was noted that the BAF would be brought to the July BOD Meeting.	6.7.17		
175/16 3.11.16	**UPDATE FROM SUB-COMMITTEES** **Audit and Risk Committee – DECLARATIONS OF INTEREST** The Company Secretary explained that there would be a change to the declarations of interest policy as new guidance was due to be published in December. An update would be brought to a future Board meeting.	VP	**2.2.17** The Company Secretary advised that Guidance was still awaited. It was requested that this remain open on the Action Log for a report to come back in March 2017. **3.2.17** It was noted that this item would be taken to the Audit and Risk Committee in April with a proposed solution.	3.8.17		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			1.6.17 New guidance to be discussed at WEB in June and taken to the July ARC. It was agreed that the revised policy would be brought to the August 2017 BOD.			
31/17 2.2.17	**WHISTLEBLOWING ANNUAL REPORT** It was agreed that a greater awareness of the Raising Concerns/Whistleblowing process was required in the Trust and this would be taken through the Workforce Well-led Committee and reported back to the Board.	IW		TBC		
28/17 2.2.17	**RISK REGISTER** Board agreed that a review of the EPR risk and its relation to a potential CQC re-inspection be considered alongside a review of the narrative at year-end in order to archive risks as appropriate and identify tolerance ratings for endemic risks. It was agreed that this would be undertaken by BB and VP and would be taken through the Audit and Risk Committee for review before returning to Board in June 2017.	BB	**2.3.17** Discussion took place regarding the nasogastric tube risk and it was agreed that a position statement would be brought to the Board in June. **6.4.17** Dr Linda Patterson reported that discussion had taken place at the Quality Committee regarding the nasogastric tube risk and it was noted that a task and finish group had been convened to oversee the outstanding work and a further report was expected to the June Board meeting. **1.6.17** It was noted that further would was being undertaken and the Board would receive a position statement on the nasogastric tube risk at a future meeting (July or August)	TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
9/17 5.1.17	**INTERNATIONAL STAFF** The Acting Chief Executive reported that discussions had taken place regarding abuse towards international staff from patients or their families. The Board agreed that this would not be tolerated and the Executive Director of Workforce and OD agreed that a system would be put in place to safeguard against this via NHS Protect.	IW	**2.3.17** The Executive Director of Workforce and OD reported that work was still being undertaken nationally and once this was complete feedback would be brought to the Board.	TBC		
2.3.17 49/17	**CARE OF THE ACUTELY ILL PATIENT – CULTURE** The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report and reminded the Board on the overall aim of the programme to reduce mortality. It was noted that this is divided into six themes: 1) Investigating causes of mortality and learning from findings 2) Reliability in clinical care 3) Early recognition and treatment of deteriorating patients. 4) End of life care 5) Caring for frail patients 6) Clinical coding	DB		6.7.17		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	The Executive Medical Director reported that HSMR is currently falling and is now 103.76 however it remains a concern. There is evidence that the improvement work has contributed to the reduction of HSMR over the last year and this would continue to be monitored. Discussion took place regarding Sepsis and as discussed at the last meeting, the Executive Medical Director reported that work continued to be undertaken regarding this to ensure that all staff treated sepsis as a medical emergency. It was agreed that an update would be brought to the Board to assure the Board that attitudes and behaviours were being addressed in the Trust to ensure that the care of the Sepsis patient was made a priority.					
6.4.17 65/17	**GOVERNANCE REPORT – CONSTITUTIONAL CHANGES** At the MC meeting on Wednesday 5 April, the MC considered a number of amendments to the Constitution. One of the items for discussion was the name of the Council to change the name to Council of Governors. This was in line with the	VP		1.6.17		1.6.17

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	majority of other Trusts nationally. It was agreed that the full amended Constitution would be presented at the next public Board of Directors meeting.					
6.4.17 66/17	**CQC UPDATE ON ACTION PLAN** It was noted that deep dives would be undertaken into the Action plan key themes:- Maternity, CDU and ICU to the next three Board meetings.	BB		1.6.17 – Maternity 6.7.17 – Critical Care		
1.6.17 83/17g	**BOARD TO WARD VISITS** The Company Secretary advised that reports were being obtained from the Executive Team following the visits undertaken during March-May and a formal report would be brought back to the Board.	VP		TBC		
1.6.17 86/17	**SAFEGUARDING ADULTS AND CHILDREN UPDATE AND ANNUAL REPORT** Information within the report was noted. It was agreed that BB and LP would meet outside the meeting to discuss how this information can be made 'real' for the Board in order to give them assurance on the progress/improvements being made.	BB				Meeting arranged 6.7.17

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
1.6.17 87/17	**HOSPITAL PHARMACY SPECIALS (HPS) ANNUAL REPORT** The Annual Report was received and production development noted. The DoF reported that in order for the service to undertake large scale products, significant investment was required and a Business Strategy would be brought to the Board later in the summer.	GB		TBC		
1.6.17 90/17	**HARD TRUTHS – DISCHARGE PROCESS** As part of the Hard Truths paper, discussion took place regarding the new discharge processes which had recently being introduced with the help of Age Concern. It was agreed that once the service had been evaluated. The COO would report to the October CoG Meeting and give an update.	HB		26.10.17 CoG Meeting		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 6th July 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: CQC 'DRIVING IMPROVEMENT - CASE STUDIES FROM 8 NHS TRUSTS' - The Board is asked to receive and note the contents of the Care Quality Commission (CQC) document 'Driving Improvement - Case Studies from Eight NHS Trusts'	
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 CQC undertook a review of eight trusts which had made a significant improvement on their rating following inspection to understand whether there were any common themes and what lessons could be learned.

Main Body

Purpose:

The report uses case studies of eight trusts which improved by either one or two ratings between inspections. The Board is asked to consider the report and any learning for the Trust.

Background/Overview:

Drawing on findings from inspection reports, CQC's 2016 State of Care report concluded that effective leadership and a positive, open culture are important drivers of change. In hospitals rated as good or outstanding, the trust boards had worked hard to create a culture where staff felt valued and empowered to suggest improvements and question poor practice.

The Issue:

The CQC chose to look at this further and selected eight trusts on the basis that they had achieved a significant improvement on their rating.

Next Steps:

The findings of this report will be considered as part of the Trust's improvement plan and preparation for the new CQC inspection.

Recommendations:

The Board is asked to receive and note the contents of the CQC document 'Driving Improvement - Case Studies from Eight NHS Trusts' and consider any learning for the Trust.

Appendix

Attachment:

20170614_drivingimprovement.pdf

Care Quality Commission

Driving improvement

Case studies from eight NHS trusts

JUNE 2017

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England.
We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Contents

Foreword

Professor Sir Mike Richards
Chief Inspector of Hospitals

What enables trusts to improve? What do you need to do to turn round an organisation with thousands of staff, operating on a number of sites and with growing pressures on services?

Drawing on findings from inspection reports, CQC's 2016 State of Care report concluded that effective leadership and a positive, open culture are important drivers of change. In hospitals rated as good or outstanding, the trust boards had worked hard to create a culture where staff felt valued and empowered to suggest improvements and question poor practice.

In determining how well-led a trust is, CQC takes into account leadership capability and capacity, culture, vision and strategy, governance, staff and patient/public engagement, and the drive for continuous improvement.

We set out to explore what eight trusts had done to become 'well-led' trusts. We wanted to hear from people in those trusts about how they had achieved those improvements, specifically the steps leaders had taken and the effect of those actions on staff and patients. To do this, we interviewed a range of people from each trust, including chief executives, medical and nursing directors, non-executives, heads of communications, front line staff, patient representatives and external stakeholders.

We found that when trusts went into special measures or received a rating of requires improvement, some staff were unaware of the extent of the issues. They hadn't realised that things in the trust were not as they should be. Or, they were so focused on their own service that they could not see the bigger picture of care across the trust.

But this was not a common view. In most of the trusts we visited, staff knew things weren't right and were taking steps to make improvements.

Those driving improvement in the trust felt supported when leaders accepted the need for change.

Some trusts changed the leadership team to help drive improvement. For others, it was about empowering existing staff to take leading roles in effecting organisational change. Trusts that unleashed the potential of their staff now see improved patient outcomes and higher staff morale.

One of the first steps on an improvement journey starts with changing the culture of the organisation. Typically, trusts rated as inadequate are disjointed organisations. That may be a disconnect between clinicians and managers, between medical and nursing teams, between specialist and general services, or between different hospitals in the same trust. The priority for leaders is to bring all the elements of the trust together. This is best done by engaging and empowering staff – underpinned by shared values.

Leaders need to lead and be seen to lead. Our improving trusts placed emphasis on the visibility of leaders: chief executives and senior staff spending time on the 'shop floor', meeting staff and setting up regular channels of communication.

An outward looking approach is another aspect that's enabled improvement. We heard how trusts reached out to their communities and encouraged staff to use social media to share stories and interact with patients and the public. They also involve patients and the public in the work of the trust, shaping services and providing feedback. Some of our case studies show how collaboration with local people and patient groups such as local Healthwatch has helped to drive improvement in a trust.

The feedback we received suggests that inspection does help improvement. As well as identifying problems and helping trusts develop improvement plans, reports can give a rigour and discipline to improvement work as well as giving clinicians and managers the boost to make changes.

These case studies support the premise of 'Developing People – Improving Care', the national framework for action on improvement and leadership development in NHS-funded service – that improvement and leadership capability leads to improved care for patients and more value for money.

The trusts featured in this publication show the strong correlation between improvements in each of the characteristics of 'well-led' that CQC uses to inspect and rate trusts and overall improvements in quality and safety. We want to encourage others to look at and learn from these case studies to help them in their own improvement work.

I would like to thank everybody connected with the featured trusts for the time and help they have given us in producing this publication.

Professor Sir Mike Richards
Chief Inspector of Hospitals

"These trusts have all worked fantastically hard to improve the services they offer their communities. The leaders have taken the time to really listen to both their staff and patients and have reaped the benefits. There is a lot in this report that all providers can learn from as we strive to make the kind of change we all want to see in our NHS."

Jim Mackey, Chief Executive, NHS Improvement

The trusts that we interviewed

We selected eight trusts on the basis that they had achieved a significant improvement on their rating. Five trusts have improved by two ratings, and three trusts have improved by one rating.

	Trust	From	To
+ 2 level ratings	University Hospitals of Morecambe Bay NHS Foundation Trust	Special measures	Good
	East Lancashire Hospitals NHS Trust	Special measures	Good
	Cambridge University Hospitals NHS Foundation Trust	Inadequate	Good
	Wexham Park Hospital	Inadequate	Good
	University Hospitals Bristol NHS Foundation Trust	Requires improvement	Outstanding
+ 1 level rating	Barking, Havering and Redbridge University Hospitals NHS Foundation Trust	Special measures	Requires improvement
	Leeds Teaching Hospital NHS Foundation Trust	Requires improvement	Good
	Mid Essex Hospital Services NHS Trust	Requires improvement	Good

Source: CQC inspection reports

CQC, through the Chief Inspector of Hospitals, will normally recommend that a trust is placed in special measures when an NHS trust or foundation trust is rated as inadequate in the well-led key question (for example, there are concerns that the organisation's leadership is unable to make sufficient improvements in a reasonable timeframe without extra support) and inadequate in one or more of the other key questions (safe, effective, caring, and responsive).

Some of the trusts went into special measures following a review in 2013 by NHS England's Medical Director, Sir Bruce Keogh, before CQC started its comprehensive inspections.

For each trust we interviewed a range of people including: Chief executives, directors of nursing, chief operating officers, medical and nursing directors, senior consultants, front line staff, non-executive directors, heads of communications, patient representatives, and external stakeholders – such as Overview and Scrutiny Committee members.

We asked each interviewee questions that were common across trusts:

- What was your reaction to going into special measures/getting a low rating?
- How did you view the hospital/trust prior to it going into special measures/getting a low rating?
- How did you approach improvement?
- What support did you receive?
- What were the obstacles to improvement? How did you overcome them?
- How did you involve staff/public and patient representative groups?
- How did you ensure a focus on equality and human rights in your improvement journey?
- Did your inspection report help you to improve?
- Examples of tangible improvements
- Examples of improved outcomes for patients
- What next on the improvement journey?

A number of common themes emerged from the interviews, but as not all were given the same weight by our interviewees, we have not covered them all equally in each trust's case study.

University Hospitals Bristol NHS Foundation Trust

Acknowledgements

We would like to thank everyone involved in the production of this publication. This work would not have been possible without the support and time of the eight trusts who agreed to be case studies for improvement.

We are especially grateful to the staff, patients and members of the public who took the time to give their views on the improvement journey of their trust.

We would also like to thank all the local Healthwatch and Overview and Scrutiny Committees for their input into this publication.

NHS Staff Survey

"Improvement starts and ends with staff engagement"

Chief Executive of East Lancashire Hospitals

Each year NHS staff are invited to take part in the NHS Staff Survey. This gathers views on staff experience at work. The 2016 survey was carried out between September and December 2016 across 316 NHS organisations. The survey had 423,000 responses from staff.

The survey results show how staff attitudes towards the trusts featured in this publication have become more positive. Staff are increasingly happy to work in their organisation and are more willing to let their friends or relatives be cared for at the trust.

Barking, Havering and Redbridge University Hospitals NHS Trust

NHS Staff Survey 2016 trust scores

	I would recommend my organisation as a place to work		If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	
Trust name	**Agree/strongly agree (%) 2016**	**Change since 2014 (%)**	**Agree/strongly agree (%) 2016**	**Change since 2014 (%)**
Barking, Havering and Redbridge University Hospitals NHS Trust	59	10	64	9
Cambridge University Hospitals NHS Foundation Trust	65	7	83	6
East Lancashire Hospitals NHS Trust	65	5	70	10
Leeds Teaching Hospitals NHS Trust	64	11	74	11
Mid Essex Hospital Services NHS Trust	71	8	76	2
University Hospitals Bristol NHS Foundation Trust	67	11	81	10
University Hospitals of Morecambe Bay NHS Foundation Trust	60	11	65	9
Frimley Health NHS Foundation Trust*	67	-10	77	-12
England average for acute trusts**	61	4	70	5

* Between the 2014 and 2016 surveys, Frimley Park Hospital NHS Foundation Trust acquired Heatherwood and Wexham Park Hospitals NHS Foundation Trust (and was renamed Frimley Health)

** This is the mean average, so each trust's results are weighted equally rather than being weighted according to their size

Source: NHS Staff Survey 2016

Leeds Teaching Hospitals NHS Trust

Key themes

"Staff had phenomenal stories about their improvement, but I suppose when I arrived I found quite a fear of sharing improvement"

Director of Communications at Barking, Havering and Redbridge University Hospitals

Each case study in this publication shows key themes of improvement. We hope that these themes will help to inspire other trusts to start and maintain their own improvement journey to help patients, who are at the heart of everything we do.

Reaction to initial inspection report/rating

We saw that trusts were able to make rapid improvements when leaders viewed our inspection report as an opportunity to drive change. Trusts that had recognised issues in their organisation were able to have open and honest conversations with staff and patients on how they could make improvements, and then take action to put these in place. Leadership teams who were in denial about problems made little or no initial progress in improving their organisation.

Some trusts were initially reluctant to accept the findings in the inspection report. "Initially I felt demoralised…but when you step aside and look overall, you can accept what the report was saying as fair" said one Consultant at Leeds Teaching Hospital.

However, other trusts told us that the inspection report validated the concerns they already had. These trusts were confident in knowing that care could and should be better for their patients, and were determined to make this happen.

In most of the trusts we spoke with, a change in leadership was the catalyst for accepting the findings in a report and working to drive improvement.

Leadership

Our case studies point to leadership qualities that really help to drive improvement. Leaders knew they needed to be visible and approachable in order for staff to feel supported. For example, Mid Essex Hospital Services' 'Clinical Tuesday', where all the matrons and lead nurses come and work on the ward, bridging the gap between the management and the ward staff; the meetings where the Chief Executive of University Hospitals of Morecambe Bay (UHMB) takes questions from staff; and the accessible video briefings from the Chief Executive of University Hospitals Bristol.

Good leadership is about building strong teams. Chief executives commented on the importance of having a strong executive team and we heard examples of how teamwork was fostered on wards and departments through rewards for achievements and by enabling better working between clinicians and managers. Visibility of leaders was also crucial to gauging cultural change in trusts.

But as Frimley Hospitals' Chief Executive put it, "You don't turn an organisation around just by appointing a new CEO or executive team". He emphasised the importance of clinical leadership, with clinicians having a vital role in setting the standard of what good looks like.

Cultural change

Trusts knew that it was not enough to create an improvement plan – they had to get the staff engaged and motivated to help drive it. "Improvement starts and ends with staff engagement", the Chief Executive of East Lancashire Hospitals told us, "getting staff to understand that they had the answers and the means to improve was critical". In Leeds, the Chief Executive wrote to more than 2,000 managers before he took up the post, setting the tone of his approach. In Bristol, 'Breaking the Cycle' events are held with staff to focus on operational problem-solving.

Moving from a culture of blame to one that celebrates success is another key theme of the trusts. "Staff had phenomenal stories about their improvement, but I suppose when I arrived I found quite a fear of sharing improvement…so we needed to do a lot of work with people to improve confidence and help them to understand that their journey of improvement is something that they should be proud of and that they should want to talk about", said the Director of Communications at Barking, Havering and Redbridge University Hospitals (BHRT).

East Lancashire Hospitals NHS Trust

"We're reporting more and more things. And that's really letting people start to have conversations – we're empowering staff to fix things."

Associate Medical Director at Barking, Havering and Redbridge University Hospitals

The trusts recognised the need to tackle equality and diversity issues relating to staff and patients and in the wider community. "If you can't be who you are at work, you are not going to give 100%," according to UHMB's Chief Executive, who took steps to engage doctors by working with the British Association of Physicians of Indian Origin. Cambridge University Hospitals has regular discussions with staff to highlight discrimination, and has a graphic to show the flags of the different home countries of staff as a visual representation of diversity. At Wexham Park Hospital, doctors made note of languages spoken during ward rounds.

Vision and values

Leaders placed an emphasis on getting to know how staff felt about working at the trust. They worked with staff to produce a set of shared values that would underpin positive cultural change. The trusts understood that staff needed to have ownership of the values if they were to be meaningful. Leeds used technology to 'crowdsource' staff views on how to make the trust a great place to work; Bristol billed 2015/16 as a 'year of engagement' that helped to establish a patient-focused culture and the Chief Executive at BHRT spoke of the values and behaviours that had been designed and developed by staff.

Governance

Addressing problems with governance was a priority for most of the trusts. The right connections needed to be in place from board to ward. There was a keen understanding of this at BHRT. "The processes and systems had been broken for some time," the chair explains. "So the financial systems and systems for setting budgets had been broken, the governance systems for managing the board, and clinical governance… There was no consistent oversight of the organisation."

Good governance meant looking at how the board worked and putting new systems in place throughout organisations – for example, Bristol's focus on getting the governance structure and processes right around clinical incidents.

Getting finances in order often came alongside tackling governance. As we heard from the former Chief Executive of Mid Essex: "You might have to invest to save: you might have to put in an extra clinician to deliver a new service but, if that means patients get treated, and they don't have to go into hospital and can go home, that's saving the system money."

Improving safety

Trusts knew that they needed to change their approach to quality improvement. Both Leeds and BHRT are two of five trusts that have been chosen to work with the Virginia Mason Institute as part of a programme led by NHS Improvement. Leeds adapted the approach to become 'the Leeds improvement Method', transforming the way patients move through the hospital. At Wexham Park, an independently chaired Quality and Improvement Committee oversaw improvement, while in Cambridge the Chief Nurse set up a Quality Improvement Programme to assure and challenge improvement plans.

Leeds Teaching Hospitals NHS Trust

As well as corporate initiatives, we also heard about localised quality initiatives such as BHRT's 'model ward', which gives ward staff the responsibility to define what a good ward looks like and then to take responsibility for improvement. At UHMB, quality improvement is driven by staff through Listening into Action projects, where front line staff propose projects that will make a difference to patient care. Quality improvement has become a front line activity in many trusts. For example, daily ward 'huddles' in Leeds, or Cambridge's '08.27' meetings.

Improving trusts are asking questions about the quality of their services. For example, in East Lancashire, each ward gets an unannounced visit from a panel of five staff members who carry out a 'CQC style' inspection to assess quality of care.

Strengthening processes for reporting and learning from incidents was also integral to improvement for most trusts. At BHRT, the Associate Medical Director commented that the rate of incident reporting is one area where the hospital's data highlights a tangible difference: "We're reporting more and more things. And that's really letting people start to have conversations – we're empowering staff to fix things."

"We followed up every action. I don't believe we'd have got the rate of improvement and acceleration without the reports and action plans."

Medical Director, University Hospitals of Morecambe Bay NHS Foundation Trust

Patient and public involvement

Taking the views and experiences of patients and the public into account is vital to making improvements. At Wexham Park, focus groups help to address cultural sensitivities, and Mid Essex emphasised that a fundamental part of its improvement journey has been listening to staff and patients, including through a series of 'In Your Shoes' listening events and through the ongoing work of the Patient Council.

Looking outwards

Some trusts pointed to the power of being open with staff and the public. For example, UHMB, Leeds and Cambridge all used social media as a tool to share stories of improvement. According to Cambridge's Senior Communications Manager, "We used the #myCUH hashtag on Twitter to help show staff involvement in developing the improvement plan, but it was also used by staff themselves as a platform to share their own improvement stories."

Better public engagement has also helped improvement. For example, the 'Tell Ellie' campaign at East Lancashire took the trust out to patients for the first time and the trust established a stakeholder listening event to take place every quarter.

CQC engagement

The feedback we received suggests that inspection does help improvement. As well as identifying problems and helping trusts develop improvement plans, reports can help to give structure to improvement work as well as giving clinicians and managers the vigour to effect change. A Medical Director at UHMB said, "They brought a rigour and discipline to improvement work and pointed to where you need to drill down… We followed up every action. I don't believe we'd have got the rate of improvement and acceleration without the reports and action plans."

CQC inspectors commented that the cultural change was notable as trusts improved, for example, in the way that trusts engaged more regularly and openly with inspectors.

Barking, Havering and Redbridge University Hospitals NHS Trust

Next on the improvement journey

All trusts have the ambition to keep improving. Trusts such as UHMB, Leeds and Cambridge are looking at their involvement in the wider health and care systems locally.

For Frimley Chief Executive Sir Andrew Morris, Wexham Park needs to maintain the improvements that have happened so far, as well as continue to enable staff to make further improvements. "Like a soufflé, which will flop if you aren't careful, the challenge for the trust will be to maintain the improvements made and to continue to make further improvements."

University Hospitals of Morecambe Bay NHS Foundation Trust

February 2017

Rated as good

December 2015

Came out of special measures

July 2015

Rated as requires improvement

June 2014

Went into special measures

University Hospitals of Morecambe Bay NHS Foundation Trust serves a population of around 365,000 covering South Cumbria, North Lancashire and surrounding areas. It is made up of three hospitals: Furness General, the Lancaster Royal Infirmary and Westmorland General, as well a range of community facilities.

The trust was placed into special measures in June 2014 following an inspection in February 2014. An inspection in July 2015 resulted in a rating of requires improvement, with the trust coming out of special measures in December 2015. In February 2017 the trust was rated as good following an inspection in October 2016.

Reaction to initial inspection report/rating

When the trust went into special measures there were mixed views from staff and patients. "We were disappointed in ourselves. We felt we had done a lot and moved on and made enough progress to have made a more positive mark," says Phil Woodford, Director of Communications. There was a general disappointment for staff who were working so hard under pressure, and for the community that supported the hospital.

Chief Executive Jackie Daniel joined in August 2012 at what she describes as the "low point" for the trust. "The board had gone, and there was an interim chair. The report findings were not unexpected and I came in with my eyes open. The report rang true." Jackie comments that staff morale

"was low when we were so busy. With staff shortages, training needs were not being met, which led to staff being disengaged".

Consultant Andrew Higham – now Clinical Director for Medicine – was not at all surprised. "A good few years before the 'big trouble', the way the trust was being managed was increasingly a cause for concern." Non-Executive Director Denis Lidstone also had concerns when he joined the board in 2012 to focus on governance. "I saw how bad things were. The board was disconnected from the organisation."

Leadership

Jackie says, "The first thing was to get some sense of direction and support – and clear communications on how we were going to get through this. We needed to start to tell the story of what had gone wrong and why, so staff could make sense of it and then tell them what we needed them to do, in what order, to put things right."

As Chief Executive, Jackie started by asking five questions: have we got a strategy? How are we approaching quality and safety? Are we building relationships with staff? What partnerships have we got to support what we do? How is our performance?

"For me, the first job was to scan these areas and understand what we had and hadn't got. This framework guides me now, week by week, month by month."

> **"People feel engaged because they've been listened to, not just told what to do."**
>
> **Andrew Higham, Clinical Director for Medicine**

Jackie set about identifying gaps, setting priorities and putting a plan in place. "We needed to make sure we had good wiring from board to ward: for example, a good board assurance framework, a risk management framework, a performance management framework – the things any well-run organisation needs."

When Andrew Higham became Clinical Director for Medicine, he appointed 11 clinical leads in the specialties. "Suddenly, I had 11 deputies to share the burden. We appointed clinical managers to support the clinical leads. It was like a breath of fresh air. We now have clinical teams much more engaged with that journey of constant improvement. People feel engaged because they've been listened to, not just told what to do."

Cultural change

From Non-Executive Director Denis Lidstone's perspective, getting the culture of the organisation right was crucial. "You had to get everyone on the same page and be clear about people's roles. Culture is about how you get people to think and act differently."

Jackie Daniel recognised that the best plans and strategies would fail if the people she relied on to make them work were not engaged and empowered. The staff needed a clear sense of direction.

Listening into Action to make a difference to patient care

Listening into Action (LiA) involves front line staff proposing projects that will make a difference to patient care. The project has to get patients and staff involved. Examples include:

- An intensive care unit project led by nurses to tackle the pain caused by nose tubes and pressure sores. Pressure sores can lead to infection, affect a patient's length of stay and incur unnecessary costs. The project almost eliminated the incidence of pressure sores and has led to savings of tens of thousands of pounds.
- Specific education and training to spot signs of acute kidney infection. Following up an NHS England alert about mortality, an associate specialist doctor recognised that this could be easy, so she set up a LiA project and a training programme that is saving lives today.

Development and training with the British Association of Physicians of Indian Origin

Jackie Daniel saw that engaging with Black and minority ethnic (BME) groups of staff in the organisation was difficult.

She attended the British Association of Physicians of Indian Origin (BAPIO) national conference and presented the trust's work on equality and diversity. Phil Woodford thinks this was a turning point. "I think our Indian and Pakistani doctors who were there saw it as more than a token gesture." The trust then formed an agreement with BAPIO for development and training and established a BME network with BAPIO.

Regional local representatives from BAPIO worked with the trust on understanding the issues that are different for staff from BME groups.

Jackie says, "One of the ways I can help turn this issue around is by creating an environment where every member of staff can flourish in whatever way is important to them – but bring their best self to work. If you can't be who you are at work, you are not going to give 100%. And I think that equality and diversity work is a real cornerstone of that whole agenda."

"The Chief Executive gave up time to talk to staff," says Director of Communications Phil Woodford. "Jackie asked people, 'if you could change something, what would it be, why would that make a difference and what longstanding change do we need to make?' Jackie knew she would be held to account at the next staff survey or governors' meeting if she hadn't delivered promises."

The trust also focused on empowering clinicians to deliver best practice. As the Clinical Director for Medicine, Andrew Higham believes, this was about enabling clinicians to lead. "We had gone too far down the road of management control and clinicians being disenfranchised with no say. We had lost a lot of discretionary effort among clinicians; they just came, did the job and went home."

An early change was to establish five clinical divisions, each led by a clinician. "We asked a group of people to take responsibility who hadn't had to before," says Denis Lidstone. "We worked with them to get them to control their own areas. We provided training for managers and non-executives mentored people and divisions."

The trust tried to make sure that everyone was involved in improvement. The Listening into Action (LiA) project, which asked front line staff to identify improvements, is a good example as it led to all kinds of clinical leaders emerging to lead hundreds of projects.

> **"The temptation is to pull up the shutters, but actually the thing to do is keep up a dialogue."**
>
> **Jackie Daniel, Chief Executive**

Improving safety

"We are much better at reporting and learning," says Andrew. "Some things did happen before but they were not well-structured or embedded. The link between wards and boards is better."

The executive team now has weekly meetings to review incidents. Sister and Ward Manager Michelle McLaughlin says, "Every month I have a governance meeting with my staff where we look at learning from incidents, recalls and alerts. That results in better patient care and safety – that's a big change of culture."

Senior leaders became more visible around the trust. "We now know senior managers," says Michelle. "Before, staff would say 'who's that?' Now we see senior staff around a lot more, coming on to wards."

Denis Lidstone also emphasises quality. "Because we were missing a lot of targets, we started putting money into things. In some cases, money we didn't have – for example, to start recruitment. The money came later. We needed to focus on quality." Medical Director David Walker agrees with this. "It's about focusing on the basics of quality," he says. "You need the information to understand the business. We needed to provide clinicians with the information to do their job well."

Looking outwards

Jackie Daniel stresses how important it was to work with the local population. "The temptation is to pull up the shutters, but actually the thing to do is keep up a dialogue." The trust held a listening event with a local GP practice in Barrow-in-Furness, modelled on CQC listening events. Commenting on the event, Phil Woodford added, "It was a revelation for our staff because you realise when you live in a bubble of failure you think everything is bad. People spoke about the good care they'd had too."

CQC engagement

Part of Jackie's mission as Chief Executive was to make sure that improvement did not become too bureaucratic. Action plans need to be "good enough to get the right level of improvement without sinking people in process," she says. "We've looked to create as many ways as possible for staff to get involved in lighter, less formal, less bureaucratic and less hierarchical ways."

There was general agreement that CQC's inspection reports helped to drive improvement. "They brought a rigour and discipline to improvement work and pointed to where you needed to drill down," says David Walker. Jackie agrees, "We followed up every action. I don't believe we'd have got the rate of improvement and acceleration without the reports and action plans." As a Clinical Director, Andrew views the inspection process as helpful as "it gives clinicians and managers some ammunition to effect change".

Sandra Sutton, CQC's Inspection Manager, praises the trust for the engagement with CQC between inspections. "They wanted to share progress with us and wanted to hear the feedback we were getting." She thinks this open approach supported improvement and commented, "The improvement plan following the inspection in October 2016 was the best that I have seen."

Next on the improvement journey

The trust is aiming for a rating of outstanding. As Phil Woodford puts it, "We have the staff and the talent. It's about freeing them to do more." Chief Executive Jackie says she is going to use the staff survey as her number one indicator over the next 12 months. "My mission is to get the most significant improvement in the staff survey next year."

At the same time, the trust is central to the development of an accountable care system in the area, breaking down the traditional boundaries between hospital care, community-based services, primary medical services and adult social care services.

For more information about University Hospitals of Morecambe Bay NHS Foundation Trust, email **communications.team@mbht.nhs.uk**.

Involving local people in the new maternity unit

Lesley Bennett is one of the parents involved in helping to shape the design of the trust's new maternity unit. She says that local people were fully involved in the development by meeting the architect and contractors, looking at the options and making suggestions. "We got everything we said we wanted. The new unit is better than we could have hoped for. We were not there to look good; they really listened to us and our opinions counted."

The trust acted on the parents' suggestion of using the bereavement room as a place to stay for families with a terminally ill child or a child receiving special care.

Lesley says, "The Head of Midwifery always said this maternity unit belongs to the community – the trust just staffs it, runs it, and provides the service. It was always about what the people wanted and how best it can be for them. It's the start of a new beginning for families. If you get that experience right, you set up a family for life because you always think back to the birth."

"We have the staff and the talent. It's about freeing them to do more."

Phil Woodford, Director of Communications

East Lancashire Hospitals NHS Trust

2015

Rated as good

May 2014

Rated as requires improvement and came out of special measures

July 2013

Went into special measures

East Lancashire Hospitals NHS Trust serves a population of 521,000. The trust has two acute sites: Royal Blackburn Hospital and Burnley General Hospital as well as three community sites.

East Lancashire Hospitals NHS Trust went into special measures in July 2013, following a review by Sir Bruce Keogh. In May 2014, a CQC inspection found that the trust had made enough progress to come out of special measures, and rated the trust as requires improvement. A focused inspection in 2015 led to the overall rating being upgraded to good.

Reaction to initial inspection report/rating

Many members of staff were shocked and disappointed when the trust entered special measures. At the time, the trust was working confidently towards gaining foundation trust status. Peter Rowe, who joined the trust as a Non-Executive Director in June 2013, recalls the "complete devastation" when it was announced that the trust would go into special measures. That same shock and disbelief was felt across the organisation. For Shirley Vicary, Ward Manager, "It was a real knock; it didn't feel like we were that bad."

Chris Pearson recognised the determination of staff to make positive changes when she joined the trust as Director of Nursing in January 2014, five months after the trust had entered special measures. "Some staff were sad and some disheartened, but many felt that going into special measures was the awakening that the organisation needed and they were determined to make things better."

Leadership

Six months after the trust entered special measures, there were a number of changes to the trust's leadership team. "Jim Birrell came in as Interim Chief Executive and he had a way of unifying people," says Dr Ian Stanley, Deputy Medical Director.

Peter Rowe agrees. "Jim and the new leadership made it very plain at board level that quality was a priority and dropped any ambition for foundation trust status. We began to move away from being reactive reporters and started supporting staff to be proactive in identifying and tackling variations in quality. It was a real paradigm shift that involved a huge amount of staff engagement."

The executive team spent time being out and about, talking to staff on the front line and letting staff know they would be supported. "Previously there had been a profound divide between the board and the staff," says Peter Rowe. Dr Ian Stanley agrees. "It was only when the changes in the team led to a more open atmosphere that there was a change of mind-set – we just had to be honest and work together to tackle the issues at hand." Ward Manager Shirley Vicary feels that the trust is now a "far more open place to work" and that "if there is any issue that staff feel is not right, they will raise concerns, and it was never like that before."

Cultural change

Getting the culture right was also key for Dr Stanley. "At the start, there was a culture of not wanting to measure things, not wanting to monitor things and not wanting to report things because if you did you might get shot down, because you weren't reporting good stuff. One of the first things that we had to do was to change the approach to quality improvement and convey the idea to staff that we are measuring to improve, not to comply or tick a box."

For Foundation Trainee Doctor Rebecca Kuruvilla, "There's an unspoken camaraderie – almost like being in the trenches – a feeling of 'we're all in it together'". Rebecca feels there is a real emphasis on listening to what the staff want and what ideas they have. "The leadership style is very inspiring and it must have had a big effect on how things have been turned around – I can't see how it didn't."

For Kevin McGee, who took over as Chief Executive in 2014, improvement "starts and ends with staff engagement". He speaks from experience, having previously been Chief Executive at George Eliot Hospital NHS Trust where he took the trust out of special measures. "At both trusts, getting staff to understand that they had the answers and the means to improve was critical. After that it's about giving staff the practical tools to make and maintain those improvements."

When Chris Pearson joined in January 2014, one of her first actions was to set up regular meetings with all ward managers. "At the first meeting, I asked them all to tell me something good that had happened on their area and no-one said a word. They had never been asked about the positives before and at that moment I knew had a real job to do around changing the culture."

Tackling variation in quality on wards

Director of Nursing, Chris Pearson, introduced the Nursing Assessment Practice Framework in a bid to tackle the variation in quality between wards.

Chris says, "Each ward gets an unannounced visit from a panel of five staff members who carry out an inspection 'CQC style' to assess quality of care. On the panel there'll be a safeguarding lead, a matron from another area and other members of staff. Each ward is scored red, amber or green for how they are meeting each KLOE. We've not completed every ward yet, but we've done 89 assessments so far. A ward scored red (not meeting standards) gets another visit in two months. If they achieve more standards against the indicators they get amber. When a ward gets three consecutive greens, they get an accreditation." Chris is clear that this has really helped to highlight areas for improvement and drive changes in practice.

Establishing a pressure ulcer collaborative

Throughout 2014, the trust provided learning sessions and a summit to engage staff in a new quality improvement methodology aimed at reducing pressure ulcers.

"We haven't had a Grade 4 pressure ulcer in this organisation across both acute and community services (we've got over 1,000 beds) since August 2014, which is a huge achievement," says Chris Pearson. We can absolutely scrutinise every pressure ulcer, whether it's acquired or inherited, consider what we're going to do about it and prevent it happening again. We're down to single figures of Grade 2 pressure ulcers now.

"We showed the staff the data and what they'd achieved. That gave them the boost to want to get involved in more improvement collaboratives."

Vision and values

Embedding the trust's vision of "Safe, Personal and Effective" was also crucial. Chris Hughes, Director of Communications, worked hard to promote this vision and the objectives that underpin it. "We had posters made and put them everywhere, we referenced the vision and values in every publication, and we flooded the organisation with the message that this is what we are about and stand for."

Improving safety

The trust's focus on quality improvement and harm reduction has led directly to improved outcomes for patients. "We have a systematic approach to dealing with harm now and a clear reporting mechanism," says Dr Stanley. "Through the harm reduction programme we have reduced the number of pressure ulcers and falls and improved infection control practices. Mortality rates have also improved."

> **"There's an unspoken camaraderie – almost like being in the trenches – a feeling of 'we're all in it together'"**
>
> **Rebecca Kuruvilla, Foundation Trainee Doctor**

Looking outwards

The outside world seemed to perceive services as inadequate. This had an effect on staff morale and made it difficult to recruit new staff. According to Chris Hughes, it was about re-launching the organisation, re-establishing its reputation and taking some control. When she joined the trust in February 2014, one key task was to turn around what was a very hostile relationship with the local media and make a concerted effort to have a higher profile. "It was about working with the local media and not against them. We had to be brave and honest."

The consensus is that entering special measures has benefited the trust, but the initial scrutiny from external regulators was at times testing. "Everybody wanted information and that was an added pressure," says Chris Pearson. Dr Stanley acknowledges this. "It took an awful long time for the clinical commission group (CCG) and others to trust us and that is understandable. They asked questions about every decision we made and we had to re-build our relationship with them to get that trust back."

Patient and public involvement

Public engagement has improved. The introduction of the 'Tell Ellie' campaign (East Lancashire Listens, Involves and Engages) marked a significant change as it took the trust out to patients for the first time. "Previously, the trust had waited for patients to come to them and in reaction they launched the Tell Ellie campaign and took staff out into the community to meet and engage with local people," says Chris Hughes. "While it was limited in its reach, it served a purpose and was the start of a different approach to engaging with the public."

After being appointed as Director of Communications, Chris Hughes established a stakeholder listening event every quarter to widen the public audience. "We invite people from a lot of interested organisations, including a number representing patient groups, to come and talk to the board. We get a lot of valuable 'soft' intelligence and it's directly used to inform changes in how we deliver services."

Individual local patient groups are more involved. Russ McLean is the Chair of Patient Voices in Lancashire and has worked closely with the trust to make sure that the views of the public feed into improvements to services. He says, "The trust is far more responsive to us now. We really work with them and they listen to what we're telling them."

Representatives from local Healthwatch have also been involved in the trust's Patient Experience Committee, which meets regularly to discuss patient feedback.

Non-Executive Director Peter Rowe also notes how the trust has improved its process for handling complaints. "Previously it was meticulous in terms of following an auditable process, but it lacked any sense of humanity. The process has been completely overhauled. The moment something goes wrong a patient or carer can contact a matron by a bleep and we tackle the issue there and then. We get far fewer complaints now."

CQC engagement

There is general agreement that CQC inspections have helped. For Chris Hughes, "The CQC requirements allowed us to get a real campaign going internally. We all knew we had to get through the re-inspection and get through it well. Everyone had a shared objective."

Chief Executive Kevin McGee says, "The CQC process gives you a real focus for improvement. I was able to say to commissioners, 'some of these areas for improvement are systems issues and I need your support,' whether that is in terms of resources, changes to primary care services or whatever."

Next on the improvement journey

Chief Executive Kevin McGee is committed to continuing with the quality improvement work. "The emergency pathway work we have done has led to excellent quality services, but we need to improve on timeliness and meeting the four-hour target."

Similarly, Kevin wants to continue the work to improve the trust's reputation to help attract new staff. "There are still one or two areas where we struggle with recruitment – A&E consultants for example. I want to try to do more to show people that this is a great place to work."

Kevin is aiming for an outstanding rating. "I'd like the work we have put in to improve clinical quality and staff engagement to be recognised with a rating of outstanding. We've got here, but we have to keep moving. We must continue to evolve."

For more information about East Lancashire Hospitals NHS Trust, email **commications@elht.nhs.uk**.

Partnership in care

This project aims to improve the quality and experience of one-to-one care for vulnerable patients. In 2016, the trust successfully trialed a number of initiatives on three wards, including:

- communication aids for staff, designed to promote a 'partnership in care' with relatives and carers
- pocket cards for staff listing a set of standards to follow when providing one-to-one care
- a partnership in care leaflet for families and carers that recognises their rights as carers and experts in knowing what the patient's personal preferences might be
- an activity log to help support engagement and stimulation with patients who receive one-to-one care
- the 'Enhanced Care' risk assessment tool, which helps provide a standard and assurance to determine which patients need one-to-one care so they receive the right care at the right time.

Shirley Vicary, a Ward Manager of a complex care ward, feels lucky she was able to be involved in the trial as "the immediate benefit to patients has been clear". The project has now been rolled out to other wards and the learning is being shared with trusts across the country.

Cambridge University Hospitals NHS Foundation Trust

January 2017

Rated as good and came out of special measures

September 2015

Rated as inadequate and went into special measures

Cambridge University Hospitals NHS Foundation Trust is one of the largest in the UK with around 1,400 beds. The trust provides a major trauma centre for the east of England, a range of specialist services and district general hospital services to patients coming from Cambridgeshire, Essex, Suffolk and Hertfordshire.

Following a CQC inspection in April 2015, the trust was rated as inadequate and placed into special measures in September 2015. A focused re-inspection in February 2016 and a comprehensive re-inspection in September 2016 found the trust had made improvements in the quality and safety of services. The trust was taken out of special measures and rated as good in January 2017.

Reaction to initial inspection report/rating

Staff at the trust initially felt shocked at being rated as inadequate. Chief Pharmacist Sarah Pacey felt "surprise and disappointment" at the news, but recognised that "there was a large element of learning and improvement to be taken from the report and its findings". Sarah was impressed with the trust's "immediate and prompt" response.

Roland Sinker joined the trust as Chief Executive in November 2015 when the quality improvement plan was well under way. He comments that inspection reports "are a good reflection of the situation of things as found by CQC when they visit," and he felt the report published in September 2015 was very fair.

After his initial shock at the rating, Chair Dr Mike More felt that the "issues were recognised for what they were". Mike refers to the inspection period as a "perfect storm," with issues in the new IT system, finance concerns and bed pressures, as well as a disconnect between the senior leadership team and frontline staff.

Sandie Smith, Chief Executive of Healthwatch Cambridgeshire and Peterborough, sympathised with the trust as it was in a "state of flux" at the time of the inspection. The trust was rated as outstanding for CQC's caring key question, which for Rachel May, Division A Head of Nursing, was "nice for us to hold on to despite the overall rating". Like many staff, Rachael drew strength from feedback from patients, who were "very supportive and happy with their care, which in turn helped us".

Chief Nurse Ann-Marie Ingle stepped forward to lead the improvement work. She reflects on the difficulty of dealing with the rating on a personal level. "As a reasonably new executive at the trust, and as someone who was leading improvement, dealing with the shock of the report, and the scrutiny and challenge on the executive team was an additional pressure at a very difficult time. The trust and the Royal College of Nursing were both very supportive – but it shows that you have to be strong to lead in a trust that's had a critical report."

Leadership

One of Roland Sinker's first priorities was to "calm people down, listen to them and go to see them physically – both patients and staff". Roland felt it was "crucial to show that the senior leadership team was listening and visible".

Mike More says, "As an organisation, we took ownership of the issues and challenges identified, and this was important, as being defensive is a negative action to take in this type of situation." He explains that the board took it as an opportunity to "hold the mirror up to ourselves so we can recognise our weaknesses as an organisation as opposed to casting blame into the system".

> **"As an organisation, we took ownership of the issues and challenges identified, and this was important, as being defensive is a negative action to take in this type of situation."**
>
> **Mike More, Chair**

A lot of work went into improving the visibility of the executive team. New channels enabled and encouraged staff to ask questions and share ideas or concerns. Executive visits were a particular success, where each director was 'assigned' a clinical division and visited the departments in it, acting as a champion for staff engagement. This created rapport and the sense of a guaranteed voice at an executive level that was otherwise missing.

The Quality Improvement Programme

Work started at the time of the inspection in April 2015 as soon as CQC shared initial findings. After the report was published, Chief Nurse Ann-Marie set up and led a more formalised quality steering group and developed the project management process needed to deliver improvements. Ultimately the team identified 24 clear quality actions.

The first thing she did was to study themes in the inspection report, arriving at five priority themes for improvement: quality issues; leadership; culture; estates; and finance.

In each strand of the quality improvement programmes (for example, pain management), each one has had an assurance programme, linked to peer reviews that challenge the improvement plans. Ann-Marie says this has helped to "give more context and enables good dialogue with colleagues in other trusts".

Improving communication from 'board to ward' at 8.27 meetings

"As a result of the initial findings in April 2015, we made a commitment to improve the communications from 'board to ward'. As a part of this, we introduced the 8.27 meeting," says Senior Communications Manager Dail Maudsley-Noble. "The meeting is held weekly at 8.27am every Tuesday morning and gives staff an opportunity to ask questions and hear about the trust's progress directly from the CEO and executive team."

The meetings usually last until 8.53am sharp – giving staff time to attend any 9am meetings they may have.

Although not a mandatory meeting, Dail explains that it is popular as it "really generates constructive discussion when managers from across the trust can raise issues and suggest solutions between them". Rachael May, Division A Head of Nursing, feels that these meetings are helpful as there is "no hierarchy and information is cascaded to staff afterwards".

Cultural change

In 2015, staff morale was low. Fiona Allinson, a Head of Hospital Inspection at CQC, reflects that at the time of the rating, nurses in particular felt "disempowered" working in the trust.

As Mike More explains, "We put a lot of effort into internal staff engagement to create a culture of listening and support – to make sure that our staff felt reassured and understood their importance to the organisation."

The communications team put together a full range of activities to keep staff, patients and stakeholders informed from day one. To find out the main issues for staff, Senior Communications Manager Dail Maudsley-Noble used surveys and staff focus groups. "We talked to all staff groups to get a better understanding of the challenges," says Dail. "Their feedback enabled us to highlight the major issues around the trust and specific areas where we could support improvement." The trust also encouraged departments to reach out to peers in other organisations to review processes and share knowledge.

As Roland puts it, "Our journey is about empowering staff in the clinical teams and frontline staff who work with patients to drive improvement. I wanted to help people feel empowered so they could feel able to do things themselves and see that our plans for improvement were achievable."

Initially, it was hard for the trust to communicate to staff why it went into special measures. "It was a huge challenge," says Chief Nurse Ann-Marie. "It took a long time – going out and explaining to staff what it was about."

Social media helped to get staff on board. "We used the #myCUH hashtag on Twitter to help show staff involvement in developing the improvement plan, but it was also used by staff themselves as a platform to share their own improvement stories and the work they were proud of," says Senior Communications Manager Dail Maudsley-Noble.

Before being placed into special measures, learning was not routinely shared across the organisation. "Even where someone's small team was working well, they didn't always understand what the whole team was doing," says Ann-Marie.

Roland explains that immediate action plans were started and proactively shared internally and externally to show "the energy that was being put into shaping where the organisation was going".

Using the inspection report, the trust developed a detailed tracking management document, which included CQC recommendations and other improvement actions. "We became determined to improve cohesiveness between ourselves," says Rachael May, Division A Head of Nursing. Sharing the improvement plan across the organisation enabled people to take responsibility for the concerns in the inspection report. "It was good to have the physical improvement plan and it was helpful as a guide to decide what to do next." Rachael added that it also helped staff to have "open conversations with senior leaders, which made a big difference".

Ann-Marie comments on the changes seen during the 2016 re-inspection, "By February, all staff knew what the improvement plan was and CQC inspectors saw a palpable difference in people's views."

Looking outwards

The trust has improved its links with external organisations. "We had talks with Healthwatch, patient representative groups, councils, MPs and the press so we could provide them with reassurance about the trust," says Dr Mike More.

Before special measures, Healthwatch Cambridgeshire and Peterborough had only one point of contact for the trust. Its Chief Executive Sandie Smith felt that the trust tended to be a "corporate" organisation that was "not always that inclusive or willing to work in partnership". Now she says, "the relationships we have with people across the trust are much more comprehensive…they put in place a direct line to all different areas of the trust – including a line to Roland Sinker." The trust involves Healthwatch in discussions and specific work, as well as organising 'Enter and View' visits at Addenbrooke's Hospital. "Addenbrooke's were quite insular before, but are now more community focused and thinking more collaboratively," says Sandie.

The trust also established quarterly liaison meetings with the Health Overview and Scrutiny Committee (HOSC). Departments were also encouraged to reach out to peers in other organisations to review processes and share knowledge.

CQC engagement

"It can feel like you are on the inside of a problem," says Ann-Marie. "So I picked up the phone." Ann-Marie researched CQC reports of trusts that had achieved good and outstanding to "build up a network of support."

Next on the improvement journey

Roland feels that the move from inadequate to good has been a "powerful" one. However, "the fundamentals are still the same – to listen to patients and staff, get a grip on quality and waiting times, staffing and money." Roland has set the agenda for making Cambridge University Hospitals NHS Foundation Trust the "best trust it can possibly be in terms of governance and staff empowerment". For Roland, the question now is: "how do we build an organisation that is sustainable in the long run?"

The trust as a whole will now focus on improving patient experience, as well as building on academic and clinical research, and empowering staff to do the best job they can. Improving patient flow and capacity are also priority areas, both to ensure the best patient care and to relieve pressure on staff, giving them time to focus on long-term improvements for their patients. "We are building on our progress so far and making it business as usual," says Senior Communications Manager Dail.

For more information about Cambridge University Hospitals NHS Foundation Trust, email **communications@addenbrookes.nhs.uk**.

Focusing on equality and diversity

Of the staff at Cambridge University Hospital NHS Foundation Trust, 27% are not from the UK (14% EU staff and 13% from the rest of the world). "There is an underpinning thread of equality and diversity in the work we do bringing everything together," says Division A Head of Nursing Rachael May.

The trust has worked with groups of vulnerable people and regularly discusses inclusion with staff to highlight discrimination issues. Roland says, "The focus over the next 5 to 6 years will be on listening to people about what they need, combining that with where the hospital is going and tying it all together in alignment with each other."

Following the EU referendum result, the senior team worked closely with its EU staff and as part of this, held a workshop with an MP to reassure staff and answer any questions.

The equality and diversity team provided talks, seminars and films around equality and diversity and mandatory training on unconscious bias was introduced, which Rachael says has made "a strong impact". 'Visual cues' of inclusion and diversity made from the flags of the different home countries of staff are displayed all over the trust and online.

Wexham Park Hospital

February 2016

Rated as good

February 2014

Rated as inadequate and went into special measures

Wexham Park Hospital is a district general hospital serving a population of around 465,000 people with approximately 3,400 staff and around 700 beds. Since October 2014, it has formed part of Frimley Health NHS Foundation Trust, when Frimley Health NHS Foundation Trust acquired Heatherwood and Wexham Park Hospital.

The previous Heatherwood and Wexham Park NHS Foundation Trust was inspected by CQC in February 2014. The trust was rated as inadequate. CQC re-inspected the Wexham Park location in October 2015 and found remarkable progress, resulting in a rating of good in February 2016.

Reaction to initial inspection report/rating

Although staff at the trust were disappointed with being rated as inadequate and going into special measures, many felt the hospital had been trying to make improvements.

Reflecting with the benefit of hindsight, they felt that the decision to put the trust into special measures had been the right one. When staff came into Wexham Park after the acquisition, it was clear that being rated as inadequate had hit staff morale, and this was made worse by apprehension about the consequences of the acquisition and the lack of stable senior leadership.

Staff needed to believe that the hospital had a future and overcome the sense of being "rudderless" that CQC had found in 2014. The organisation had been under financial pressure for years, but started to receive support

from NHS Improvement once in special measures. It was widely felt that going into special measures and undergoing a takeover was a fantastic opportunity to turn things around.

Leadership

The leadership team set out to tackle issues identified in CQC's 2014 inspection report about the "dysfunctional working practices" of some consultants, and the "learned helplessness" of the trust. Many staff appeared to accept the falling standards as the norm, and in some cases, felt they were not part of the solution, or could make a difference. Heidi Smoult, Deputy Chief Inspector of Hospitals, was CQC's inspection lead at the time of the 2014 inspection. Heidi says that addressing the "learned helplessness" at the start enabled the culture to change "more quickly than might otherwise have been expected".

The hospital established Chiefs of Service to lead each major clinical area. The Chief of Service leaders, along with the executive team, started to make it clear what 'good' looked like through sheer commitment and determination. This element showed staff that senior clinical and managerial leaders were committed to staff and patients. Staff started to recognise that improvement was needed, and that they could make a real difference.

Dr Prem Premachandran, Chief of Service for emergency care, spent time at Wexham Park Hospital shortly before the acquisition. Prem feels that "if you tackle things in the right way you can get huge change quickly". Prem carried out interviews with 273 staff to understand the issues at the trust and implement plans to make improvements.

Clinical leadership was recognised and clinicians had a vital role in setting the standard of what good looks like. Frimley Chief Executive Sir Andrew Morris is clear that it goes beyond bringing in new leadership. "You don't turn an organisation around just by appointing a new CEO or executive team," he says.

Cultural change

Sir Andrew's first priority was to address the culture at the newly-acquired Wexham Park Hospital. "It's about trying to get everyone to treat people as though they are their own Mum and Dad."

Medical Director Dr Tim Ho echoed the need to address the culture at the hospital. He saw that people had forgotten what good looks like and needed to start believing in themselves again. For Sir Andrew, it was about "sparking the desire to do a fantastic job".

Dr Prem Premachandran agreed that the attitude of the workforce was key to making positive changes in the organisation. Prem likened the situation of the trust to the image of the clay-covered Golden Buddha – they needed to chip away at the clay that was hiding staff talent to expose the gold underneath.

Stable leadership at executive and board level, as well as clinical engagement and buy-in, has been vital in changing the culture of the trust. The senior team focused on tackling issues that had not been addressed. As Director of Operations Lisa Glynn says, "it was like a chef coming in to

Enabling patients to speak in their language

Recognising the importance of understanding the needs of the diverse local community, staff enabled patients to express themselves using their spoken language when entering the Emergency Department (ED).

At every ward round, doctors wrote down what language each patient spoke, and staff working in the ED recorded the languages they also spoke on a whiteboard. There was also a leaflet in a variety of languages explaining the availability of translators. Therefore, all staff knew of the languages spoken by staff working that shift as well as the languages individual patients spoke and were able to match patients to staff or translators with the relevant language skills so that patients and staff could communicate fully with each other.

The Ask Andrew page

The "Ask Andrew" page, which features on the Frimley Health website, enables all patients and members of the public to contact the Chief Executive with any queries, concerns or thoughts they have about the trust. Everyone who makes contact via this webpage receives a personal response from Sir Andrew Morris. Listening to concerns helps the trust to garner the views of the public, and helps to identify any issues early on.

The Ask Andrew page, alongside a range of other feedback mechanisms, are frequently used by patients and members of the public. Many people feel that it is proof they are being listened to, and their concerns are being taken seriously by the Chief Executive. Many feel it sets a different, more inclusive tone and shows hospital staff as approachable, even at the most senior level. This stands in stark contrast to the culture that had existed previously.

your kitchen at home, and throwing out the rubbish from the cupboards." People commented that small changes can lead to big differences. After giving the staff ownership and the opportunity to show what they can do, they made "remarkable progress". Putting patients at the heart of what they do, and looking after them as they would look after their own family, was fundamental to this shift.

Georgina McMasters, a patient with a long-term condition, felt like a "voice in the wilderness" when talking about the issues in the year before the acquisition. She feels that the organisation was blind to its own shortcomings. "You never notice your own dripping tap or curling wallpaper" she says. Her view is that "staff were fabulous, but were fighting in a culturally rotten environment". Geoff Motley, another patient representative, felt that staff were not looking at patients' overall experience, but only the immediate medical issue, treating patients as a number.

> **"staff were fabulous, but were fighting in a culturally rotten environment"**
>
> **Georgina McMasters, patient**

In the year following the takeover, patient care had improved dramatically. People were being diagnosed and treated more quickly, and by the right team, which had a positive effect on patient outcomes. Staff believed that the culture had fundamentally changed and they had started to recommend Wexham Park Hospital as a good place to work.

The trust knew it was important to acknowledge the hard work of staff and how this was improving care. It recognised outstanding work through staff awards and staff with many years of service. The Chief Executive used the language of staff working "for", rather than "at" Frimley Health. One patient spoke highly of the "Ask Andrew" page on the Frimley Health website, where anyone who contacts the Chief Executive receives a personal response.

Vision and values

One way to get people on board was by sharing the organisation's values. Rather than imposing the values from Frimley Park Hospital onto Wexham Park after the acquisition, the values were re-assessed and integrated across the whole trust, with workshops and input from staff. James Taylor, Director of Communications, commented that it was important to ensure that "the trust" meant the newly-created Frimley Health, and not to overlook the positive effect of celebrating success, both internally and externally.

Patient and public involvement

The trust took the different needs of patients into account. One example of this is when the trust ensured that a patient who could not hear their name being called was notified in an alternative way. Staff were aware that in some communities, patients were not registered with a local GP practice and work was being carried out to address this. Focus groups provided input into addressing cultural sensitivities, and faith and ablution rooms were made available. The two local Healthwatch groups, Slough and Bracknell Forest, also provided valuable information, and the Listening into Action (LiA) approach was renewed and extended across Frimley Health.

The trust kept staff and patients at the heart of discussions when shaping governance and processes. They kept the idea in mind: If this was your family member or friend, would the care be good enough? The trust also surveyed staff and patients to understand how people felt things were progressing. Georgina McMasters attended panel meetings and felt "vindicated on reading the findings from CQC's inspection in 2014, having pointed out issues that CQC had also found".

Looking outwards

As well as the Board being more aware of what was happening on the ground, an independently chaired Quality and Oversight Committee (QOC), was important in bringing about improvement. The QOC has consistent and appropriate senior attendance despite competing demands on people's time. After discussions with each member, the committee's Chair Dr Stephen Richards, was clear what its priorities would be and what would be delegated to other committees. There was early agreement on the areas of focus. As well as addressing challenges, Stephen says "celebrating success was a big part of what the Quality and Oversight Committee was about". He wrote to each person who presented at the meeting, and progress was praised in hospital-wide newsletters.

Senior representatives from the five clinical commissioning groups attended meetings, as well as CQC, other partners and senior staff at the trust. Having a successful committee, holding people to account, tackling the issues and bringing together the right people to deliver improvements for patients, minimised the need for other additional meetings, which freed up time to get on with making improvements. One measure of success identified at the outset was that the Committee would be able to stand down with confidence. After an extended period of two years, the trust achieved this goal, and was rated as good.

Engagement with the trust's diverse local communities was also crucial. Colleagues from the two previous trusts worked together to understand the best ways to communicate with local communities, and doctors noted down the languages spoken during ward rounds.

Next on the improvement journey

For Chief Executive Sir Andrew Morris, the trust needs to maintain the improvements that have happened so far, as well as continue to enable staff to make further improvements. "Like a soufflé, which will flop if you aren't careful, the challenge for the trust will be to maintain the improvements made and to continue to make further improvements."

The Chief Executive and Medical Director explain that this was part of a five year journey for the trust. Despite what CQC describes as "very significant" improvements, the trust acknowledges that there is still work to be done and a need to continuously improve, especially when changing the trust's culture. The ambition is for people to think of Wexham Park Hospital as *the* place to go to – to work, to train, and to be treated.

For more information about Wexham Park Hospital, email **communications@fhft.nhs.uk**.

"It's about trying to get everyone to treat people as though they are their own Mum and Dad."

Sir Andrew Morris, Frimley Chief Executive

University Hospitals Bristol NHS Foundation Trust

March 2017

Rated as outstanding

December 2014

Rated as requires improvement

University Hospitals Bristol NHS Foundation Trust is made up of eight hospitals and is one of the largest NHS trusts in the country. It is an acute teaching trust and became a foundation trust in June 2008.

The trust was rated as requires improvement in December 2014 due to improvements needed in safety, responsiveness, and leadership of some services. After improvements in engagement with staff, patients and partners, the trust achieved an outstanding rating in March 2017.

Reaction to initial inspection report/rating

Staff were disappointed with being rated as requires improvement, but felt that the findings in CQC's report accurately reflected the reality of the pressures they faced. Staff morale in some places was low, and some staff felt they were not being listened to. This chimed with the 2014 staff survey results, which revealed below average scores in staff engagement. It made the leadership team think hard about why they were losing the goodwill of staff.

Chief Executive Robert Woolley believes that at that time, "the leadership team were not messaging internally strongly enough or inclusively enough in a way that connected with staff and the reason that staff come to work – which is not about making savings, or designing the future of the NHS, but is about delivering the best care they can possibly give themselves in the moment". Robert felt that there was a "disconnect between what the leadership team was expressing and what the staff was experiencing".

Reflecting back on 2014, some staff felt that it was a time of upheaval; multiple ward moves, consultations and operational changes made it hard

for them to get clarity on the trust's priorities for improving patient care. Robert explains how the trust had put in various programmes of work and support before the rating, which "clearly hadn't borne fruit in 2014" but have helped to achieve the outstanding rating this year.

Senior Sister Sarah Beech explains that the improvement work was "heading on an upwards trajectory – but it was all happening at the same time so it was difficult". Robert put a strong emphasis on the care that staff provided. "The senior leadership team was continuing to get the message across about compassion being equally as important as technical care."

Cultural change

Robert Woolley described 2015/16 as a "year of engagement", with leaders focusing on staff experience and patient involvement. He says this initiative "improved staff engagement… helping to establish a fully patient-focused culture and advancing the trust's strategy".

Breaking the Cycle Together events focused on operational problem-solving, and the trust introduced Schwartz rounds, a structured forum for staff to reflect on the emotional effects of caring for patients. The trust has used new posters and infographics in visual messages to staff, Chief Executive video briefings, safety bulletins, and the *We are Proud to Care* film, showcasing what Robert calls "the compassion and commitment of all trust staff".

> **"There is value in having an open conversation with staff and understanding what the staff feel. It's about making sure that we don't pay lip service to it, but we actually understand what challenges staff are facing and what we are doing to overcome them."**
>
> **Fiona Jones, Divisional Director of Diagnostics and Therapies**

Fiona Jones, Divisional Director of Diagnostics and Therapies, speaks of the value of staff engagement, calling it the "best gauge for the culture of the organisation". Fiona believes, "There is value in having an open conversation with staff and understanding what the staff feel. It's about making sure that we don't pay lip service to it, but we actually understand what challenges staff are facing and what we are doing to overcome them."

Alison Ryan, Non-Executive Director and Chair of the Quality and Outcomes Committee explains that they had to move away from the "we know best" attitude and move towards an organisation that was learning from mistakes and keeping patient safety at the heart of everything they do. Sarah Beech says, "Staff at the trust are now patient focused and quality focused". Patient Representative Jim Houlihan says, "Even in a resource-lean environment, the staff are never complacent."

Brenda Massey, Councillor for Southmead, believes that the trust has gone from having "a hands-off approach" to being a place where the staff are "willing to go in and look around and ask questions". The trust has a greater sense of "self-awareness" about the things they need to do to

Transformation of patient letters project

In response to complaints from patients, the trust introduced the Transformation of Patient letters project to improve the quality of its correspondence. Patients had missed their appointments because of shortcomings in the letters or because the content was confusing and unclear. The trust held a 'Letter Champions Week' when volunteers interviewed patients in outpatient clinics across the trust to find out how the letters could be improved. Patients' feedback informed a new set of Letter Quality Standards, which was applied to all existing letter templates in the trust's patient administration system.

Understanding staff satisfaction with The Happy App

The 'Happy App' is an interactive web-based tool to gather real-time feedback from staff. They can use the app to indicate how happy they are at work and record why. The app gives managers the opportunity to monitor and understand staff satisfaction and engagement, and enables them to act on issues. It has had a positive effect on local team culture and the trust is supporting it to continue, as well as helping other trusts to adopt the approach.

change, and that the environment is now a place where there is "so much more capacity to engage with one another".

Vision and values

For Chief Executive Robert Wooley, "The values are embedded across the organisation" and "staff feel a greater sense of pride to work at the trust". He refers to the "visible pride and confidence of staff that's reflected in CQC's report". Fiona Reid, Head of Communications, thinks that staff sharing the values of *respecting everyone*, *embracing change*, *recognising success*, and *working together* helped the trust on its improvement journey. She says, "The values are the blueprint for how we want to work together, and are a massively unifying element that helps to reinforce what we are trying to achieve".

> **"The values are the blueprint for how we want to work together, and are a massively unifying element that helps to reinforce what we are trying to achieve"**
>
> **Fiona Reid, Head of Communications**

Governance

Auditing played a key role in the trust's improvement journey. An internal audit on the role of the ward sister found that many ward sisters and ward staff were not clear on the management role and responsibilities of the post. Alison Ryan, Non-Executive Director, describes a "perpetual tension" where "neither party felt empowered to work constructively in that relationship" despite it being one of the most important driving relationships. For Alison, the internal audit team is "magical" and "sometimes provides everything that you need to know". Alison stresses the importance of getting the governance structure and processes right, particularly around clinical incidents, to ensure awareness and learning and how her accountability as a Non-Executive Director to the trust's governors has helped with transparency.

Improving safety

Clinical processes needed to improve to benefit patient care and staff morale. Sarah Beech reflects, "I recognised there weren't enough processes, and ways of doing things that were the same throughout the trust, so we all did slightly different things. Our ways of doing things were different so our processes and our clinical skills could be slightly different." Senior Sister Alice Kershaw added, "You would strive to give the best care that you could, but unfortunately you would be up against different blocks that might stop you from doing that, whereas now there's been a lot of work to remove those blocks."

As part of the work to improve clinical processes, Senior Sister Alice Kershaw credits the new clinical lead for the tissue viability team who set up training and education for ward staff, which "empowered staff to engage more with the service". The clinical lead worked on recognising

the tissue viability needs of patients on admission and improving incident forms, documentation and reviews of the service.

Planning has also improved the efficiency of some services. Staff now attend daily 10:30am flow meetings, which help to plan for admissions. Alice describes it as a "move from having a 'shift by shift' attitude, to having a proactive attitude towards finding the correct processes and constantly challenging ourselves to be more efficient". Specialist teams such as the infection control team are "proactive and visible" and "genuinely prepared to come and help you".

Next on the improvement journey

Staff are proud that the trust has been rated as outstanding, and they are seeing that success reflected back in its recent granting of NIHR Biomedical Research Centre status. There is a strong desire to continue to provide outstanding care. As Sarah Beech puts it, "You don't want to plateau out – you want to be the best you can be."

Robert Woolley believes that the next step in the trust's improvement journey is to focus on patient flow in the emergency department, and the consequences of having demand in excess of what they can manage. The biggest immediate priority is to establish new models of emergency care that reduce the need to admit to hospital, or allow staff to discharge patients from hospital far earlier than they currently do.

> **You don't want to plateau out – you want to be the best you can be."**
>
> **Sarah Beech, Senior Sister**

As a patient at the trust and end of life care steering group lay representative, Jim Houlihan says a focus for the trust is to develop its relationship with social care. He believes there is work to do with other trusts. "There needs to be better collaboration between trusts and less of a competitive attitude."

For Fiona Jones, it is about achieving consistency in patient care. "We need to make sure that patients are having the same experience, no matter what time of day, what day of the week, what time of year they are admitted."

For more information about University Hospitals Bristol, email **communications@uhbristol.nhs.uk**.

Improving patient fitness using the prehabilitation programme

The prehabilitation programme aims to improve a patient's fitness before major surgery. Patients on the programme are encouraged to stop smoking, manage their alcohol intake, eat healthily and manage their medicines effectively. The collaborative programme involves surgeons, anaesthetists and Macmillan nurses, academics at Bristol Research Unit and Elizabeth Blackwell Institute, digital start-up companies and the trust's hospital charity Above & Beyond. Prehabilitation has been established as a pathway in thoracic, hepatobiliary and pancreatic, and obstetrics and gynaecology surgery. The trust has also worked with colleagues at North Bristol Trust to develop this in urology and vascular surgery.

Barking, Havering and Redbridge University Hospitals NHS Trust

March 2017

Came out of special measures

March 2015

Rated as requires improvement

December 2013

Went into special measures

Barking, Havering and Redbridge University Hospitals NHS Trust serves a population of over 750,000 in outer North East London. The trust operates from two sites: Queen's Hospital, Romford, and King George Hospital, Ilford.

The trust was placed into special measures in December 2013, following an inspection in October 2013. In March 2015, a further inspection revealed encouraging signs, and the trust was rated as requires improvement. The trust came out of special measures in March 2017.

Reaction to initial inspection report/rating

"The way I would describe it is, you had professionally qualified staff coming to work – underpowered in terms of numbers, underpowered in terms of systems – and a demand from the top to sort it out." This is how Dr Maureen Dalziel remembers the period before October 2013. Now Chair, Maureen had been on the board for a short time, and was one of a number of non-executive directors who had already expressed concerns.

"The processes and systems had been broken for some time," she explains. "So the financial systems and systems for setting budgets had been broken, the governance systems for managing the board, and clinical governance. All the back-office systems had been stripped out so they were at a minimal level. The board oversight had gone through a revolving door for about 15 years. There was no consistent oversight of the organisation."

Havering councillor Jason Frost sat on the borough's Overview and Scrutiny Committee at the time of CQC's inspection. He is clear about the

challenges the trust faced. "It serves three of the most populous boroughs in East London, that have the highest percentage of people with chronic illness," he explains. "But we only have one major regional hospital. So it's a question of capacity. When Queen's Hospital was planned, the demographic dramatically shifted beyond the original projections. So the hospital was set up to deal with a smaller and healthier population."

"There'd been a succession of crises, particularly around maternity, that preceded their inspection," he remembers. "So there was this background noise about how the hospital may be falling down in several areas of its performance. It was in that context that the report was published."

"All the senior players in the borough were worried about the hospital," says Anne-Marie Dean, Chair of Healthwatch Havering. Concerns about the quality of care were made worse by poor relations with the trust's senior management. "It was very difficult to create any sort of relationship with them. The very senior team were quite remote from everybody," she recalls.

"The other thing that you got a strong sense of was that the consultant body was quite remote from the management team and, in lots of ways, quite remote from the staff," she says. "So it didn't feel like a unified organisation at all. And when patients used to give us feedback, they often used to say they felt sorry for the staff."

Leadership

Matthew Hopkins was appointed Chief Executive in April 2014, a few months after CQC's report was published. Early on, he formed the view that staff were strongly committed to providing good care, even if they hadn't always been supported by clear direction, resourcing and prioritisation.

A priority Kathryn Halford, Chief Nurse, shares with other leaders across the trust is making sure that she is visible and accessible, and communicating well with staff. She has weekly meetings with senior ward managers, matrons and divisional nurses to keep her "in touch with the shop floor all of the time". Taking part in plenty of walkabouts ensures she spends time with both staff and patients.

Cultural change

The approach of Director of Communications, Rachel Royall, hinged on four aspects of improvement. "How can communication and engagement help support operational performance and patient experience? How can we help improve employee engagement? How can we help improve stakeholder advocacy? And – if we got those three right – then the fourth priority, reputation management, would look after itself," she says.

Improving employee engagement was crucial, particularly in an organisation where local reputation and the associations of special measures had had an inevitable effect on staff. When the trust went into special measures, only half of frontline staff said they were happy with the level of care they were providing for patients; the recent staff survey has shown a 30% increase.

"Staff had phenomenal stories about their improvement, but I suppose when I arrived I found quite a fear of sharing improvement," Rachel

Partnership with the Virginia Mason Institute

The trust is one of five trusts chosen to work with the Virginia Mason Institute as part of a five-year partnership led by NHS Improvement.

Virginia Mason teaches healthcare organisations to use lean methods to support a patient-centred culture. As part of this, it helps them to develop their own 'Kaizen Promotion Office' (KPO): an in-house centre of excellence that helps to adopt continuous improvement methods across the whole organisation.

"Kaizen is a Japanese word for continuous improvement," explains KPO Director Alf Theodorou, who leads the trust's work with Virginia Mason. "We're learning their quality improvement method, which is derived from Toyota. They adapted it for health care and now they're coaching us to deliver it here."

The trust has a particular focus on two elements of the approach: a lean-based improvement methodology – applied consistently across all improvement projects – and a cultural shift towards proactive improvement. "It doesn't have to be broken for us to fix it," he says.

The trust has focused on two areas, voted for by staff, patients and visitors: the first 24 hours in hospital for frail and older patients, and cancer diagnostic processes. Part of the KPO team's work involves observing processes in action, making notes and timing stages to identify opportunities for improvement.

(continued on next page)

(from previous page)

It's an approach that can sometimes seem unfamiliar to hospital staff, and the team relies on good communication to win hearts and minds.

One of their successes on the diagnostics pathway was a large reduction in the time taken to prepare samples. "It was taking 22 hours and 14 minutes to prepare biopsy samples for analysis. It now takes four hours and 52 minutes, which means we can run more cycles of the analyser and it means patients are more likely to have their results on the same day," Alf explains. The two teams involved in processing the samples, who worked nearly 200 metres apart, have now been moved next to each other "so you're saving time by not having people walking backwards and forwards," he says. "And we've also seen that the error rate has come down – not in terms of sampling errors but in terms of all the documentation or repeat paperwork needing to be done – that's come down as well, just by that co-location."

says. "One of the divisional directors who had an excellent stroke service explained that he didn't want to tell anyone about it. It would be a bit like bragging about his kitchen when his house was falling down. So we needed to do a lot of work with people to improve confidence and help them to understand that their journey of improvement is something that they should be proud of and that they should want to talk about."

This reluctance to celebrate success is a theme that is also familiar to Kathryn Halford, who joined as Chief Nurse in early 2016. "I think they'd spent years being told they were rubbish," she says. "One of the things that was really evident when I came here was there was a lot of very good practice – clearly there were some things that needed to be improved – but actually, people didn't recognise themselves as delivering good services."

Vision and values

"I talked about three things, regularly and consistently, over the first year or two," Matthew Hopkins says. "The first one is improvements for patients. We didn't have a single method of improving things – as we do now. But the roll-out had come out of a set of values and behaviours that had been designed and developed by the staff, and the words were the staff's words, so they resonated with them. We used the values and behaviours to underpin our improvement work."

> **"One of the divisional directors who had an excellent stroke service explained that he didn't want to tell anyone about it. It would be a bit like bragging about his kitchen when his house was falling down. So we needed to do a lot of work with people to improve confidence and help them to understand that their journey of improvement is something that they should be proud of and that they should want to talk about."**
>
> **Rachel Royall, Director of Communications**

Governance

"Priority two was that we needed to get a much better grip on the money. Quality and money are two sides of the same coin – you can't do one without the other. The third priority was being much better organised – so things like getting our governance right, getting the structure of the organisation right. We restructured the executive team, restructured the board, got our information capability right, and got our meetings properly organised."

For Kathryn Halford, one of the keys to improvement is being able to clearly articulate the standards staff should strive for. "I feel very strongly that one of my key objectives was to describe what good needed to look like and then support people to be able to achieve it," she explains. "So I think if you went and spoke to people now, they would be much clearer about what good looks like, what they need to do to improve and how that's measured."

Improving safety

Senior Sister Nicola Osborn has seen improvements in patient safety – an area where she believes the organisation has made some of its most important gains. "I think we're very good now at learning from incidents," she says. "When things go wrong, we look at it and we ask: were we working to the PRIDE Way?" PRIDE spells out the trust's values of passion, responsibility, innovation, drive and empowerment. It draws together the trust's shared vision, values and operational plan. "I think the PRIDE Way makes people re-evaluate things and think about what we're meant to be doing and why we're doing it. It's helped with communication and I think it's helped bring departments together – we're all working together as a team," says Nicola.

The rate of incident reporting is one area where the hospital's data highlights a tangible difference. "Our incident reporting is going up exponentially," says Associate Medical Director Dr Andy Heeps. "We're reporting more and more things. And that's really letting people start to have conversations – we're empowering staff to fix things. When this started, we saw Serious Incident (SI) rates start to go up. I think that was really powerful because that meant people were actually reporting and learning from harm. And as incident reporting has continued to rise, the SI rate has now started to come down."

Next on the improvement journey

"We've made massive progress on standards, particularly around referral to treatment and cancer waiting times," says Chief Executive Matthew Hopkins. "We want to continue to strengthen our emergency access as well. So that's our number one priority. Number two is the way we continue to reach out to community settings. And the third area is continuing patient input into improvement work."

The trust's progressive shift away from addressing 'CQC must-dos' towards a more proactive and self-sufficient improvement culture is a theme that comes up more than once. For Andy Heeps, how this evolves is central to what comes next.

"I think we need to stay patient-focused and keep building our own assurance systems," he says. "How do we assure ourselves that we're doing what we say we're doing – and not relying on CQC to come in and find out when it's too late? My own area of interest in improvement is how it can be completely decentralised. How do you skill people to come in one day and say: this isn't working, let's try this. It's the incremental wins. If you can say today we're a little bit better than we were yesterday, then I think that's not a bad philosophy for someone working on an NHS ward."

For more information about Barking, Havering and Redbridge University Hospitals NHS Trust, email **communications@bhrhospitals.nhs.uk**.

Giving staff autonomy with the model ward

Director of Productivity Scott Fitzgerald has seen a major shift in attitudes since he introduced improvement walks at the trust in 2015. "The idea of turning up on a ward and rolling your sleeves up to support the staff and assure the senior teams was alien to the organisation," he explains. But the walks have become an opportunity for staff to raise issues or ask for help.

"The improvement walks tell us what we need to focus on and ensure we don't slip back," says Lead Quality Improvement Nurse Tracey Thorne. Tracey is leading the development of a ward accreditation programme, which was prompted by the success of the improvement walks. It was an idea first suggested by an inspection report on Salford Royal Hospital, rated as outstanding in 2015. The team learned about the Salford programme as well as similar schemes at other trusts but opted to design their own.

Dubbed 'the model ward', the BHRUT programme is designed around four pillars: patient experience, staff experience, safety and efficiency. "We're looking at how we can measure whether a patient feels comfortable on a ward," Scott explains. "Were they welcomed? Were their fears allayed?"

Involving staff has highlighted the shift towards self-reliance over external scrutiny. "We asked staff what reward they wanted for being a good ward," he explains. "And what they want is autonomy. They want to get to a level where they can continuously improve, delivering their own service."

Leeds Teaching Hospitals NHS Trust

September 2016

Rated as good

July 2014

Rated as requires improvement

Leeds Teaching Hospitals NHS Trust serves a population of around 780,000 in Leeds and up to 5.4 million in surrounding areas, treating around 2 million patients a year. The trust employs around 15,000 staff and provides 1,785 inpatient beds across Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital and Chapel Allerton Hospital.

The trust had its first CQC comprehensive inspection in March 2014, which resulted in being rated as requires improvement in July 2014. Following a comprehensive inspection in May 2016, the trust was rated as good in September 2016.

Receiving the rating

There was no great surprise or shock at being rated as requires improvement. Chief Executive Julian Hartley had been in post for just six months when the inspection took place. Julian had come into the trust fully aware that there were issues that needed to be addressed. "The report was as expected," he says. "I had already got a strong sense of where the trust was." Most of his executive and non-executive teams were also relatively new to the organisation.

From his first day as Chief Executive, Julian began a programme of engaging staff and getting them involved in setting the values of the organisation. However, staff were disappointed that the work they had been doing up to that point did not seem to be reflected in CQC's report.

Consultant Alison Cracknell had been championing improvement in her area and says, "Initially I felt demoralised. Were we not doing a good job? We were trying hard and improvements were happening. But when you step aside and look overall, you can accept what the report was saying as fair."

Chief Medical Officer Dr Yvette Oade also admits to some disappointment, but recognises the value of the rating. "If we had got a good rating, perhaps that would not have been helpful. If we had been good, we may not have been able to engender the same degree of momentum and energy to take us on the improvement journey."

> **"If we had got a good rating, perhaps that would not have been helpful. If we had been good, we may not have been able to engender the same degree of momentum and energy to take us on the improvement journey."**
>
> **Yvette Oade, Chief Medical Officer**

Leadership

Julian Hartley and his executive team set about improving communications and becoming more visible to staff. On his first day as new Chief Executive, he sent out a bulletin to all staff – *Start the Week*. It continues to go out every Monday, with staff keen to have their achievements included.

"I spent my first 100 days largely visiting all clinical areas to cement the idea of collective commitment and that we are here to support staff," he says. Associate Director of Communications, Jane Westmoreland points out that "this wasn't just a 100-day project – he's still doing it".

The importance of visibility is echoed by Deputy Chief Executive, Chief Nurse and Chief Operating Officer Suzanne Hinchliffe. "I still do clinical shifts and every six weeks I will visit every ward and department in this trust." She also goes on regular walkabouts with Chief Medical Officer Dr Yvette Oade to show that medicine and nursing are aligned.

Cultural change

Before he started at the trust, Julian Hartley personally wrote to more than 2,000 staff. "I introduced myself and asked for their three top challenges. There was a tremendous response and the main messages were clear: there was a real problem with engagement, the leadership was detached and invisible, and it was all about money and targets."

The new leadership team encouraged people to say how they felt about the trust. Staff were encouraged to talk about their roles, what they felt was positive and what stopped them delivering great care. An online tool called Wayfinder was used to get staff involved and engaged in developing the trust's values, called the 'Leeds Way'.

The development of the Leeds Way helped to drive improvement in the trust. Summed up by Julian Hartley as "the way we do things around

Shaping the trust's direction with the Leeds Way

After writing to the managers before he joined the trust, Julian Hartley was determined to use their feedback to look for solutions through employee engagement. To meet the challenge of reaching 17,000 staff, the trust 'crowdsourced' to find answers, using an online system called Wayfinder.

Every member of staff could log in and respond to a series of questions that asked what they thought were the most important values and behaviours, and how they could make the hospital a great place to work and a great place for patients. There were more than 45,000 responses. Submissions were anonymous, and people could comment on others' suggestions and vote on them. The output was developed further at two large scale engagement events.

Responses were distilled to five things, which became the hallmarks of the 'Leeds Way' – the organisation's values: patient centred; collaborative; fair; accountable; and empowered. "These were clear and powerful in the way they influence the culture of the organisation," says Julian Hartley.

Clinical service units have used Wayfinder to develop their own plans, strategies and stakeholder involvement. An annual programme of corporate campaigns now uses Wayfinder to engage staff in shaping the direction of the trust. Campaigns include gathering ideas on how to learn more from incidents and how to improve the intranet and website.

Measuring progress and celebrating success with safety huddles

Safety huddles involve ward teams discussing one or more patient harms such as falls, pressure ulcers and avoidable deterioration in a daily focused safety meeting. "The ward team meets for a five to 10 minute focus around an area they are worried about. They review data and learning, for example, to understand how the last patient fell," says Alison Cracknell.

The huddles include regularly measuring progress and celebrating success, helping teams to continually learn and improve. Ward staff report that the huddles encourage healthy competition between wards, for example on the number of days passed without a patient falling. Posters show a record of the number of days since the last harm event, and improvement charts track progress. Good safety performance in clinical teams is recognised and teams receive certificates when they achieve milestones.

In October 2016, 65% of the wards that had huddles on falls saw a steep reduction in falls. Nine of the 20 wards focusing on pressure ulcers achieved their longest stretch between a pressure ulcer occurring since before huddles were introduced.

here", it became the engine room of improvement because it allowed the trust to move forward together. Staff were empowered to make changes. Consultant Alison Cracknell explains, "We've gone from a few individuals who might do improvement in their own patch, to an organisation that wants to empower everyone to do it."

> **"We've gone from a few individuals who might do improvement in their own patch, to an organisation that wants to empower everyone to do it."**
>
> **Alison Cracknell, Consultant**

Engagement and visibility set the tone and the trust received a boost in 2015 when it was selected to be one of five trusts in a national programme led by NHS Improvement on embedding the Virginia Mason system, a quality improvement method to help improve patient pathways.

The trust has adapted the Virginia Mason system to become the Leeds Improvement Method. "It is transforming the way our patients move through the hospital and the way individual services redesign pathways – to take out waste and inefficiency, reduce waiting times and make the experience better for staff and patients," says Julian Hartley.

According to Non-Executive Director Mark Chamberlain, the Leeds Improvement Method team is enthused about the difference it is making. "By sharing experiences and improvement stories, other areas want to get involved. We need people to be thinking about improvement, what they can do to support it and what that means for patients."

Promoting equality and human rights is integral to the Leeds Way. Even though policies and strategies had been in place, Chris Carvey, Deputy Director of HR, says, "There is now a greater commitment and visibility, with an equality and diversity strategic group that gives high-level ownership and commitment to equalities objectives."

Governance

The new senior team recognised that governance needed to improve – to make sure that good reporting and learning became second nature, and that the board could be assured that actions were being taken when needed.

Professor Suzanne Hinchliffe, Deputy Chief Executive and Chief Operating Officer felt that many things needed to be put right from the last inspection. "We looked at governance and made it more fluent. We needed to make sure the organisation was clinically led and management supported – a complete turnaround from the previous way it had been managed. We wanted to get the new clinical management structure to work through a process of earned autonomy and also devolve decisions to teams."

Senior Sister Kate Varley recognises the changes in the trust and says, "Working here is different now. On face value it may not look that way. However, it is when you see how departments work together. We are working better as departments to be more cohesive with delivering our care. Things are working faster and patient care is improving."

Improving safety

At the time of the first inspection in March 2014, staff felt that the trust had a blame culture that could sometimes deter people from reporting incidents. For Senior Sister Sally Rollinson-White, the previous leadership team had had a "dictatorial approach".

Joint ownership and sharing problems and solutions has been crucial in combating this blame culture. Jane Westmoreland cites the example of motivating staff around hitting emergency care standard targets. "The message was that this is not just an A&E problem. We asked everyone in the trust to think of one thing they could do that could affect the pathway and enable us to deliver better care."

Chief Medical Officer Dr Yvette Oade highlights the improving reporting culture and reduction in never events. "We have not had a retained swab in the last 18 months and no retained items." Mark Chamberlain agrees. "Our accuracy and reliability of reporting and triangulation has improved as a board and as an organisation."

Patient and public involvement

Non-Executive Director Mark Chamberlain thought that the patient focus needed to change. "The perception was that the hospital had areas of excellence, but the way patients experienced some elective encounters was not where it should be."

Local resident Pat Newdall, who has been involved in 'Enter and View' visits on behalf of Healthwatch Leeds, says that tackling long waits in outpatients was a main focus for the trust. She believes there are now shorter waits in outpatients, and as a result, patient experience has greatly improved. Pat also says that the trust now involves patients in planning services and has an active Patient Experience Group.

CQC engagement

CQC Inspection Manager Sarah Dronsfield commented that in the trust's second inspection it was evident how much staff had embraced the culture change and now felt engaged. "We could see that they were more prepared to put themselves forward and raise concerns. The new leadership structure had really helped to embed the organisation's values and beliefs."

Next on the improvement journey

Alison Cracknell sums up the trust's ambition, "Before, I would have thought 'chip away, just keep doing improvement…' but now we can be really ambitious about what we can achieve throughout the organisation. Building on what we have already done, working with Virginia Mason and knowing we have got support to take this further, we are in a really good place."

For more information about Leeds Teaching Hospital NHS Trust, email **communications.lth@nhs.net**

Addressing inequalities in the wider community

The trust has worked hard to raise awareness of equality and diversity among staff, local people and the wider community. Suzanne Hinchliffe says the trust has replaced lengthy "dry" equality reports "that people didn't read" with four eye-catching charts that highlight equality and diversity issues and how the trust performs for staff and patients.

In particular, work has focused on addressing the most pressing inequalities, such as exploring how staff can support transsexual patients to have the best possible experience.

There is also work with the voluntary sector to reach out to groups of people known locally and nationally as least likely to access hospital services and raise any concerns, including Gypsies and travelling communities, asylum seekers and refugees, people with mental health needs and lesbian, gay and bisexual people.

Suzanne Hinchliffe says, "Using the support of Healthwatch, the voluntary sector and our wider patient engagement groups, we are trying to make sure that the community we serve is represented in health care and that we are meeting their needs as patients."

All this work is supported by training and development for staff and wider cultural activity, such as involvement in activities to support the Leeds Pride festival.

Mid Essex Hospital Services NHS Trust

December 2016

Rated as good

April 2015

Rated as requires improvement

Mid Essex Hospital Services NHS Trust provides local elective and emergency services to 380,000 people. The trust, based in the city of Chelmsford in Essex, employs around 4,000 staff, and provides services from five sites.

A CQC inspection in November 2014 resulted in a rating of requires improvement in April 2015. Inspections in June 2016 found notable improvements and resulted in a rating of good in December 2016.

Reaction to initial inspection report/rating

Staff at the trust described their reaction to being rated as requires improvement in April 2015 as "disappointing" and "terrible". Cathy Geddes, Chief Nurse at the time, says, "I felt devastated; I felt personally responsible," but adds that the organisation's senior leaders were "not surprised."

Although Peter Davis, Consultant Histopathologist, was not surprised by the rating, he says the effect of the report on frontline staff was different. "Staff morale suffered a dip after the report came out. People were doing their best. There were certain things about governance and processes that people didn't feel they had the time to do because they were firefighting. So being told 'you are inadequate' felt like a kick in the teeth."

Sister and Ward Manager Prabha Guske felt the report revealed the inconsistency of quality between different hospital departments – her own ward had come out well in CQC's inspection report, but she didn't feel there had been much opportunity to share learning with other areas. "I was

thinking 'I wish everybody could work the way we work. I wish everybody could take this as an example, and share learning experiences.'"

But Prabha felt that some aspects of the report – how it highlighted problems with communication and patient flow "were not a surprise".

Leadership

To support the culture work, the trust needed to reinstate a supportive management structure. Consultant Peter Davis remarks, "It was for the trust's leaders to say: 'how are we going to turn this around?'".

Cathy explains, "Clinicians were trying to do it all with no infrastructure. The organisation should be clinically led, but clinicians need managers to help them.

"We had to try to bring back a managerial structure without worsening the financial position. Addressing that problem wasn't cost-neutral, but there was recognition from the board that the lack of structure wasn't sustainable."

Sister Prabha said she could see that this change was about more than just putting people into posts, "It was a dramatic change. For example, Cathy introduced a new 'Clinical Tuesday', where all the matrons and lead nurses – including Cathy herself – had to come and work on the ward. She bridged that gap between the management and the ward staff.

"I've been here 15 years. I've seen so many changes, but up until this point I hadn't seen management who proved that, if we want, we can get things done the right way."

This extended to empowering staff to take responsibility for quality improvement. Peter Davis explains, "We wanted wards to feel that they had responsibility, that they had power, and that they were being listened to."

This certainly reflected Prabha's experience, "I feel comfortable speaking to management. If something is needed to improve the ward, they help. We have to make a financial assessment and provide a rationale, but if it is needed they would say 'go ahead'." One example is when Prabha asked for partitions to separate the observation beds to help preserve the dignity and privacy of patients. The trust immediately set to work achieving this.

> **"I feel comfortable speaking to management. If something is needed to improve the ward, they help. We have to make a financial assessment and provide a rationale, but if it is needed they would say 'go ahead'."**
>
> **Prabha Guske, Sister and Ward Manager**

Dan Spooner, Deputy Director of Nursing, is studying for a degree in NHS leadership. He stresses the importance of investing in people so that the whole team becomes engaged with the improvement journey. "It means that people are starting to understand what quality looks like and how to get it.

"For example, we provided our healthcare assistants with dementia training and they have since come up with innovations to improve dementia care. It's important to give staff the context and help them understand why."

Recognising excellence with the 'Time to shine' programme

The 'Time to Shine' programme was launched around the time of the trust's CQC re-inspection, and gave staff the opportunity to highlight areas of excellence around the trust, providing every clinical area with a chance to celebrate the good work they were doing.

Examples of excellent clinical practice were shared internally with all staff by email and through the internal staff newsletter Staff Focus, and externally in press releases. The initial idea for the programme came after a previous CQC visit highlighted areas of excellence that the trust thought were not being emphasised.

The 'terrific tickets' scheme

The 'terrific tickets' scheme allows staff to nominate a person or department for an award, in recognition of care and service that is above and beyond their normal daily work. The tickets allow a member of staff to share a coffee with a friend, and the employee or department of the month receive vouchers presented by the Managing Director. Plus, the employee receives a certificate to display on the ward.

"This didn't feel like rocket science. It just felt like these were the right things to do"

Cathy Geddes, Chief Nurse

Cultural change

Addressing the culture of the organisation was a top priority for the trust. Cathy Geddes explains, "There was a disconnect between some members of the executive team and the rest of the organisation. Our staff were loyal – many had worked there for years – but they didn't feel listened to, recognised or rewarded. Not everyone on the executive team was conscious of that being a risk."

Dan Spooner describes how that 'disconnect' had felt from the front line, "If you had a problem in A&E, you had to fix it on your own. This wasn't feasible, because A&E is a barometer of the whole hospital."

Dan says that the culture is different now. "A&E is everyone's problem now. Now we have an emergency floor, which is responsible for that flow through the hospital and out of the hospital. Now we have a team approach to solving the daily challenges."

Prabha says the change is visible to her teams. "Our management team are seen on the ward much more now. Before, some staff didn't know who the chief nurse was – they knew the name, but had hardly spoken to them. Now you see the management team on the floor, actually walking through your door and saying, 'well done team – thanks for all your hard work.' Two or three little words make a massive difference for staff."

"Underlying all of the improvement that we made, I do think it was about the culture, about the leadership, about staff feeling valued and empowered, and feeling that they were listened to – and that safety and quality of care was our top priority as an organisation," says Cathy Geddes.

Cathy goes on to say, "This didn't feel like rocket science. It just felt like these were the right things to do. It just was about trying to be open, honest, approachable, visible and listening. There was an improvement plan to respond to the CQC report but that wasn't what made the difference. It was changing the culture."

Governance

Cathy Geddes explains how the trust managed to improve its financial position alongside making quality improvements. "You have to focus on the money obviously, but if you get quality right and you get efficiency right then the money does – to a degree – look after itself.

"You might have to invest to save: you might have to put in an extra clinician to deliver a new service but, if that means patients get treated, and they don't have to go into hospital and can go home, that's saving the system money."

Improving the quality of care has had a positive effect on the trust's finances. One example of this is the trust working to reduce the use of agency staff. For example, Dan Spooner explains that the Acute Medical Unit had been "a department nobody wanted to work for". But since improving the ward as a place to work, they have been able to bring a number of agency workers into substantive posts, reducing its agency staffing costs by half within a year.

Patient and public involvement

A fundamental part of the improvement journey has been listening to staff and patients, including through a series of 'In Your Shoes' listening events and through the ongoing work of the Patient Council. Robert Lee Bird explains, "The patient council has a genuine influence on the trust. We're not governors; we've got no legal powers. But we are like the trust's conscience."

Looking outwards

Victoria Parker, Interim Director of Communications and Engagement, would recommend speaking to colleagues at other organisations who have been through a similar experience and improvement journey: "There is an enormous amount of goodwill out there. You're not on your own; there are people that have been through it. There are lots of people that have gone before you who can help you – and you can only improve."

Above all, keep your focus in the right place, advises Non-Executive Director Nick Alston. "There are financial challenges in the local health system; local authorities are struggling to find social care places. So you're fighting challenges on a number of fronts. And what CQC does is come back to remind you that what matters most is the quality of care."

Having stepped into the role of interim Chief Executive in summer 2015, Cathy Geddes has since moved on to work for NHS Improvement as an Improvement Director. "Try to take a positive view," would be her advice for other trusts receiving a disappointing report from CQC. "Even if you don't agree with everything in the findings, see beyond your initial reaction."

CQC engagement

CQC's report made the organisation realise what really needed to change. "We were all working very hard but often there wasn't the right focus," said Cathy, who was appointed as the trust's interim Chief Executive in summer 2015. It was important to get the message across that this wasn't about responding to CQC, "It was about how to make things better for patients and staff."

The trust used the CQC inspection as a lever for clinical improvement. As Consultant Peter Davis, puts it, "we needed to get people into a room to talk together, to develop a solution."

"Our workforce was very reactive, and always firefighting. The organisation was going through lots of change, trying to manage financial challenges, but we had no clear plan or sense of direction."

This sense of effort was echoed by Non-Executive Director Nick Alston, "We already knew there were challenges. Everybody was already trying hard – so rather than being a great shift, it was about focusing, and making a renewed commitment to do better."

For more information about Mid Essex Hospital Services NHS Trust, email **communications@meht.nhs.uk**.

'In Your Shoes' listening events

The 'In Your Shoes' listening events were initially held in autumn 2015 as the first step in looking at the culture of the organisation, and examining how the trust wanted patients and staff to see it, and what levels of service and care were being provided.

The events involved separate focus groups with patients and staff, as well as joint meetings where feedback included shared experiences.

These events resulted in the trust's values and behaviours, which were agreed with patients and staff, and were adopted as part of the 'Creating Our Culture' project.

The trust is now running the next series of events to find out whether people think they got the values right last time, and whether they think the values and behaviours are being demonstrated across the trust.

How to contact us

Call us on > 03000 616161

Email us at > enquiries@cqc.org.uk

Look at our website > www.cqc.org.uk

Write to us at

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter
@CareQualityComm

Please contact us if you would like a summary of this report in another language or format.

Published June 2017

CQC-367-062017

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, 6th July 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 23 June 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, 20 June 2017.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

To assure the Board of Directors that all risks are accurately identified and mitigated adequately through reviewing the risks identified on the high level risk register.

Background/Overview:

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

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

The Issue:

The attached paper includes:

i. A summary of the Trust risk profile as at 23 June 017 which identifies the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks.

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

During June one risk has been added to the high level risk register following discussion at the Risk and Compliance Group. This is risk 6977, scored at 16, relating to mandatory training.

The CQUIN risk has been re-freshed for the financial year 2017/18, with a new reference number of 6990 and a risk score of 16:

One risk, risk 6503, delivery of the electronic patient record programme has reduced its score further from 15 to its target score of 5 and has been removed from the high level risk register..

Next Steps:

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

Recommendations:

Board members are requested to:

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

Appendix

Attachment:

combined High-level Risk Register as at 23 June 2017.pdf

HIGH LEVEL RISK REGISTER REPORT

Risks as at 23 June 2017

TOP RISKS

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

RISKS WITH INCREASED SCORE

6967 Non delivery of 2017/18 financial plan has increased from 20 to 25.

RISKS WITH REDUCED SCORE

None

NEW RISKS

There has been one new risk added to the high level risk register in June following discussion at the Risk and Compliance Group on 20 June 2017.

This is a risk related to completion of mandatory training, risk 6977, scored at 16.

CLOSED RISKS

Risk 6503, previously scored at 20, delivery of Electronic Patient Record Programme, has been reduced to its target risk score of 5 following implementation and is proposed for closure.

June 2017 - Summary of High Level Risk Register by type of risk for 6 July2017 Board meeting

Risk ref	Strategic Objective	Risk	Executive Lead	MONTH							
Strategic Risks				Nov 16	Dec 16	Jan 16	Feb 16	Mar 17	Apr 17	May 17	Jun 17
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme - transformation	Director of THIS (MG)	=20	=20	=20	=20	=20	=20	↓ 15	=15
Safety and Quality Risks											
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	=20	↓15	↑ 20	=20	=20	=20	=20	=20
6886	Transforming & Improving Patient Care	Non-compliance with 7 day services standards	Medical Director (DB)	-	!15	=15	=15	=15	=15	=15	**=15**
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=16	=16	=16	=16	=16	=16	=16	=16
2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20	=20	=20
6990	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/18	Medical Director (DB)	!16	=16	=16	=16	=16	=16	=16	=16
5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	!16	=16	=16	=16	=16	=16	=16	=16
6829	Keeping the Base Safe	Aseptic Pharmacy Unit production	Director of Nursing	!15	=15	=15	=15	=15	=15	=15	=15
6841	Keeping the Base Safe	Not being able to go live with the Electronic Patient Record – operational readiness	Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15	=15	=15
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	↑20	=20	=20	=20	=20	=20	=20	=20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD	=16	=16	=16	=16	=16	=16	=16	=16

Risk ref	Strategic Objective	Risk	Executive Lead	MONTH							
6977	**Keeping the base safe**	**Mandatory training 2017/18**	**Director of Workforce and OD**	-	-	-	-	-	-	-	**! 16**
6903	Keeping the base safe	ICU/Estates joint risk	Director of Estates and Performance (LH)	-	-	-	-	-	**!16**	↑ 20	=20
6924	Keeping the base safe	Misplaced naso gastric tube for feeding	Director of Nursing (BB)	-	-	-	-	**!15**	**=15**	**=15**	**=15**
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15	=15	=15
6971	Keeping the base safe	Endoscopy provision	Divisional Director of Surgery and Anaesthetics							!15	= 15
Finance Risks											
6967	Financial sustainability	Non delivery of 2017/18 financial plan	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20
6968	Financial sustainability	Cash flow risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20
6969	Financial sustainability	Capital programme	Director of Finance (GB)	15 =	=15	=15	=15	=15	=15	↑ 20	=20
Performance and Regulation Risks											
6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Director of Workforce (IW)	=15	=15	=15	=15	=15	=15	=15	=15
People Risks											
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce (IW	=20	=20	=20	=20	=20	=20	=20	=20

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

Trust Risk Profile as at 23/06/2017

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6693 Failure to comply with monitor staffing cap = 6715 Poor quality / incomplete documentation	= 6345 Staffing risk, nursing and medical	
Likely (4)				= 4783 Outlier on mortality levels = 6658 In efficient patient flow = 6300 CQC improvement actions = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 5862 Falls risk = 6990 CQUIN sepsis ! 6797 mandatory training	= 2827 Over reliance on locum middle grade doctors in A&E = 6967 Not delivering 2016/17 financial plan = 5806 Urgent estate work not completed = 6131 Service reconfiguration = 6968 Cash Flow risk ! 6903 ICU/ resus estates risk ↑ 6969 Capital programme
Possible (3)					= 6841 EPR operational readiness = 6829 Pharmacy Aseptic Unit = 6886 Non-compliance with 7 day services standards = 6924 Misplaced naso gastric tube = 6503 Non-delivery of EPR programme = 6971 Endoscopy provision
Unlikely (2)					
Rare (1)					

Risk No	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6967	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 (4% 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 1718 plans - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach Financial recovery actions were agreed by Turnaround Executive on 13th June.	Further work ongoing to tighten controls around use of agency staffing. For 2017/18 the Trust has been given a £16.86m ceiling level for agency expenditure by NHS Improvement. Agency spend must be reduced considerably from the level of expenditure seen in 16/17 if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding.	20 5 x 4	25 5 x 5	15 5 x 3	Whilst the Trust has agreed the 17/18 Control Total of £15.9m, serious concerns about the achievability of this target have been raised with the regulator. It leaves the Trust with a planning gap of £3m that 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 only £14.5m of the £17m CIP target and the forecast shows £5.9m as currently unidentified, with only £11.1m at Gateway 2. The year to date position is extremely precarious, with activity and income below the planned level. EPR implementation has had a significant impact on the capture and coding of activity and £2.6m 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. Underlying expenditure is not below plan and achieving Control Total in the year to date has relied on the release of one third of our Contingency Reserve and a number of non recurrent benefits that are one off in nature and cannot be repeated. Failure to achieve the Control Total in future months would also impact on Sustainability & Transformation funding. There remains a gap between the Trust's activity plan and that of local Commissioners that is linked to QIPP plans. If commissioners are successful in delivering these plans, the Trust will need to ensure that costs are reduced to compensate any associated loss of income.	Jul-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell
2827	Apr-2011	Developing our workforce	There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints. Locum shifts not being filled by the Flexible Workforce team and gaps not being escalated to the clinical team in a timely manner. ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps	20 4 x 5	20 5 x 4	12 4 x 3	April 2017: Impact of IR 3 has led to worsening of position in terms of filling vacant shifts and requests for increased pay rates from long term locums. Discussion being had with individuals. Trust decision to support the service by agreeing to pay increased rates through the agencies. May 2017: 3 long term, full time agency locums are in the process of converting to CHFT bank contracts. 2 additional MGs have been appointed. June 2017: 3 Locum Consultants recruited onto bank contracts (all picking up a line on the MG rota). Awaiting start date of 2 substantive consultants. 2 Middle grade doctors being pursued following successful interview (1 is starting the CESR programme). Experienced ACP recruited - will go onto junior doctor rota. 2 junior doctors being pursued for substantive posts through successful recruitment.	Jul-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Caroline Smith

6345	Jul-2015	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas - lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements Therapy Staffing - posts designed to be as flexible as possible - review of skill mix and development of Assistant Practitioners. - flexible working - aim to increase availability of flexible work force through additional resources / bank staff	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	**June 2017** Nurse Staffing - Applicants from International recruitment trip to the Philippines are progressing. 120 offers were made in country, since March 2017; 3 candidates have withdrawn, 90 are completing their training for the International English Language Test System (IELTS), 20 are due to take their IELTS exam before the end of August and 6 have passed their IELTS and are progressing with their NMC application. - Process for nursing internal moved to the new recruitment system Trac to allow for monitoring and reporting purposes. - All nursing vacancies to include the Head Nurse for Professional & Workforce Development to support the process of advertising within departments as well as centrally. Medical Staffing - Since January 2017, the Trust has offered substantive consultant posts in Acute Medicine, Diabetes and Endocrinology, Stroke Medicine, Emergency Medicine and Ophthalmology. Another joint Divisional advert was published in the BMJ on 25 March 2017. As a result of this second collaborative advert, offers have been made to substantive Consultant posts in a number of areas including Emergency Medicine. - There is an advert currently in the BMJ for CESR opportunities in Emergency Medicine. - Work has been undertaken to promote the role of Physician Associates (PAs) within the Trust, and the business case was approved to recruit new PAs across Medical, Surgery and Anaesthetics and Families and Specialist Services. Interviews were held on 10 June and 16 offers were made. The posts will be in Medicine and Surgery.	Jul-2017	Jan-2018	WF	David Birkenhead, Brendan Brown, Ian Warren	Rachael Pierce

6131	Oct-2014	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	10 5 x 2	March 2017 update - .JOSC met in February and agreed to meet in July and make a decision on referral to SoS once the full business case is completed **June 2017 update** - JOSC will meet in July to consider the Trust and CCG responses to the 19 recommendations and will then make a decision on referral to SoS. FBC due to be completed by the end of June and considered through formal governance processes in July before submission to NHS Improvement	Jul-2017	Aug-2017	WEB	Anna Basford	Catherine Riley
5806	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure.	Each of the risks above has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	The lack of funding is the main gap in control. Also the time it takes to deliver some of the repairs required. In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.	16 4 x 4	20 5 x 4	6 3 x 2	April 17 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so within the current budgetary constraints. The 17/18 Capital Plan is currently under review for approval while short term minor projects are being progressed to ensure continuity. May 17 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so within the current budgetary constraints. The 17/18 Capital Plan is currently under review for approval while short term minor projects are being progressed to ensure continuity. **June 17** The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The level of risk to the services at HRI is increasing as the number of major building risks increases	Jul-2017	Mar-2018	RC	Lesley Hill / David McGarrigan	Paul Gilling / Chris Davies

6968	Apr-2017	Financial sustainability	Risk that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as going concern.	* Agreed £8m capital loan from Independent Trust Financing Facility. * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from NHS Improvement * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Revenue support loan has been made available year to date to cover the deficit and delays in the receipt of Sustainability and Transformation funding	The level of outstanding debt held by the Trust is being closely monitored but is not entirely within the Trust's ability to control. The majority of this is owed by other NHS organisations.	20	5 x 4	20	5 x 4	15	5 x 3	The Trust plan for 17/18 is reliant on cash support from Department of Heath of £28.80m. £8m of Capital funding has been approved as part of an existing Capital Loan facility, the remaining revenue support loan requirements will have to be applied for on a monthly basis and will be subject to a potentially variable interest rate.	Jul-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell
6969	Apr-2017	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2017/18 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. Following a mandate from NHS Improvement to reduce Capital expenditure for 2017/18 due to national funding pressures, the Trust's Capital Programme has been severely curtailed and a number of capital schemes have had to be removed. This has increased the risk to the development and sustainability of services and has the potential to impact on clinical, safety and performance issues.	Agreed £8m capital loan from Independent Trust Financing Facility (ITFF) to support capital programme, specifically the Electronic Patient Record (EPR) investment. Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Capital Management Group met in May to prioritise the Capital programme. A further review is underway to asses the risk against those Capital schemes that have not been approved and a small contingency remains in place to cover any further changes.	.	20	5 x 4	20	5 x 4	12	4 x 3	The planned capital expenditure for 17/18 is £14.40m. From a cash perspective, all capital expenditure, including any slippage on the EPR programme, must be contained within available internally generated capital funding, supplemented in 17/18 by the remaining £8m of our pre-approved capital loan facility.	Jul-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell
6903	Dec-2016	Keeping the base safe	Collective ICU & Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to access for estates maintenance and capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU & RESUS, currently this is not achievable due to inadequate access and budget constraints.	20	5 x 4	20	5 x 4	0	0 x 0	April Update - Short term Business Continuity Plans discussed with surgery, contingencies and resilience. Medium / Long term plan to refurbish / move service. May Update - Short term Business Continuity Plans discussed with surgery, contingencies and resilience. Medium / Long term plan to refurbish / move service. RESUS collective risk added to ICU risk. **June Update** - Business Continuity Plans discussed with surgery, contingencies and resilience. Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.	Jul-2017	Sep-2017	RC	Lesley Hill / David McGarrigan	Chris Davies

6596	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	April 2017 The training course was delivered. Senior staff in corporate services will be asked to become investigators to increase the number of available investigators. Targeted effort during April to close down those with extended investigation periods. May 2017 Continued focus on closing investigations with 17 submitted during March and April. Information on corporate staff to support investigations being confirmed during May. Any staff requiring training to be offered training date of 28 June. Departure of senior investigations manager in May. Post revised and recruited to with start date of August 2017. **June 2017** Reviewing capacity of corporate staff to assist with investigations to support clinical investigators.	Jul-2017	Jul-2017	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove

6598	Jan-2016	Keeping the base safe	There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation. Further essential skills subjects are been identified and added to the list with increasing frequency. This obviously not only extends the period of time the roll out project will take but also leads to a re-prioritisation exercise around establishing which are the key priority essential skills to focus on first.	There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject. Compliance measurement will be enabled as each target audience (TA) is set although this is a lengthy process within the confines of the current Learning Management System. A database is being completed showing departmental training completion dates. This is to be hosted on the intranet to allow access at department level for updates and will feed into ESR. This is anticipated to be live by June 2017. Brendan Brown / Lindsay Rudge are restricting additions to the list to keep it to a manageable number.	1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. 4/ There are issues with PC settings which leads to completed e-learning not been recorded as complete. 5/ Planned updates to system not due until April 2017 so limitations as above will remain until this time. 6/ There are frequent requests for new essential skills to be added with no clear process to approve such requests. 7/ Heavy focus on EPR training and implementation has an impact on staff being able to complete essential skills training due to time and resource implications. 8/ Now all clinical staff have been issued a bank contract there are some discrepancies with competencies assigned to bank position but not their substantive post. These are small in number.	16 4 x 4	16 4 x 4	12 4 x 3	May 2017 ESR Manager Nigel Collins has suggested alternate methodology within OLM to allow compliance reporting in a different way. Blood transfusion essential skills target audience have now been completed as a result of this. **June 2017** Tissue Viability essential skills e-learning package now available to staff and TA is now set. Clarification is being sought around the issue with competences differing between bank / substantive contracts for some staff members.	Jul-2017	Oct-2017	WF	Ian Warren	Ruth Mason

6658	Mar-2016	Keeping the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20 4 x 5	16 4 x 4	9 3 x 3	April 2017 Much improved situation with 97% ECS. Anticipation to reduce risk scoring over next month. May 2017 Performance in month has reduced significantly and longer waits have been experienced by patients this is a consequence of introducing the new EPR. Divisions are developing an action plan which identifies the key blockers, micromanagement in place until the end of the month. **June 2017** Flow out of the departments had initially improved at the beginning of the month but with increasing attendances and lower discharges we continue to see increasing waiting times. Further actions taken- Point prevalence on the medical wards to understand delays. Senior attendance on ward rounds offering support and challenge to improve discharge planning. Cancellation of non urgent surgical elective patients.	Jul-17	Jun-2017	BOD	COO Helen Barker	Bev Walker

6300	May-2015	Keeping the base safe	As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services.	-CQC Response Group monitors improvements and progress with actions System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being held to monitor progress with the action plans chaired by the Chief Nurse - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, has been conducted and an action plan developed. Nearly all actions have been delivered and assurance gained. The Risk and Compliance Group will now oversee any areas outstanding.	The inspection report has shown us to be in the "requires improvement" category	16 4 x 4	16 4 x 4	8 4 x 2	April 2017 All actions are now green. An end of plan review will be now undertaken and the last actions to be embedded will be overseen by the Risk and Compliance Group. No dates have been issued for further inspection. May 2017 Year-end position: all of the actions in the plan are rated blue – embedded or green – action complete. There are 3 remaining green actions on the plan; embedded dates for these have been extended from 31.3.17 to Sept / Oct 2017. These are must do actions: Mandatory and Essential Skills Training and Appraisals; Medicines management and should do action: Seven day working in radiology. Progress with these actions will be reported to the Risk and Compliance Group. **June 2017** Year end report has been presented to the Board of Directors. Position with the plan remains as the Mary 17 position. Updates are being provided to the Board of Directors by core services rated requires improvement. A number of activities have now commenced to enable the Trust to prepare for a re-inspection this is being overseen by the Risk and Compliance Group. There is no date yet known for re-inspection	Jul-2017	Dec-2017	WEB	Brendan Brown	Juliette Cosgrove
4783	Aug-2011	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	3 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine, Stroke and Complex Medicine which will give guidance on areas of further improvement. Action plans for these areas being developed based on preliminary report findings. Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised 2016 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Improvement to standardised clinical care not yet consistent. Care bundles not reliably commenced and completed	20 4 x 5	16 4 x 4	12 4 x 3	April 2017 update HSMR is now 101.97 and SHMI 108 and both are in expected range. There are no alerts for the second month for specific conditions. All other actions within the CAIP plan are making progress. May 2017 update Mortality Surveillance Group continues to meet monthly. 3rd month with no alerts in SHMI and HSMR **June 2017 update** HSMR is 100.37 and SHMI 108 and remain in the expected range. Structured Judgement Reviews have replaced our 2nd level reviews from April deaths.	Jul-2017	Sep-2017	COB	David Birkenhead	Juliette Cosgrove

5862	Aug-2013	Keeping the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls.	Insufficient uptake of education and training of nursing staff, particularly in equipment. Staffing levels due to vacancies and sickness. Inconsistent clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12	4 x 3	16	4 x 4	9	3 x 3	April update New falls action plan signed off. Targeted work in the acute medical directorate has commenced including a focus on falls at night. Implementation of a post falls checklist. A reduction in falls is being seen. May update MAU team at CRH are to commence working with NHS Quest to focussed improvement work. All other actions continue as per April update. **June update** Actions as per plan, team meeting monthly, no improvement noted in falls numbers but there is an improvement in reliability of some care factors.	Jul-2017	Sep-2017	PSQB	Brendan Brown	Juliette Cosgrove
6990	Jun-2017	Transforming and improving patient care	CQUIN target at risk of not being met for 2017/18 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non - compliance with NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also financial penalties.	Awareness and new controls for ward areas Divisional plan, medical leads identified in all divisions -improvement action plan in place, improvements seen in data for 2016/17 -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign was launched introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards -sepsis prompt in EPR	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of communication and joined up working between nursing and medical colleagues	16	4 x 4	16	4 x 4	4	4 x 1	**June 2017** Assess impact of EPR sepsis prompt Improve safety huddles to include sespis Coordinate activity with the Deteriorating Patient Group Strengthen divisional leadership	Sep-2017	Dec-2017	SC	David Birkenhead	Juliette Cosgrove
6977	May-2017	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period compromising the 100% appraisal target. This risk is exacerbated by the requirement to complete EPR training in the same timeframe and the current unavailability of the National IG e-learning package. 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: - There conflicting demands on colleagues time available for training due to the very important EPR training programme that is currently active in the Trust	All electronic mandatory training programmes are automatically captured on ESR at the time of completion. The number of mandatory training subjects has been reviewed and reduced for 2016 – 2017 Classroom learning sessions for IG have been provisioned for February and March 2017 to offer an alternate to the unavailable IG e-learning package. It is understood that the refreshed National IG e-learning tool will, be available from April 2018 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	Sporadic failure on the part of the training data inputters to log appliance data into ESR Amount of immediate real time data for line managers	16	4 x 4	16	4 x 4	4	4 x 1	A data consolidation exercise for mandatory and essential skills subjects will be conducted by the Business Intelligence team in March 2017 to ensure all compliance data is accurate and captured A pay progression policy approach including mandatory training compliance has been approved by Board.	Aug-2017	Mar-2018	WF	Ian Warren	Ruth Mason

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

6924	Feb-2017	Keeping the base safe	Risk of mis-placed nasogastric tube for feeding due to lack of of knowledge and training in insertion and ongoing care and management of NG feeding tubes from nursing and medical staff resulting in patients fed into the respiratory tract or pleura and possible death or severe harm	Risk overseen by Nutritional Steering Group Task and finish group established by director of nursing to address elements of NPSA alert 22.7.16 on nasogastric tube misplacement Training package available Nursing staff have been encouraged to undertake self assessment and declaration of competency Check X rays are performed where aspirate is not obtained, or greater than pH5.5 Radiology team flag when sighted if tube is in the lung following xray Training and competency package in place for nursing staff identified from high use areas	Initial X Rays are reviewed by medical staff - currently have no record of training or competency assessment for medical staff working at CHFT Daily process for checking is dependent on individuals competency to be performed accurately Training data base is only available through medical device data base and is not monitored for compliance No assurance that all medical and nursing staff who are inserting and managing NG tubes have the competency required to do this No policy in place at CHFT to support guidelines	15	5 x 3	15	5 x 3	8	4 x 2	NPSA self -assessment has been completed and action plan is in development High use areas identified and training plan in place to ensure all nursing staff are trained and assessed as competent by 1st April 2017 Training figures monitored weekly for compliance from these areas Task and finish group – next steps will be a focus on training of medical staff Draft nutrition policy has been developed – plan to sign off through task and finish group. Currently with medical staff for comments. Update 17.5.17 Response sent re NPSA alert Nutritional Policy has had medical review and is awaiting final sign off. NG training continues – slight delay in completion due to EPR training Dr Uka has joined the task and finish group to work through training requirements and plan for medical staff. **June Update 20.6.17** Training for nursing staff in high risk areas has been undertaken and all areas identified are at 75% or over Training added to induction for nursing staff Task and finish group meeting 23.6.17 to work through medical staff training with attendance from associate medical director - training package written and ready to implement Policy in draft delayed - Junior CNS asked to pick up with colleagues locally. Nutritional Policy has had medical review and is awaiting final sign off. NG training continues – slight delay in completion due to EPR training Dr Uka has joined the task and finish group to work through training requirements and plan for medical staff.	Jul-2017	Aug-2017	QC	Brendan Brown,	Jo Middleton

6971	Apr-2017	Keeping the base safe	Business continuity risk relating to reduced endoscopy provision / capacity due to increased demand on the Automatic Endoscope Reprocessing (AER's) machines at HRI following fire in endoscopy at CRH and additional workload for AER machines at HRI, which increases the risk of machine failure and potentially fire resulting in further reduction in capacity / service delivery if machines need to be turned off. The risk of a complete equipment failure would result in a seizure of endoscopy services at CHFT due to individual AER failures reducing service delivery and disruption of the service. This would adversely impact the Trust's ability to achieve all access targets, list down time, reputational damage, complaints/litigation associated with poor patient experience/delayed diagnosis, delayed / cancelled procedures may cause distress to patients, extended waiting time in the Endoscopy Department for procedures and additional cost in resource and repairs could result in escalation of costs and further cancellation of procedure. Patient safety risk due to impact of reduced endoscopy provision and an increasing back log of patient's awaiting flexible sigmoidoscopy under the bowel cancer	Machines checked and monitored daily by endoscopy technicians whilst in use and all cycles are now conducted under physical supervision. The trust fire officer has ensured that there is adequate fire fighting equipment and decontamination staff are compliant in their use. Increased estates support and improved access to gettinge (maintenance contractor) technicians in place for all AER's across both sites A full downtime 36 hour period for maintenance schedules to be completed and all relevant tests to ensure all compliance is met. In sourced provider (medinet) contracted to deliver up to 60 lists worth of activity concentrating on fast track patient cohort (23/04/17 - 06/08/2017. (update 23/0617 lists populated for medinet service delivery on Saturdays through CRH)	Reliance on HRI AER's due to AER's failures in testing at CRH (review June 17)	20	5 x 4	15	5 x 3	5	5 x 1	To replace all AER's as part of the endoscopy decontamination replacement scheme, by expediting the scheme the risk will be mitigated. CRH decontamination to have replacement AER's in place and commissioned by mid July focus will be concentrated on recovering the flexible sigmoidoscopy patients by increasing lists from 5.5 this will take approx. 6 weeks. Early July invites will be sent out to out to patients on the bowel cancer screening programme to ensure continuity is maintained in service delivery following a lead time of weeks for invite to appointment. (update 23/06/17 enabling works completed today, equipment delivered 26/06/17 installation and commissioning works to commence July 17) September, supporting decontamination unit to be built at HRI that will support the decontamination replacement on both sites. (Update 23/06/17 Still in line with project plan) **June 2017** No update	Jul-2017	Sep-2017	DB	Julie O'Riordan	Jason Bushby

6693	Mar-2016	Keeping the base safe	Risk of financial penalties and reputational damage due to non compliance with NHSI cap rules resulting in tighter control and scrutiny by regulatory bodies (special measures).	Weekly reporting of all off-cap breaches Assurance via Finance, Performance & Well-led Group Centralisation of agency bookings via FWD to ensure governance of SOP Prioritising bank cover over agency use Adhering to a Preferred Supplier List (PSL) of framework agencies Executive control of off-cap engagements Divisional action plans to replace all medium/long-term agency contracts with alternative cover Ongoing implementation of NHS-I agency spend toolkit recommendations and Workforce Modernisation Programme initiatives. As from 13 March Allocate Bank system now used for Medical staff, Allied Health Professionals and Non-Medical Non-Clinical and non-rostered nursing areas, roll out plan in place for nursing to transfer across to Allocate from RosterPro Central and all should be transferred across by end of July 2017. 13 March 2017 - now able to capture all wage cap breaches to NHSI Weekly report on bank and agency usage now submitted to the Deputy Director of Workforce & Organisational Development, data now being captured via two electronic booking systems and manipulated into one report. Once all nursing transferred onto Allocate, one system will be used for all data capture and reporting. Much improved compliance around the centralised sourcing and booking of all agency staff. Medical bank numbers slowly increasing, recent shortlisting of 23 candidates. Substantive staff having bank contracts set up before leaving the Trust. Allocate Health Medix procured and project team requirements being scoped to implement Trust wide e-rostering to automate booking processes and embed rostering efficiencies.	Recent evidence that three agency bookings are going outside of SOP, i.e. not going through FWD High cost agency workers being engaged to meet short-term demand/pressures No robust action plan yet to replace medium/long-term agency use Due to no prospective cover in A&E rota medical locums being engaged to cover annual leave in A&E Trust has not yet embedded internal agency cap levels recommended by Workforce Programme.	15 3 x 5	15 3 x 5	15 3 x 5	Awaiting ratification of Agency Control Panel from WEB/WWLC Regional Working Group of MD's to co-ordinate regional approach to determine regional bank solution NHS-I to provide peer review of Trust status against agency spend toolkit recommendations and to assist in further action identified where appropriate. Downgraded to current risk level 15 due to ability to provide data on demand and up to date no enforcement notice from NHSI or negative press cover. **June 2017** No update	Jul-2017	Aug-2017	WF	Ian Warren	Lisa Cooper

6715	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication and multidisciplinary working.	Monthly clinical record audits (CRAS) with feed back available form ward to board A further qualitative audit is undertaken monthly by Matrons that includes patient understanding . Medical audits are undertaken Analysis and action planning is managed through divisional patient safety and quality board A multi professional clinical documentation group meets bi monthly to ensure new documentation is ratified, standards on documentation are addressed. Group receives reports and audits on documentation and identifies to the divisions areas (teams, wards departments) of concern as well as any specific areas of concern within a specific standard. Clinical records group monitors performance, highlighting best and worst performing wards and action plans are developed and managed through the divisions, including specific areas for improvement. January Update Work is progressing to devise and implement a ward assurance tool that will audit nursing documentation. The CRAS audits remain suspended. There has been little progress in fluid balance documentation which has been noted by the Director of Nursing as a result he is revising the improvement methodology and leadership to support this. May 2017 The Trust has gone live with the EPR on the 1st May, Matrons are undertaking some audit to ensure compliance. Reports will be produced once the system is further embedded. The senior nurse team will commission reporting to ensure it is included in the ward assurance framework. A meeting regarding Quality is being chaired by the Chief Nurse to establish understanding and way forward on the 17th May. Professional standards of documentation will improve as the EPR system automatically registers, username, time date,	The number of audits undertaken can be low Unable to audit to allow and act on findings in real time The discharge documentation is under going review Fluid balance is being reviewed, the evidence base is being examined by the Deputy Director of Nursing Awaiting the ward accreditation review in order to recommence audit (which will not collect comparable information)	20 4 x 5	15 3 x 5	6 3 x 2	Go live date for EPR planned for 1st May # May 2017 The Trust has gone live with the EPR on the 1st May, Matrons are undertaking some audit to ensure compliance. A meeting regarding quality is being chaired by the Chief Nurse to establish understanding and way forward on the 17th May. Professional standards of documentation will improve as the EPR system automatically registers, username, time date, legibility. **June 2107** The EPR has been implemented since the 1st May; on the 30th June, the Deputy Director of Nursing is leading a session with the nursing colleagues, the agenda is to review CQC guidance, ascertain how to ensure nurses are using the system to produce excellent nursing records, understand the reports produced from the system and ensure assurance is linked to the ward assurance tool. The intention is that the improvement work identified will be delivered by Matrons supported by the senior nurse team. .	Mar-2017	Aug-2017	QC	Brendan Brown	Jackie Murphy

6829	Aug-2016	Keeping the base safe	The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately 50,000 pa ready to administer injectable medicines with short expiry dates for direct patient care. Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service(SPS) on behalf of NHSE. The latest audit undertaken on 5 April 2017 rated the overall risk assessment to patient safety as high with two major deficiencies. It was strongly recommended that the workload is not increased in the HRI facility and consideration must be given to close the facility if a business case for replacement is not approved.Capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards to enable the closure of the HRI facility.	Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. Self-audits of the unit External Audits of the HRI unit will be undertaken by the Quality Control Service on behalf of NHSE every 6 months. Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance. The capacity plan of the HRI unit will not be exceeded. A strategy of buying in ready to administer injectable medicines will be implemented but there are concerns about the sustainability of the current pharmaceutical supply chain.	If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance' rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.	15	3 x 5	15	3 x 5	3	3 x 1	3 April 2017 Initial Feasbility Study received from Engie but further clarification required on technical specification. Meeting to be arranged with Engie, Pharmacy and Technical expert.The external audit of the HRI Unit is to take place on 5 April and the outcome of this audit will inform risk ratings and timescales. 16.May.17 (JD) Costings of feasibility study still awaited. EL Audit of HRI unit took place on 5th April 17 but report has not yet been received due to need for it to be peer-reviewed (expected by 22nd May) 25 May 2017.External audit report of HRI Unit received. Overall risk assessment to patient safety is high. Two major deficiencies: One involving in process controls. The other the state of the facility. 'A commitment to gain approval for the development of a new facility must be assured as a matter of urgency. **22 June 2017** A draft business case to be presented to the FSS Divisional Performance Meeting on 5 July 2017.	Jul-2017	Oct-2017	DB	Brendan Brown	Mike Culshaw

6841	Sep-2016	Keeping the base safe	Risk of: Not being able to go live with the Electronic Patient Record POST GO LIVE Inability to use the system effectively once the extended support mechanisms start to reduce following Early Live Support. Lack of confidence of the system due to any quality and/or performance issues. Efficiency and productivity may reduce due to inexperience of using the system Inability to report against regulatory standards Resulting in: Reputational damage arising from inability to go live with the EPR , financial impact, impact at every point of patient care (appointments, patient flow, records, MDT s, payment) and continued use of paper records which can impact on safe, efficient and effective patient care. National and local targets may be put in jeopardy. Contractual Penalties for the Trust.	Pre go-live - A robust governance structure is in place to support the implementation of the EPR, including EPR specific risk register reviewed at weekly EPR meeting. - Weekly EPR operational board with direct escalation to WEB (and sponsoring group) - 90/60/30 day plans will aid control - 1:1 consultant plan Cut over: - Strong cut over plan with a developed support structure for BAU post ELS. - Command and control arrangements for cut over (Gold, Silver, Bronze) Post go-live: - gap - CYMBIO Support - CHFT Support/BTHFT Programme resource gap covered (£320k capital)	1. Need to address requests for 'Mop up' Training in some areas 2. Address Hardware requirements (Walk around 23/24th May) 3. Further work from CYMBIO around DQ 4. Time to understand reporting position	15	15	10	April Update: Technical & Operational readiness is still on plan for the cut-over being the 29th of April. - Resources identified / secured for Friends, floorwalkers, service desk, corporate friends etc. - There is a shortfall around Manual Data Migration of around 15 wte. - Progress of Operational Checklist / Work off list. - Training figures as at COP 03/0417: 3041 (51%) people trained 4889 (82%) staff booked on training 11% DNA rate 1% failure rate - The successful completion of the above would mitigate the risk but not enough to lower the score at this point. May Update (Post go-live, end of week 3): Position statement: The Trust cut-over to Cerner Millennium EPR successfully on the planned weekend. The cutover plan worked well from an operational perspective with minimal delay with inpatients up and running in most area's prior to Outpatients on the 2nd May. Initial issues were due to End User Access and Role functionality followed by 'How do I?' type questions. Cut-over Risk: Mitigation and controls were effective, clear plans and operational structure (silver command etc) worked well. Post Go-live Risk: The post go-live risks outlined under description still exist at this early stage although initial assessment of the mitigation/controls would suggest the likelihood will reduce post ELS. Additional gaps will be addressed including 'Mop up' training, additional CYMBIO support around DQ and Reporting and a Hardware assessment across both sites. Both the Impact and likelihood scores stay the same until ELS is complete and mitigation is proven. **June 2017 Update** In reference to the 'Post go-live' risk. There are still a number of un-resolved issues following ELS. Around 1300 logged on RoD and further issues remaining from Silver Command. A process has been agreed at WEB (15th June) supporting a focused approach in clinical areas with the priority being set by the Divisional Ops Board. There are currently 10 focus areas plus 4 over arching areas (e.g. Access etc). Until these remaining issues are reduced the impact and likelihood of this risk remain the same.	Jul-2017	Sep-2017	RC	Helen Barker	Mandy Griffin

New Risk Register Entry Form

Calderdale and Huddersfield NHS
NHS Foundation Trust

Division:	Estates & Facilities		**Status:**	Awaiting Validation	
Directorate:	Trust Wide		**Source:**	Investigation	
Department:	Trust Wide		**Category:**	Health & Safety	
Goal:					
Responsible Committee:	Risk & Compliance	**Executive Director Lead:** Lesley Hill		**Lead Person:**	K Rawnsley / A Wilson / C Davies
Entry Date:	26th June 2017				

Risk Description:	The Risk of:-	Following the tragic incident at Grenfell Tower there is a perceived risk that CHFT could potentially experience a similar incident.
	Due to :-	This is due to a number of CHFT property facades being clad.
	Resulting in:-	Which, if the cladding was of the same type, fitted in the same manner and exposed to the same conditions as at Grenfell Tower, could present a fire risk to the organisation.
Existing Controls:	19th June 2017 - An initial risk assessment of CHFT has been carried out by CHFT (Estates Director, Fire Safety Manager, Estates Manager, PFI Manager and P21 providers). The risk assessment established a number of CHFT building facades are fitted with cladding. However, the types of cladding has been established and not deemed hazardous. Any further emerging risks will be managed at a matter of priority. 25th June 2017 – our local operational West Yorkshire Fire and Rescue (WYFR) team visited HRI. They were assured with the controls we had in place and the level and competence of our safety advice and support provided by our Fire Manager and Authorising Engineer. WYFR did not deem CHFT as having an urgent fire safety risk and are now focussing on buildings and organisations which are considered to be high risk. Based on our current findings, and feedback from WYFR, CHFT are not deemed an “urgent fire safety risk” above that which is being managed through controls and mitigation. Capital works continues across CHFT with the ongoing fire alarm upgrade, fire compartmentation works and emergency lighting. 27th June 2017 – Feedback received from **Deputy Chief Fire Officer Dave Walton – WYFR** West Yorkshire Fire & Rescue have taken guidance from the National Fire Chief’s Council who have been working with the NHS, Home Office and Department of Health to clarify the position. That combined approach resulted in the creation of a list of 39 hospital premises across the UK, further work has refined that list to 9 premises which it is felt require intervention and inspection by the local Fire and Rescue Service due to fire safety issues which are not solely in relation to cladding. WYFR are pleased to say that none of those nine buildings are in West Yorkshire area and neither were any of the 39 hospital premises.	
Gaps in Controls	Government / Fire and Rescue Services continue to investigate the Grenfell Tower incident and are requested to share the composition of cladding and adhesive that is deemed to be high risk which contributed to the incident.	

For Risk Score Guidance see page 2/3

Initial Risk Score Risk Score on entry to Risk Register	Impact (I)	5	Likelihood (L)	2	Risk Score (I x L= Risk Score)	10
Target Risk Score At what level will this risk be tolerated	Impact (I)	1	Likelihood (L)	1	Risk Score (I x L= Risk Score)	5

Further Actions:	Risk to be reviewed on receipt of Grenfell Tower cladding specification.

Next Review Date	10th July 2017
Target Date for Risk to be reduced to the Target Score.	

Risk Raised By: **Estates & Facilities**
Committee Discussed at: **Weekly Executive Board**
Date of Committee: **29th June 2017**

Risk score agreed at 15+ and for discussion at Risk & Compliance Committee: YES/NO

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

2 Likelihood score

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

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

Table 3 Risk scoring = Impact / Consequence x likelihood

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

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

1 - 3	Very Low risk
4 - 6	Low Risk
8 - 12	Medium Risk
10-12	High Risk
15-25	Significant

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 6th July 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: BOARD ASSURANCE FRAMEWORK - The Board is asked to approve the update to the Board Assurance Framework	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Audit and Risk Committee, Quality Committee, Finance and Performance Committee, Workforce Well Led Committee, Risk and Compliance Group	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board Assurance Framework has been updated following approval of the one year plan for year ending 2018 at the Board in June.

Main Body

Purpose:

The Board Assurance Framework (BAF) sets out the risks to the achievement of the Trust's strategic objectives and has been refreshed following the approval of the one year plan for year ending 2018.

Background/Overview:

The Directors review the risks to the delivery of the Trust's strategic objectives on a bi-monthly basis.

The Issue:

There are a number of proposed changes to the BAF following the most recent review of the risks:
Risks to be closed
005 - Failure to successfully implement the Trust's EPR - it proposed that a new risk relating to the realisation of benefits resulting from EPR opened.
006 - Failure to secure patient and public involvement in transformational change - the requirements of the new well led framework will be reviewed and any identified risks included on the BAF at its next review.
015 - Failure to deliver the financial position for 2016/17 - a new risk relating to the 2017/18 financial position is included
016 - Failure to progress and agree a five year strategic turnaround plan - this risk is duplicated by 003 - Failure to progress service reconfiguration, therefore it is proposed to close this risk and combine the controls and assurances in risk 003.

Risks with an increased score
There is one risk with an increased score - 008 Governance - this is due to the performance and financial position

Risks with a reduced score
There are 3 risks with a reduced score:
001 - HSMR / SHMI - the Trust's HSMR and SHMI scores have fallen further
004 - Seven day services - due to the Trust's assessment position
013 - Ability to attract clinical leadership - the Medical Director's office is in place and there have been appointments to a number of key clinical posts across the Trust

Next Steps:

For the next review the following risks will be considered for inclusion in the BAF:
- Whether the risks associated with IR 35 are sufficiently reflected in the current BAF
- The increasing importance being placed on Carter efficiencies by NHS Improvement
- The role of patient and public involvement and the requirements included in the new CQC well led inspection guidance.

As it is two years since this version of the BAF was adopted by the Board, the Company Secretary and Head of Risk and Governance will be undertaking a review to ensure that it remains fit for purpose, working with colleagues from across West Yorkshire and Harrogate.

Recommendations:

The Board is asked to approve the update to the Board Assurance Framework and recommend any areas for further consideration.

Appendix

Attachment:

MASTER - latest update June 2017.pdf

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2017/18

Contents:

compassionate care

REF	RISK DESCRIPTION	Current score	Lead	Link to RR
Transforming and improving patient care				
001	Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and/or SHMI	12 ↓	DB	6313 2827 6596
002	Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (EPR, CIP, CQC preparation and service reconfiguration) while keeping the base safe	20 =	OW	6346
003	Faliure to progress service reconfiguration caused by an inability to agree a way forward across health and social care partners	20 =	AB	6131 2827 4783
004	Inability to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	10 ↓	DB	
005	Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care	15 =	Proposal to close and replace with 20.1718 below	
006	Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust	6 **TARGET**	Proposal to close and reassess against new CQC inspection guidance	
020	Failure to realise the benefits from the implementation of the Trust's EPR	15 **NEW**	MG	
Keeping the base safe				
007	Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety	15 =	BB	6300 6694 6594 6596 6299 6598 6829 6299 6715 6234 6300
008	Failure to implement robust governance systems and processes across the Trust	12 ↑	OW	6694
009	The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement	15 ↓	OW	4706 6693
010	Failure to achieve local and national performance targets	20	HB	6658
011	Failure to maintain current estate and equipment and to develop future estates model to provide high quality patient care	20	LH	6300 6299 5806 6723
A workforce fit for the future				
012	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop collegues.	20 =	BB / DB	6345 6497 6723
013	Failure to attract and develop appropriate clinical leadership across the Trust.	12 ↓	DB	
014	Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites.	12 =	IW	
Financial sustainability				
015	Failure to deliver the financial forecast position for 2016/17 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity	15 =	Proposal to close and replace with 021 below	
017	Failure to progress and agree a five year strategic turnaround plan across the local health economy	15 =	Proposal to close due to duplication	
019	Failure to maintain a cash flow	20 =	GB	
021	Failure to deliver the financial forecast position for 2017/18 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity	25 **NEW**	GB	6131 2827 4783
022	Failure to secure sufficient capital	20 **NEW**	GB	

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly likely (5)		4. Seven day services ↓		11. Estate fit for purpose 19. Cash flow =	21. Financial delivery 2017.18 **NEW**
Likely (4)					2. Large scale transformation = 3. Service reconfiguration = 12. Staffing levels = 10. National and local targets = 22. Capital **NEW**
Possible (3)				1. Mortality ↓ 14. Staff engagement = 8. Governance ↑ 13. Clinical leadership ↓	20. EPR **NEW** 7. Compliance with quality standards = 9. Compliance with NHS Improvement ↓
Unlikely (2)					
Rare (1)					

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
1.1516	Quality Committee	Executive Medical Director	**Risk** Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI. **Impact** - Inaccurate reporting of preventable deaths - Increased regulatory scrutiny - Inability to learn lessons - Increased risk of litigation and negative publicity. - Possible increase in complaints and litigation	• Safety thermometer in use on wards • Safety huddles implemented • Tighter process in place in relation to SI reporting and investigation • 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 • Nervecentre roll out across the Trust • Ongoing work to improve the care of frail patients • Implementation of care bundles	<u>First line</u> Mortality dashboard in divisions Mortality reviews provide themes to improve standards of care Coding review putting Trust in upper quartile for some areas Mortality Surveillance Group established <u>Second line</u> Care of the Acutely Ill patient report to Board PSQB reports to Quality Committee Mortality review updates to Quality Committee <u>Third line</u> Independent review of cases by Professor Mohammed HSMR has fallen to 100 - the national average. SHMI has fallen to 108 - within the expected range.	Coding improvement required following the implementation of EPR. Improvement to standardized clinical care not yet consistent. New mortality review process to be implemented. Job plans for 2017/18 will include requirement to undertake mortality reviews		Initial: 5x4 = 20	Current: 3x4 = 12	Target: 3x4 = 12

Action	**Timescales**	**Lead**
New mortality review process to be implemented	September	SU
Job plannning process to be agreed and implemented	November	CP

Links to risk register:
Risk 2827 - Clinical decision making in A&E
Risk 6313 - Inability to progress service transformation
Risk 6596 - SI reporting

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
2.1516	Board of Directors	Chief Executive	**Risk** Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (STP, EPR, CIP, CQC readiness and service reconfiguration) **Impact** - Delivery of safe clinical care - Financial sustainability - Low staff morale. - Viability and competitiveness of Trust is compromised	• Programme Management Office established to manage schemes •Turnaround governance arrangements in place including weekly Turnaround Executive • Joint EPR governance arrangements in place with BTHT • Moderisation WEB and report to F&P Committee / Board on progress with delivery of EPR • Full board complement in place • WYAAT meetings • Risk reporting and review arrangements • Hospital Programme Board • Partnership Board with CCGs • Joint Overview & Scrutiny Committee	<u>First line</u> Modernisation WEB held every 6 weeks EPR implementation Risk and Compliance Group overseeing CQC preparation and implementation of actions EPR operational board <u>Second line</u> Integrated Board Report EPR report to Finance and Performance Committee / Board Turnaround Executive scrutiny weekly Monthly report on turnaround to Finance and Performance Committee <u>Third line</u> QRM meetings with NHS I demonstrate progress Well Led Governance Review showed some areas of good practice EPR Gateway assurance report NHS Digital presentation on EPR	Outstanding items for resolution on the EPR Details of new-style CQC inspection only just received Lack of clarity on sign-off process for FBC Full CIP not yet identified Financial position challenging requiring recovery planning		Initial: 4x4 = 16 Current: 4x5 = 20 Target: 3x3 = 9

Action	Timescales	Lead
FBC to go through internal governance processes	July	AB
Clarity on NHS I approval process to be sought	July	OW
Review of CQC inspection guidance to be undertaken and governance arrangements put in place	July	BB
Reporting of progress with outstaning EPR actions to be finalised	July	HB

Links to risk register:
Risk 6346 - Capacity and capability to deliver service transformation

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
3.1516	Board of Directors	Director of Transformation and Partnerships	**Risk** Faliure to progress service reconfiguration caused by inability to agree way forward across health and social care partners **Impact** - Delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance; Compliance with Paediatric Standards; Compliance with Critical Care Standards; Speciality level review in Medicine - Unable to meeting 7 day standards - Inabilty to recruit and retain workforce in particular medical workforce (increased reliance on Middle Grades and Locums) - Potential loss of service to other areas	• Participation in Hospital Services Board by key senior staff. 20/1/16 CCGs made the decision to commence public consultation on the future configuration of hospital services. • CCGs and NHS England representatives included in roundtable discussion with NHS I • There is an agreed consensus between the CCGs and the Trust on the preferred clinical model.This has been reviewed and endorsed by Yorkshire and Humber Clinical Senate. • NHS I support for development of Full Business Case. • ED business continuity plan developed • Additional consultant posts agreed for ED • Interim actions to mitigate known clinical risks • Nurse led service managing Paediatrics • Critical care still being managed on both sites • Frequent hospital to hospital transfers to ensure access to correct specialties	<u>First line</u> Vanguard work in Calderdale showing an impact <u>Second line</u> 5 Year plan progress report to Finance & Performance Committee and Board Urgent Care Board and System Resilience Group in place <u>Third line</u> Recent Trauma review shows positive position for CHFT QRM meeting with NHS I and roundtable meeting tracks progress Reconfiguration included within WYSTP	• Difficulty in recruiting Consultants, Middle Grade and longer term locums • Estate limitations inhibit the present way of working • Consultant rotas cannot always be filled to sustain services on both sites	• High use of locums • Lack of clarity on process for approval of the FBC • Lack of capital funding availability	**Initial** 5x5 = 25	**Current** 4x5 = 20	**Target** 3x5 = 15

Action	**Timescales**	**Lead**
Particpation in JOSC meeting	July	AB
FBC approval process to be clarified with NHS I	July	AB

Links to risk register:
Risk 6131 - large scale service change
BAF risk 2.1516

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
4.1516	Quality Committee	Executive Medical Director	**Risk** Inability to deliver appropriate services over seven days resulting in poor patient experience, greater length of stay and reduced quality of care. **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Working group set up and workshop held with senior colleagues to develop plan • Perfect week learning shared • Governance systems and performance indicators in place • Part of the West Yorkshire early implementers	First line Improvement in performance against some key indicators including pre 12 o'clock discharge and reduction in outliers Second line Integrated Board report Benchmarked against four key Keogh standards Paper received at WEB Third line Independent review of mortality cases by Professor Mohammed Visit from NHS Improvement Medical Director gave positive feedback	• Latest benchmarking report to be reviewed to identify gaps and appropriate actions • National consultant contract negotiations outcomes awaited • Capacity to deliver 7 day service action plan	• Included within new Single Oversight Framework. Need to understand metric measured and impact on Trust • Scope for futher implementation limited without service reconfiguration or additional investment	Initial 5x3 = 15	Current 5x2= 10	Target 2x3 = 6
Action					**Timescales**			**Lead**		
Benchmarking report anto be reviewed actions to be agreed					July			SU		
Links to risk register: No corporate (>15) risks										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
5.1516	Finance and Performance Committee	Interim Director of The Health Informatics Service	**Risk** Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care **Impact** - Inability to realise the benefits - Non delivery of improvements in clinical outcomes - inability to realise return on investment or financial value for money	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Financial appraisal and selection of preferred supplier that included full benefits realisation and implementation plan. • Modernisation Programme Management and Governance structure to manage the implementation and roll-out of the EPR system within the Trust-wide IT Modernisation Programme. • A detailed project plan and timelines have been agreed with Cerner (EPR Provider) and Bradford for the roll-out of the EPR. • Current state gap analysis completed • Go live date planned for 1 May	First line Regular reporting showing progress against plan CHFT has met exit criteria for the majority of areas Second line Joint Transformation Board with BTHT meets on a monthly basis chaired at Chief Executive level. Assurance Board that includes Non-Executive directors. Report to Finance and Performance Committee Third line 2nd Gateway assurance report Monthly update to NHS Improvement as part of PRM reporting arrangements	• Training plan to be fully described and populated		Initial 3x5 = 15	Current 3x5 = 15	Target 1x5 = 5
Action					**Timescales**			**Lead**		
Communications and Engagement plan to be implemented Training plan to be completed and delivered ~~Go-live date to be agreed~~					Ongoing starting in September ~~September~~ May COMPLETE			MG MG		
Links to risk register: Risk 6503 - Non delivery of EPR Risk 6841 - EPR go-live BAF risk 2.1516										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
6.1516	Quality Committee	Executive Director of Nursing	**Risk** Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust **Impact** - inability to make require service change impacting on the delivery of safe clinical care - reputational damage with stakeholders	• Patient and public involvement plan implemented for development of SOC / OBC and used as template for other engagement activity • Full engagement and consultation commissioned from CSU for movement of child development services from Princess Royal Health centre • EPAU and Gynae engagement completed with CCG scrutiny and OSC oversight • Particpation, communication and engagement s[illegible] group with CCGs. • Patient and Public involvement plan developed for the Trust and being implemented • Greater clarity on process for engagement and consultation sign off for service redesign with CCGs • Engagement champions in place across divisions and quarterly learning events held • Clear lines of communication with HealthWatch and OSCs • Member of Calderdale Community wide Public and Patient Engagement Group and attend quarterly meetings	First line Some PPI activity included in divisional patient experience reports to Patient Experience Group each quarter Second line Contribution to CCG Annual Statement of Involvement PPI included in Quarterly Quality Report to Board [illegible] SOC [illegible] and appr[illegible] Child Development Unit; EPAU / Emergency Gynae engagement plan; Cardio & Respiratory engagement plan.	• No identified capacity to deliver co-ordinated approach to PPI • Membership Strategy requires review and appropriate action plan putting in place		**3x4= 12**	**2x3 = 6 TARGET**	**2x3 = 6**
Action					**Timescales**			**Lead**		
Membership Strategy review to be completed Awaiting outcome of CQC report to identify any further action to be taken					~~September November~~ May COMPLETE - no actions identified			RM		
Links to risk register: No corporate (>15) risks										

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
NEW 20.1718	Finance and Performance Committee	Interim Director of The Health Informatics Service	**Risk** Failure to realise the benefits from the implementation of the trust's electronic patient record to ensure delivery of high quality, efficient and cost effective patient care **Impact** - Non delivery of improvements in clinical outcomes - inability to realise return on investment or financial value for money	• Modernisation Programme Management and Governance structure to manage the ongoing implementation EPR system within the Trust-wide IT Modernisation Programme. • Operational Delivery Board in place with cross divisional representation • Business as Usual structure in place • Transformation Board reporting • Operational Delivery Board in place with cross divisional representation	First line Operational Board reporting Second line Joint Transformation Board with BTHT meets on a monthly basis chaired at Chief Executive level. Assurance Board that includes Non-Executive directors. Report to Finance and Performance Committee Third line Improvement as part of QRM reporting arrangements	• Number of issues following implementation still to be addressed • Business as usual structure doesn't include development structure • Training plan for new starters and follow-up training to be agreed and implemented • Governance and process around benefits realisation for the trust now the system is operational to be confirmed.	• Lack of capital funding for developments	**3x5 = 15**	**3x5 = 15**	**2x5 = 5**

Action	**Timescales**	**Lead**
Training plan to be completed and delivered	August	MG
Benefits paper to be presented to Finance and Performance Committee	July	MG
WTGR workshop to work thorough governance and opportunities.	July	MG

Links to risk register:

TRUST GOAL: 2 KEEPING THE BASE SAFE

Ref	OWNER Board committee	OWNER Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING Initial	RATING Current	RATING Target
7.1516	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale	• Quality governance arrangements revised and strengthened • Revised SI investigation and escalation process in place • Strengthened risk management arrangements • Risk and Compliance Group overseeing implementation of actions and preparation plans for well led inspection • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures and introduction of ward assurance tool. • Board to ward programme in place • Process in place for policy reviw and approval • Process tightened around review and compliance with NICE guidance	<u>First line</u> Staffing levels reported to WEB Clinical audit plan reviewed Assessment of compliance with NICE guidance Improvement in HSMR & SHMI Vacancy and agency use reporting Improvement in staff sickness absence <u>Second line</u> Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs in Integrated Board Report. PSQB reports to Quality Committee CQC Action plan progress reported to Quality Committee & Board DIPC report to Board <u>Third line</u> CQC report showed requires improvement; no inadequate areas in line with Trust's self-assessment Quality Account reviewed by External Auditors and stakeholder bodies Well Led Governance review Independent assurance on clinical audit strategy Ongoing relationship and review with arms length regulatory bodies Independent Service Reviews and accredirations	• Consistent mandatory training compliance • Operational and financial priorities impacting on capacity and ability to maintain consistent quality of care • Standard of serious incident investigations needs further improvement • Estate issues identified • Scale of change and pace impacting on staff morale and engagement	• CQC assessed the Trust as requires improvement • National Clinical Advisory Team recommendations not fully addressed • Staff FFT response to recommendation as a place to work and place to be cared for declining • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements	3x5 = 15	3x5 = 15	2x5 = 10

Action	Timescales	Lead
CQC response action plan to be implemented	September	BB
Introduction of ward assurance programme	July	BB
Leadership development programmes to be rolled out	July	IW
CQC preparation plan to be agreed	September	BB

Links to risk register:

Risk 6694 - Divisional governance
Risk 6299 - Medical devices
Risk 6598 - Essential Skills
Risk 6594 - Radiology
Risk 6715 - Documentation
Risk 6300 - CQC
Risk 6596 - SIs
Risk 6234 - Mandatory training
Risk 6829 - Pharmacy

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
8.1516	Board of Directors	Chief Executive	**Risk** Failure to implement robust governance systems and processes across the Trust **Impact** - Potential to affect the quality of patient care. - Reputational damage - Risk of regulatory action - Learning opportunities missed	• Quality governance review undertaken and implemented • Review of Board level sub-committees • Improved board level risk management reporting arrangements • PMO in place and improved governance in relation to CIP planning • Performance Management Framework implemented • Strengthened SI process in place • Mandatory training requirements clarified and communicated • Appraisal season in place • CIP reporting to Joint Overview & Scrutiny Committee	First line Divisional governance arrangements in place with Executive attendance Improved PSQB reporting Self assessment undertaken against Board Governance Assurance Framework template Second line Well Led Governance Review action plan delivered and monitored by the Board Performance Management Framework arrangements reviewed by the Board Third line QRM meeting with NHS I showing progress - moved to Quarterly meetings Well Led Governance Review identified no red flags Partnership Board meeting with CCGs Joint Overview & Scrutiny Committee	•Financial performance requiring recovery planning Aspects of operational performance away from plan • Mandatory training and appraisal not yet at full compliance Assessment of requirements of CQC Well Led inspection not yet complete	• CQC assessment as requires improvement • Full CIP not yet identified and planned targets for Q3 & Q4 significantly challenging when compared with previous years	**3x4 = 12**	**3x4 = 12**	**2x4= 8**

Action	**Timescales**	**Lead**
Financial recovery plan	July	GB
CIP identification and plan	July	GB
Mandatory training monitoring to be implemented	September	IW
Assessment of CQC Well Led inspection requirements to be undertaken	July	BB

Links to risk register:
Risk 6694 Divisional governance

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
9.1516	Board of Directors	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• QRM meeting with NHS I • Corporate compliance register in place • Review of monthly NHS I bulletins to assess any required actions • PMO in place with Turnaround Executive governance around CIP • 5 Year strategic plan completed and formally adopted by the CCGs as part of the pre-consultation business case • Well Led Governance review completed	First line Clear PMO reporting from Divisions Second line Integrated Board report showing CIP delivery CIP report to Finance and Performance Committee Well Led Governance review report to Board Board approval of 5 Year Strategic Plan Third line Quarterly PRM with NHS Improvement Round table meetings being held with CCGs, NHS England and NHS Improvement CCG acceptance of 5 Year Strategic Plan	• Performance against STF standards • Achievement of year end financial position remains challenging	• 17/18 CIP plan not yet finalised • Performance against key targets Lack of clarity on approval process for FBC	5x5 = 25	3x5 = 15	2x5 = 10

Action	**Timescales**	**Lead**
FBC to go through internal governance processes	July	AB
Clarity to be sought on external approval process	July	OW

Links to risk register:
Risk 4706 - Financial plans
Risk 6693 - Agency cap

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
10.1516	Finance and Performance Committee	Chief Operating Officer	**Risk** Failure to achieve local and national performance targets and levels required for STF **Impact** - Poor quality of care and treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders - STF withheld and financial issues	• Strengthened performance monitoring and management arrangements • Bed modelling work and additional investment made in to bed capacity • New patient flow programme • CQUINS compliance monitored by Quality directorate • Bronze, silver and gold command arrangements and escalation process • System-wide gold commanders meeting in place • Regular forum in place between Operations and THIS to strengthen information flows and reporting • Head of Performance in place • Assistant Director for SAFER appointed	First line Weekly performance review with divisions. Divisional board and PSQB reviews of performance with executive attendance Activity reporting discussed at WEB Intergrated Board report focus of one WEB each month for detailed scrutiny wtih wider representation from divisions 'Deep dive' discussions into areas of under performance Appointment slot issues action plan has resulted in reduced ASIs Work begun to develop more intuitive dashboard Second line Enhanced Integrated Board Report discussed at Quality Committee and Board Finance and Performance Committee monthly report on activity Report on compliance with best practice tariff Third line Urgent Care and Planned Care Boards and System Resilience group	• System responsiveness • Appointment slot issues backlog still to be addressed • Over delivering on outpatient and daycase and under delivering on electives • Achievement of 4 hour emergency care standard requires micro-management. • Inability to retain enough middle grades • Impact of IR 35 resulting in service gaps	• New EPR system impacting on reporting accuracy	**Initial** 4x4 = 16	**Current** 4x5 = 20	**Target** 2x5 = 10

Action	**Timescales**	**Lead**
Continued work on SAFER programme	Ongoing	HB
Review impact of EPR implementation	July	HB

Links to risk register:
Risk 6658 - Patient flow

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
11.1516	Quality Committee	Executive Director of Planning, Performance, Estates and Facilities	**Risk** Failure to maintain current estate and equipment and develop future estates model to provide high quality patient care **Impact** - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• System for regular assessment of Divisional and Corporate compliance • Policies and procedures in place • Quality Governance assurance structure revised • Estates element included in development of 5 Year Strategic plan • Close management of service contracts to ensure planned maintenance activity has been performed • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Development of Planned Preventive Maintenance (PPM) Programme • Audit of medical devices by independent assessor to identify any further actions needed • Health Technical Memorandum (HTM) structure in place including external Authorsing Engineers (AE's) who independantly audit Estates against statutory guidance. • Authorising engineer for fire • Partnership agreement with fire authorities	First line CQC compliance reported in Quarterly Quality and Divisional Board reports Weekly strategic CQC meetings Second line Health and Safety Committee monitors medical devices action plan to address recruitment issues, database, risk analysis of devices Monitor review of PFI arrangements Assurance provided by AE's following audits against Estates statutory requirements Delivery of recommendations from Internal Audit report Third line PLACE assessments CQC Compliance report Assurance received from Environment Agency regarding healthcare waste implementation plans Progress made on DoH Premises Assurance Model (PAMs) to illustrate to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe. HSE review of water management Assessment by local operational Fire and Rescue teams	• Capital funding significantly scaled back which has impacted on ability to deliver estates schemes • Medical Device database needs to be reviewed to ensure accurate formation on medical devices needing maintenance.	• Internal Audit report on medical devices has a small number of outstanding actions • Mandatory training figures remain below plan for health and safety	4x4 = 16	5x4= 20	2x4 = 8

Action	**Timescales**	**Lead**
Continue to review urgent estate work in line with capital programme	Ongoing	LH

Links to risk register:
Risk 6300 - estates risk
Risk 5806 - estates schemes
Risk 6299 - medical devices
Risk 6723 - capital

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING		
								Initial	Current	Target
12.1516	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff	• Weekly nurse staffing escalation reports • Ongoing multifacted recruitment programme in place, including international recruitment; • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure • ED business continuity plan in place; • Vacancy Control Panel in place; • E-roster system in place. •Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place. • Risk assessments in place • Nursing recruitment and retention strategy in place	First line Staffing levels, training and education compliance and development reported to WEB Divisional business meetings and PSQBs consider staffing levels as part of standard agenda IBR shows slight decrease in sickness levels, and reduction in agency spend Bi-annual review of ward nursing levels Weekly meeting on agency spend Number of PA posts recruited to Second line Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs embedded in Integrated Board Report. PSQB reports to Quality Committee Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues	Current hotspots are: Emergency Care; Radiology; ; opthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; therapies; Recruitment and retention strategy for medical and therapy staffing required Continued spend on locums and agency remains above the NHS I cap leading to financial pressures in year. Multi-professional e-roster yet to be rolled out	• Not yet clear of the impact of agency figures on the new Single Oversight Framework assessment • Need to embed workforce plan • Impact of IR35	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
Workforce strategy for medical staff to be developed	December	DB
New allocate system to be fully implemented	September	IW

Links to risk register:
Risk 6345 - overall staffing risk
Risk 6497 - Nurse staffing
Risk 2827 - Middle grade staffing

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING** Initial	Current	Target
13.1516	Quality Committee	Executive Medical Director	**Risk** Failure to attract and develop appropriate clinical leadership across the Trust. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities	• Devolved clinical structure • Work together get results programme in place • Positive feedback from Junior doctors on medical training • Performance appraisal based around behaviours • Coaching circles process • All CIP schemes have clinical lead • Development of new roles across professional groups • Good revalidation compliance • Performance Management Framework agreed including job description for clinical leads. • Development of medical director's office • Development programme being rolled out - first two cohorts	First line Established escalation framework to prioritise action to address week areas Clinicians leading of transformation programmes e.g. cardio /respiratory Engaged leaders toolkit in place Clinical lead particpation in star chamber approach Job planning framework approved Recruitment to key roles across the Trust Second line Integrated Board Report Revalidation report to board Third line IIP Accreditation Feedback from Royal Colleges Junior doctor GMC questionnaire feedback	• Education proposal not yet finalised • OD plan for medical workforce to be developed	• Acquire independent assessment of clinical leadership arrangements • Staff FFT / Survey results deteriorating	4x4 = 16	3x4 =12	3x3 = 9

Action	**Timescales**	**Lead**
OD plan for medical workforce to be developed	September	IW

Links to risk register:
No corporate (>15) risks

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
14.1516	Well Led Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Leadership visibility increasing and impact of EPR work • Quarterly staff FFT in place • Work together get results programme in place • 'Ask Owen' being responded to • Good evidence of colleague engagement in OBC / FBC development • Celebrating success annual awards • Staff survey action plan • Health and wellbeing strategy • Implemented star award recognition scheme • Board to ward programme in place • Board to ward programme in place • BME network in place and well attended	First line Divisional leadership approach CQC preparation for self assessment shows some areas reporting GOOD in well led domain Significant number of actions delivered against action plan Second line Integrated Board report shows sickness absence slightly improved CQC Mock inspection feedback from focus groups Third line Staff FFT / staff survey provides some positive feedback IIP accrediation - Bronze award	• Cultural barometer indicators to be developed • Continued difficulty in engaging clinical staff • Outstanding actions on WRES action plan • Go engage programme to be delivered	• Staff FFT response rate deteriorating along with number of staff who would recommend the Trust as a place to work • Still a number of well led indicators on the IBR showing red • Number of areas in CQC assessment showing requires improvement	**Initial**	**Current**	**Target**
								3x4 = 12	**3x4 = 12**	**1x4 = 4**
Action					**Timescales**			**Lead**		
Revised colleague engagement plan to be approved and delivered					October			IW		
Links to risk register: No corporate (>15) risks										

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
15.1516	Finance and Performance Committee	Executive Director of Finance	**Risk** Failure to deliver the financial forecast position for 2016/17 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity **Impact** - financial sustainability - increased regultory scrutiny - insufficient cash to meet revenue obligation - inability to invest in patient care or estate	• Financial recovery and cost improvement programme plan in place • PMO tracking of delivery against CIP plan • Budgetary control process • Detailed income and activity contract monitoring • Bottom-up forecasting process • Star chamber process to support CIP schemes off track • Quality directorate overview of progress against delivery of CQUIN • Authorisation process relating to agency spend • Standing Financial Instructions set authorisation limits	First line Divisional Board performance reports Second line Turnaround Executive Reports NHS I scrutiny at Finance and Performance Committee and Board Integrated Board report including CQUIN delivery reporting Third line [illegible] NHS I [illegible] NHS I Well Led Governance Review Internal Audit Report on divisional performance management arrangements	• Temporary staffing remains a cost pressure due to recruitment challenges • Remain gap between activity and agreed contract	• Agency spend levels not falling as required.	4x4 = 16	4x4 = 16	1x4=4
Action					**Timescales**			**Lead**		
Ongoing monitoring of financial position through F&P and Board					Ongoing			GB		
Links to risk register: Risk 6828 - PMU Risk 6822 - Sepsis CQUIN Risk 6723 - Capital Risk 6721 - Financial plans										

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref	**OWNER**		**RISK DESCRIPTION**	**KEY CONTROLS**	**POSITIVE ASSURANCE &**	**GAPS IN CONTROL**	**GAPS IN ASSURANCE**	**RATING**		
								Initial	**Current**	**Target**
17.1516	Board of Directors	Director of Transformation and Partnerships	**Risk** Failure to progress and agree a five year strategic plan across the local health economy **Impact** - financial sustainability - viability of certain services - inability to compete or collaborate with other WY acute trusts	• PRM process • Roundtable discussions introduced including Monitor, CCGs and NHS England • EY appointed to develop 5 year plan. 5 Year Strategic Plan completed at end December 2015 and updated in January 2016 to take account of 16/17 planning guidance. Plan approved by Trust Board in January 2016. • Public consultation completed	<u>First line</u> WEB assessment of direction of travel <u>Second line</u> Board scrutiny and approval of 5 Year Plan. Hospital Services Programme Board discussions to ensure plan aligned with local health economy plans - this has enabled CCGs in January to confirm decision to commence public consultation on future configuration of hospital services. <u>Third line</u> PRM meetings with NHS Improvement and Roundtable discussions with CCGs. NHS I oversight of strategy development process. NHSE assurance of CCG processes and readiness to commence public consultation. CCG decision to progress on 20 October 2016 Third party assurance of consultation process.	Capacity to deliver FBC	Awaiting JOSC meeting February 2017 followign workshop on 30 January 2017	4x5 = 20	3x5 = 15	2x5 = 10

Action	**Timescales**	**Lead**
Particpation in JOSC meeting	Workshop 30.01.17 / Meeting February 2017	AB
Develop plan for FBC	March	AB
Develop FBC	June	AB

Links to risk register:
Risk 6131 - mortality standards
Risk 2827 - clinical decision making in A&E
Risk 4783 - Service reconfiguration

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY									
Ref	**OWNER**		**RISK DESCRIPTION**	**KEY CONTROLS**	**POSITIVE ASSURANCE &**	**GAPS IN CONTROL**	**GAPS IN ASSURANCE**	**RATING**	
19.1617	Board of Directors	Director of Finance	**Risk** Failure to maintain a cash flow position so that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash. resulting in external scrutiny, significant reputational damage and possible inability to function as going concern **Impact** - financial sustainability - external scrutiny - reputational damage - ability to continue as a going concern	* Agreed £8m capital loan from Independent Trust Financing Facility. * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from NHS Improvement * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Revenue support loan has been made available year to date to cover the deficit and delays in the receipt of Sustainability and Transformation * Profile of cash management is being raised at Divisional level * Agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner.	<u>First line</u> WEB financial performance report Cash Management Committee <u>Second line</u> Finance and Performance Committee reports <u>Third line</u> Bi-monthly PRM with NHS Improvement	Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Cash continues to be a high risk due to the knock on impact of I&E risks and the fine balance required in managing working capital The level of outstanding debt held by the Trust is being closely monitored but is not entirely within the Trust's ability to control. The majority of this is owed by other NHS organisations.	The Trust plan for 17/18 is reliant on cash support from Department of Heath of £28.80m. £8m of Capital funding has been approved as part of an existing Capital Loan facility, the remaining revenue support loan requirements will have to be applied for on a monthly basis and will be subject to a potentially variable interest rate.	**Initial** 5x3 = 15	**Current** 5x4=20	**Target** 5x3=15

Action	**Timescales**	**Lead**
Further work to raise profile of cash management across the Trust	Ongoing	GB

Links to risks register:
Risk 6967 - Non-delivery of financial plan
Risk 6968 - Cash
Risk 6969 - Capital

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
NEW 21.1718	Finance and Performance Committee	Executive Director of Finance	**Risk** Failure to deliver the financial forecast position for 2017/18 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity **Impact** - financial sustainability - loss of STF - increased regultory scrutiny - insufficient cash to meet revenue obligation - inability to invest in patient care or estate	• Financial recovery and cost improvement programme plan in place • PMO tracking of delivery against CIP plan • Budgetary control process • Detailed income and activity contract monitoring • Bottom-up forecasting process • Star chamber process to support CIP schemes off track • Quality directorate overview of progress against delivery of CQUIN • Authorisation processes for agency spend • Standing Financial Instructions set authorisation limits • Detailed recovery plan in place including non-pay review, tightening of vacancy control panel process, controls around additional hours.	<u>First line</u> Divisional Board performance reports <u>Second line</u> Turnaround Executive Reports NHS I scrutiny at Finance and Performance Committee and Board Integrated Board report including CQUIN delivery reporting <u>Third line</u> Monthly return to NHS I QRM meeting with NHS I Well Led Governance Review Internal Audit Report on divisional performance management arrangements NHS I review of CIP arrangements	• Temporary staffing remains a cost pressure • Remain gap between activity and agreed contract • Activity recording challenge due to EPR • Unidentified CIP	• Spending levels still high • CIP remains unidentified	**Initial** 4x4 = 16	**Current** 5x5=25	**Target** 1x4=4

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through F&P and Board Reporting to Turnaround Exective on progress with CIP	Ongoing ongoing	GB AB

Links to risk register:
Risk 6967 - Non-delivery of financial plan
Risk 6968 - Cash
Risk 6969 - Capital

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
NEW 22.1718	Finance and Performance Committee	Executive Director of Finance	**Risk** Failure to secure sufficient capital to meet ongoing needs risking the the development and sustainability of services and has the potential to impact on clinical, safety and performance issues. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Agreed £8m capital loan from Independent Trust Financing Facility (ITFF) to support capital programme, specifically the Electronic Patient Record (EPR) investment. Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Prioritised capital programme. Small contingency remains in place to cover any further changes.	First line Reporting through WEB on capital prioritisation Second line Turnaround Executive Reports Scrutiny at Finance and Performance Committee and Board Capital Management Group reports Third line Monthly return to NHS I QRM meeting with NHS I	The planned capital expenditure for 17/18 is £14.40m. All capital expenditure, including any slippage on the EPR programme, must be contained within available internally generated capital funding, supplemented in 17/18 by the remaining £8m of our pre-approved capital loan facility.	• Not meeting regulatory requirement in relation to capital	Initial 4x5 = 20	Current 4x5 = 20	Target 3x4=12
Action					**Timescales**			**Lead**		
Ongoing monitoring of financial position through F&P and Board					Ongoing			GB		
Links to risk register: Risk 6967 - Non-delivery of financial plan Risk 6968 - Cash Risk 6969 - Capital										

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CSU	Commisisoning Support Unit
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
NHS I	NHS Improvement
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PMU	Pharmacy manufacturing unit
PPI	Patient and public involvement
PRM	Progress review meeting (with NHS Improvement)
PSQB	Patient Safety and Quality Board
SI	Serious incident
SHMI	Summary hospital-level mortality indicator
SOC	Strategic Outline Case
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
WYSTP	West Yorkshire Sustainability and Transformation Plan

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
BB	Brendan Brown, Director of Nursing
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Director of Finance
HB	Helen Barker, Associate Director of Operations
JC	Juliette Cosgrove, Assistant Director of Quality
MG	Mandy Griffin, Interim Director of the Health Informatics Service
LH	Lesley Hill, Executive Director of Planning, Estates and Facilities
RM	Ruth Mason, Associate Director of Engagement and Inclusion
VP	Victoria Pickles, Company Secretary
CP	Cornelle Parker, Deputy Medical Director
SU	Sal Uka, Consultant Paediatrician and 7 day services clinical lead
IW	Ian Warren, Executive Director of Workforce and Organisational Development
OW	Owen Williams, Chief Executive
ALL	All board members

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 6th July 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: One year plan update - Year Ending 2018 - The Board is asked to note the progress made against the delivery of the one year plan year ending 2018.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's one year plan for year ending 2018.

Main Body

Purpose:

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's one year plan for year ending 2018.

Background/Overview:

In June 2017, the Board of Directors agreed the updated one year plan for year ending 2018.
The plan describes the objectives to be achieved against the four goals of the Trust:
- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

The Issue:

This report describes the progress made against each of the 20 objectives and identifies where the Board should expect to receive more detailed assurance of how the work is progressing.
This report highlights that of the 20 deliverables:
• None are rated red
• Six are rated amber
• 14 are rated green
• None have been fully completed
This is an expected position at this point in the year.

Next Steps:

The Plan will be discussed at the Board of Directors / Council of Governors workshop in July. The Board will receive quarterly updates on progress. Risks to the delivery of any of the objectives will be identified in the Board Assurance Framework and the risk register.

Recommendations:

The Board is asked to NOTE the progress against delivery of the one year plan for year ending 2018.

Appendix

Attachment:

Progress against strategy Board report July 2017.pdf

Calderdale and Huddersfield NHS Foundation Trust
Annual Plan Year ending 2018 - Progress Report July 2017

Introduction

The Trust's vision is:
Together we will deliver outstanding compassionate care to the communities we serve.

In June 2017, the Board of Directors agreed the refreshed 1 year plan for year ending 2018. The plan describes the four goals of the Trust:

- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

These goals are underpinned by the four behaviours:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

The plan sets out the key areas of delivery to support the achievement of each of the goals described in the table below. The risks of not delivering our goals have been assessed and are included in the Board Assurance Framework. The risks associated with each area of delivery have also been assessed and are included in the corporate risk register. The identified risks are reviewed and escalated as appropriate in line with the Trust's risk management arrangements.

Year Ending 2018				
Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Submit a full business case to NHS Improvement to secure approval of capital funding and agreement to implement	Maintain a Single Oversight Framework rating of 3 or better	Implement the 5 year workforce strategy	Deliver a robust financial plan for 2018 including CIP
		Strengthen patient and public engagement in particular learning from incidents, complaints process, and in listening events	Develop and deliver an organisational development plan	Refresh the commercial strategy in light of current economic climate
	Delivery of 17/18 SAFER (patient flow) programme objectives	Implement the actions resulting from the findings of the CQC inspection in readiness for the new-style inspection.	Create and deliver an engagement strategy that ensures colleagues have a voice	Continue to proactively contribute to WYAAT and the WYSTP.
	To work as an early adopter toward the implementation of selected 7 day NHS England standards (2,5,6 and 8) in agreed specialties	Develop the Quality Strategy and implement the local quality priorities (see separate page)	Develop workforce roles and service models that enable the Trust to deliver care within planned resources and minimise use of agency & temporary staffing	Lead on the development of the IM&T and Estates schemes and progress these to full business case.
	Realise the benefits and transformational change opportunities from the new EPR	Implement year 3 of the health and safety action plan; develop and deliver robust emergency planning and business continuity arrangements	Deliver a leadership and succession planning development programme	Develop a clear plan to meet the organisations capital requirements
			Deliver a programme of workforce information systems modernisation	

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan 2017/18.

Structure of Report

The report is structured to provide an overview assessment of progress against key deliverables responses and this is rated using the following categories:

1. Completed (blue)
2. On track (green)
3. Off track – with plan (amber)
4. Off track – no plan in place (red)

For each area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 20 deliverables:

- None are rated red
- Six are rated amber
- 14 are rated green
- None have been fully completed

This is an expected position at this point in the year.

Recommendation

Trust Board Members are requested to:

- Note the assessment of progress against the 2017/18 goals.
- Discuss and agree the future action and assurance that may be required

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Submit a full business case to NHS Improvement to secure approval of capital funding and agreement to implement.	**On track (green)**	The Trust has developed the draft Business Case and this will now progress through internal governance processes during July prior to submission to NHS Improvement.	**Lead: AB** Hospital Services Programme Board Board NHS I Quarterly Review Meeting
Delivery of 17/18 SAFER (patient flow) programme objectives	**On track (green)**	SAFER programme in place and seeing some impact on key indicators. Ambulatory Care and Community Place are running and having an impact. Frailty Service commenced at HRI and plans to expand. Building on the work undertaken by WYAZ.	**Lead: HB** Reported to Weekly Executive Board and Quality Committee.
To work as an early adopter towards the implementation of selected 7 day NHS England standards (2,5,6 and 8) in agreed specialties	**On track (green)**	Compliance with 7-day services now included as an indicator in the Single Oversight Framework for Trusts. Most recent benchmarking report received and being reviewed to identify gaps and any further actions required.	**Lead: DB** Quality Committee Weekly Executive Board
Realise the benefits and transformational change opportunities from the new EPR	**Off track – with plan (amber)**	Cut-over and go-live took place as scheduled over the weekend from 28 April. Number of outstanding issues identified and being addressed through managed process overseen by Operational Board and Weekly Executive Board. Business as usual team in place.	**Lead: MG / HB** Monthly to Board and Finance and Performance Committee Sponsoring Group Executive Board

<table>
<tr><th colspan="4">Goal: Keeping the base safe</th></tr>
<tr><th>Deliverable</th><th>Progress rating</th><th>Progress summary</th><th>Assurance route</th></tr>
<tr><td>Maintain a Single Oversight Framework (SOF) rating of 3 or better</td><td>On track (green)</td><td>The Trust is currently achieving a SOF rating of 3.</td><td>Lead: VP
Progress Review Meeting feedback to Board
Audit and Risk Committee</td></tr>
<tr><td>Strengthen patient engagement particularly in learning from incidents, complaints and in listening events</td><td>Off track – with plan (amber)</td><td>We are introducing patient readers into the complaints process and have patients working with maternity colleagues looking at serious incidents. A programme of listening events is planned for the autumn. HealthWatch colleagues are also attending Calderdale Royal each month to talk to patients about health services. A plan that describes the actions already taken and further steps is being pulled together and will go to Quality Committee for approval.</td><td>Lead: BB
Monitored through Quality Committee</td></tr>
<tr><td>Implement the actions resulting from the findings from the CQC inspection in readiness for the new-style inspection</td><td>On track (green)</td><td>As at end of April 2017 the progress against the Blue / Red / Amber / Green rating on the CQC Action plan was:
<table>
<tr><th>Rating</th><th>Must do</th><th>Should do</th><th>Total</th></tr>
<tr><td>Delivered and sustained</td><td>18</td><td>12</td><td>30</td></tr>
<tr><td>Action complete</td><td>2</td><td>1</td><td>3</td></tr>
<tr><td>On track to deliver</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>No progress / Not progressing to plan</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Total</td><td>20</td><td>13</td><td>33</td></tr>
</table>
Following release earlier in June of the new well led inspection framework, work is underway to help the Trust prepare for this and a number of ‘go-sees’ have been undertaken to Trusts who have already been inspected. A more detailed assessment of the Trust’s positon and a plan for preparation will be brought to Quality Committee.</td><td>Lead: BB
Monitored through Quality Committee, Weekly Executive Board and Board of Directors</td></tr>
</table>

Develop the Quality Strategy and implement the local quality priorities	**On track (green)**	A Quality Improvement Strategy will be drafted by the end of July and shared with Quality Committee for review prior to approval by the Board.	**Lead: BB** Quality Committee
Implement year 3 of the health and safety action plan; develop and deliver robust emergency planning and business continuity arrangements	**On track (green)**	Progress has been made on delivery of year three of the health and safety action plan. Business continuity plans were refreshed in preparation for EPR and were tested during go live and early live support. The learning from this is being built into th plans. Emergency planning and counter terrorism training in place. A lockdown plan has been developed. Security adviser from Leeds is providing support to the Trust. In addition, following the recent fire at Grenfell Tower, the appropriate checks on the Trust's buildings have been made with oversight from the local operational fire and rescue service and no issues have been identified.	**Lead: LH** Monitored through Health and Safety Committee to Quality Committee and reported six-monthly to the Board.

Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Implement the 5 Year workforce strategy	**On track (green)**	Workforce Strategy and implementation plan approved by the Board in January 2017. Workforce Modernisation Group in place to manage delivery of the plan reporting to the Well Led Workforce Committee.	**Lead: IW** Workforce Modernisation Group reporting to Well Led Workforce Committee
Develop and deliver an organisational development plan	**Off track – with plan (amber)**	A draft OD approach and plan has been written and is awaiting initial feedback prior to approval. Tenders for organisational development being assessed.	**Lead: IW** Well Led Workforce Committee.
Create and deliver an engagement strategy that ensures colleagues have a voice	**Off track – with plan (amber)**	The proposed plan has been discussed with the Colleague Engagement Network. The Trust has been working with Wrightington Wigan and Leigh NHS FT to adopt the 'Go Engage' programme. A small task and finish group of members of the colleague engagement network has been set up to develop an implementation plan for Go Engage. The BME network continues to meet and is well attended.	**Lead: IW** Well Led Workforce Committee.

Develop workforce roles and service models that enable the Trust to deliver care within planned resources and minimise use of agency and temporary staffing	**Off track – with plan (amber)**	Work underway on Right Skills, Right Time programme. Recruitment of 14 Physician Associates to our services. Agency spend in month was below planned levels.	**Lead: IW** Well Led Workforce Committee.
Develop a leadership and succession planning development programme	**On track (green)**	Compassionate Leadership in Practice (CLIP) programme launched on 27 June with the first two cohorts delivered by HealthSkills for current and future leaders. Programmes being developed to provide management skills for clinical leaders, coaching and financial management skills.	**Lead: IW** Well Led Workforce Committee.
Deliver a programme of workforce information systems modernisation	**Off track – with plan (amber)**	A paper was presented to the Well Led Workforce Committee in January. A modernisation programme board has been established to oversee all of the workforce-related IT systems. Purchased Allocate software to provide multi-specialty e-rostering and job planning for medics.is ESR upgraded and work being done to improve use of functionality.	**Lead: IW** Workforce Modernisation Programme Board Well Led Workforce Committee

Goal: Financial sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver a robust financial plan including CIP for YE 2018	**Off track – with plan (amber)**	Trust has delivered financial plan at Month 2 with the release of contingency funding. The total CIP identified is £14.08M at Month 2 against a full year target of £20M. This financial position is challenging and a number of actions have been put in place as part of a recovery plan including tighter controls around non-pay spend; vacancies; and additional hours. Briefings are planned for all parts of the organisation to encourage greater control and generate ideas for efficiency savings.	**Lead: GB** Weekly progress monitored through Turnaround Executive. Reported to Finance & Performance Committee
Refresh the commercial strategy in light of current economic climate	**On track (green)**	The Commercial Strategy is being refreshed for presentation to the Board in August.	**Lead: AB** Finance and Performance Committee
Continue to proactively contribute to WYAAT and WYSTP	**On track (green)**	The WYAAT Committee in Common governance arrangements have been finalised and the first meeting held. Chairing responsibility transfers to CHFT from	**Lead: AB** Finance & Performance Committee

		August. West Yorkshire network agreed for vascular services looking at on call, sub specialisation teams and shared workforce approaches. Other workstreams looking at single radiology imaging system and pharmacy stores business cases.	
Lead on the development of the IM&T and Estates schemes and progress these to full business case	**On track (green)**	Estates and Facilities and THIS schemes are progressing to the next stage.	**Lead: MG / LH** Business cases reviewed by Board and WYAAT Committee in Common
Develop a clear plan to meet the organisation's capital requirements	**On track (green)**	Prioritised plan approved.	**Lead: GB** Capital Management Group Weekly Executive Board

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, 6th July 2017	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient (CAIP) programme - This report provides ans update of the progress of the CAIP programme	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Report provided monthly to Clinical Outcomes Group (COG) and quarterly to the Quality Committee	
Governance Requirements: Transforming and improving patient care	
Sustainability Implications: None	

Executive Summary

Summary:

The Care of the Acutely Ill Patient (CAIP) programme has an overall aim to reduce mortality and is divided into six themes:
1) Investigating causes of mortality and learning from findings
2) Reliability in clinical care
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Caring for frail patients
6) Clinical coding
This report provides a brief update of each theme

Main Body

Purpose:

This progress report is intended to keep the BOD informed of the work of the CAIP Programme

Background/Overview:

as per the Executive Summary

The Issue:

Although good progress has been noted in the HSMR it is unknown how the EPR may affect this, particularly with the clinical coding. Work in ongoing to both understand and mitigate this risk.

Next Steps:

Continue to monitor the CAIP at COG through the CAIP dashboard

Recommendations:

to note the content of the report

Appendix

Attachment:

CAIP programme summary for BoD July 2017.pdf

APPENDIX TO FOLLOW

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jean Robinson, Lead Infection Prevention and Control Nurse
Date: Thursday, 6th July 2017	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Annual DIPC Report - The Board is asked to receive this annual report on the position of healthcare associated infections for Year 2016/17.	
Action required: Approve	
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:

The Board is asked to receive this annual report on the position of healthcare associated infections for Year 2016/17.

Main Body

Purpose:

None

Background/Overview:

None

The Issue:

None

Next Steps:

None

Recommendations:

The Board is asked to receive this annual report on the position of healthcare associated infections for Year 2016/17.

Appendix

Attachment:

DIPC Annual Report 2016-17 Final.pdf

Calderdale and Huddersfield
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2016-17

Executive Summary

This report details the activities of the Infection Prevention and Control Team (IPCT) during the period April 2016 to March 2017. The Director of Infection Prevention and Control (DIPC) who is also the Executive Medical Director, leads the IPCT and reports directly to the Chief Executive.

This year has seen challenges with an increase in post 72-hour Clostridium *difficile* Toxin positive (CDT) cases and two MRSA bloodstream infections.

Key points:

The Trust complies with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (updated 2015) and associated Care Quality Commission (CQC) guidance. Compliance is demonstrated through a self-assessed HCAI programme of work and audit for 2016/17 that includes the 10 criteria identified in the code.

- There were 2 trust apportioned Methicillin-Resistant Staphylococcus aureus (MRSA) bacteraemias reported against a ceiling target of zero.
- There were 32 trust apportioned *Clostridium difficile* toxin (CDT) positive cases this year against a ceiling target of 21. All were subject to Root Cause Analyses (RCA) – 8 were identified as potentially avoidable owing to 'lapses in care' identified at RCA. Lapses in care principally related to antibiotic prescribing out with policy and poor documentation. Areas for improvement feed into the Trust and Divisional HCAI action plans.
- There were 13 Trust attributed Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemias, which is an increase from 9 during 2015/16.
- The trust reported 48 E.coli bacteraemia infections demonstrating an increase on last year's performance of 25. Analysis of all cases has not demonstrated a common underlying cause. Detailed collaborative work within the health economy during the forthcoming year will be established.
- A parainfluenza outbreak on SCBU was investigated as a Serious Incident (SI).
- An MRSA cross transmission incident on Ward 11 HRI was investigated as an SI.
- There were 19 wards affected (either closed or restricted) with viral gastroenteritis, resulting in 264 bed days lost.

- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of hand hygiene compliance for the year was 98.9%.
- The Trust participated in mandatory 3 month orthopaedic surgical site infection surveillance (SSIS), and extended this to six months for some procedures with post discharge surveillance.
- Two patients were identified as carrying Carbenpenemase-producing enterobacteriacae (CPE) via the Trust screening programme during 2016/17.
- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust Intranet and Internet sites. Nine policies have been approved at Executive Board during 2016/17.

Contents

1. Infection Control Arrangements

See appendix 1, Calderdale and Huddersfield Foundation Trust: **Section A - Infection Prevention and Control Arrangements** *and appendix 2 Infection Control Committee (ICC) terms of reference.*

- Two staff successfully completed the Infection Control Certificate last year

The Director of Infection Prevention and Control (DIPC) has presented the Trust Board with the following agenda items on IPC during 2016/17.

- The annual DIPC report 2015/16 – endorsed.
- Quarterly DIPC reports – endorsed.
- Quarterly ICC minutes highlighting outbreaks and areas of concern and providing assurance around infection control practice across the organisation.
- Monthly Trust MRSA bacteraemia trajectory progress and areas of concern.
- Monthly Trust Clostridium *difficile* trajectory progress and areas of concern.
- Monthly Trust MSSA and E-coli bacteraemia results.
- A narrative of any off target indicators is provided in the integrated board report, detailing actions being taken to get us back on plan.

Infection Prevention and Control representative at relevant groups
To provide infection and prevention advice and ensure liaison between the IPCT and key groups, representation is provided at the following:

- Infection Control Performance Board (reinstated January 2017)
- Healthcare economy wide meetings
- Divisional patient safety quality boards
- Medical devices and clinical product review
- IV Strategy Group
- Urinary Catheter steering group
- Sisters Meetings
- Nursing and Midwifery Committee
- Nursing and Midwifery Practice group
- Water management and air quality group
- Estates and Facilities Capital planning group
- Matrons forum

- Health & Safety Committee
- Patient Safety Group
- Decontamination Committee

Infection Control Budget 2016/17

The Infection Control Team has a budget of £483,433 per annum. Of this £28,618 is for non-pay including ICNet licensing, training expenses as well as travel and mobile phone costs. The Lead Nurse is both the budget holder and budget manager. Excess costs associated with outbreaks are funded separately from within the Trust.

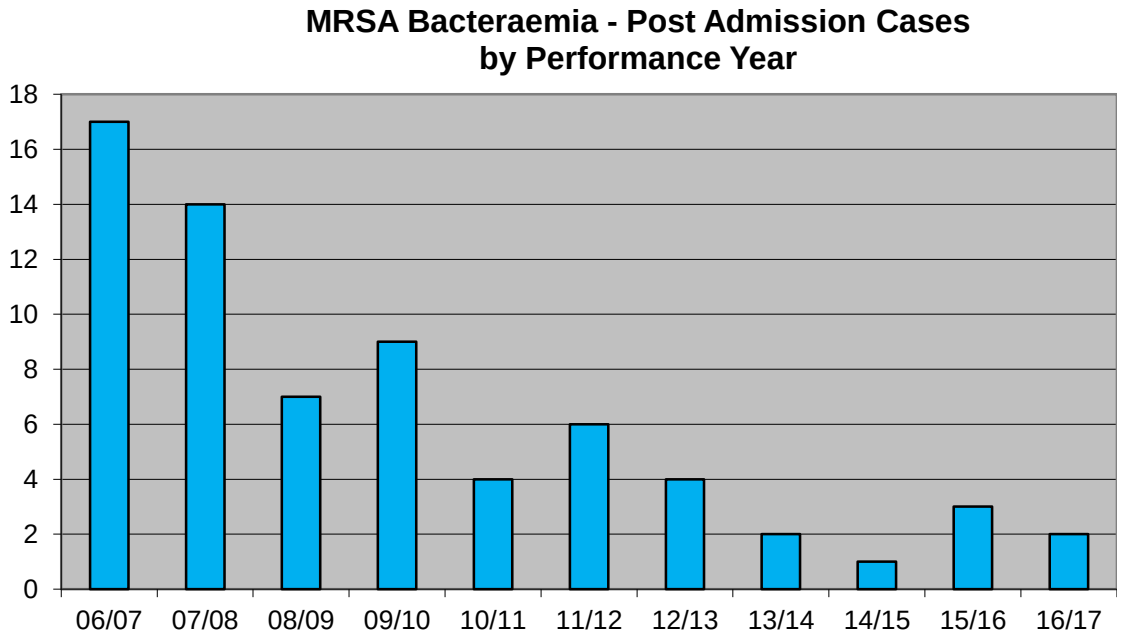
2. Mandatory reporting of HCAI

Mandatory reports are made to Public Health England (PHE) of the following organisms causing the stated infection.

- Staphylococcus aureus bacteraemia (MRSA & MSSA)
- *Escherichia coli* bacteraemia
- *Clostridium difficile* toxin positive cases post 48 hours.
- Orthopaedic Surgical Site Infection Surveillance

Meticillin-resistant Staphylococcus aureus

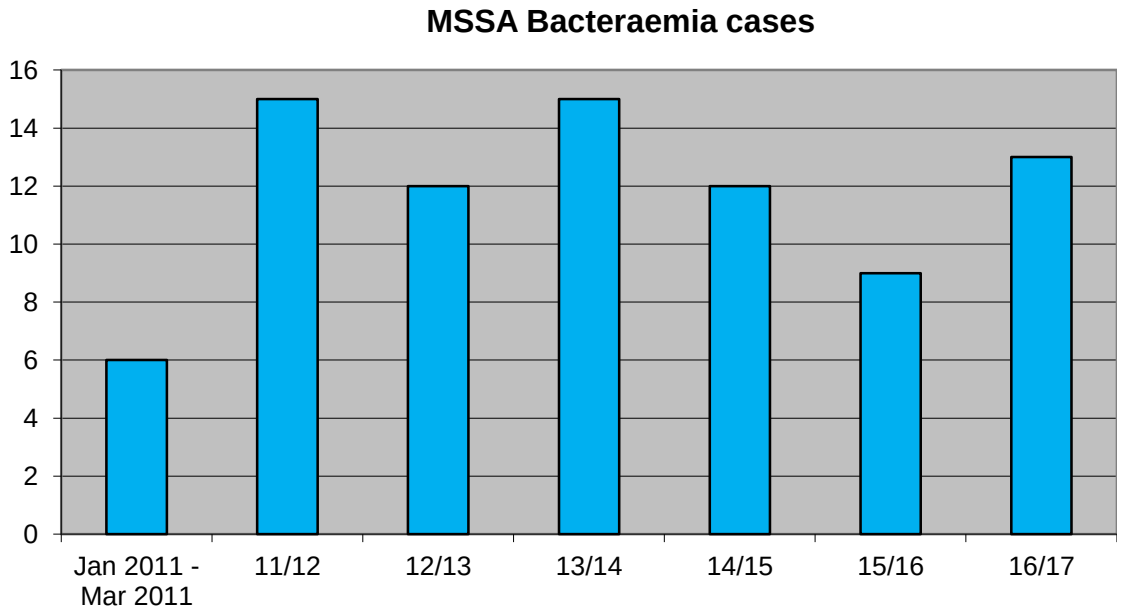
MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemia are reported nationally and the Trust had seen a significant reduction over the last few years. Disappointingly we had 2 cases in 2016/17. All cases are subject to a Post Infection Review to identify if there were any lapses in care to aid prevention of further cases. Both cases were deemed to have been avoidable at PIR. Actions were generated and incorporated within the divisional action plans.



Meticillin-sensitive Staphylococcus aureus

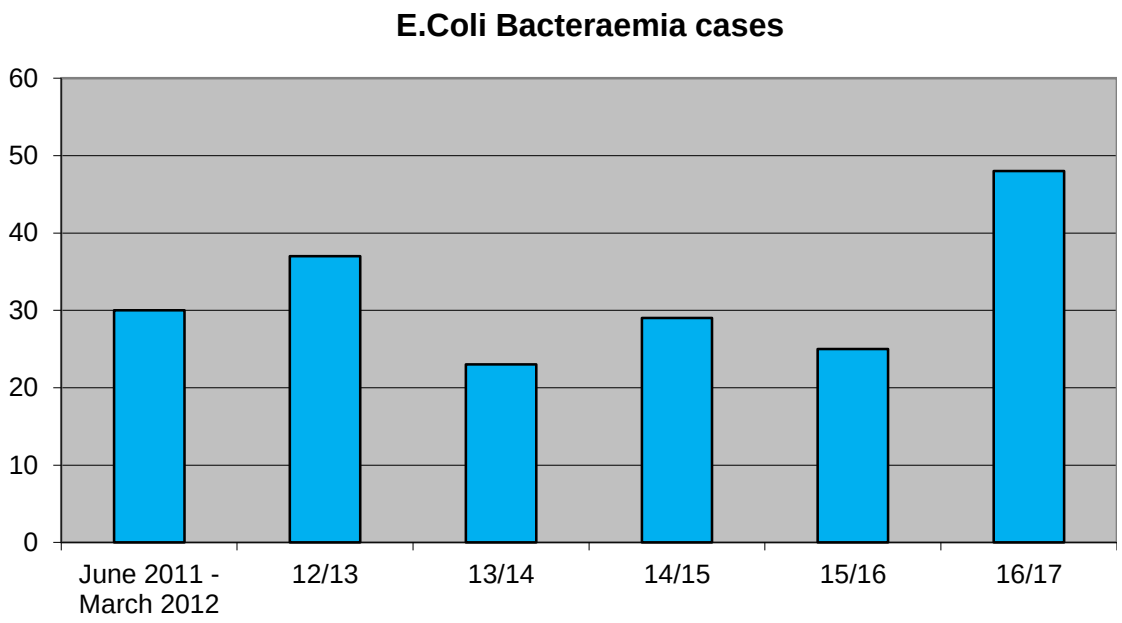
MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemia are reported nationally but there is no national set target. A local target was set using the 2014-15 out turn of 12 cases. Nine cases were recorded in 2015/16. Unfortunately we have seen an increase to 13 cases during 2016/17. A case note review of all these cases has been completed and recommendations have been included in the Trust Infection Control Action plan as a result of the this.

The chart below shows the number of post admission MSSA bacteraemia.



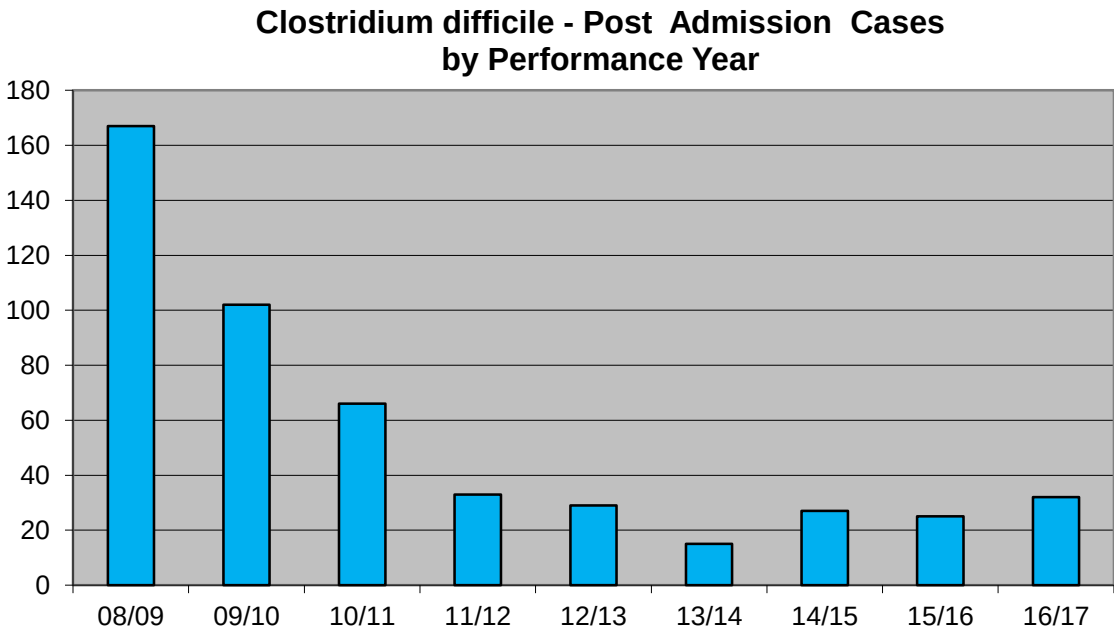
E.coli Bacteraemia

There is no national set target for post 48 hour E.coli bacteraemia. There were a total of 48 cases in 2016/17, compared to 25 the previous year. A case note review was carried out for 25 of the cases. In total, five were related to the presence of a urinary catheter. The remaining 20 cases were caused by a multitude of reasons. Actions to reduce the incidence of E. coli bacteraemia will be incorporated in the HCAI action plan for 2017/18.



Clostridium difficile

Clostridium difficile (*C. difficile)* is one of the major causes of infective diarrhoea. The target set for the Trust in 2016-17 was a ceiling of 21. In the last year there was an increase in cases compared to the previous year. All the cases were subject to investigation by way of root cause analyses (RCA). Following RCA investigations of the 32 cases, 8 showed lapses in care which had action plans implemented. In the remaining 24 cases there were no lapses in care that had contributed to the infection. The slight increase in C. difficile cases from 2016/17 are in keeping with a national rise in the number of reported cases of *Clostridium difficile* infection, and CHFT continues to report below the national average for rates of C. difficile infection.



3. Untoward Incidents

- May 2016: the Special Care Baby Unit (SCBU) in the Calderdale Royal Hospital was closed for a period of 1 week due to an outbreak of *Parainfluenza* 3 virus (PF3). Six babies were infected, four of whom required admission to the Neonatal Intensive Care Unit (NICU). All of the babies recovered fully from the infection. During the period of closure, high risk deliveries were transferred to other units. This was a stressful time for the parents of both the infected and non-infected babies, and equally for staff members on the unit, particularly in the period prior to the identification of the pathogen. This incident was investigated as a Serious Incident from which a monitored action plan was generated.

- July 2016: a child attended Huddersfield Day Surgery Unit with a rash. This was found to be chicken pox. Three other children had their operations cancelled that day as they were at risk of contracting chickenpox which could have complicated their post-operative recovery.

- September 2016: a scabies outbreak occurred on Ward 5, HRI following the admission of a patient with a highly infectious form of scabies (crusted scabies). The ward was closed for 10 days while completion of treatment of patient and staff was being carried out. This resulted in 45 bed days lost. A total of 3 patients and 10 members of staff were infected. Permethrim treatment was issued to 180 staff members plus 20 treatments for family members of infected staff

4. Preventing Healthcare Associated Infections – Divisional reports

Surgery and Anaesthetics Division

The year-end position for the division of post 72 C Difficile cases is 10.

Of these 5 were deemed as unavoidable, 3 were avoidable and 2 are awaiting outcome of RCA.

Learning from RCAs identified with antibiotic prescribing, clarification of cleaning roles and medical staff hand hygiene. As a result of one case of C Difficile a bed space has been closed on SAU which was found to be in breach of standards in terms of proximity to other patients. Cleaning of bed spaces in ICU has been addressed and learning appears to be embedded regarding roles and responsibilities of ICU staff versus the cleaning team.

Hand hygiene amongst medical colleagues has been a challenge in the division this year. There has been focused work on this led by the Divisional Director with a clear message and approach adopted across the division for staff found to be non-compliant revisited. Clinical teams have been asked to report hand hygiene compliance pre prompting to ensure an accurate picture of practice across all areas. Matrons remain on high alert to recognise and action issues and this message is reinforced through the Divisional Director and through divisional colleagues at the Patient Safety and Quality Board. There will be a continued focus on this issue as a high priority area in 2017/18.

Frontline Ownership Audits (FLO) audits continue to address environmental issues with all areas scoring Green or Amber FLOs this year. Ward 3 continues to be a challenge in terms of clutter and general environment. This was reinforced through a recent PRASE study by the Improvement Academy where patients identified that the ward felt cluttered due to a lack of storage. The matron for this area continues to address ongoing issues and the possibility of relocation will be explored as part of the wider reconfiguration debate across the organisation. Performance against key indicators in this area is good.

Improvements in practice around PPE, ANTT and hand hygiene in operating services has been sustained this year. This will be supported by increased surveillance by the service leads who will be visible into theatres on a daily basis. The teams in operating services have fully embraced a proactive approach to developing a safety culture that ensures environmental standards are maintained.

HRI ICU has had issues with pseudomonas in water supply which has now been rectified. There is an environmental risk in this area regarding flooring and air filters which requires ongoing surveillance and management of risk. This is being overseen by colleagues in the Estates division and the Surgical Division is currently working through Business Continuity Plans in the event of an immediate relocation of ICU.

There have been 18 combined quality audits conducted across the division with 12 areas rated green and 6 areas amber.

Work is ongoing to ensure compliance with ANTT training. The year-end position for nursing staff is 91% with medical staff trained at 74%.This continues to be a priority for 2017/18.

Decontamination has been a challenge across Endoscopy Services following a fire at CRH Endoscopy unit in February 2017. A full report of the cause of the fire is awaited. Staff have worked hard to maintain business continuity across both sites however there has been an impact on capacity in the service. A full business case regarding Decontamination is currently being developed in the division overseen by The Director of Estates and Facilities.

The Division has developed an Infection Prevention and Control Action plan for 2017/18. Key priorities include:

- Improvement in number of emergency MRSA screens undertaken (current position 89%)
- Ongoing focus on hand hygiene with particular focus on medical staff
- Maintain environmental standards in all areas
- Reduction in number of post 48 hour CDiff cases with timely completion of RCAs and dissemination of learning across all teams.

Medical Division

The Division of Medicine has continued to progress its infection control agenda to support the Trust action plan. A Divisional action plan has been compiled to focus areas of infection control practice and management with particular emphasis on training compliance for all staff groups and learning from experience.

There have been 2 MRSA bacteraemia cases over the last 12 months in the Trust
Unfortunately both the above cases occurred within the Medical Division. Key areas for learning from both cases were that MRSA screening was not undertaken at the time of admission or on subsequent transfer to the ward. The second case also identified the procedure for the correct collection and documentation of blood cultures.

MRSA screening and adherence to the process on admission is an area identified that requires improved compliance within the Divisional action plan. Current compliance is 90% with a target of at least 95%.

The Trust C-*difficile* ceiling for 2015/16 was 21 with the Medical Division having 18 cases in total.

Thematic reviews of the cases of C-difficile have highlighted several areas of learning;

- Delay in obtaining a stool specimen
- Completion of the Bristol Stool Chart and assessing patient bowel habits.
- Delay in isolation – wards awaiting specimen results before isolation of the symptomatic patient
- Antibiotic prescribing often occurring within a community setting
- All cases are sporadic in nature with no dominant strain being identified.

Work continues to improve compliance with the above issues has been emphasised within the Division to ensure early completion and shared learning and actions.

There have been several wards with the Division affected at CHFT with Norovirus on both sites.

There have been continued challenges to comply with side room isolation requirements for all our patients however proactive management from wards and teams have worked hard to minimise risks for our patients
The ICPN have continued to support bespoke bite size education sessions to ward areas identified either during incidents or at the Ward Sisters or Matrons requests. These have been well received on the wards.

The Division strongly supports the LIPCP program with quarterly educational workshops and cascade of information and practice within clinical areas. There is an expectation that each ward has a link practitioner and supports time for training within the ward environment.

Many of the Divisional LIPCP were also proactive flu vaccinators and contributed towards achieving the Trust overall compliance of 75% of front line staff receiving flu vaccines in Winter 2016.Improving safety for our patients, staff and local community.

The Division has taken action to improve the performance levels of nurses and medical staff who have completed ANTT training following a period where these levels were below the standard expected. This is monitored closely each month at PSQB Board. ANTT competency matrix are being supplied with their individual clinical area matrix so that they can target those staff who are not ANTT assessed, this is proving to have a positive effect. Additional support provided to ANTT assessors by the IPCNs new assessors have been trained to improve numbers available on ward/departments.

To improve consistency with reporting standards for the Matrons FLO audits the process has changed by which all FLO audits to be submitted on the 15th of every month to match with safety thermometer process. Infection prevention and control remains a fundamental part of the matron's role and as such they play a key role in improving standards at ward level with strong partnership working with the ward sister.

Wards and departments continue to audit hand hygiene compliance and staff are encouraged to report actual practice so that any problems can be identified. Ward staff have been asked to focuses on the WHO '5 moments' of hand hygiene when monitoring compliance.

Families and Specialist Services division

Families and Specialist Services Division continue to work in collaboration with the Infection Control and Prevention team to continuously improve safety and reduce harm.

Link Infection Control and Prevention Practitioners maintain an active presence across all service areas and their contribution to overall Divisional performance is acknowledged. 2016-2017 ANTT compliance for the Division was 89.95%; an improvement on last year's results and better that Trust overall compliance of 85.02%. All areas in the Division assessed to date have achieved a score of silver across all areas in the Exemplar Ward Accreditation Programme.

In May 2016, the Special Care Baby Unit (SCBU) in the Calderdale Royal Hospital was closed for a period of 1 week due to an outbreak of Parainfluenza 3 virus (PF3). Six babies were infected, four of whom required admission to the Neonatal Intensive Care Unit (NICU). All of the babies recovered fully from the infection. During the period of closure, high risk deliveries had to be transferred to other units. Root causes of the outbreak were identified as:

- Failure of hand hygiene
- Assurance processes around hand hygiene compliance were found to be suboptimal
- Cot spacing is not compliant with current national recommendations – The Trust is not compliant with national guidance around cot spacing, such that in the SCBU in particular, cots have less than half the space recommended. The lack of space is compounded by a visitor policy that allows up to three visitors at a time.

An action plan was developed and all actions fully addressed.

In the last year, significant improvements have been made in:

- Improving standards of cleaning and housekeeping on LDRP and NICU
- Improving the robustness of the Matron and Ward Manager FLO audit process by commencing a programme of Divisional peer audits
- Addressing infection control and prevention environmental issues in children's outpatients, antenatal clinic, wards 9 and 1d which have arisen as a result of damaged flooring and chips to worktops and poor decor.

CHFT's campaign to vaccinate pregnant women against influenza was highly successful with overall uptake of the vaccine in Calderdale 55.6% (highest in West Yorkshire and third highest in the region) and Greater Huddersfield 52% (joint 4th in West Yorkshire). For pregnant women with co-morbidities uptake and performance was higher. Calderdale 69.5% (2nd in West Yorkshire) and Greater Huddersfield 72.6% (1st in West Yorkshire).

Occupational Health

Influenza – staff immunisation campaign 2016-17

This was the first season that a CQUIN had been attached to the uptake of frontline healthcare workers of the annual flu vaccine. Target uptake was 75% frontline healthcare worker uptake by 31 December 2016. CHFT achieved full CQUIN standard requirement for payment.

A high profile campaign was launched in October 2016, building on our experiences of past campaigns, and drawing on information from staff engagement events. Additional incentives and prizes were offered, and around 100 peer immunisers trained to be able to offer the vaccines in nearby workplaces on and off site reaching most staff around the clock.

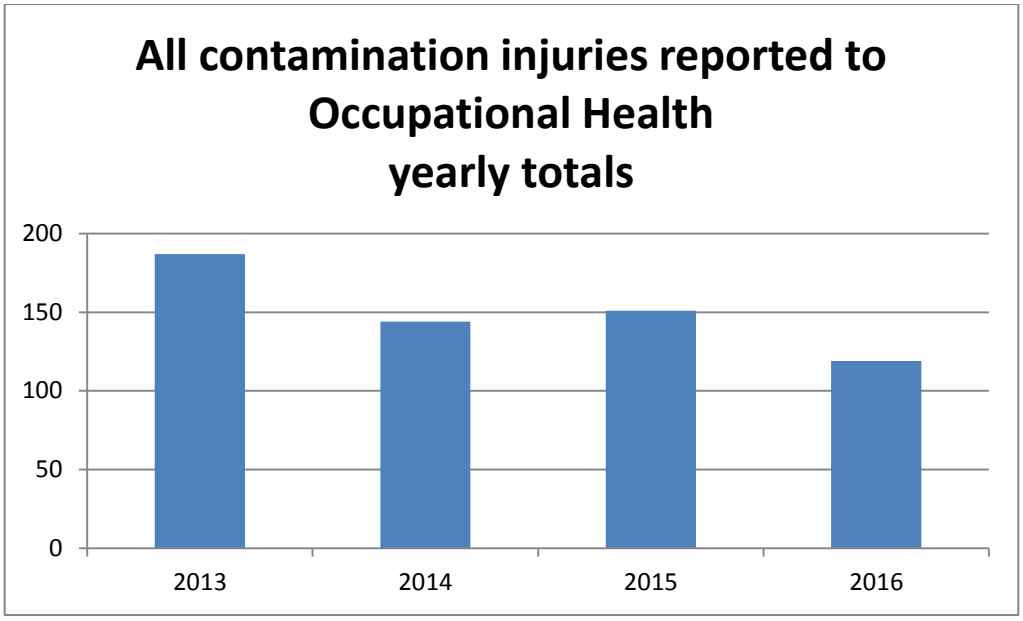
The final uptake of frontline healthcare workers reported to ImmForm (Department of Health) was 76.5%, with 75.9% by the 31 December deadline. The whole trust (all staff) uptake response of 69.6%

The Flu steering group is developing the plans for the season 2017-18 which will keep an internal target of 75% uptake by 31 December 2017, however the national CQUIN target has reduced to 70% uptake, and the time frame lengthened to 28 February 2018

Contamination Risk Injuries

OH has seen a reduction in reported contamination risk injuries since the introduction of needle safe devices in 2013 from 187 to 119 in the year 2016. Most notably there has been a reduction of injuries arising from the disposal of IV needles and injection needles.

A quarterly report is made to the Infection control committee, and a small working group led by health and safety, interpret and follow up on learning from injuries to further reduce risks.



5. Antimicrobial Prescribing

Antimicrobial stewardship committee

This was set up in January 2017 as a multidisciplinary meeting with representation from microbiology, infection prevention & control, pharmacy, medical, surgical and FSS divisions, health informatics and primary care. It is chaired by the Trust antimicrobial lead.

The committee will meet quarterly and report to the Trust infection control performance board and infection control committee. The monthly Antimicrobial team (AMT) meetings will feed into the above.

Southwest Yorkshire area-prescribing committee (APC) antimicrobial subgroup

This was formed in March 2016 with clinical and pharmacist representation from CHFT, Midyorks, CCGs (Kirklees and Calderdale), Locala and primary care. The aim is to drive antimicrobial stewardship across the whole health economy and ensure that up-to-date guidelines and resources are available to prescribers. The group meets quarterly.

Antibiotic Prescribing Guidelines:

Since May 2015 all adult antibiotic prescribing guidelines have been updated and approved by Medicines Management Committee (MMC) and are available on the Trust Intranet. There are ongoing challenges due to national supply problems with several antibiotics; guidelines are continually amended to reflect these supply issues.

Quality Improvement work

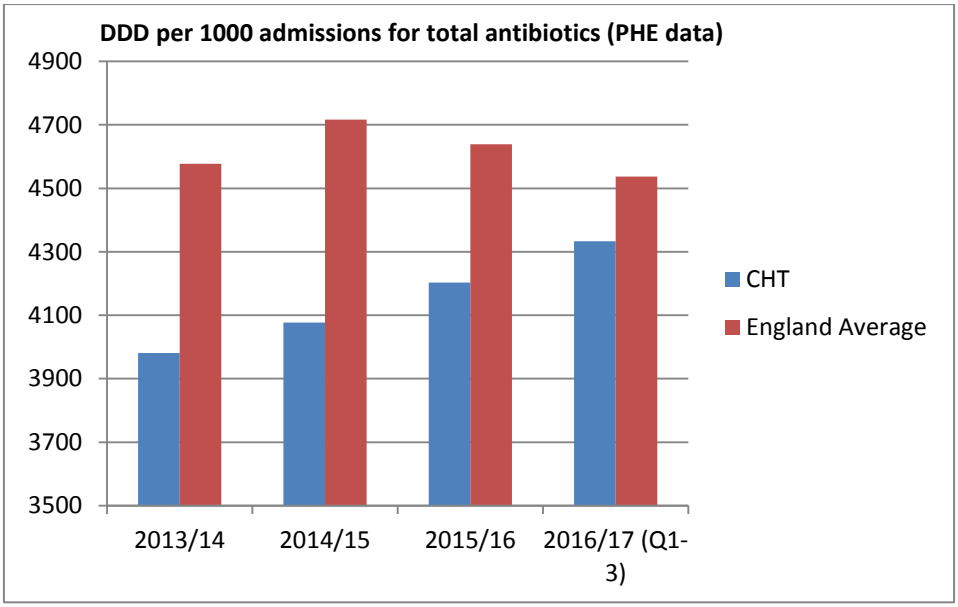
Antibiotic CQUIN 2016/17

The main focus of the Quality Improvement work has been trying to meet the CQUIN targets:

- **A. Reduction in antibiotic consumption per 1000 admissions**

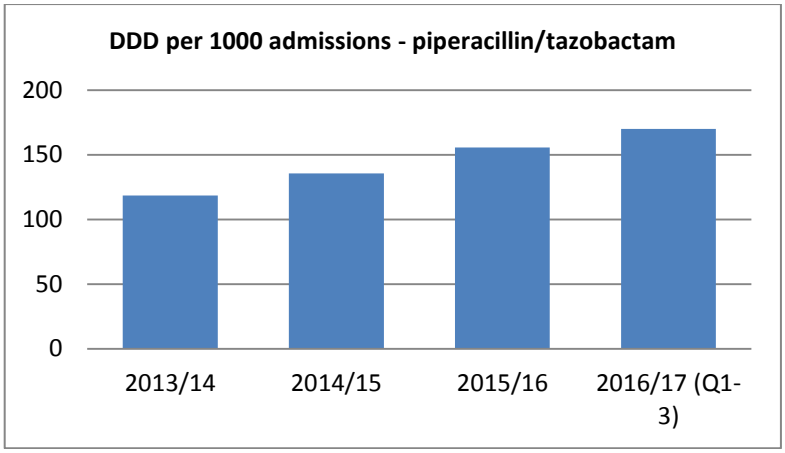
    a) *Reduction of 1% or more in total antibiotic consumption against the baseline 2013/14.*

Although there has been a steady rise in the consumption of all antibiotics between 2013/14 and 2016/17, consumption at CHT has remained below the national average each year. Around 40% of total antibiotic usage is from outpatients and A and E prescribing. Audits are being undertaken in these areas to assess appropriateness.



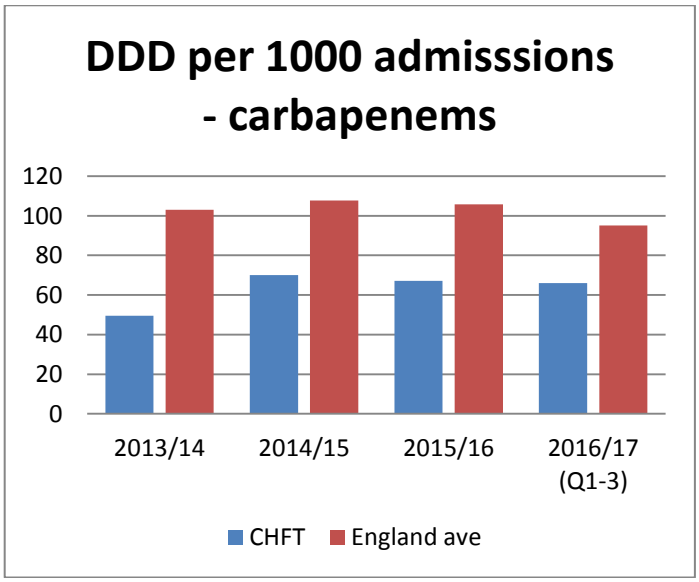
    b) *Reduction of 1% or more in piperacillin-tazobactam consumption against the baseline 2013/4.*

There has been a steady rise in the use of piperacillin-tazobactam at CHFT since 2013/14. The work being undertaken to ensure timely identification and treatment of sepsis could be contributing to this rise. Various wards have been identified as high users of piperacillin-tazobactam and patients on theses wards are regularly included in the targeted antibiotic ward rounds. In April 2017, due to a supply problem with piperacillin-tazobactam it has now been removed from the majority of our guidelines and the limited stock we have is being reserved for a few specific indications.



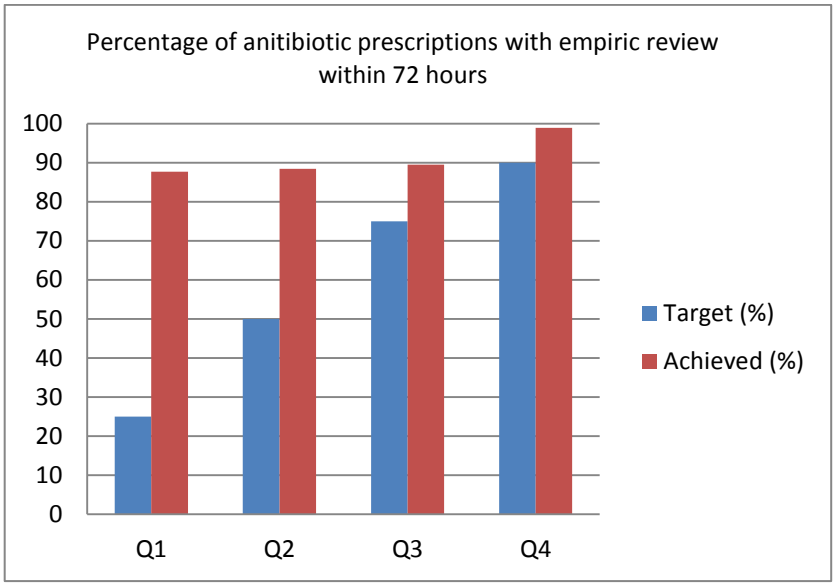
c) *Reduction of 1% or more in Carbapenem consumption against the baseline 2013/4.*

There was a large increase in the use of Carbapenems at CHFT post 2013/14. This has been monitored closely due to continued national concerns regarding Carbapenamase producing enterobacteriacae (CPEs). Review of patients on Carbapenems has been a focus of the consultant microbiologist-led antibiotic ward rounds to ensure appropriate use and timely step-down/de-escalation. As a result, we are seeing a slight reduction in consumption.



The target reductions for part A of the CQUIN were not met at quarters 1-3. Discussions are ongoing with the CCG with the aim of setting more realistic and achievable targets.

- **B Empiric review of antibiotic prescriptions within 72 hours**



Targets were met at Quarters 1-4.

A medicines management newsletter was written and distributed to junior doctors highlighting the importance of 'Start Smart – then focus'. This included guidance on how to assess whether IV to PO switch is appropriate and empiric stepdown choices.

Antibiotic Pharmacists are scheduled to talk at the sister's meeting to encourage nursing staff to prompt antibiotic reviews on the wards.

Audit of Antimicrobial Prescribing in A&E

A retrospective audit of 50 patients who had been diagnosed with an infection in A&E (CRH and HRI) during a week in September 2016 was undertaken. Patients were randomly selected by health informatics to include 20 patients who went on to be admitted and 30 patients who were discharged from A&E. The main results include:

- 50% patients were septic. 70% of these patients received antibiotics within 1 hour
- 76% compliance with trust antibiotic guidelines
- 100% of the patients admitted had their antibiotics reviewed between 48-72 hours.
- 73% of antibiotic prescriptions were compliant with recommended durations.
- No antibiotics were given for common viral infections

Improvements are required in some areas and results have been fed back to the doctors in A&E.

Point Prevalence Survey

CHT collected data in November 2016 as part of the national point prevalence survey. 34.7% inpatients were prescribed an antimicrobial at the time of data collection. In the top 10 antimicrobials prescribed, other than Piperacillin/Tazobactam and Co-amoxiclav (approximately 20% each), the rest were narrow spectrum. Antimicrobial use seemed equally split between medicine and surgery. 17 patients were prescribed antimicrobials for surgical prophylaxis and 5 of these were for >24 hours. 5.5% of patients had a Healthcare Acquired Infection (HCAI), these were also spilt evenly between surgery and medicine. The commonest HCAI was UTIs (32.4%) and half of these were catheter associated. This was a higher incidence of UTIs compared to the data in 2011. An agreed action from this audit is to carry out enhance surveillance with respect to HCAI UTIs and to undertake targeted work to reduce E.Coli bloodstream infections secondary to HCAI UTI. The majority of results showed similar patterns to the data we gained when we undertook the same study in 2011. The results are to be presented at the next Antimicrobial Stewardship Committee.

Antimicrobial Ward Rounds

The Consultant Microbiologists continue to carry out both regular (ICU, W3, W12) and targeted (supported by infection control and pharmacy) ward rounds. We prioritise review of complex patients, and those on Carbapenems, Fidaxomicin with Clostridium Difficile or on prolonged courses of intravenous antibiotics.

Outpatient Parenteral Antibiotic Therapy (OPAT) antibiotics:

An OPAT service is provided for Kirklees and Calderdale patients for up to 12 antibiotic administrations per day in each community area. A multi-disciplinary health economy-wide project group has continued to meet regularly. There is now a single OPAT pathway to guide clinicians on assessing suitable patients. The service has adapted and more than 20 antibiotics and methods of administration have been used for OPAT patients. Patients have a weekly “virtual” review by a multi-disciplinary team led by a Consultant Microbiologist. The service has accepted and treated 464 patients between Jan-Dec 2016.

Education and Training

Education and Training is provided in a number of ways and aimed at different professional groups including Medical staff (Trust-wide Junior Doctor Inductions, Anaesthetic registrar teaching, Orthopaedic registrar teaching, Trust-wide consultants, clinical audit meetings), multi-disciplinary events (Health-care associated infections (HCAI) champions events, Infection Control Link Practitioners Workshops), the pharmacy team and to our potential future staff (third and fifth year Medical students)

Antibiotic Awareness Week - November 2016

This year the week coincided with the point prevalence survey. The Microbiology Consultants presented at the clinical audit meetings and Trust Communications raised further awareness by promoting "Start Smart - Then Focus" material in CHFT news and tweets. Antibiotic Clinician Champions were photographed and this was displayed alongside their antibiotic stewardship messages on screensavers on all trust computers.

Safety of Antibiotic Prescribing

Root Cause Analysis

There is a Microbiologist and/or a Pharmacist attendance at *C. difficile* root cause analysis (RCA) and MRSA post infection review (PIR) meetings. Learning related to antibiotic prescribing from these RCAs is disseminated, as required.

Electronic Prescribing

The Consultant Microbiologists and Antibiotic Pharmacists have advised the team developing the Electronic Patient Record. This is due to be launched at the beginning of May 2017 and it is hoped that this will greatly benefit the antimicrobial stewardship at CHT.

Key Challenges in 2016-7:

There have been challenges due to national supply problems with several antibiotics, guidelines have been amended to reflect these supply issues.

It has not been possible to meet Part A targets of the antimicrobial resistant CQUIN. Discussions are ongoing with the CCG regarding this and quality improvement work is ongoing.

Future Challenges

The launch of EPR (Electronic patient records) in CHFT at the end of April 2017 will revolutionise antimicrobial prescribing, surveillance and prescriber feedback. As a group, we will need to learn new tools and initiate novel ways of stewardship.

CQUIN target 2 (2017/18) - Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) is the infection targeted CQUIN for the new financial year. This will involve the sepsis collaboration and the AMT working closely together.

Ongoing shortages of broad-spectrum antibiotics will require us to keep reviewing our local guidelines and resistance patterns and ensuring prompt communication with our main prescriber groups.

6. Decontamination

The Health Technical Memorandum 2016 supersedes the Choice Framework for local Policy and Procedures (CFPP) series, which was a pilot initiative by the Department of Health.

The CFPP series of documents are reverting to the Health Technical Memorandum title format. This will realign them with HTM 00 – 'Policies and principles of healthcare engineering' and 'HTM 01-05: Decontamination in primary care dental practices' and the naming convention used for other healthcare estates and facilities related technical guidance documents within England. It will also help to address the recommendation to align decontamination guidance across the four nations.

In 01-01 and 01-06 DH will be retaining the Essential Quality Requirements and Best Practice format, this maintains their alignment with HTM 01-05 and the requirement of 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' which requires that "decontamination policy should demonstrate that it complies with guidance establishing essential quality requirements and a plan is in place for progression to best practice".

A safe decontamination service contributes to successful clinical outcomes and the wellbeing of patients and staff. The trust is required by law to comply with essential levels of safety and quality which are assessed by the CQC. These levels are set in law through registration requirements, one of which covers cleanliness and infection control.

HTM draws on current advice to provide comprehensive guidance on the management and decontamination of surgical instruments used in acute care, which includes clear definitions of what constitutes Essential Quality Requirements (EQR) and Best Practice (BP)

The Trust receives its decontamination service from a third party provider, BBraun Sterilog Yorkshire Limited. They use British and European Standards to demonstrate compliance with the essential requirements of the Medical Devices Directive (MDD 2007/47/EC) and have a quality system in place, ISO13485 against which they are independently audited by the British Standards Institute (BSI). This therefore offers assurance to the Trust that the service delivered is safe and achieves recognised standards.

Within the Decontamination Services Agreement (DSA) there are key performance indicators (KPIs) associated with logistics, quality outcomes and

turnaround times that are embedded to ensure the delivered service continues to meet the Trust needs and expectations. The KPI's also ensure national and international guidelines and recommendations are met.

BBraun Sterilog Yorkshire Limited is recognised as having validated processes and as such is fully compliant against all guidelines as detailed via the National Decontamination programme where independent verification by the British Standards Institute (BSI) confirms compliance by a six-monthly review audit and certificated accordingly.

The operating reporting structure for the remainder of the contract term is as follows:

a) Joint Management Board (JMB) (strategic) comprising of the three partnering Trusts & Braun, currently Chaired by C&HFT.
b) Project Board (PB) (strategic) comprising of the partnering Trusts and Chaired as above.
c) Technical Review Committee (operational) comprising representatives of the three Trusts & Braun with the Contract Manager Chairing the committee.
d) Service Review Meeting (operational) comprising CHFT stake holders & Braun and is Chaired by the Decontamination Manager (currently under review)

Day to day service delivery is monitored within the organisation to ensure the service maintains a fit for purpose status.

Endoscopy

The centralised endoscopy units at HRI and CRH have been designed and built to meet all relevant and current standards of build including Mechanical and Electrical services.

These state of the art units provide a first class, decontamination compliant, JAG certificated service to our patients who can be confident the level of care delivered is supported by a rigorous audit regime associated with the service delivery.

The environment in which decontamination is carried out should be one that minimises both the risk of recontamination of flexible scopes and the possibility of generating aerosols. This implies the use of a separate room or rooms for the accommodation of clean (output) and dirty (input) work. These rooms are built

into the endoscopy units and are used for this purpose only and access restricted to those staff performing decontamination duties or maintenance regimes.

The policy and guidance specifically designed for flexible endoscope reprocessing HTM 01 – 06 is driven by the aim of ensuring progressive improvement in decontamination performance both in centralised facilities and at a local level giving a continuous reduction in infection rates from both conventional (virus, bacterial fungi and spores) and prion infection disease.

The guidance provides options to flexible endoscope decontamination practices within which choices may be made and a progressive improvement programme established. Coordinated use of the guidance across the quality inspection processes will help the Trust to achieve a satisfactory level of risk control together with equivalent compliance with the "Essential Requirement" of the Medical Devices Regulations.

Additionally, further independent monitoring carried out by the Joint Advisory Group (JAG) which is recognised as a pathway of quality improvement, where acceptable standards for endoscopy units are continually met, and assurance that endoscopy training and quality are consistently achieved and therefore the patient experience and outcomes are of the standard expected.

A planned project to replace the equipment associated with decontamination i.e. Automated Endoscope Reprocessors, (AER's) Reverse Osmosis water treatment plants (RO) and Drying Cabinets is planned to take place in 2017. The project will take account of the need to ensure that effective measures to reduce disruption to patient care during the replacement programme are understood and managed via the provision of an on-site temporary decontamination facility that meets current standards.

It is noted that a fire incident occurred within the CRH endoscopy unit in February 2017 that involved one of the two automatic endoscope reprocessors AERs and at the time of writing this update the forensic details in regard to cause are awaited, however once all the information is known a report will be produced.

ENT

ENT Naso-endoscope reprocessing is carried out at the Huddersfield Royal Infirmary (Acre Mill) via a state of the art unit using automated processes with independent validation at the heart of the process and is in line with Best Practice principles as described in HTM 01-06. Calderdale Royal Hospital currently reprocess locally in the ENT OPD area where manual cleaning takes

place after each patient use followed by a daily high level disinfection via the Endoscopy unit daily, which complies with the essential quality requirements of the HTM guidance for this flexible scope type.

Decontamination Committee

The Decontamination Committee was established during 2016 and meets bi-monthly, with its core members drawn from multidisciplinary backgrounds including, Infection Control, Estates, Surgery, Medicine, Decontamination, Engie, Procurement, Facilities, General Managers and is Chaired by the Director of Planning, Estates and Facilities.

The aim of the Committee is to undertake the development of high quality decontamination processes, policy and procedures to ensure that a safe, properly managed and effective decontamination & sterilization process is adopted for all re-usable medical devices and equipment after and between each patient use. This is an essential element of routine infection control practice. The purpose of which is to provide a governance arrangement for the organisation to ensure effective and safe delivery of decontamination management and mitigation of risk through both internal and external review processes.

The Committee will support the safe delivery of decontamination in respect of all reusable medical devices and equipment across the wider organisation.

To date the Committee have reviewed compliance in regard to the following:

- Endoscopy / ENT Reusable Medical Devices via the Trusts independent Authorised Engineer Decontamination AE(D)
- BBraun Sterilog via British Standards Institute in recognition of MDD 93/42 EEC Annex V, section 3.2 under article 12
- Laundry in recognition of HSG(95)18 / CFPP 01-04and EN14065
- PPM regimes associated with hard FM services
- Pharmacy Manufacturing Unit compliance

Other work undertaken

- Establishment of validation processes associated with quarterly and annual maintenance regimes for Automatic Endoscope Reprocessors AERs.
- The appointment of a new Authorising Engineer Decontamination AE(D)

The Trust is working with colleagues within the region of West Yorkshire where a sub group has been established that will review the delivery of decontamination services and how best to deliver these in future using commonly agreed processes and procedures. The group is called West Yorkshire Association of Acute Trusts Estates and Facilities Working Group.

The key aims of WYAAT EFWG are to create a shared purpose in providing excellence in the delivery of Estates and Facilities services and therefore:

- Review the decontamination processes across the WYAAT area and produce a process map for each stage which identifies number of instruments processed, process times, provision of decontamination equipment (washers/autoclaves etc).

- Identify the structure of each Sterile Services & Medical Devices in each organisation.

- Share each organisations Decontamination / Medical devices Policy for review and approach to compliance with a view to a standardised approach.

- Review the appointment arrangement for Authorising Engineers (Decontamination) with a view to standardisation

- Review the AP & CP compliance structures of each organisation

- Review the appointments of the ISO accreditation organisations used by each organisation with a view to standardisation

- Review HTM and ISO with a view to standardised approach to compliance

- Review each organisations approach to life cycling of medical equipment

7. Cleaning Services

The provision of cleaning services continues to be delivered by both an in-house service at HRI, Broad Street Plaza and Beechwood Community Health Centre and an outsourced service under the PFI (Private Finance Initiative) agreement by ISS Facilities Healthcare Services at CRH and OCS cleaning services at Acre Mill outpatients HRI.

A 24-hour Rapid Response Team continues to be provided at CRH and HRI for out of hours cleaning at both sites.

The Infection Prevention Quality Improvements audits continue to be successful in driving improvements across the Trust. This was updated 2015-2016 driven by changes to PLACE (Patient led Assessments of the Care Environment) and CQC guidance.

The Front line Ownership (FLO) whereby nursing staff at three different levels assess compliance with 10 key infection control areas quickly using a standardised tool, continues to be used and has been adapted in 2016. Ward and Department Managers assess their areas weekly and report their finding to their Matron. Matrons provide a further monthly check. This helps to identify issues quickly and strengthens the assurance process.

Performance management systems are in place with key performance indicators produced on a monthly basis in line with the national specification for cleanliness**.** The monthly scores are displayed on each wards public facing board at the entrance to the ward and on the infection control notice board within outpatient departments.

Through the service performance report any concerns raised relating to cleaning for HRI are reported at the Estates and Facilities Quality and Safety Board. The GM for Facilities also attend the Infection Control Committee

At CRH site a monthly PFI Service Performance meeting is held including attendance by the General Manager for ISS the lead nurse for Infection Control and SPC ltd (Catalyst).The service performance report is discussed including audits/spot checks undertaken by the service performance team

For Acre Mill HRI a service performance meeting is also held monthly. This is chaired by Savills and attended by service performance team and the manger for OCS cleaning services. Any spot checks undertaken and audits are discussed and concerns highlighted if not rectified

A Contract Management Board (CMB) meeting is also held every 2 months for the PFI site at CRH. The CMB is in place to seek to ensure that a good working relationship and level of communication is in place at an operational level between the Trust and the PFI Partner. Its Terms of Reference are based on the functions of monitoring and review of the Contract for the Provision of hard and soft FM, and provision of Calderdale Hospital. Any concerns relating to cleaning are highlighted at this meeting

The Trusts Service performance team also monitors cleaning on the HRI, Acre Mill and CRH site. The reports for all areas are sent electronically to heads of cleaning services with clear time scales for any concerns to be rectified. The services respond with signed rectified actions.

Schedule 2 monitoring audits are also performed by the Service Performance Team at CRH in accordance with the PFI concessions agreement but do not audit against the 49 elements.

This information also forms the monthly service performance report and is discussed at the monthly service performance meeting and at the quarterly Contract Management Board

The Facilities Matron continues to work closely with all disciplines including cleaning services across both hospital sites and is the link between clinical and non-clinical teams. The matron attends the Trust Infection Control Performance Board as the Estates and Facilities representative.

Hydrogen Peroxide Vapour (HPV), a powerful bio-decontamination agent which reduces the biomass in the built environment, has continued to be used. The service is funded as part of the contract with Hygiene Solutions. For 2017/2018 this will be CHFT final year with Hygiene solutions as the trust will require to go out to tender for 2018/2019.

The reactive service remains to be operated in house by cleaning services staff on both hospital sites primarily to provide high level decontamination of isolation rooms. HPV is used in the final decontamination of a clinical area after discharge of an infected patient to ensure the room is safe for the next patient.

HRI was re accredited in October 2016 as a training centre to deliver British Industry of Cleaning Science (BICSc) cleaning methods and safe systems of work.

Four members of cleaning services gained a BICSc licence to practice allowing them to deliver and assess BICSc training to all members of cleaning services. This will ensure a consistent method of cleaning is delivered to all areas at HRI.

HRI cleaning service has been audited in April 2017 against the Cleaning Industry Management Standards (CIMS) as their quality management system. CIMS is the first consensus based management standard that's outlines the primary characteristics of a successful quality cleaning organisation. HRI are awaiting confirmation of the assessment.

Estates and Facilities division are reviewing an electronic combined audit system which will produce reports on all aspects of cleaning whether this was through Infection prevention and quality audits, spot checks undertaken by service performance team or the cleanings audits.

8. Estates

The trust continued with the ongoing capital programme of improving the estate and resilience; improvement works include:

- Install a new Surgical air plant to provide segregation between Surgical and Medical air
- Work has started to install a backup medical oxygen plant the other side of the site
- A second water main has been installed into the site from a diverse supply to provide resilience in case of mains supply failure
- Replacement of degraded pipework has taken place throughout the Hospital
- Continuation of Environmental improvements throughout

In addition, work has continued on the site infrastructure in order to provide a safe environment that is compliant with HTM requirements, improvement works include:

- Emergency Lighting
- Fire Detection improvements and replacement
- Roof repairs
- Air handling units replacement

Women Health Unit

The old Dermatology was refurbished as a dedicated area for Pre-Opp Assessment and an interim home for the Women's Health Unit while their new home at the old Eye clinic corridor is been refurbished.

A & E Resus

Design work has started to refurbish and upgrade Resus at HRI A & E to provide a spacious and modern environment in accordance with guidance.

Theatre Upgrade Programme

The Theatre upgrade programme was completed with some infrastructure works carried out in recovery.

Fire Compartmentation

Continuation of fire compartmentation throughout HRI, to reduce the spread of fire risk.

Estates

The estates team continue to work through HTM action plans following independent compliance audits for engineering services in 2016/17 to ensure full compliance with DoH requirements. The estates department are committed to replacing / upgrading services to ensure the very highest quality is delivered to patients and staff.

The Water and Air management/safety group ensure scrutiny and clinical governance arrangements are in place for both systems, any concerns/information is subsequently raised at the Estates and Facilities Quality and Safety Board & Infection Control Committee.

Water and Air Management is controlled and delivered via written control schemes/ Estates Management Plans administered by the Authorising Engineer / External Consultant Microbiologists.

Waste management continues to be well managed across both CRH and HRI Sites. "Bag to Bedside" has now been implemented in all wards to reduce the number of bins, so reducing clutter and noise. Improvements in segregating clinical and medicinal waste streams have also continued.

Patient-led Assessments of the Care Environmental (PLACE)

HRI :- Cleanliness 99.8%, Condition and appearance 94.83%

CRH:- Cleanliness 98.86% condition and appearance of 95.79%

9. Infection Prevention and Control Audit Programme

The audit programme for 2016/17 was completed and all action points were shared with the divisions for follow-up. This programme included:

- Urinary Catheter annual prevalence audit
- Peripheral Venous Cannula prevalence audit
- Isolation audit
- Commode audit
- Sharps disposal
- CPE screening compliance audit

The Infection Prevention and Control Team (IPCT) are involved in the Quality Improvements audits which are undertaken on an unannounced basis in all clinical areas. The development of this process has interlinked services to provide a cohesive joined-up service; this is led by the Service Performance team.

The annual hand wash roadshow (HWRS) was undertaken throughout the organisation between the 10th October 2016 and 26th October 2016. In a bid to expand the HWRS format it was taken in to the community setting for the first time for a period of 2.5 days. All wards and departments were visited in the acute trust and a number of health centres were also selected based on the number of staff working from them. Furthermore, for the second time in the hand wash roadshow's history the use of the 'Sure Mash Machine' was employed. It is digital technology that takes each user through the correct stages of washing their hands using motion sensors built in to the machine. The machine can provide feedback to the infection prevention and control team on compliance with hand washing and also the principles of 'Bare Below Elbow' (BBE).

As part of the 2016 Hands On: hand wash roadshow 354 staff at Calderdale, 215 staff at Huddersfield, and 66 community staff were also assessed using the following tool: Audit of compliance with aspects of hand care and uniform policies. This was to review if staff adheres to the trusts stance of 'Bare Below Elbow' and also give the opportunity for the IPCN to ensure appropriate training for the areas highlighted as non-compliant. The results of this audit are demonstrated in the report below. Also 475 staff in total used the 'Surewash' machine throughout the roadshow.

Results of compliance

From the 635 staff assessed throughout the organisation the overall compliance with 'bare below elbow' is 94%. As demonstrated below this is an increase from last year by 13% which is excellent.

10. Infection Prevention and Control Policies

All core policies as required by the Hygiene Code 2008 have been reviewed and have been published on the Trust Intranet and Internet. The following policies have been approved at Executive Board during 2016/17:

Section A	Infection Control Arrangements Policy
Section D	Meningococcal Disease Policy
Section E	Major Outbreaks of Infection Policy
Section J	Multi Resistant Organism including CPE Policy
Section N	Viral Haemorrhagic Fever Policy
Section O	CJD policy
Section R	Specimen Collection Policy
Section T	MRSA including PVL Policy
Section U	MERS-CoV Policy

11. Education and training

Annual updates on Infection Prevention and Control are mandatory for all staff and are delivered via an online training package that includes questions to assess knowledge and understanding.

The Bi-annual face-to-face update sessions continue with staff having attending 'Beyond the basics' and 'Right from the start' for new starters.

The team strive to improve compliance by providing extra sessions, targeting low compliance areas and attending key clinical meetings. Specific training has been given to our colleagues in Estates and Facilities across site.

The IPCT also support Aseptic Non Touch Technique (ANTT) training, supporting compliance and safety metrics and zero harm; the Trust overall compliance at the end of March 17 reported 85% compared to 73% in March 2016.

The IPCT provide comprehensive Infection prevention training for the Junior Dr induction day, including the assessment of (ANTT).

Throughout the period of this report, the IPCT sessions consistently scores 'good' or 'excellent' in feedback from participants. Other comments include 'effective and concise', 'useful, current and appropriate'.

Appendix 1:

Link to the Infection Prevention & Control Arrangements Policy

http://nww.cht.nhs.uk/fileadmin/intranet/policies/documents/479/C-64-2014%20-%20IPC%20Arrangements%20V9%20Amendment.pdf

Appendix 2:

Terms of Reference for the ICC

Terms of Reference	
Committee Name	**Infection Prevention & Control Committee**
Chairperson	Infection Prevention & Control Doctor
Date	June 2015
Version	2
Receives reports/minutes from:	Occupational Health Decontamination Manager Divisions: Surgery;Medical;FSS;Community;Estates & Facilities PHE CCGs
Meeting and attendance frequency:	Minimum four times per year.
Definition of Quorum	Eight members (five of which are not members of the IPCTeam), including senior member of Infection Control Team and divisional representation
Membership	Current list available from IPC secretary
Core membership:	All members expected to attend every meeting or send appropriate representative in their absence.
Associate Membership:	Must attend on an adhoc basis dependent on the agenda

Scope of responsibilities (duties) : See below

Infection Prevention and control is a high priority within CHFT, in order to ensure adherence and maintenance of standards as set out by the CQC and the Health and Social Care Act 2008.

Remit

- To ensure that Calderdale and Huddersfield NHS Foundation Trust provides a safe environment, in terms of infection risk and within the sphere of current knowledge, for patients, staff and visitors.

- To oversee the organisation and development of infection prevention and control services across the Trust, including surveillance, education and audit.

Accountability

- To the Trust Board.

Function of the Committee

a) Advice and Reports
   - To advise the DIPC on all matters concerning Infection Prevention and Control within the Trust.
   - To advise and support the Infection Prevention and Control Team.
   - To act as a referral centre for infection prevention and control advice within the Trust.
   - To support the DIPC to produce an Annual Report to the Trust Board.

b) Policies and Guidelines
   - To examine and approve new and updated Infection Prevention and Control Policies and guidelines for the Trust.
   - To monitor the implementation and application of the Trust's Infection Prevention and Control Policies.
   - To ensure that the Trust implements infection prevention and control advice and guidelines contained in Department of Health documents and professionally approved reports.
   - To ensure all staff abide by the Health and Social Care Act (2008), Code of practice on the prevention and control of infections and related guidance

c) Strategy
   - To receive and endorse the Annual Infection Prevention and Control Programme and review its results.
   - To receive the Trust's Annual HCAI Action Plan and receive quarterly review of progress.
   - To lead the Infection Prevention and Control Education Programme for staff development within the Trust.
   - To ensure that there is on-going audit and surveillance activity which mirrors the needs of the Trust and supports the Department of Health's strategic programme.

d) Surveillance
   - To receive up to date reports and statistics advising the Committee on current status of hospital acquired infection and to make recommendations where appropriate.

e) Outbreak/incident Management
   - To discuss and review all matters relating to outbreaks of infection in Trust premises and makes recommendations to address shortcoming and avoid recurrences.
   - To draw to the attention of the chief Executive and Trust Board, any serious problems or hazards relating to infection control.

f) Collaboration and Partnerships
   - To work closely with the Clinical Commissioning Groups.
   - To establish partnerships and work closely with the local social care partners.
   - To liaise with external agencies where appropriate e.g. Public Health England.

Composition of the Infection Prevention and Control Committee

The Committee is a multi-disciplinary one that includes senior professionals from key agencies across the Trust. The composition of its membership should assist the Committee to discharge its responsibility for overseeing all aspects of infection prevention and control within the areas managed by Calderdale and Huddersfield NHS Foundation Trust.

The Members of the Infection Control Committee

Infection Prevention and Control Doctor (Chair)
Medical Director & Director of Prevention and Control of Infection
Assistant Director of Infection Prevention and Control
Consultant Microbiologists
Lead Infection Prevention and Control Nurse
Senior Infection Prevention and Control Nurse
Head of Infection Prevention & Control, Calderdale Council
Senior Community Infection Prevention and Control Nurse, Kirklees Council
Consultant in Communicable Disease Control, Public Health England
Senior Nurse, Occupational Health
Lead Nurse - Medicine
Lead Nurse - Surgery and Anaesthetics
Lead Consultant - CWF
Lead Nurse - CWF
Associate Director - Estates and Facilities
ISS Manager, Calderdale Royal Hospital
Cofely Manager, Calderdale Royal Hospital
Decontamination Manager
Non Executive Director
Other members may be co-opted as appropriate, e.g

- Catering manager
- TB Nurse

Minutes

- Open.
- Sent to the Trust Clinical Effectiveness Committee and the Executive Board.
- Distributed to the rest of the organisation via the Divisional Representatives.

Updated June 2015

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, 6th July 2017	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Guardian of Safe Working Hours Quarterly Report - The Board is asked to receive and approve the contents of the Q2 Safe Working Hours report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Please see attached.

Appendix

Attachment:

2nd quarterly report May 2017.pdf

2nd QUARTERLY REPORT ON SAFE WORKING HOURS: May 2017

Miss Tamsyn Grey, Guardian of Safe Working Hours, CHFT

Executive summary

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

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

There is still a significant problem with some supervisors not addressing exception reports despite reminders and offers of additional training

There is no admin support provided to the Guardian of Safe Working Hours with regard to managing the flow of exception reports. Even with only a minority of the Trust's Junior Doctors on the new contract so far, it has not been possible to address and problems in the timeframe suggested by the contract within the time available to the Guardian. The regional Guardians' forum of Health Education England working across Yorkshire and the Humber has suggested that 1 WTE administrator will be needed to support the Guardian from August 2017.

Among doctors on the contract so far, the majority of exception reports have fallen within the Surgery and Anaesthetics division (all in surgical specialties), seemingly due to a heavier workload in these specialties. 3 fines have been issued on the general/urology/vascular surgery F1 rota, which runs very close to 48 hours at baseline

In common with other Trusts, we have a significant number of vacancies with use of mostly agency locums (with a weekly cost of around £100,000) to fill these gaps. 20% of vacant shifts are left unfilled, leading to additional strain on the junior doctors and consultants who are working

Introduction

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

High level data

Number of doctors / dentists in training (total):	Approx 215
Number of doctors / dentists in training on 2016 TCS (total):	45 FY1s & some paediatric and GP trainees from February 2017
Amount of time available in job plan for guardian to do the role:	2 PAs
Admin support provided to the guardian (if any):	None

Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Amount of job-planned time for clinical supervisors: None

a) Exception reports (with regard to working hours) 7 December 2016 – 30 April 2017

So far, all exception reports have been from FY1 doctors. Of the 45 doctors in the Trust at this grade, 16 have used the exception reporting system. I was not involved in the induction of the core and higher trainees who went onto the 2016 TCS in February, and have not received a contact list for them, so I am not convinced that they have received adequate information regarding the exception reporting system.

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

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

Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
31	10	80	108

Hours monitoring (2002 contract)

A monitoring exercise was performed with all junior doctors in the trust being asked to monitor either in late 2016 or early 2017 depending on specialty. The only group who returned enough online diary cards was ophthalmology. The outcome was that they are non-compliant with New Deal and EWTR due to a lack of breaks, and band 3 back pay is currently being negotiated along with changes to the rota to encourage break compliance.

A further pan-specialty monitoring exercise is due to commence on 5th June.

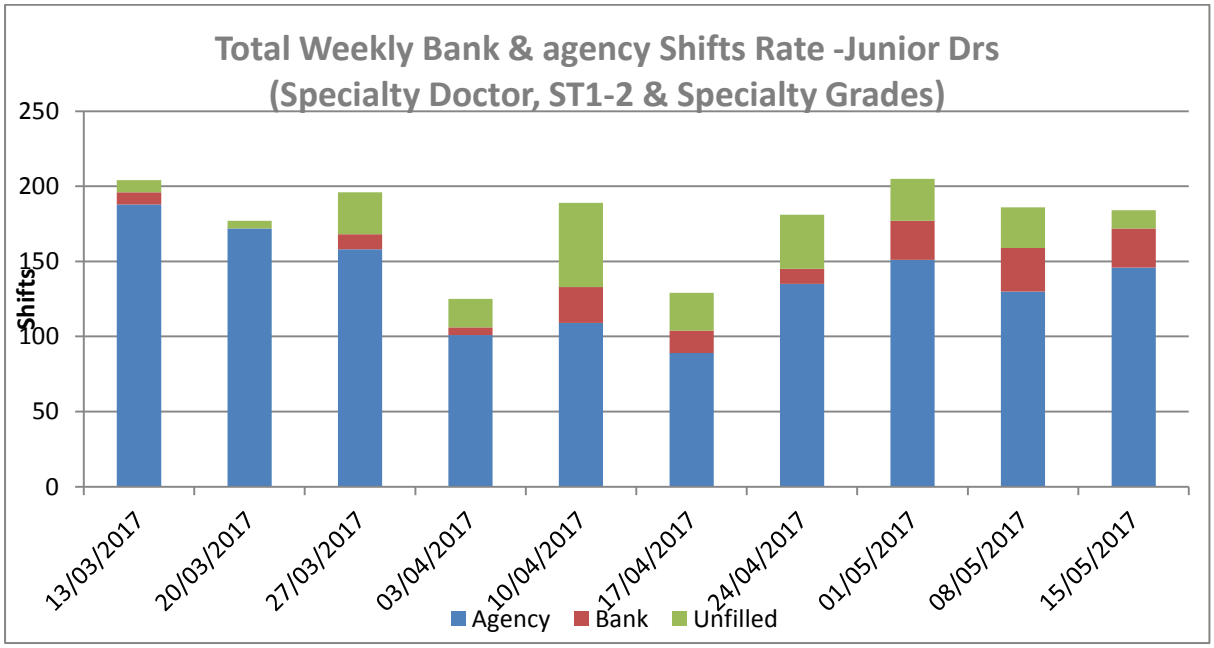
b) Work schedule reviews

Work schedule reviews by department	
Vascular surgery	1
ENT	1
Trauma & orthopaedics	1

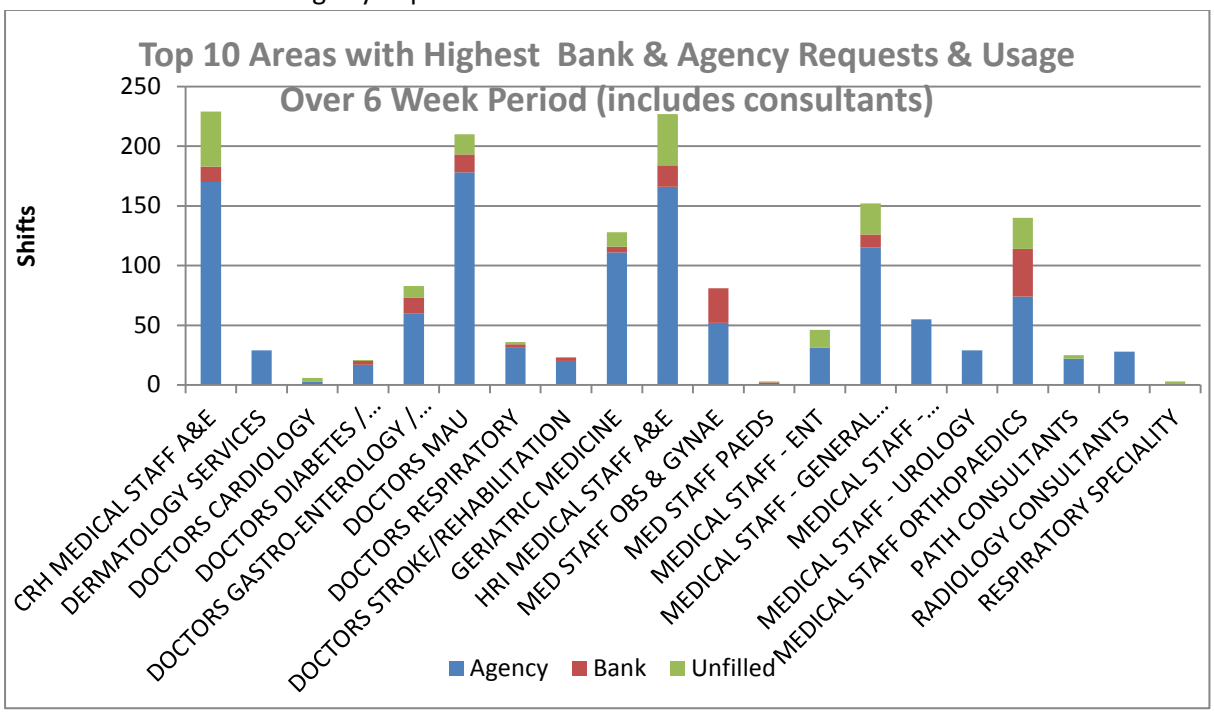
There have been 3 work schedule reviews due to a pattern of reporting. The reviews in ENT and vascular surgery addressed the problem by adding more flexibility into the personal work schedules; however, this has not been possible in T&O due to rota gaps at core trainee level creating an ongoing excessive workload for the FY1. There has not been a formal appeal or level 2 review regarding this.

c) Locum bookings

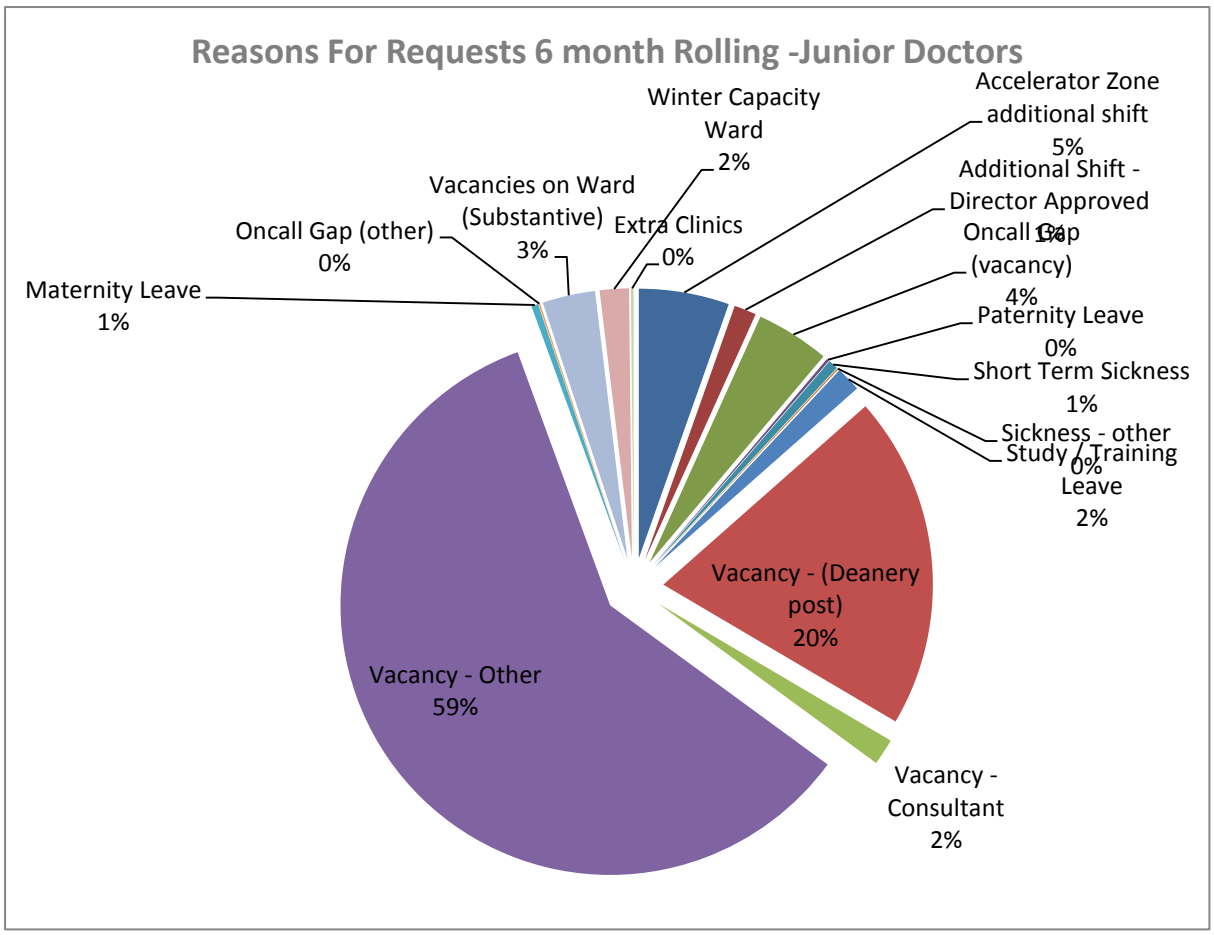
I have been provided with data from w/c 13/3/17 (when medical HR started collecting, none was held centrally before this) to w/c 15/5/17. Across all divisions junior doctor 100-200 locum shifts are requested per week (see below), with the weekly cost ranging from £62573.64 to £130016.61.



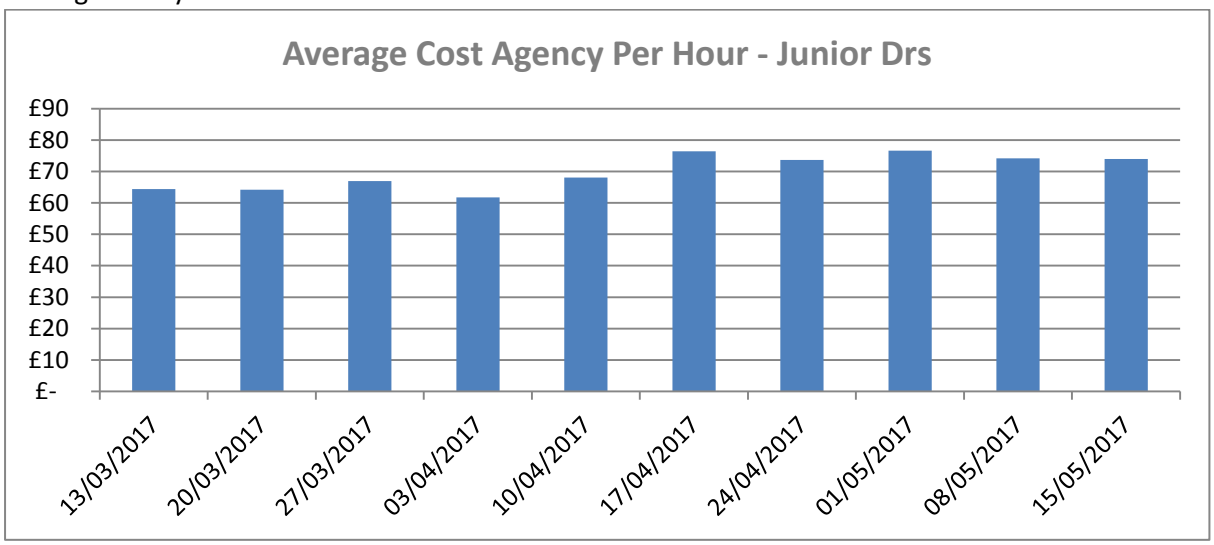
Below is a chart of bookings by department



Reasons for request:



Average hourly cost:



704 locum shifts requested in the 4 weeks up to 7/5/17 with 145 (20.6%) unfilled, leading to additional strain on the junior doctors present.

d) Vacancies

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

Rota	Site	Grade	Gaps on rota Feb-August 2017	Usual cover (if known)
Surgery/ENT/ T&O	CRH	Core	5/10	Agency locum
General surgery/ vascular/ urology	HRI	Core/FY2	3/10	2 long term agency locum 1 ad hoc internal/agency cover
General surgery/ vascular/ urology	HRI	FY1	1/13 (Apr-Aug 2017)	Usually internal cover
T&O	HRI	Core	6/10	Internal/agency cover for on call only (reduced ward cover)
ED	HRI	Core	1/8	Agency
ED	CRH	Core	1/8	Long term agency locum
ED	HRI/CRH	Higher	No data provided to GSW	
General Surgery	HRI	Higher	2/10	Usually agency locum, some internal cover
General Surgery	CRH	Higher	1/5	Usually internal cover

Urology	HRI	Higher	1/5	?
Medicine	HRI	Core/FY2	3/18	1 long term agency locum
Medicine	CRH	Core/FY2	2/17	?
Medicine	HRI	Higher	2/12	?
Medicine	CRH	Higher	0.5/12 (1 no nights)	2 long term agency on wards, not on call
Medicine	HRI	FY1	0/13	
Medicine	CRH	FY1	1 (Dec 2016-Apr 2017)	
O&G	CRH	Higher	3/13	?
O&G	CRH	Core	Cannot access	
Anaesthetics	HRI	Higher	?(definitely some gaps)	Often consultant covered
ENT	CRH	Higher	none	
Opthalmology		Higher	No specific gaps but sometimes consultant is first on	
Paediatrics	CRH	Higher	0/12 (4 slot shares)	
Paediatrics	CRH	Core	No data	

e) **Fines**

3 fines have been issued on the surgery FY1 rota. This rota runs at 47.76 hours so does not take much to warrant a fine if payment is awarded for an exception report. The recurring issues were having to stay late on normal days after consultants had been on call due to heavy work load, and being asked to stay for handover in the evening (no handover period is built into the rota in an attempt to keep it under 48 hrs)

Fines by department		
Department	Number of fines levied	Value of fines levied
Surgery	3	£854.04

Qualitative information

In general our junior doctors at the Trust feel happy and well-supported, as evidenced by the GMC Training Survey. They do not appear to be particularly politicised and attendance at the Junior Doctors' Forum has not been particularly high, with most issues being raised by one FY2 doctor.

Issues arising

Collecting data that encompasses the whole period for this report has been quite challenging, particularly with respect to locum usage and vacancies. This is perhaps because there was no Medical HR department until last year, and certainly there have been improvements in data collection over the past few months. Without data to highlight the scale of the problem it is difficult to work towards solutions.

In terms of exception reporting my main concern is the lack of engagement of some supervisors with the process. It would be easy to say that these supervisors should not continue to have trainees, however this would increase the problem of obtaining supervisors which could potentially lead to the number of deanery trainees in the Trust being reduced, with a subsequent increase in rota gaps.

We currently offer 0.125 SPAs per trainee to Educational Supervisors (half the nationally recommended amount) and no SPA time to Clinical Supervisors (recommended 0.25 SPA for any number of supervisees), and as the burdens placed on supervisors by the new contract increase, we could end up having problems recruiting to these roles.

We have a number of rotas that run close to 48 hours (in surgery, anaesthetics, ED and O&G) for which it will only take a small number of exception reports to tip trainees beyond this safe working hours limit and therefore generate fines. Clinical Directors and rotamasters have been contacted regarding this and are working on improvements where possible. The appointment of Physicians Associates could be used to mitigate some of these problem areas, although I believe the bulk of them have been appointed to jobs in Medicine, which does not have any at risk rotas.

A further issue appears to be the use of long-term agency locums. I am certainly aware of 2 doctors within my department who are working as such, and who would probably have taken a trust grade contract had it been offered.

Actions taken to resolve issues

In terms of issues relating to existing work schedules, some problems have been addressed by amending personalised work schedules (for example in vascular surgery and ENT). In other areas of concern that have been flagged up by the exception reporting system (FY1s in orthopaedics, and those on the general surgery/vascular/urology rota) there does not appear to be enough slack in the system to allow more time off in lieu, and they remain an ongoing problem.

Medical HR are currently working with rotamasters, CDs and clinical leads to try to ensure compliant rotas for doctors starting in August. This process has been complicated by the change in rota management software from DRS4 to Allocate, which uses a different reference period and has made some previously compliant rotas non-compliant.

Summary

According to exception reporting data there is no significant problem with hours for FY1s in the medical division. This is in stark contrast to the surgical division which has problems with both the general/vascular/urology rota and with the day to day workload for some doctors, particularly in general surgery and T&O.

As core and higher trainees come onto the new contract in August, further hours related problems will potentially arise in the specialties with the most rota gaps and highest locum usage, so issues are likely to arise in ED and acute medicine, and also with the potentially tight rotas in O&G and anaesthetics.

In common with many other Trusts, we have a number of rota gaps which cannot be filled.

Questions for consideration

There are still a number of questions regarding staffing levels and hours at levels above FY1, about which we will gather more data as more doctors start to use the exception reporting system.

In terms of supervisors using the system I believe the board should recommend an increase in SPA time for those supervisors who engage to get towards recommended national or at least peer levels, but also reduce the allocation or remove the role altogether from those who do not engage.

In terms of my role, I do not intend to continue as Guardian of Safe Working Hours, and I believe urgent attention needs paying to the appointment of someone to offer an appropriate level of admin support (recommended 1 WTE), otherwise the role will remain very unattractive.

Tamsyn Grey

May 2017

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 6th July 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 May 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 - 6.7.17 Quality Committee - 3.7.17	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

May's Performance Score has fallen to 61% for the Trust. The SAFE domain remains GREEN although Harm Free Care and Pressure Ulcers have deteriorated. The RESPONSIVE domain remains Amber failing to meet the Emergency Care Standard and the 2 week wait target which was missed for the first time in over 12 months. CARING has deteriorated to RED due to a number of FFT targets being missed.

EPR has impacted on the provision of several indicators this month including 18 weeks admitted and non-admitted, VTE, coding and day case rates.

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 May 2017

Appendix

Attachment:

IPR -Board Report May 2017.pdf

Board Report

May 2017

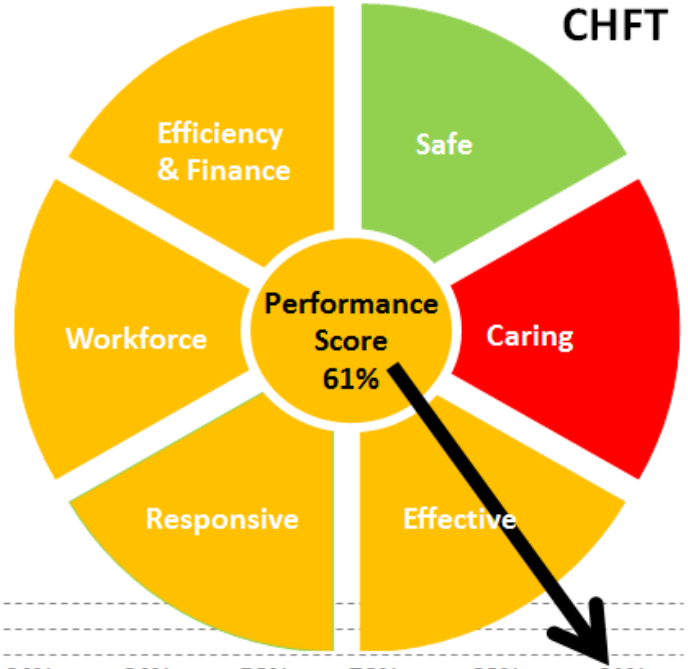
Performance Summary

May

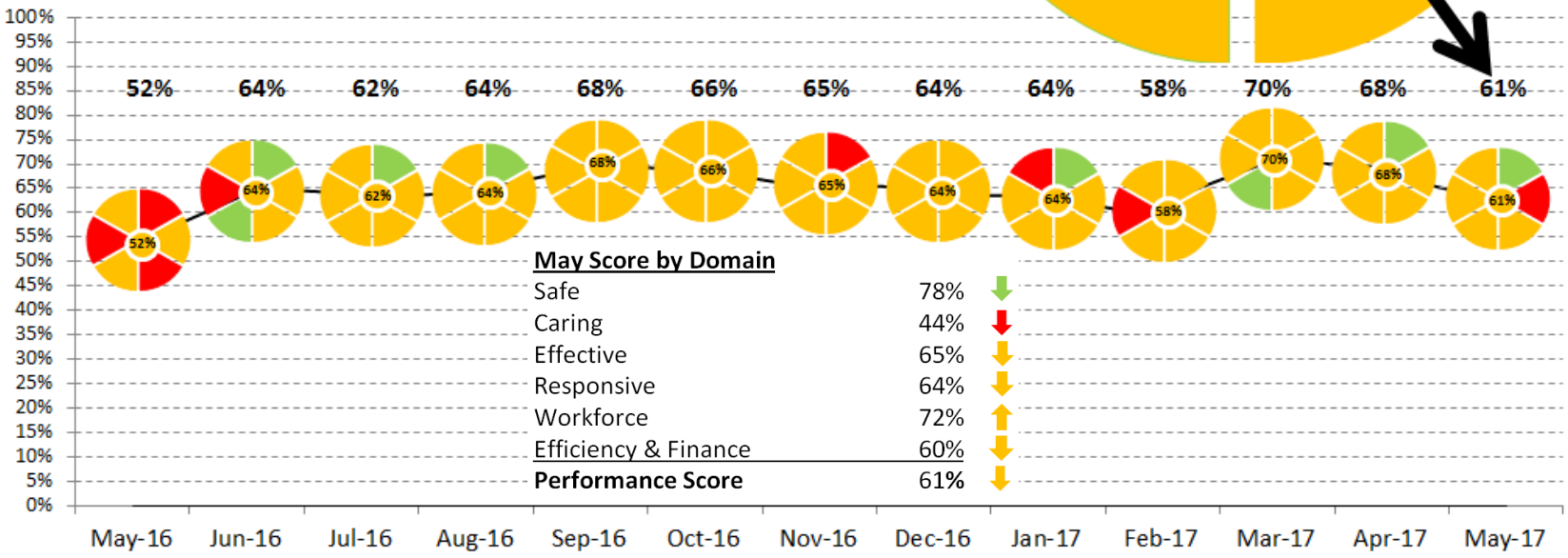
RAG Movement

May's Performance Score has fallen to 61% for the Trust. The SAFE domain remains GREEN although Harm Free Care and Pressure Ulcers have deteriorated. The RESPONSIVE domain remains Amber failing to meet the Emergency Care Standard and the 2 week wait target which was missed for the first time in over 12 months. CARING has deteriorated to RED due to a number of FFT targets being missed.

EPR has impacted on the provision of several indicators this month including 18 weeks admitted and non-admitted, VTE, coding and day case rates.



Total performance score



May Score by Domain

Safe	78%
Caring	44%
Effective	65%
Responsive	64%
Workforce	72%
Efficiency & Finance	60%
Performance Score	61%

SINGLE OVERSIGHT FRAMEWORK

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

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

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	98.3%	98.2%	↑	96.3%
	Inpatient Complaints per 1000 bed days	2.4	1.8	↑	TBC
EFFECTIVE	Average Length of Stay - Overall	4.41	5.12	↑	5.17
	Delayed Transfers of Care	2.70%	2.28%	↓	5%
	Green Cross Patients (Snapshot at month end)	119	114	↓	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	100.85	100.37	↓	100
	Theatre Utilisation (TT) - Trust	81.7%	84.9%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.93%	0.53%	↓	0.6%
	Emergency Care Standard 4 hours	85.11%	95.09%	↓	95%
	% Incomplete Pathways <18 Weeks	94.33%	94.97%	↓	92%
	62 Day GP Referral to Treatment	91.2%	84.3%	↑	85%
SAFE	% Harm Free Care	93.96%	94.51%	↓	95.0%
	Number of Outliers (Bed Days)	1048	334	↓	495
	Number of Serious Incidents	4	3	↓	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: Sickness Absence rate (%) achieved 3.6% in April (target 4%) with both long and short term sickness achieving target.

Improved: Friends & Family Test (IP and Maternity Survey) - % would recommend the Service - although FFT performance has struggled in some areas these 2 areas reached a peak in May at 98.3% and 98.6% respectively.

Improved: Falls per 1000 bed days was at its lowest position for 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.

MOST DETERIORATED

Deteriorated: Friends & Family Test - % Response Rate (Inpatients, Outpatients and A&E) and % Would Recommend the Service across Outpatients, A&E and Community.

Deteriorated: Two Week Wait From Referral to Date First Seen reduced to 84%. First time 93% target has been missed for over 12 months. Key issue for May was reduction in capacity due to last minute departure of agency locums due to IR35 and booking centre pressures post-EPR deployment.

Deteriorated: Emergency Care Standard 4 hours. Two areas of pressure, EPR deployment and Middle Grade doctor capacity. The former was a known risk at deployment but impact was greater than anticipated due to access issues, capacity management and high volumes of attendances. Middle Grade availability post IR35 has had a significant impact particularly overnight where availability and quality has been inconsistent.

ACTIONS

Action: Divisional action plans to be presented at June Performance Review meetings.

Action: Additional admin capacity invested into booking centre to support registration and management of backlogs. Additional capacity found to support some specialties however June continued to see pressures around capacity. Additional escalation process established and brought forward from 7 to 5 days. Deep dive being undertaken in July to ensure sustainable improvement actions are clear.

Action: Supported teams with additional staff both clinical and the EPR team. Prioritised some key changes with several elements eg Tap and Go still to be concluded. Tracking is a specific issue for AED Coordinators and developing a business case to implement admin tracking roles. Middle Grades: Several doctors have now moved to Trust contracts however still dependent on high cost agency staff. Reviewing business continuity arrangements.

Arrow direction count ↔ 1 ↑ 7 ↓ 11

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	8.0	7.9	↑	
Sickness Absence Rate	3.61%	3.71%	↑	4.0%
Turnover rate (%) (Rolling 12m)	12.00%	11.83%	↓	12.3%
Vacancy	393.09	434.53	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q2	82%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q2	64%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£2.17	-£0.66	🔴
Expenditure vs Plan var (£m)	£2.29	£0.74	🟢
Liquidity (Days)	-24.40	-27.28	🟢
I&E: Surplus / (Deficit) var - Control Total basis (£m)	£0.00	£0.03	🟢
CIP var (£m)	-£0.11	-£0.07	🔴
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	12.18%	13.71%	🟢

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care** - Performance has dipped slightly to 93.96% and remains below target. Harms in Falls, Ulcers and Catheter Associated UTIs were noted as contributing to this performance level. A deep dive review has now been completed and will be shared through divisional teams and improvement leads. • **Number of Category 4 Pressure Ulcers Acquired at CHFT** - there were 4 in April. Focused work with heightened awareness around moisture damage and categorisation of skin damage. ESR pressure ulcer module being undertaken by RN. Emphasis on improvement work for early assessment and accountability of individual RN is a contributing factor in the investigation findings.
Caring	• **Complaints closed within timeframe** - Of the 39 complaints closed in May 2017, 62% of these were closed within target timeframe. The number of overdue complaints was 26 at the end of May; which is a 36.3% increase from the end of April. This increase was to be expected with the introduction of EPR in the beginning of May, which has had a knock on effect on workload within the Divisions. The overall percentage for complaints closed within target timeframe last year (2016-17) was 45%. • **Friends & Family Test (IP Survey) - Response Rate** - EPR implementation has had an impact on most inpatient areas across the organisation especially those with a high turnover of patients. There is a new process for obtaining the patient stay number for the FFT postcards which is not fully embedded in practice currently. • **Friends and Family Test Outpatient - Response Rate** - EPR implementation has affected the process of sending text messages out to families. The texts sent out have reverted to the landline numbers rather than mobile numbers which has directly affected the potential numbers of families who are able to respond. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - There have been difficulties in appointments and outpatient clinics with the transition from PAS to EPR in the month of May. Additional staff have supported the OPD appointment service and the team have worked hard on the frontline to resolve isues as they have come to light. The Matron is overseeing the actions taken in each department to improve services and some practical improvements have occurred. • **Friends and Family Test A & E Survey - Response Rate** - dropped further to 4.8% in month. The ED team have reviewed this indicator and agreed an improvement plan for implementation in Quarter 1 and improved performance in quarter 2. The technical issue with texting also further compounded on performance. • **Friends and Family Test A & E Survey - % would recommend the Service** - at 75% reflecting a month where both departments were very busy with longer waits than normally experienced particularly for non-admitted patients who are the reported patients for this indicator. • **Friends and Family Test Community Survey** - Community FFT reported 88% would recommend the service against a 96% national average. The division is waiting for the new server that has been ordered to move to the new web form for collecting FFT data which will provide more accurate and helpful information about how services can be improved.
Effective	• **Number of MSSA Bacteraemias - Post 48 Hours** - 5 in month in Medicine. Analysis is being undertaken by the lead ICPN And Consultant microbiologist and findings will be discussed initially at infection control performance board and then disseminated to the Division through PSQB. • **Mortality Reviews** - The completion rate for Level 1 reviews reduced to 25.66% in March with 2016/17 at 40.06% compared to 2015/16 position which was 48.8%. From a screening mortality review point of view, the completion rate will continue to fall; a decision has been made to focus on the Structured Judgement (2nd level) reviews rather than the roll out of screening reviews to consultants. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge** - May's performance shows a deterioration following 3 good consecutive months. There were a number of spikes in Trauma activity and additional challenges with the introduction of EPR. Anaesthetic Trauma lead challenging Anaesthetic practices and sustained improvements in performance anticipated. • **Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG** - Has now missed target for last 3 months. Calderdale Community services continue to focus efforts on supporting people on discharge in order to prevent people being readmitted to hospital once discharged. The Virtual ward service contacts patients over 60 who have had an emergency medical admission and will provide advice, home visit and support where necessary. Community matrons and specialist matrons review any patient on their caseload that has been admitted or readmitted and review the reasons. A piece of work has been undertaken to fast track referrals by the community falls team if the matrons identify that their patients are at high risk of falling in order to reduce the risk of these patients being readmitted.

Background Context

The Electronic Patient Record (EPR) was deployed in May which required signifciant clinical, administrative and managerial input. Whilst deployment was good and staff were outstanding it has presented some challenges within the Trust, particularly in relation to productivity, capacity and the recording and reporting of data. The Trust continues to work through these issues alongside teams from Cymbio who were enlisted during go-live to assist with subsequent data quality issues.

Normal meeting arrangements were suspended with leaders and managers covering 24/7 to ensure staff were supported through deployment and Early Live Support. The Knowledge Portal was suspended and weekly reporting was unavailable for a period.

The Appointment team have had a challenging month, some data migration issues impacted on bookings and in parallel the staff had to learn the new system; this combination led to patients waiting longer to get through. These areas are continuing to improve through dedicated support and a temporary move away from Partial booking.

Flow was challenging in May as a result of continued high demand and the implementation of new systems with ward round productivity and TTO management a particular challenge. Staff were supported to ensure patients were safe and cared for, staff's own wellbeing was monitored and support given where required.

Issues affecting ECS performance have equally come from factors outside the Emergency Care directorate, including within the Medical Division, other divisions across the Trust and factors outside of the Trust in terms of peak bed days and green cross delays. In particular further nursing home closures have occured and for other homes direct CHFT support has been required. A review of the position is scheduled to be presented to July AED Delivery Board.

At CRH ward 8C has remained open throughout the month of May and at HRI ward 4 and the additional 6 beds on MAU have also remained open during this period to manage flow.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** was at 85.11% for May predomintely due to EPR deployment and Middle grade availability and quality, the latter being an ongoing risk to recovery and sustainability. • **Stroke -** % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival has reduced to 54.2% in month. 41% Stroke patients were scanned within 1 hour of hospital arrival (where indicated) against 48% target. • **% Last Minute Cancellations to Elective Surgery** increased to 0.93%, highest since May 2016. • **Two Week Wait From Referral to Date First Seen -** reduced to 84%. First time 93% target has been missed for over 12 months. Divisional action plans to be presented at June Performance Review meetings. • **38 Day Referral to Tertiary** - at 28.57% still well below the 85% target and below 42.4% achieved in 2015/16. • **Appointment Slot Issues on Choose & Book** increased to 33% in May. Action plans to be presented at divisional Performance Review meetings.
Workforce	• **Return to work Interviews** dropped significantly in month to 45.5%, worst position since June 2016.
Finance	• **Finance:** Reported year to date Deficit position in line with agreed control total of £6.14m, • Capital expenditure is below plan, • Cash position is in line with plan at £1.90m. • Delivery of CIP is behind the planned level at £1.31m against a planned level of £1.43m. • A Use of Resources score of level 3, in line with the plan. The Month 2 planned position is a deficit of £6.14m on a control total basis, including year to date Sustainability and Transformation funding (STF) of £1.01m. However, the financial position is extremely precarious with activity and income below the planned level. EPR implementation has had a significant short term impact on both productivity and the capture of activity data. Prior to any action being taken to assume either clawback of activity capture or overlay of other non-recurrent benefits, the month 2 position was a deficit of £10.8m, a £3.7m adverse variance to plan. **Month 2 prior to action: adverse variance to plan (£3.7m)** Add back: Assessment of missing activity data £2.6m Non-recurrent benefits £1.1m **Month 2 position to report: nil variance to plan £0.0m** Total reported agency spend in month was £1.14m; lower than the planned value of £1.62m and the NHS Improvement Agency Ceiling, however this value excludes agency expenditure capitalised as part of EPR implementation costs. The number of reported Agency Cap breaches was the highest for 12 months with a significant increase in the number of Nursing Price Cap breaches. The forecast continues to assume that the Trust will achieve its Control Total and secure the £10.1m STF allocation. However, the risk of failing to achieve our target deficit of £15.94m has increased and immediate action is required to stabilise the financial position.

Background Context

Vacancies remain a challenge across all disciplines and the IR35 impact has been particularly prevalent in Medical staffing.

The Community Division management team have been undertaking a number of service reviews to support the commissioners as they review services that predominantly provide support to prevent admissions or focus on early supported discharge. The team have been working with colleagues in Orthopaedics to prepare for the MSK Single point of access Go-Live which happened on 1st June.

The implementation of EPR in May has had a significant impact upon the capture and coding of both admitted and non-admitted activity. A large estimate has therefore been required to reflect the anticipated impact of inputting or correcting this backlog within the Cerner system. The reported clinical activity position in the Finance section is therefore after this adjustment has been made and capacity has been agreed to ensure this is all accurately input before freeze date. Commissioners are aware.

GP referrals were up 17.6% compared to May 2016 and this was linked to the reopening of the Electronic Referral Service (ERS) in May which saw 2 weeks of referrals in the first week of May as a result of the planned closure in April.

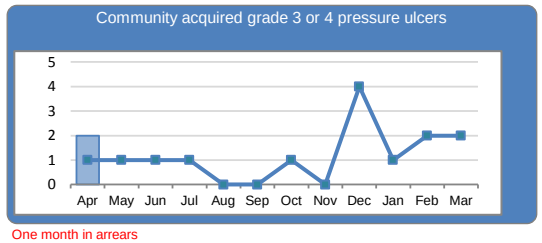
Safe, Effective, Caring, Responsive - Community Key messages

Area	Reality	Response	Result
Safe	Medication errors 2 medication errors occurred in May. One occurred in the IOC bed base where there was a delay in administration. The second was in the OPAT service resulting in a reduced dose on one occasion.	Medication errors We will continue to monitor medication errors. and utilise the skill and expertise of the pharmacist within the division. We will use the opportunities at team meetings and forums to share learning around medication errors and medication safety.	Medication errors We aim to have 0 medication errors as a result of any action by community staff within community services. By when: Review September 2017 Accountable: ADN
Effective	Patients readmitted after discharge into intermediate tier services 6 patients were readmitted to the acute bed base whilst they were in receipt of reablement or Crisis intervention team. 5 related to unstable medical conditions requiring urgent medical attention and 1 related to gait and mobility issues causing the individual to be unsafe mobilising.	Patients readmitted after discharge into intermediate tier services This is a new measure that requires us to review the condition of patients beings supported within intermediate tier services so that we can ensure we have the appropriate skills to manage the acuity and have the appropriate escalation processes if patients deteriorate.	Patients readmitted after discharge into intermediate tier services Patients will be safely discharged in a timely manner into intermediate care and will be maintained in a community setting. By when : September 2017 Accountable: ADN
Caring	Friends and Family Test Community services receive excellent feedback from patients and relatives, however our FFT responses are consistently poor with 87% responses indicating that they would recommend. We have undertaken a review of these and discovered that the majority of text and answerphone responses do not relate to community services but other services either acute or primary care. We are therefore moving to a web based system from June 2017.	Friends and Family Test The division have agreed to fund a new server to support the web based system however there was a delay in the planned installation in May and now awaiting a revised date from the web team. Web forms are ready to be used and we have agreed that staff will ask patients on a certain day each week to feedback via the web based form	Friends and Family Test A more accurate feedback mechanism will be in place enabling us to accurately report FFT and to understand where we need to focus improvements. By when: June 2017 Accountable: Head of Therapies
Responsiveness	Physiotherapy waiting times Physiotherapy vacancies have meant that demand has outstripped capacity in this service and waiting times have grown in recent months. The waiting time now stands at 15 weeks for a first appointment which we recognise as being unacceptable.	Physiotherapy waiting times The physiotherapy team have introduced a telephone first appointment to enable an assessment to be made as to whether a face to face appointment is required with the therapist. Groups have been redesigned to make better use of the band 3 workforce thus freeing up qualified therapists to focus on assessment and care planning. A request has been made for additional physiotherapy agency staff to support reduction of the backlog for a set period through the summer.	Physiotherapy waiting times Physiotherapy waiting times to return to an acceptable performance level of 6 weeks. By when: September 2017 Accountable: Head of Therapies

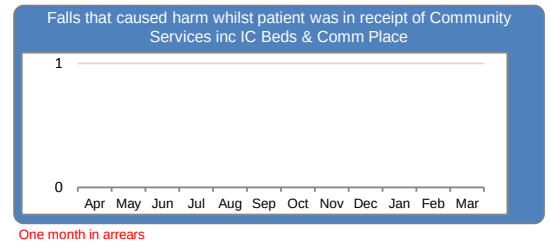
Dashboard - Community

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

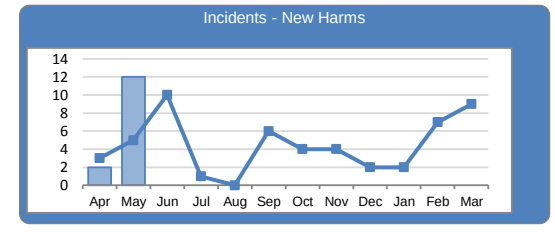
Safe

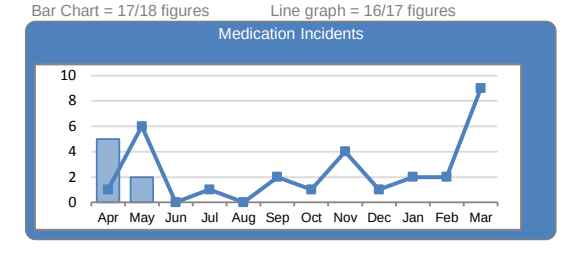


One month in arrears

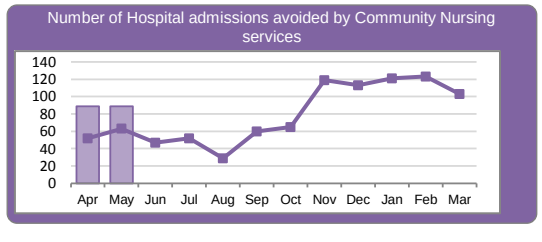


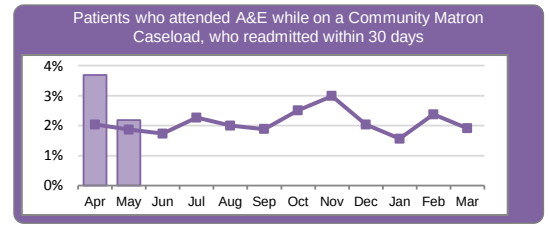
One month in arrears

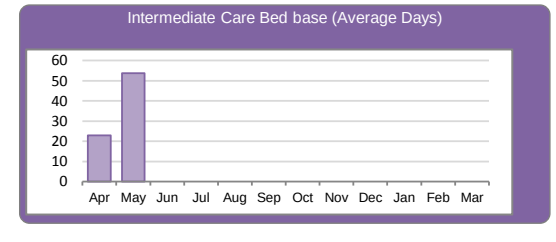


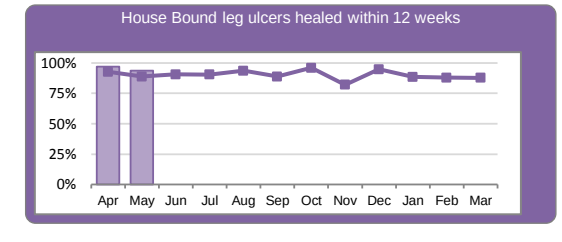


Effective

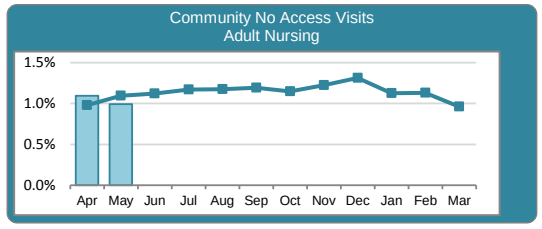


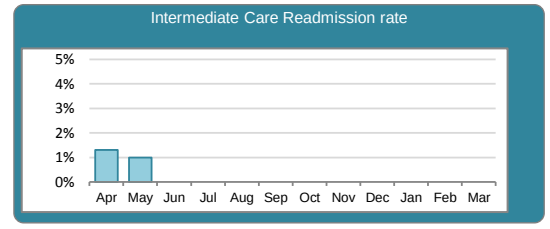


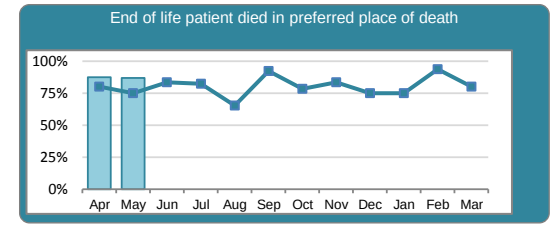


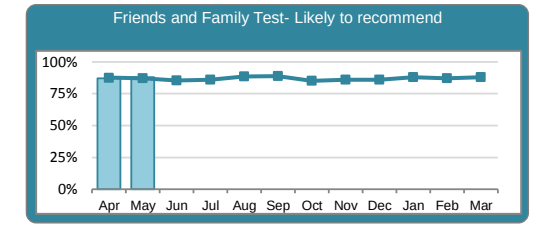


Caring

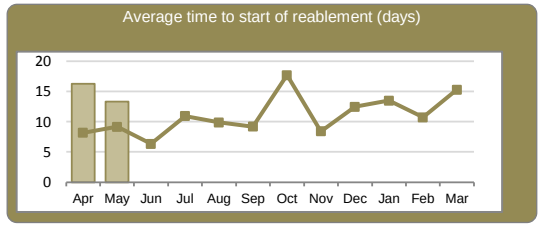


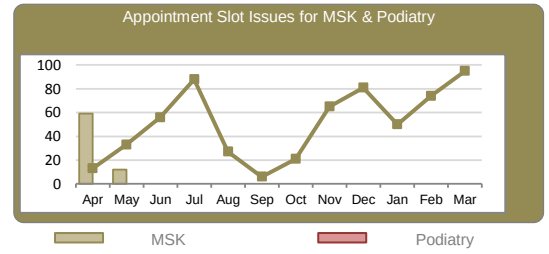


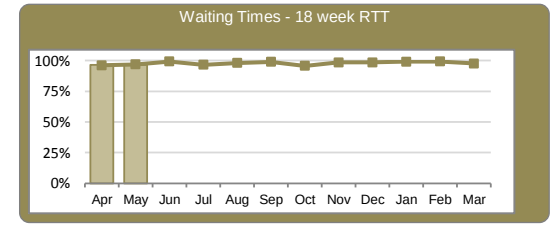


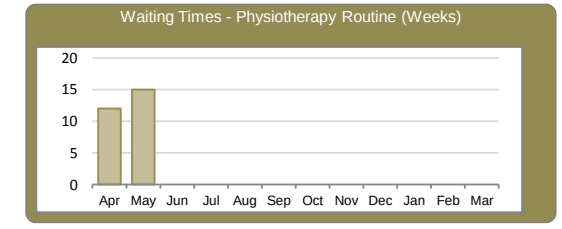


Responsive

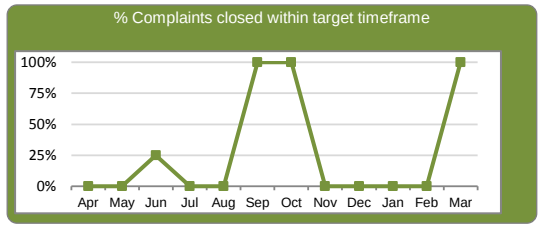


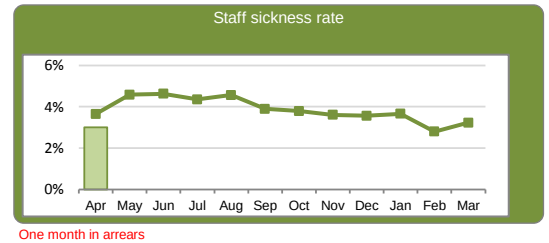




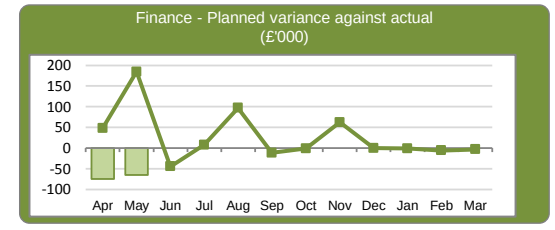


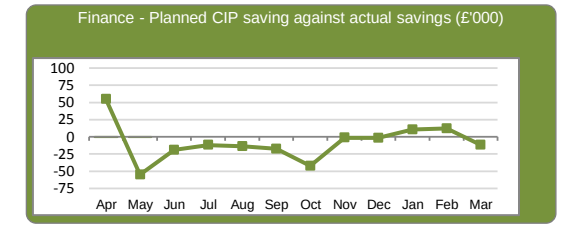
Well Led



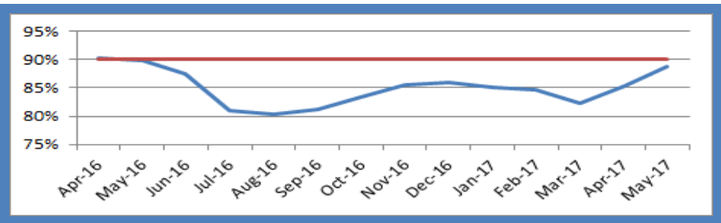
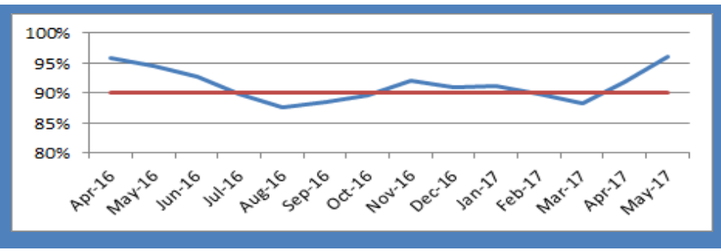
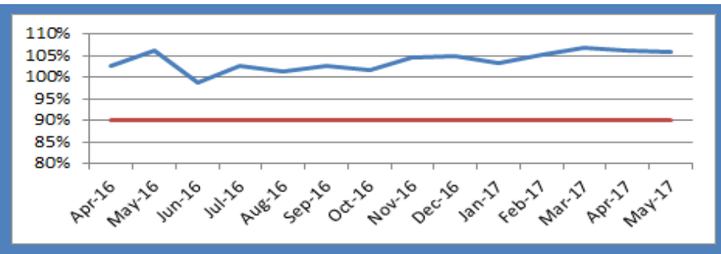
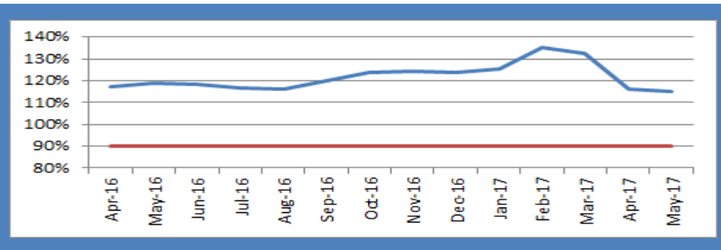


One month in arrears





Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	88.82% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% -WARD 5AD : 70.3% -WARD 17 : 68.1%
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	95.96% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% -WARD 3ABCD : 64.4% -WARD 18 : 12.0%
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	105.91 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at day <75% -WARD 17 : 66.7% -WARD 8AB : 65.9% - WARD 15 : 66.7%
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	115.04 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% -WARD NICU : 64.5%

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT					
		Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual		
CRH MAU	GENERAL MEDICINE	2376	2266.1	1539	1639	95.4%	106.5%	1364	1531	1023	874.5	112.2%	85.5%
HRI MAU	GENERAL MEDICINE	2743.5	2548.5	1674	2207.3	92.9%	131.9%	1364	1669	1023	1452	122.4%	141.9%
WARD 2AB	GENERAL MEDICINE	1906.5	1697.8	1209	1492.5	89.1%	123.4%	1364	1452	682	748	106.5%	109.7%
HRI Ward 5 (previously ward 4)	GERIATRIC MEDICINE	1674	1582	1209	1608.5	94.5%	133.0%	1023	1100	1023	1364	107.5%	133.3%
HRI Ward 11 (previously Ward 5)	CARDIOLOGY	2083.5	1918	1014	1027.9	92.1%	101.4%	1364	1327	682	649	97.3%	95.2%
WARD 5AD	GERIATRIC MEDICINE	2139	1503.5	1581	2135.5	70.3%	135.1%	1364	1320	1364	1381	96.8%	101.2%
WARD 5C	GENERAL MEDICINE	1069.5	1043	837	864.5	97.5%	103.3%	682	693	341	462	101.6%	135.5%
WARD 6	GENERAL MEDICINE	1674	1607	1209	1089.5	96.0%	90.1%	1023	1012	682	682	98.9%	100.0%
WARD 6BC	GENERAL MEDICINE	1674	1770.5	1209	1272.5	105.8%	105.3%	1364	1386	682	704	101.6%	103.2%
WARD 5B	GENERAL MEDICINE	1209	945	744	1283.5	78.2%	172.5%	682	693	682	836	101.6%	122.6%
WARD 6A	GENERAL MEDICINE	976.5	878.5	976.5	749	90.0%	76.7%	682	682	341	495	100.0%	145.2%
WARD 8C	GENERAL MEDICINE	1069.5	845.5	976.5	1153	79.1%	118.1%	682	683	341	403	100.1%	118.2%
WARD CCU	GENERAL MEDICINE	1674	1473.5	372	340	88.0%	91.4%	1023	1052	0	24	102.8%	-
WARD 6D	GENERAL MEDICINE	1674	1439.9	837	863.5	86.0%	103.2%	1023	1313	682	781	128.3%	114.5%
WARD 7AD	GENERAL MEDICINE	1674	1468	1581	1757.3	87.7%	111.2%	1023	1100	1023	1056	107.5%	103.2%
WARD 7BC	GENERAL MEDICINE	1674	1576	1581	1572	94.1%	99.4%	1023	1100	1023	979	107.5%	95.7%
WARD 8	GERIATRIC MEDICINE	1441.5	1286	1209	2059	89.2%	170.3%	1023	913	1023	1573	89.2%	153.8%
WARD 12	MEDICAL ONCOLOGY	1674	1319	837	765	78.8%	91.4%	1023	858	341	627	83.9%	183.9%
WARD 17	GASTROENTEROLOGY	2046	1393.88	1209	1072.5	68.1%	88.7%	1023	682	682	682	66.7%	100.0%
WARD 21	REHABILITATION	1209	1079.5	976.5	1194.5	89.3%	122.3%	682	737	682	694	108.1%	101.8%
ICU	CRITICAL CARE	3900	3519.45	795	663.5	90.2%	83.5%	3921.5	3449	0	0	88.0%	-
WARD 3	GENERAL SURGERY	945.5	1086	761.5	818	114.9%	107.4%	713	713	356.5	356.5	100.0%	100.0%
WARD 8AB	TRAUMA & ORTHOPAEDICS	1068	893	964	764.5	83.6%	79.3%	977.5	644.5	264.5	437	65.9%	165.2%
WARD 8D	ENT	821.5	814.5	821.5	719.5	99.1%	87.6%	713	552	0	172.5	77.4%	-
WARD 10	GENERAL SURGERY	1302	1296	589	759.5	99.5%	128.9%	1069.5	861	356.5	713	80.5%	200.0%
WARD 15	GENERAL SURGERY	1566	1429.5	1083.5	1097	91.3%	101.2%	1069.5	713	356.5	1058	66.7%	296.8%
WARD 19	TRAUMA & ORTHOPAEDICS	1751.5	1423	1286.5	1444.5	81.2%	112.3%	1069.5	1035	1069.5	1115.5	96.8%	104.3%
WARD 20	TRAUMA & ORTHOPAEDICS	1999.5	1572.5	1410.5	1461	78.6%	103.6%	1069.5	1012	1069.5	1069.4	94.6%	100.0%
WARD 22	UROLOGY	1178	1115	1178	1117.5	94.7%	94.9%	713	713	713	713	100.0%	100.0%
SAU HRI	GENERAL SURGERY	1891	1658.5	977.5	914	87.7%	93.5%	1426	1368.5	356.5	379.5	96.0%	106.5%
WARD LDRP	OBSTETRICS	4278	3794.1	945.5	731	88.7%	77.3%	4278	3862	713	667	90.3%	93.5%
WARD NICU	PAEDIATRICS	2247.5	1950.5	930	713.5	86.8%	76.7%	2139	1943.5	713	460	90.9%	64.5%
WARD 1D	OBSTETRICS	1242	1242.5	356.5	360	100.0%	101.0%	713	713	356.5	343.5	100.0%	96.4%
WARD 3ABCD	PAEDIATRICS	3140.5	2604	1208	777.5	82.9%	64.4%	2495.5	2444	356.5	341.8	97.9%	95.9%
WARD 4C	GYNAECOLOGY	713	713	465	405.5	100.0%	87.2%	713	735.5	356.5	356.5	103.2%	100.0%
WARD 9	OBSTETRICS	1069.5	966	356.5	328	90.3%	92.0%	713	713	356.5	310.5	100.0%	87.1%
WARD 18	PAEDIATRICS	793.5	741	138	16.5	93.4%	12.0%	713	701.5	0	23	98.4%	-
Trust		**63568.5**	**56459.73**	**37047**	**39237.5**	**88.82%**	**105.91%**	**45307.5**	**43476.5**	**21716.5**	**24983.2**	**95.96%**	**115.04%**

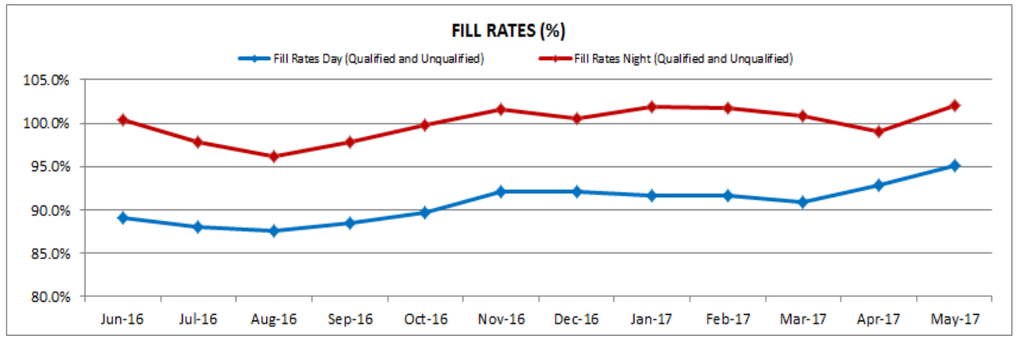
Hard Truths: Safe Staffing Levels

Care Hours per Patient Day

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

	Mar-17	Apr-17	May-17
Fill Rates Day (Qualified and Unqualified)	90.90%	92.80%	95.10%
Fill Rates Night (Qualified and Unqualified)	100.90%	99.10%	102.10%

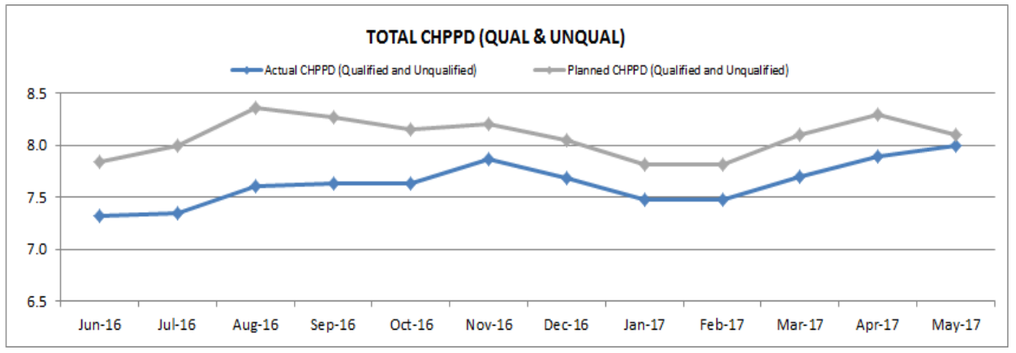
Planned CHPPD (Qualified and Unqualified)	8.1	8.3	8.1
Actual CHPPD (Qualified and Unqualified)	7.7	7.9	8



A review of May 2017 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 22 clinical areas of the 37 reviewed having CHPPD less than planned.

2 areas reported CHPPD as planned. 13 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.



Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 6th July 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: Financial Commentary for NHS Improvement - Month 2 - Attached commentary was submitted to NHS Improvement on 15th June 2017 alongside the Month 2 Financial Monthly Monitoring return.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance & Performance Committee	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

For Information (See attached)

Main Body

Purpose:

See attached

Background/Overview:

See attached

The Issue:

See attached

Next Steps:

See attached

Recommendations:

To Note.

Appendix

Attachment:

NHSI Financial Commentary Month 2 Final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 2 MAY 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 May 2017.

The report is structured into three sections to describe:

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

1. Key Messages

The Month 2 planned position is a deficit of £6.14m on a control total basis, including year to date Sustainability and Transformation funding (STF) of £1.01m.

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 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%.

At month 2 the Trust is able to report delivery of the financial plan but there are a number of assumptions with material value that are being made within this. These assumptions relate to clinical activity capture and coding in the Trust's new EPR system and therefore income recovery. Securing the reported income relies on a significant number of detailed actions being undertaken.

In addition the year to date position is reliant upon a number of non-recurrent income and expenditure benefits which cannot be replicated going forwards. Thus, in order to continue to forecast delivery of the financial plan, recovery actions are required.

Month 2, May 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	61.22	59.05	(2.17)
Expenditure	(63.29)	(61.01)	2.28
EBITDA	**(2.08)**	**(1.96)**	**0.12**
Non-operating items	(4.05)	(4.20)	(0.15)
Surplus / (Deficit)	**(6.12)**	**(6.16)**	**(0.03)**
Less: Items excluded from Control Total	(0.02)	0.02	0.03
Surplus / (Deficit) Control Total basis	**(6.14)**	**(6.14)**	**(0.00)**

- Delivery of CIP of £1.31m against the planned level of £1.43m.
- Contingency reserves of £0.66m have been released against pressures.
- Capital expenditure of £3.08m, this is below the planned level of £3.66m.
- Cash balance of £1.90m as planned.
- 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 £2.17m below plan year to date.

NHS Clinical Income

The year to date clinical income position is £49.44m, £1.96m below the planned level.

The Clinical Contract income position for Month 2 based upon activity coded and captured within EPR is £3.9m below plan. There are 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. There are also a large number of uncoded spells for which an estimate has had to be made as to the expected price of that activity. Following discussions with external experts from Cymbio, the Trust's own Health Informatics and Divisional teams, £1.7m of income has been calculated as an estimate of the value of this missing data. The receipt of this income will be reliant on the activity being added or corrected within EPR and an action plan is in place to address a list of issues with this aim.

A further £0.9m of Clinical contract income has been assumed on the basis that EPR implementation has resulted in temporary decrease in the depth of coding and capture of co-morbidities, impacting across both Emergency Long Stay and A&E income, a reduction in the capture of Best Practice Tariff activity and a resulting impact on the Emergency Threshold. Securing this income will require further action and again plans are being put in place to address this both retrospectively and going forwards as a high priority.

Following these adjustments, clinical income is still below plan and this appears to be driven by both case mix and activity volumes following implementation of EPR. Further work is being undertaken to identify the impact of HRG4+

The Trust awaits further guidance from NHSI on the mechanisms under which STF will operate in 2017/18, particularly in relation to the operational performance elements, in the meantime, the reported position assumes full receipt of STF funding including the 30% linked to A&E performance targets. Performance in the year to date is 89.9% of patients seen within the 4 hour target. This is beneath the trajectory submitted to NHSI and is directly as a result of the EPR implementation. Performance in May dipped to 85.1% but has recovered significantly in June which will support the overall quarter 1 performance. It is assumed that NHSI will recognise the exceptional nature of the impact of EPR upon A&E performance in May against the backdrop of the Trust's underlying strong A&E performance in 2016/17. Receipt of full STF monies are assumed within the year to date and forecast position.

Other income

Overall other income is below plan by £0.20m year to date. This variance was primarily due to slippage in recovery of the Apprentice Levy compared to plan and a reduction in Post Graduate Medical Education funding.

Operating expenditure

There is a cumulative £2.28m favourable variance from plan within operating expenditure across the following areas:

Pay costs	£1.06m favourable variance
Drugs costs	£0.23m favourable variance
Clinical supply and other costs	£0.99m favourable variance

Achieving the control total for Month 2 has relied on the release of one third (£0.67m) of our total Contingency Reserve and a non-recurrent benefit of £0.57m relating to prior year creditors. This is in addition to £0.36m of prior year benefits released within the year to date position and £0.2m non-recurrent income received in Month 1. The total of non-recurrent benefits in the year to date position is £1.14m.

Employee benefits expenses (Pay costs)

Pay costs are £1.06m lower than the planned level in the year to date, primarily due to the release of Contingency Reserves. The Trust has seen a reduction in Agency costs, 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 comfortably achieved the agency ceiling of £3.45m year to date, with total Agency expenditure of £2.50m.

Drug costs

Expenditure year to date on drugs is £0.23m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £0.47m below plan. Underlying drug budgets are therefore overspent by £0.24m, largely due to additional activity in the Pharmacy Manufacturing Unit which is a commercial operation.

Clinical supply and other costs

Clinical Support costs are £0.99m lower than planned. This underspend reflects some activity related underspend in clinical supplies, as well some non-recurrent benefits as described above.

Non-operating Items and Restructuring Costs

Non-operating expenditure is £0.15m above plan in the year to date. This variance is the result of higher than planned Depreciation of £1.13m 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.

£1.31m of CIP has been delivered this year against a plan of £1.42m, an under performance of £0.11m, but the Trust continues to push hard for full delivery of the £20m target and the forecast reflects this.

£5.9m of the full year CIP target is currently unidentified and as such presents a risk to the control total as was anticipated to be the case at the planning stage. In recognition of the scale of the challenge NHSI visited the Trust in June 2017 to review the programme and governance processes. The feedback received on the day was very positive in terms of the Trust's approach to CIP identification and planning and the strong governance processes in place. Further feedback is awaited and will be welcomed by the Trust on additional ideas and successful examples of change from other organisations to add to the Trust's current CIP portfolio. The Trust continues to forecast delivery of the full £20m despite the risk of this challenge.

Statement of Financial Position and Cash Flow

At the end of May 2017 the Trust had a cash balance of £1.90m as planned.

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 items excluded from Control Total	(0.03)
	Non cash flows in operating deficit	0.20
	Other working capital movements	(0.86)
	Sub Total	**(0.69)**
Investing activities	Capital expenditure	0.58
	Movement in capital creditors / Other	0.09
	Sub Total	**0.67**
Financing activities	Drawdown of external DoH cash support	(0.03)
	Other financing activities	0.01
	Sub Total	**(0.02)**
	Grand Total	**(0.05)**

Operating activities

Operating activities show an adverse £0.69m variance against the plan. The adverse cash impact of £0.86m working capital variances is offset by the cash benefit of higher than planned Depreciation charges. The working capital variance reflects an increase in receivables, particularly NHS receivables, which has been partially offset by a reduction in the payments due to suppliers in order to manage the month end position.

Investing activities (Capital)

Capital expenditure year to date is £0.58m lower than planned and the resulting cash benefit has offset the pressure on working capital described above. Capital creditors remain at a much higher level than is usual for the organisation, with the majority relating to EPR. As described in the plan commentary, cash

support over and above the level of the planned deficit will be required to facilitate settling of these liabilities over the next few months.

Financing activities

£1m of Capital loan funding was received in Month 2 as planned, part of a total of £8m Capital loan funding that has been approved to support EPR expenditure. The Trust received £9.74m of Revenue Support as planned, linked to deficit funding requirements and the delayed Quarter 4 Sustainability and Transformation funding.

3. Use of Resources (UOR) rating and forecast

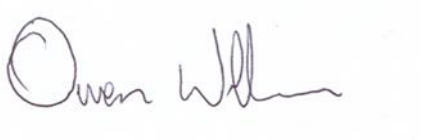
Against the UOR the Trust stands at level 3 in line with plan in year to date and forecast terms.

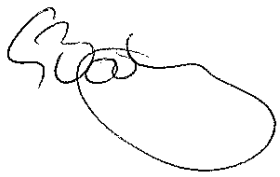
The forecast continues to assume that the Trust will achieve its Control Total and secure the £10.1m STF allocation. However, the risk of failing to achieve our target deficit of £15.94m which was high from the outset, has now increased and immediate action is required to stabilise the financial position.

The forecast assumes:

- That the Trust is able to recover the £2.6m of estimated income in the year to date position.
- That EPR data capture issues are resolved quickly and that clinical activity returns to the planned level from Month 3 or income is recovered by the year end.
- Full achievement of the £20m Cost Improvement programme including the £5.9m currently unidentified.
- Divisional recovery plans can be put in place to maintain the position in line with control total from month 3 to month 12.
- Full achievement of CQUIN targets.
- Securing STF income in full for both the finance (70%) and A&E performance (30%) elements of the target.
- That any further costs relating to EPR implementation, including those to address data capture and booking issues, can be either capitalised or offset by additional savings.
- That a programme of additional budgetary grip and control is implemented with immediate effect.

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





Owen Williams
Chief Executive

Gary Boothby
Executive Director of Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Tracy Rushworth, PA to Director of Workforce and OD
Date: Thursday, 6th July 2017	**Sponsoring Director:** Ian Warren, Executive Director of Workforce and OD
Title and brief summary: 2016 Staff Survey Response - This paper describes the approach to responding to the colleague feedback provided through the 2016 staff survey.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Workforce (Well Led) Committee 8 June 2017	
Governance Requirements: See attached paper	
Sustainability Implications: None	

Executive Summary

Summary:

See attached paper

Main Body

Purpose:

See attached paper

Background/Overview:

See attached paper

The Issue:

See attached paper

Next Steps:

See attached paper

Recommendations:

The Board is asked to approve the content of the response and support the approach.

Appendix

Attachment:

2016 Staff Survey Response - BoD 8 July 2017.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

8 JULY 2017

2016 STAFF SURVEY RESPONSE

1. PURPOSE

This paper describes the approach to responding to the colleague feedback provided through the 2016 staff survey.

2. INTRODUCTION

The Trust participated in the 2016 national staff survey from October to December 2016. From a sample of 1250 colleagues the Trust's survey participation rate was 45%, above average for acute trusts.

When compared to the 2015 survey feedback scores from the 2016 survey have improved in 18 areas, remained the same in 6 areas and deteriorated in 8 areas when compared to performance in other acute Trusts. The actual survey scores have seen 'no change' from the 2015 survey except in relation to 'percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves' which has improved compared to performance in other acute Trusts.

A brief synopsis of results compared to other acute trusts in the last three years is set out below:-

	2014	2015	2016
Best 20%	5	3	2
Better than average	6	5	6
Average	10	6	10
Worse than average	6	8	10
Worst 20%	2	10	4

The Trust's summary report detailing its survey results is available at Appendix A.

3. ACTION PLANNING

The proposed approach to effectively responding to the feedback is to produce an outcome/output/activity (input) statement that identifies a limited number of core themes to focus on ahead of the 2017 staff survey. The response statement is at Appendix B. The themes are consistent with those set out in the 2015 staff survey action plan. The core themes for inclusion in the statement are as follows:-

- Engagement
- Health and wellbeing
- Learning and development

- Reward and recognition
- Workforce race equality

Staff survey Key Factor (KF) indicators have been identified for each core theme and are to be used to measure the impact of the response.

The overall outcome from activity associated with improving the staff experience through this response is the delivery of compassionate care to our patients.

Progress will be monitored through the Workforce (Well Led) Committee with quarterly reports provided to the Board of Directors.

4. RECOMMENDATION

The Board is asked to approve the content of the response and support the approach.

Ian Warren
Executive Director of Workforce and OD

July 2017

Appendix A

2016 National NHS staff survey

Brief summary of results from Calderdale and Huddersfield NHS Foundation Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2016 national NHS staff survey conducted in Calderdale and Huddersfield NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2016 survey results for Calderdale and Huddersfield NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

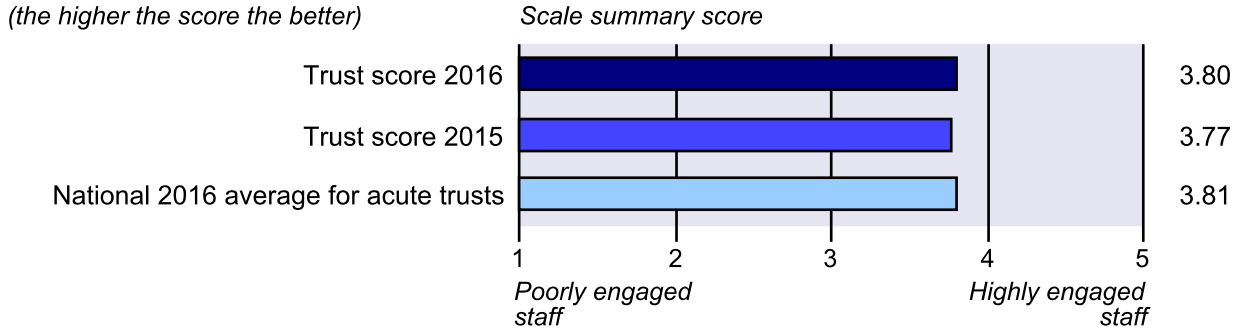
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	77%	76%	75%
Q21b	"My organisation acts on concerns raised by patients / service users"	74%	74%	68%
Q21c	"I would recommend my organisation as a place to work"	59%	62%	54%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	68%	70%	67%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.72	3.77	3.64

2. Overall indicator of staff engagement for Calderdale and Huddersfield NHS Foundation Trust

The figure below shows how Calderdale and Huddersfield NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.80 was average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how Calderdale and Huddersfield NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2015 survey.

	Change since 2015 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	• Average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	! Below (worse than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Above (better than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	✓ Highest (best) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

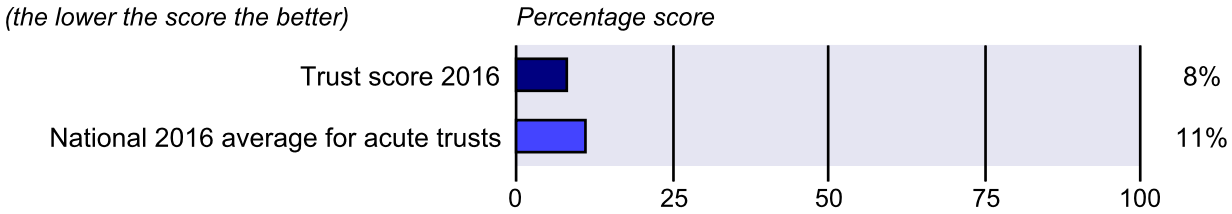
3. Summary of 2016 Key Findings for Calderdale and Huddersfield NHS Foundation Trust

3.1 Top and Bottom Ranking Scores

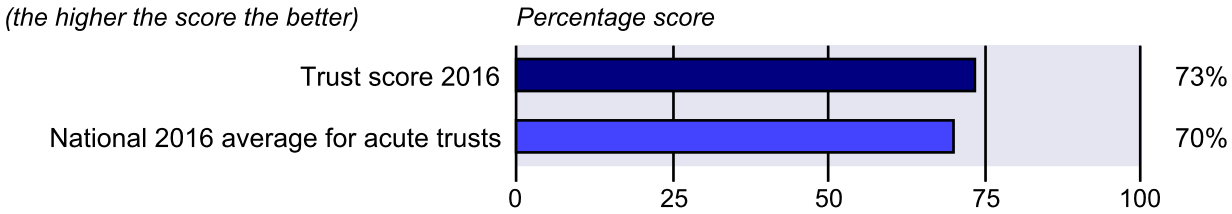
This page highlights the five Key Findings for which Calderdale and Huddersfield NHS Foundation Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

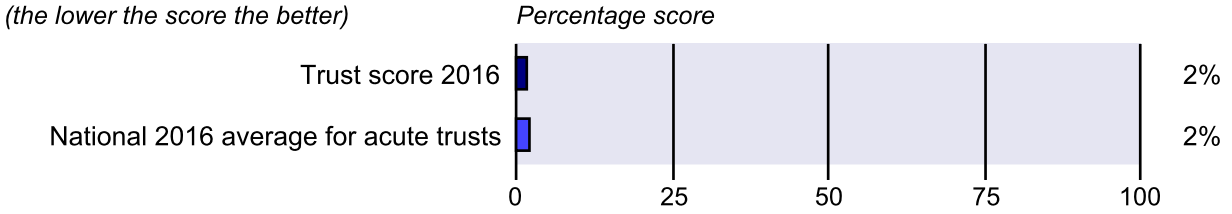
✓KF20. Percentage of staff experiencing discrimination at work in the last 12 months



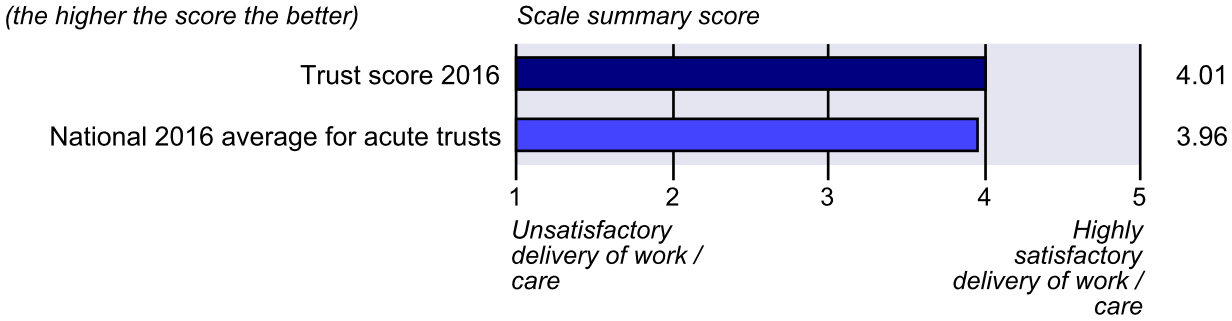
✓KF7. Percentage of staff able to contribute towards improvements at work



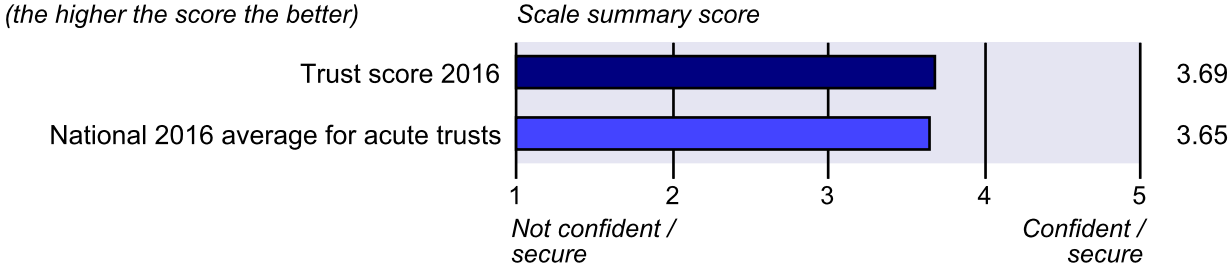
✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months



✓KF2. Staff satisfaction with the quality of work and care they are able to deliver



✓KF31. Staff confidence and security in reporting unsafe clinical practice



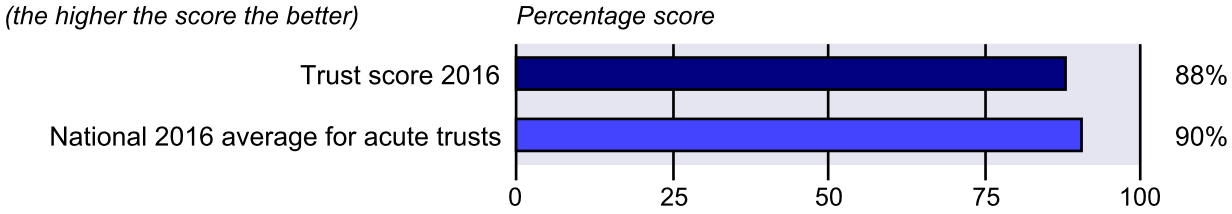
For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 98 (the bottom ranking score). Calderdale and Huddersfield NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which Calderdale and Huddersfield NHS Foundation Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

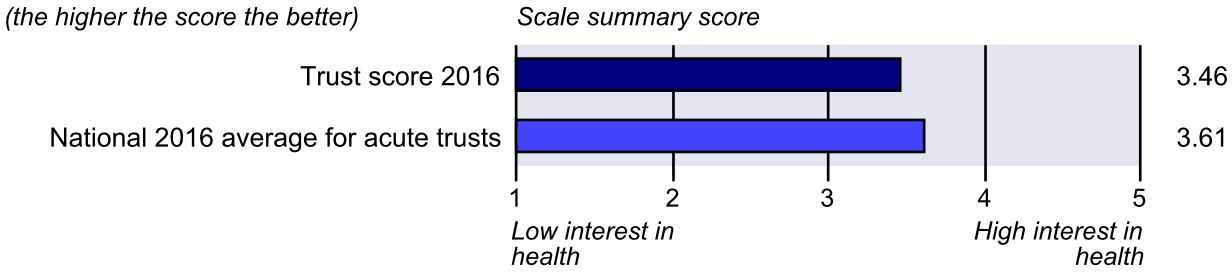
! KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



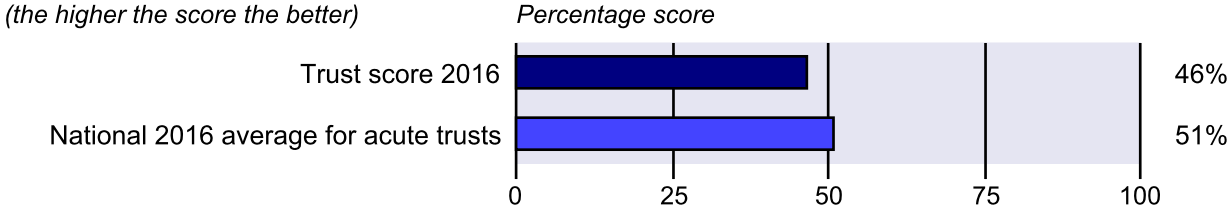
! KF19. Organisation and management interest in and action on health and wellbeing

(the higher the score the better)



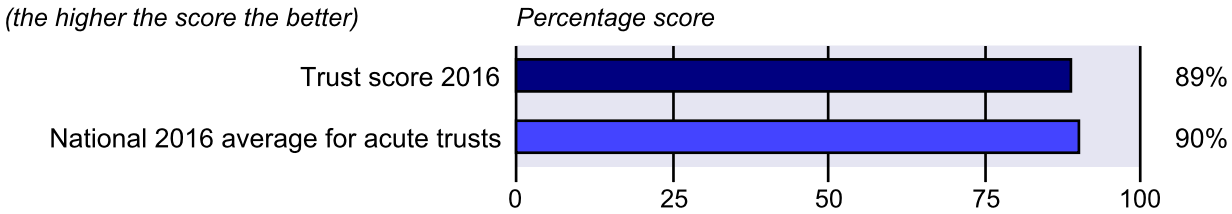
! KF15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



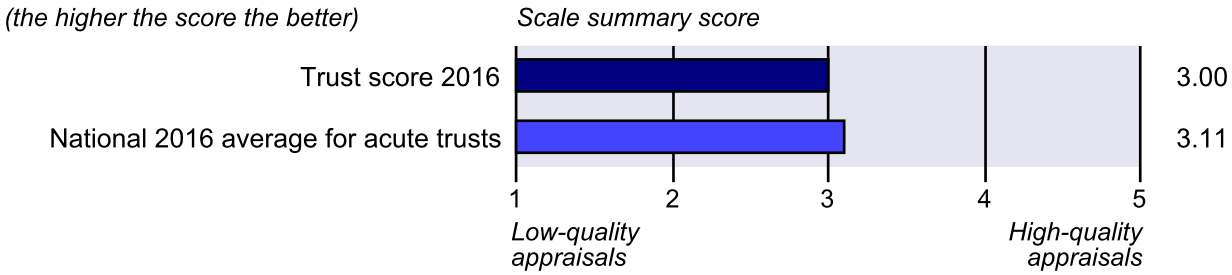
! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



! KF12. Quality of appraisals

(the higher the score the better)



For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 98 (the bottom ranking score). Calderdale and Huddersfield NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 98. Further details about this can be found in the document ***Making sense of your staff survey data***.

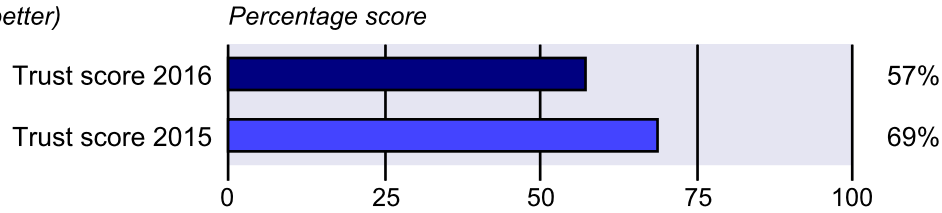
3.2 Largest Local Changes since the 2015 Survey

This page highlights the Key Finding that has improved at Calderdale and Huddersfield NHS Foundation Trust since the 2015 survey.

WHERE STAFF EXPERIENCE HAS IMPROVED

✓KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have improved the most. Rather, the extent of 2015-2016 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.2. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust

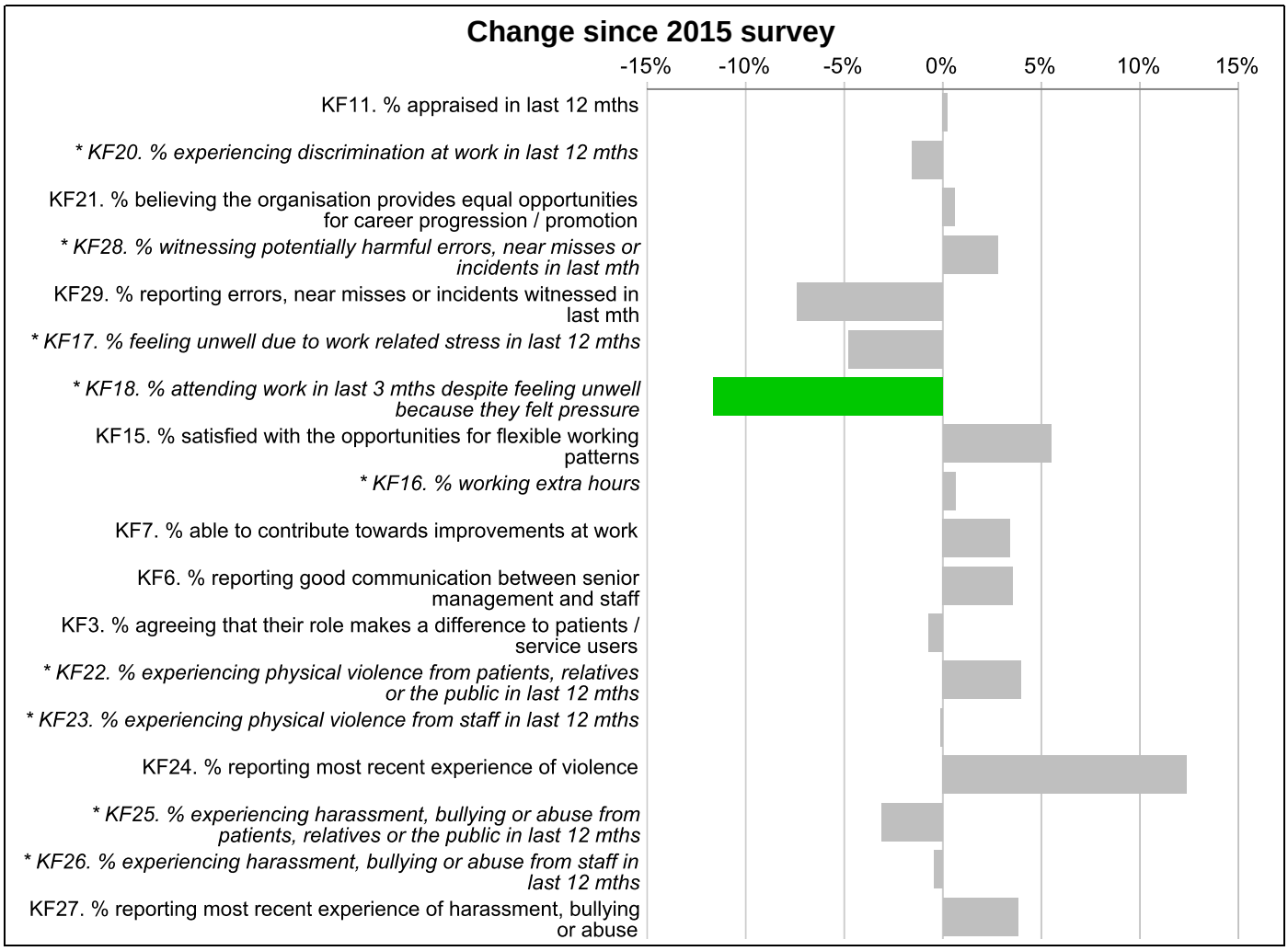
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2015 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2015 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust

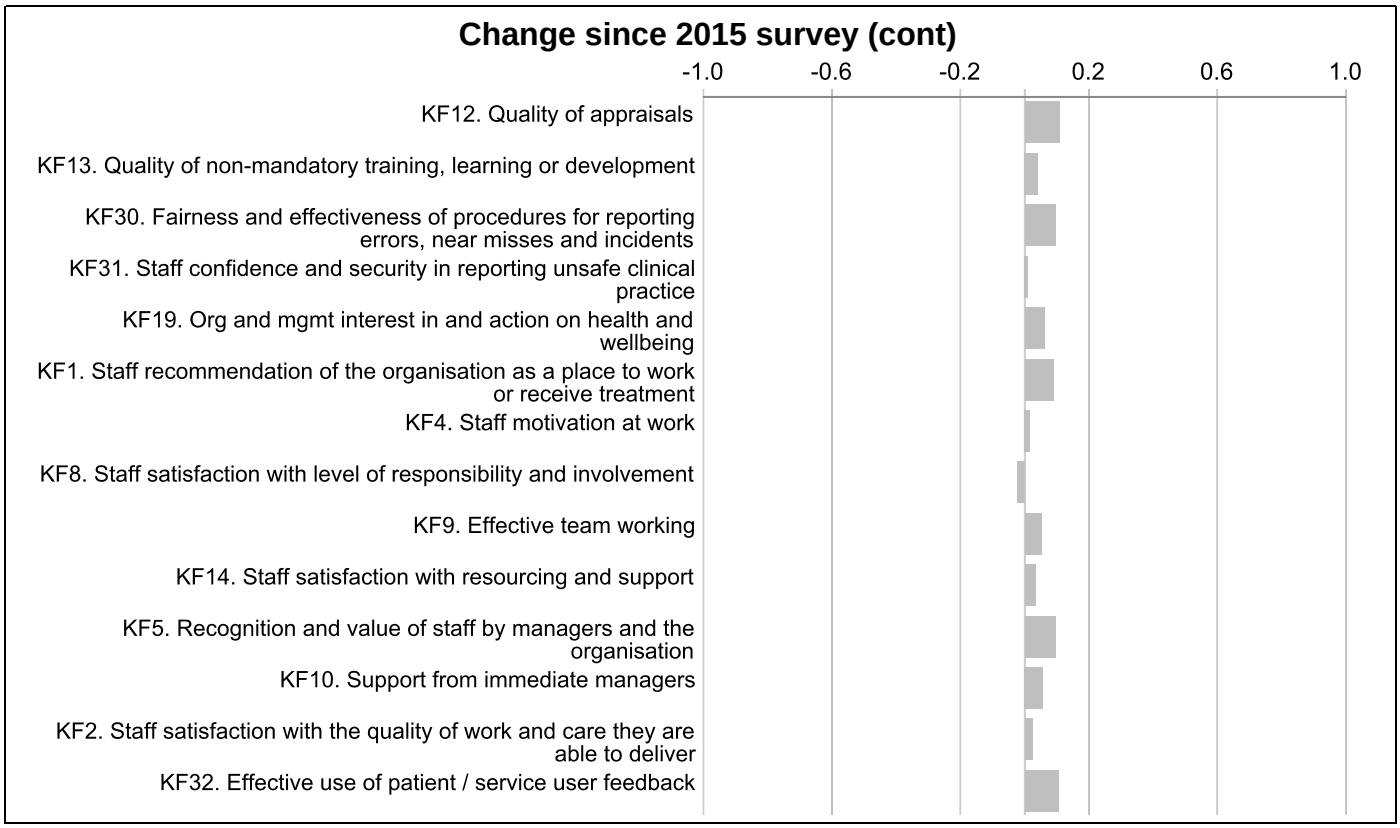
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2015 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2015 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust

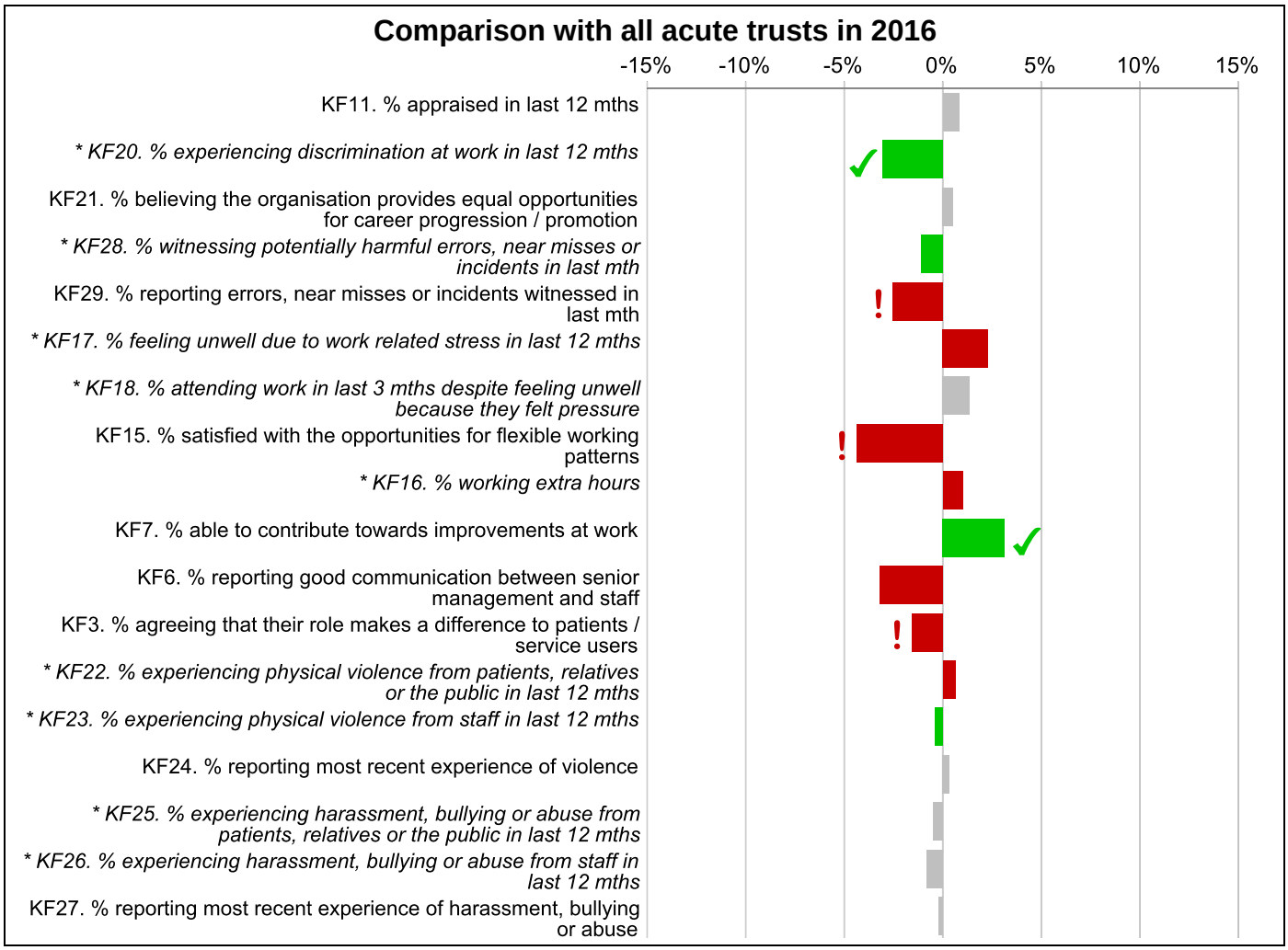
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust

KEY

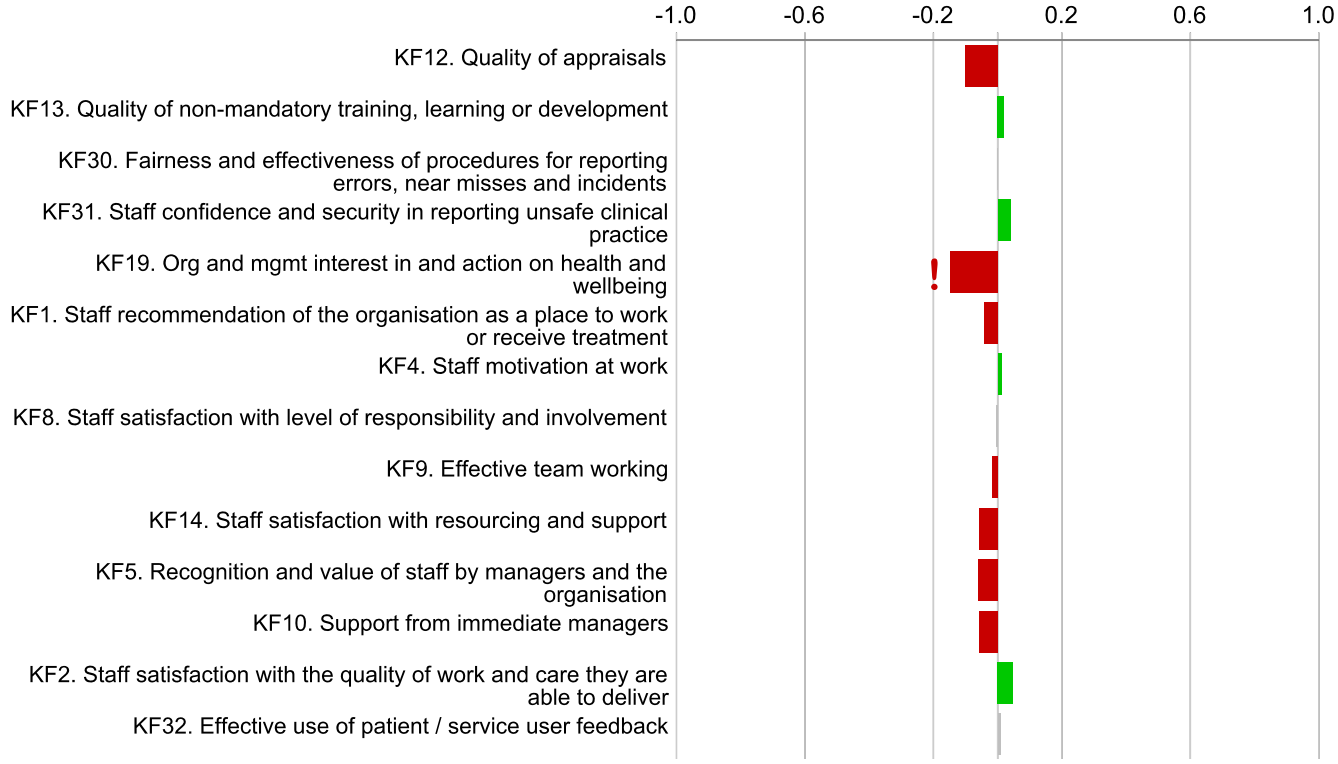
Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all acute trusts in 2016 (cont)



3.3. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2015.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2015.

'Change since 2015 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2015 survey.

-- No comparison to the 2015 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	• Average
KF12. Quality of appraisals	• No change	! Below (worse than) average
KF13. Quality of non-mandatory training, learning or development	• No change	✓ Above (better than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	✓ Lowest (best) 20%
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	• Average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	✓ Below (better than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	! Lowest (worst) 20%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	• Average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	✓ Above (better than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	! Above (worse than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	✓ Decrease (better than 15)	• Average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	! Lowest (worst) 20%
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	! Lowest (worst) 20%
* *KF16. % working extra hours*	• No change	! Above (worse than) average

3.3. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust (cont)

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	! Below (worse than) average
KF4. Staff motivation at work	• No change	✓ Above (better than) average
KF7. % able to contribute towards improvements at work	• No change	✓ Highest (best) 20%
KF8. Staff satisfaction with level of responsibility and involvement	• No change	• Average
KF9. Effective team working	• No change	! Below (worse than) average
KF14. Staff satisfaction with resourcing and support	• No change	! Below (worse than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	! Below (worse than) average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	• No change	! Below (worse than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	✓ Above (better than) average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	! Lowest (worst) 20%
KF32. Effective use of patient / service user feedback	• No change	• Average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	• Average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	• Average

4. Key Findings for Calderdale and Huddersfield NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust had 553 staff take part in this survey. This is a response rate of 45%[1] which is above average for acute trusts in England, and compares with a response rate of 40% in this trust in the 2015 survey.

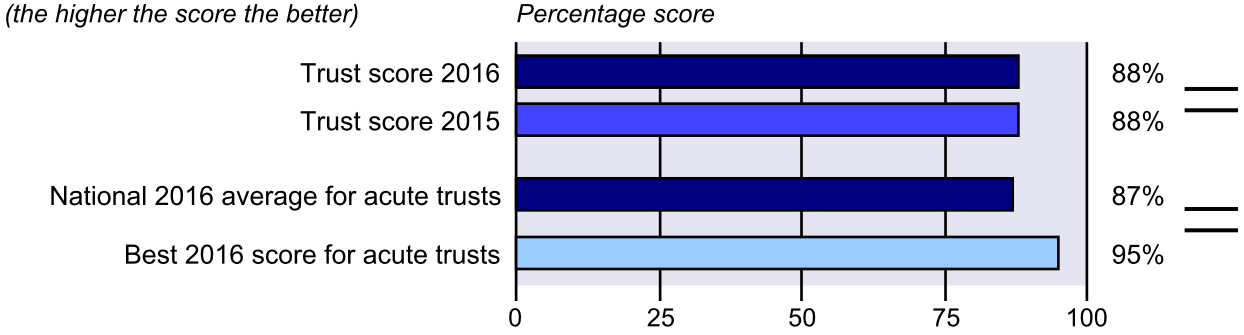
This section presents each of the 32 Key Findings, using data from the trust's 2016 survey, and compares these to other acute trusts in England and to the trust's performance in the 2015 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2015). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2015). An equals sign indicates that there has been no change.

Appraisals & support for development

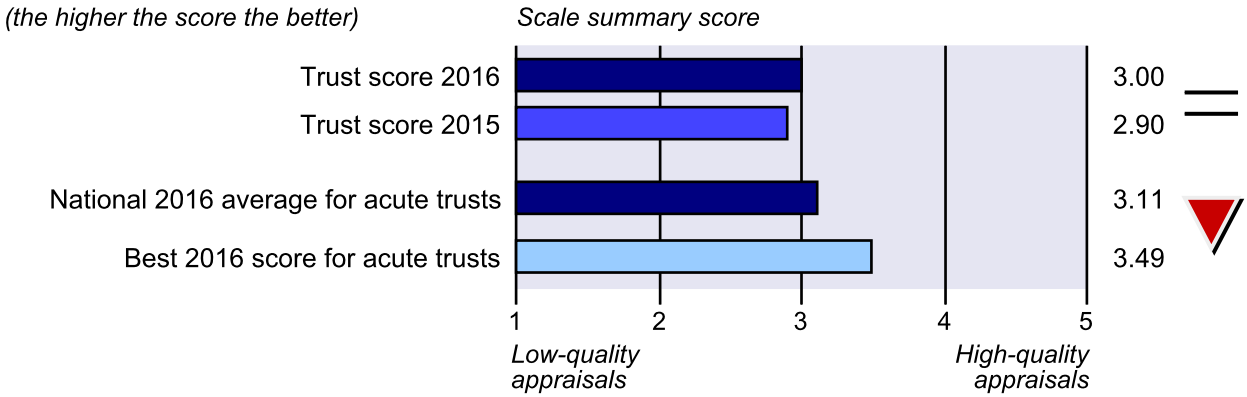
KEY FINDING 11. Percentage of staff appraised in last 12 months

(the higher the score the better)



KEY FINDING 12. Quality of appraisals

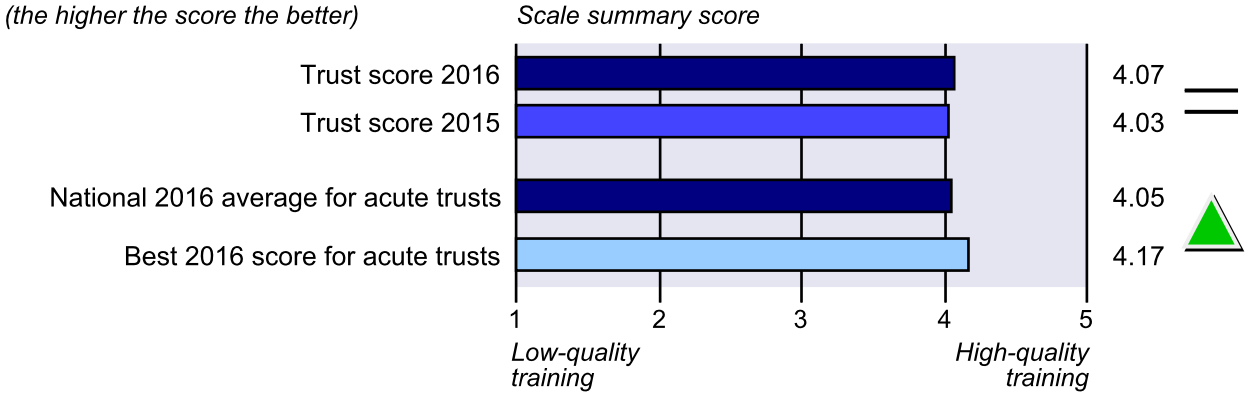
(the higher the score the better)



[1]At the time of sampling, 5661 staff were eligible to receive the survey. Questionnaires were sent to a random sample of 1242 staff. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

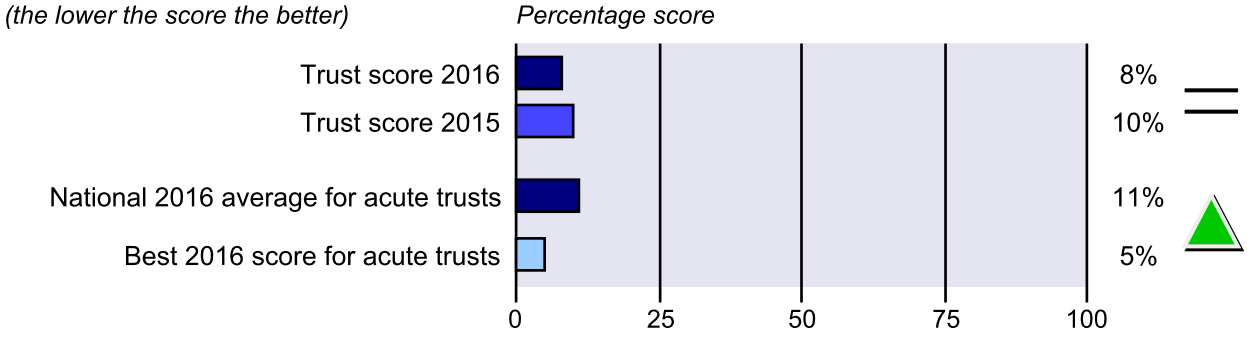
(the higher the score the better)



Equality & diversity

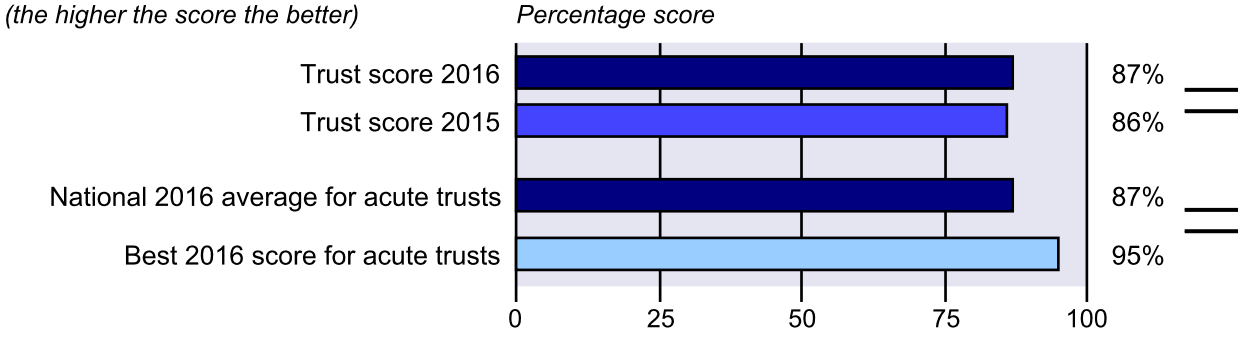
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

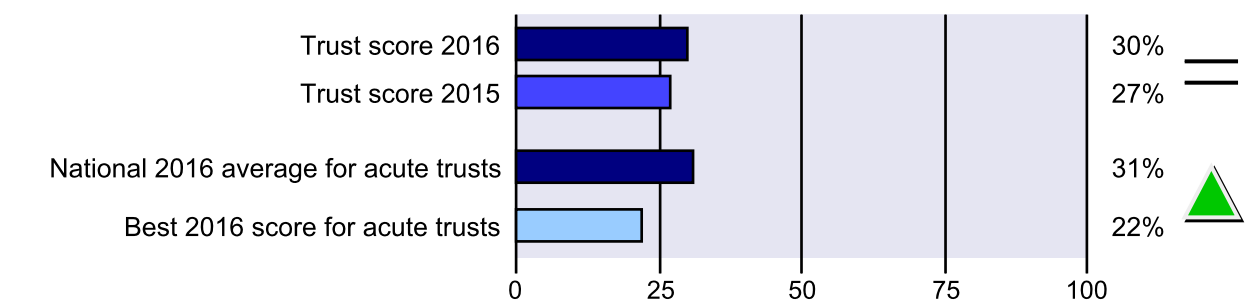
(the higher the score the better)



Errors & incidents

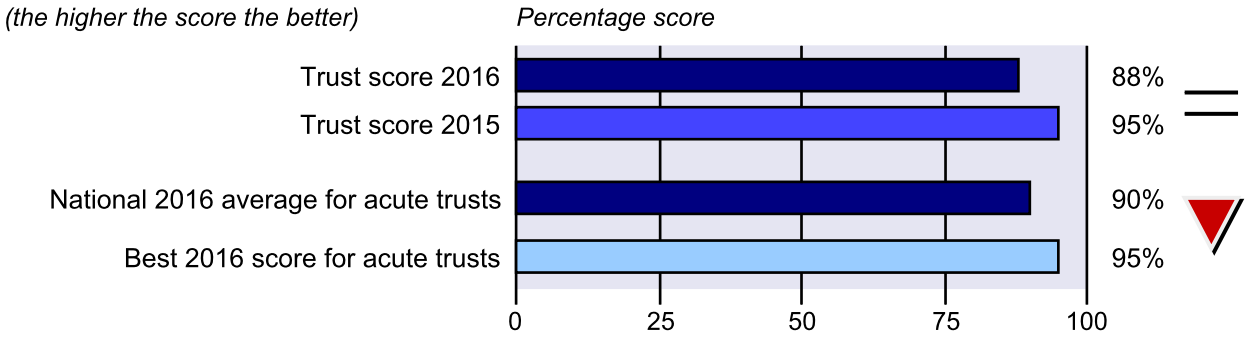
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



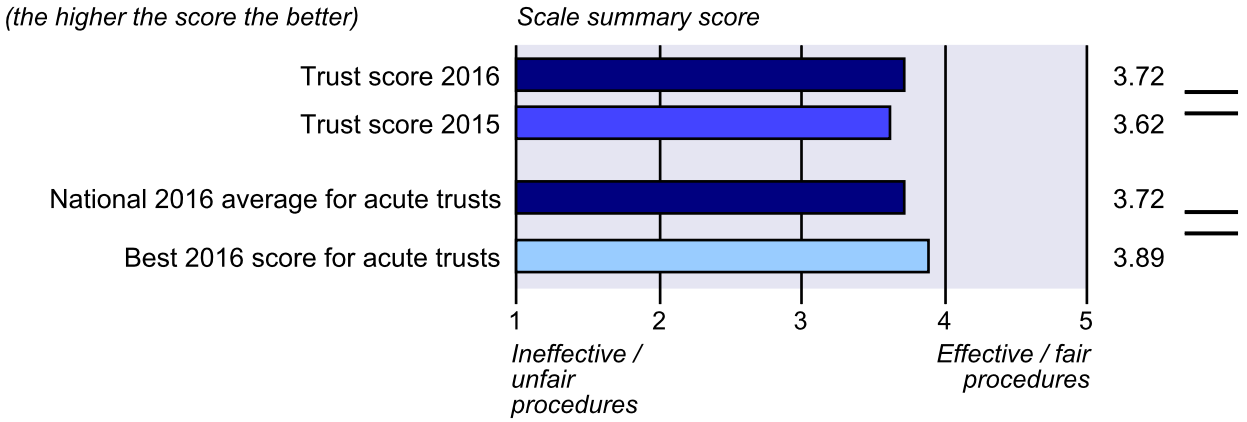
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



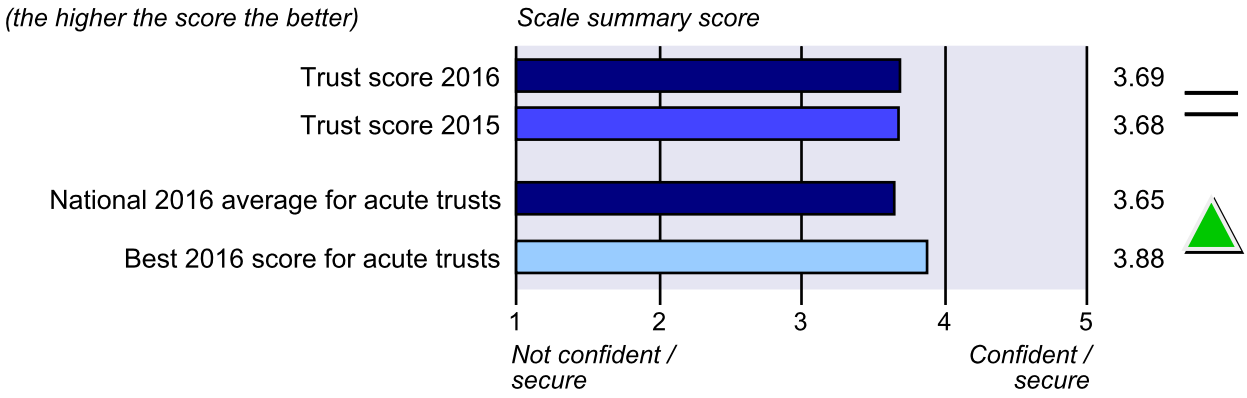
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

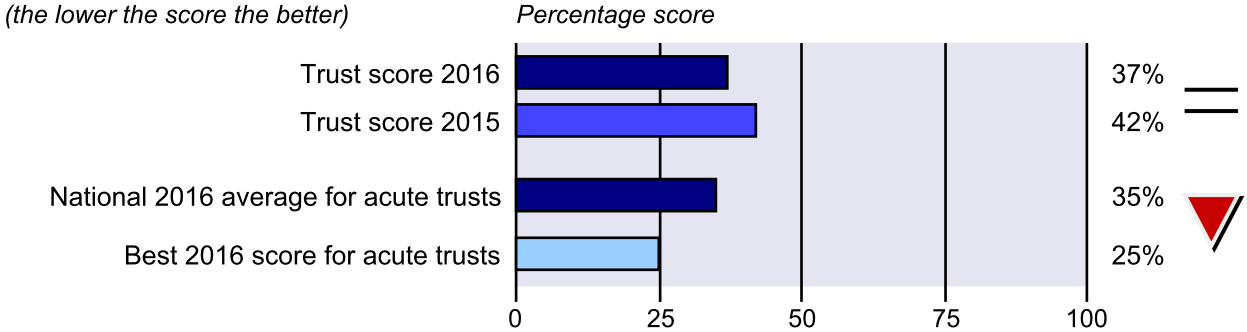
(the higher the score the better)



Health and wellbeing

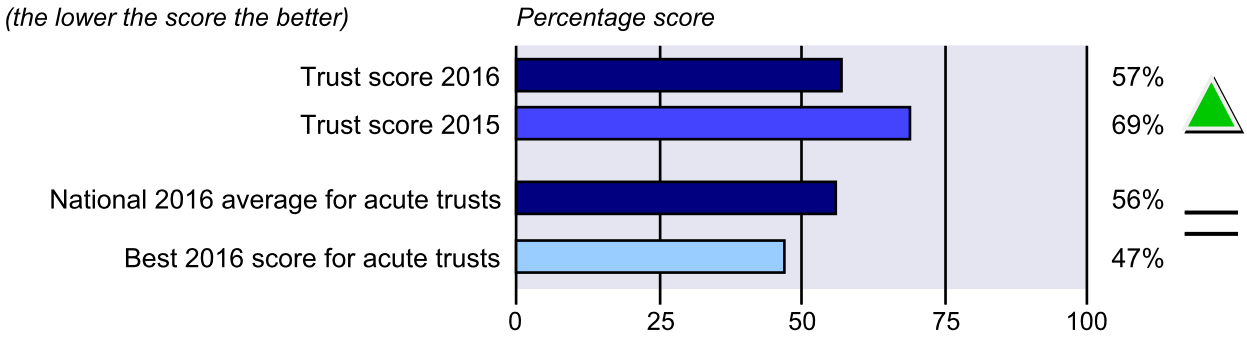
KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



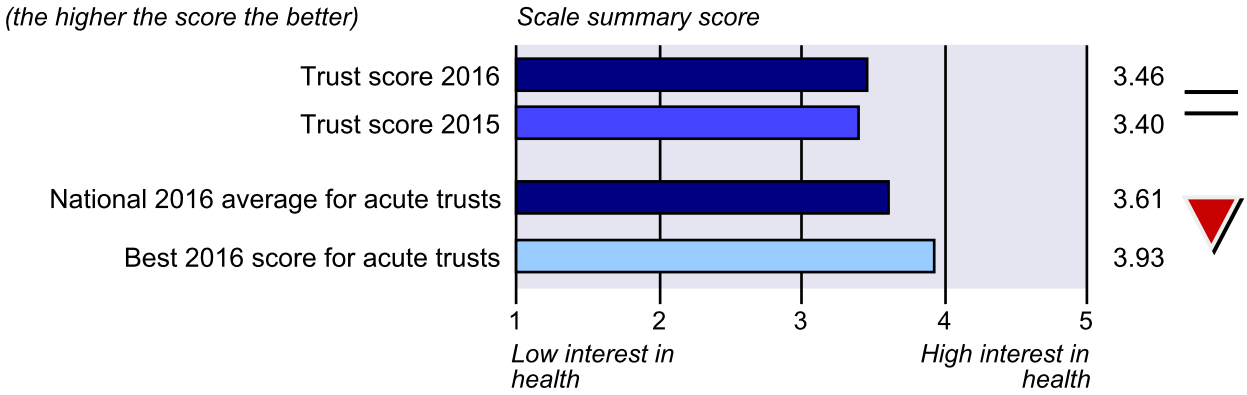
KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

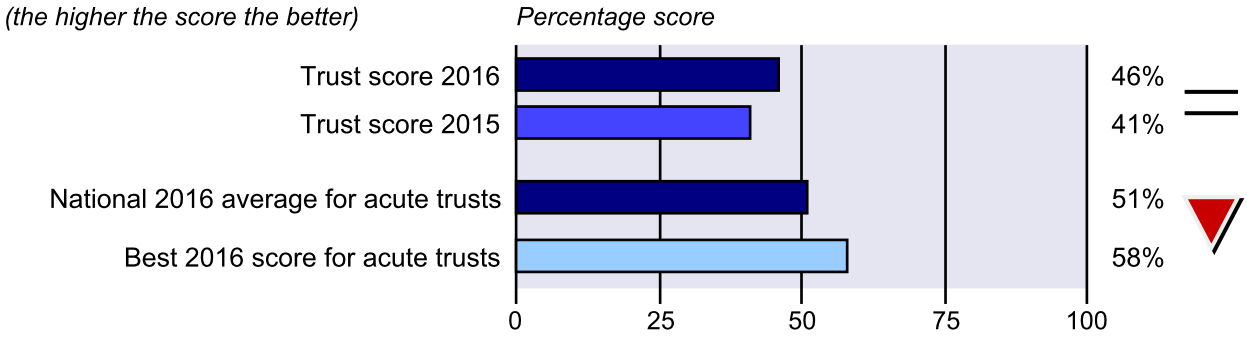
(the higher the score the better)



Working patterns

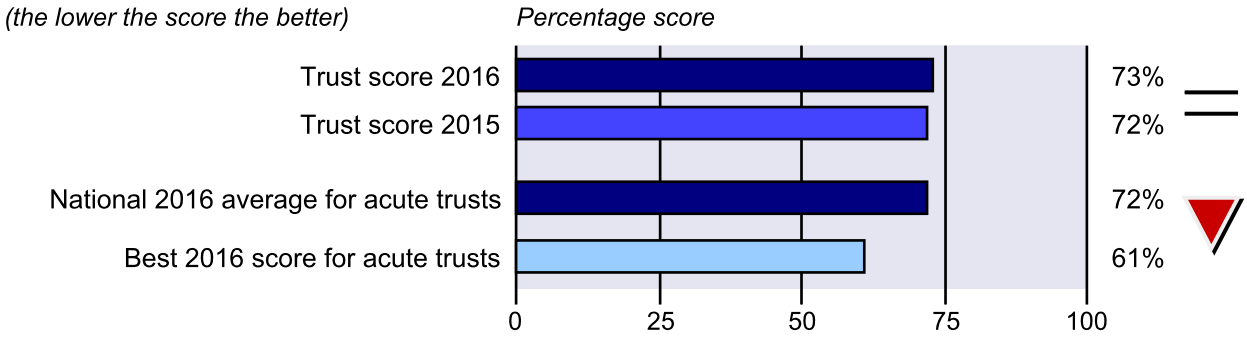
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



KEY FINDING 16. Percentage of staff working extra hours

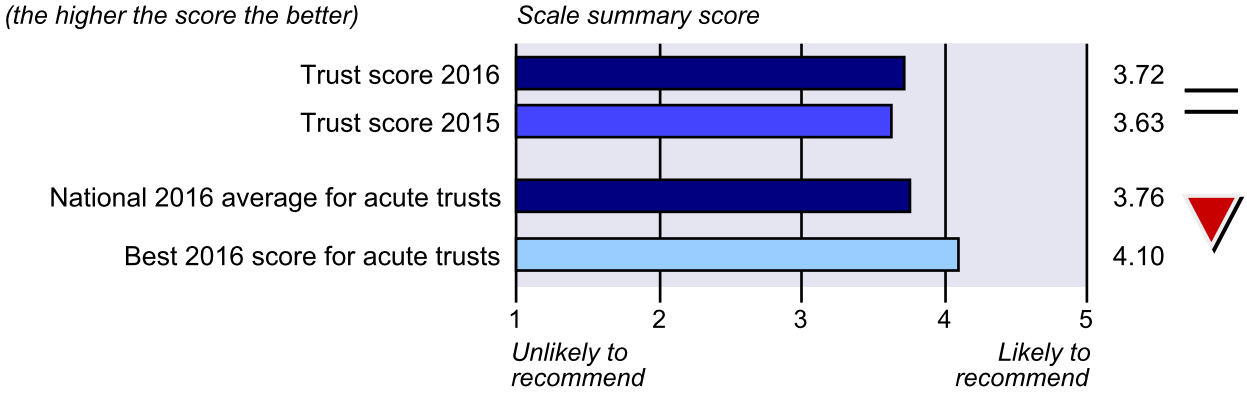
(the lower the score the better)



Job satisfaction

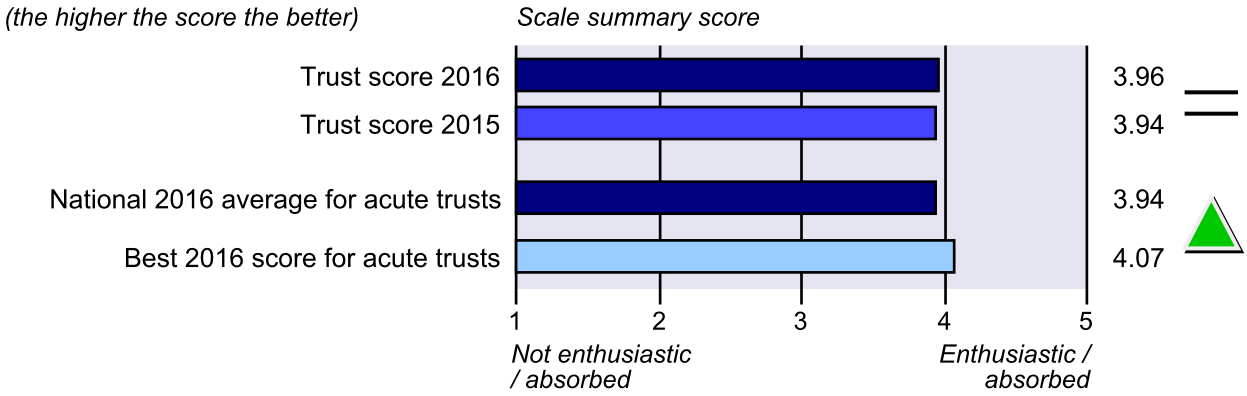
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



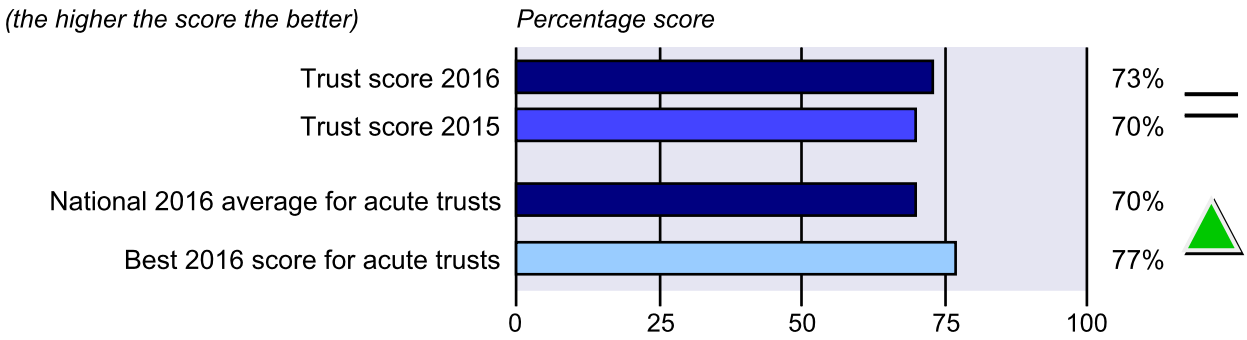
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



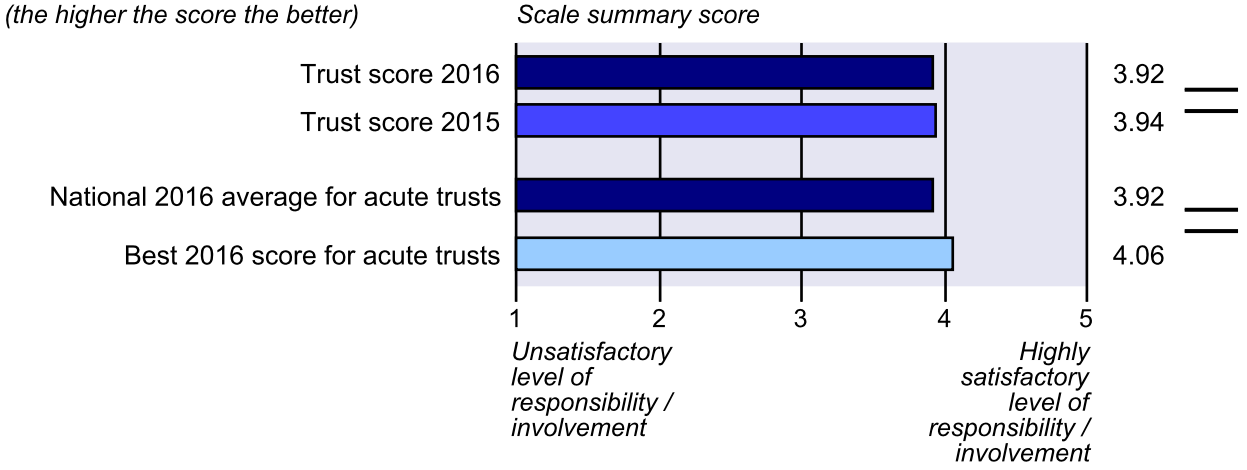
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)

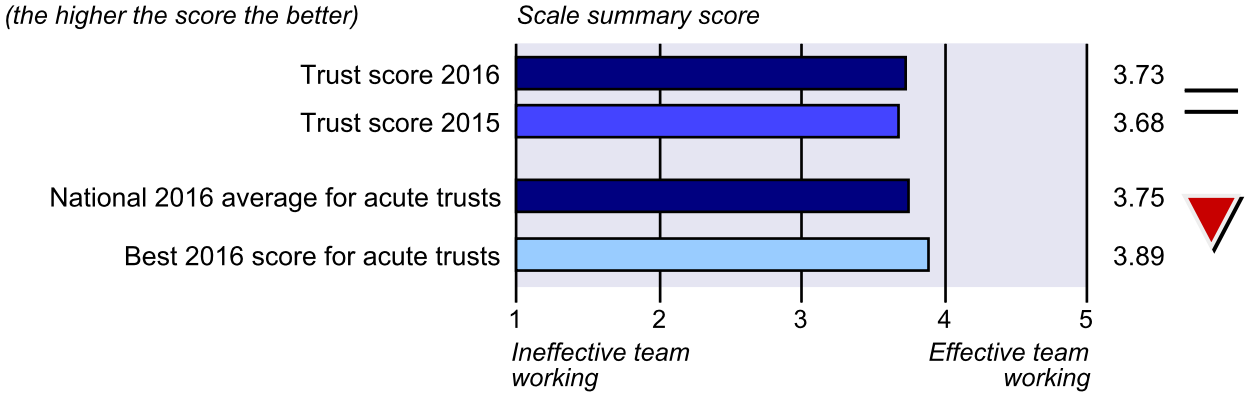


KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

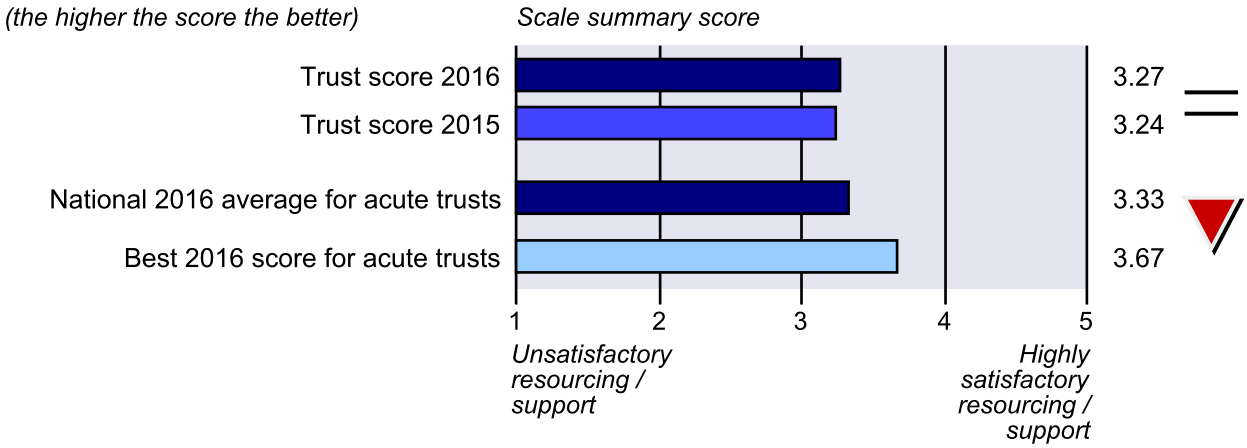
(the higher the score the better)



KEY FINDING 9. Effective team working

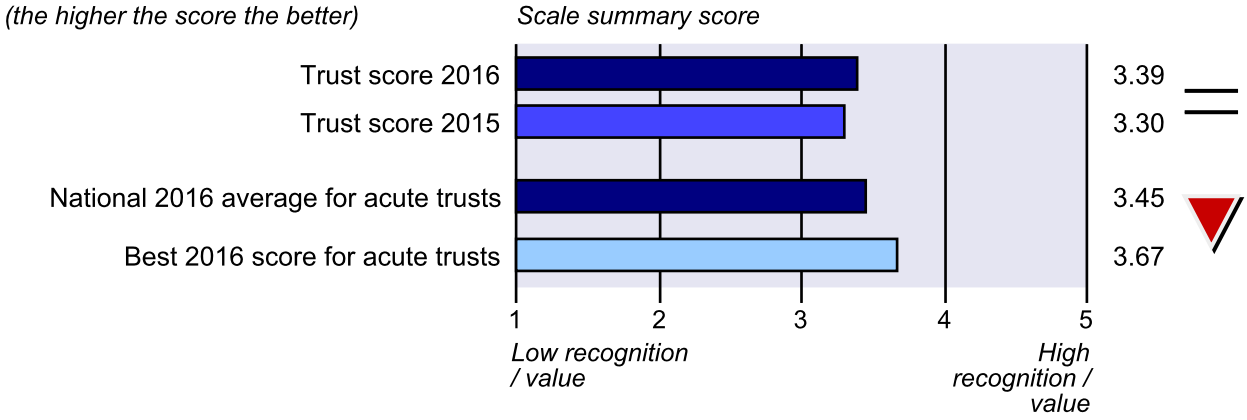


KEY FINDING 14. Staff satisfaction with resourcing and support

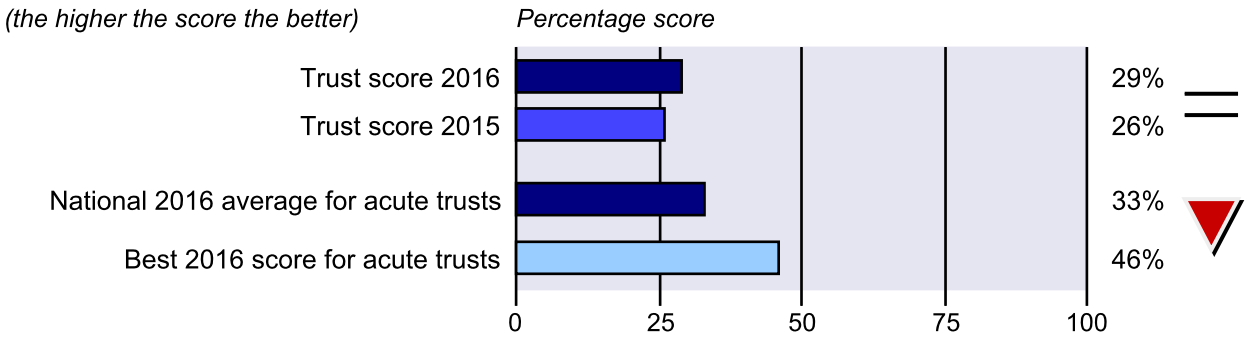


Managers

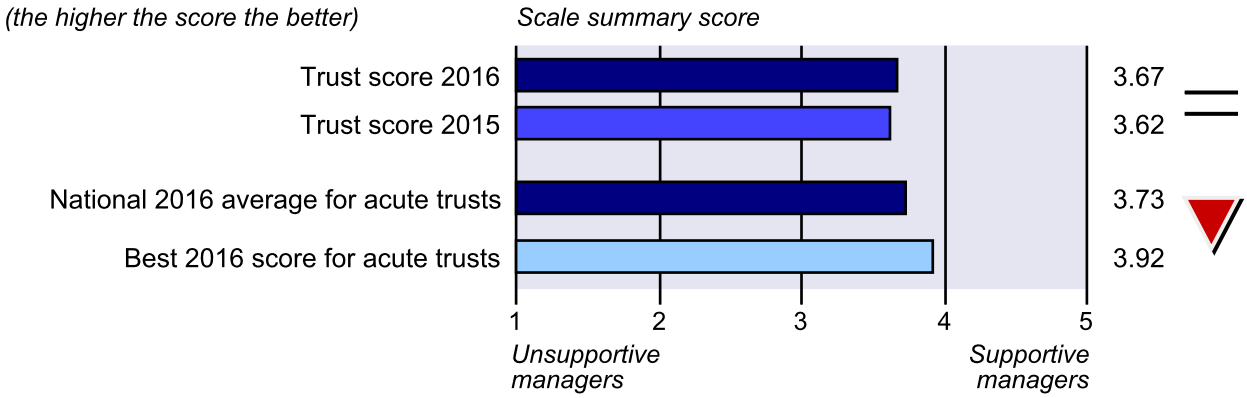
KEY FINDING 5. Recognition and value of staff by managers and the organisation



KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

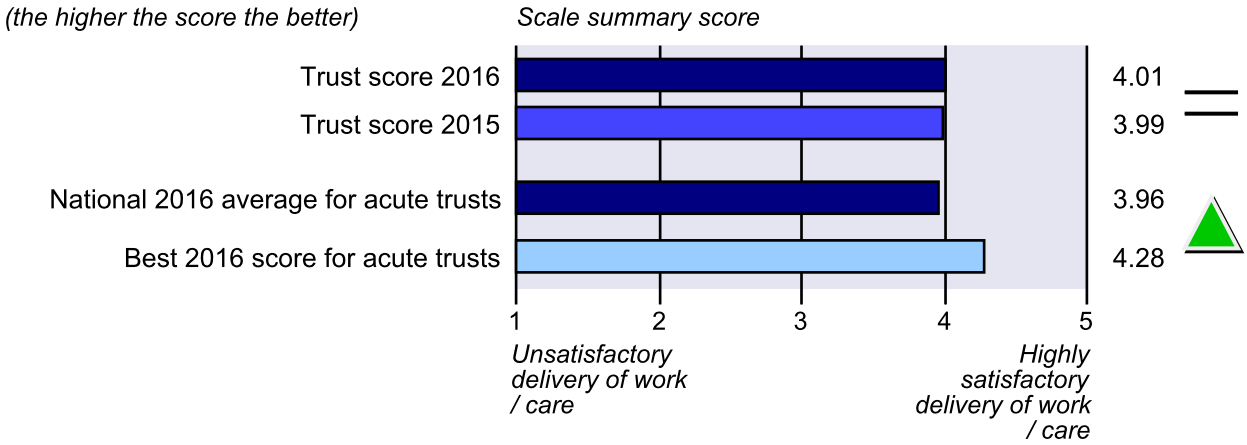


KEY FINDING 10. Support from immediate managers

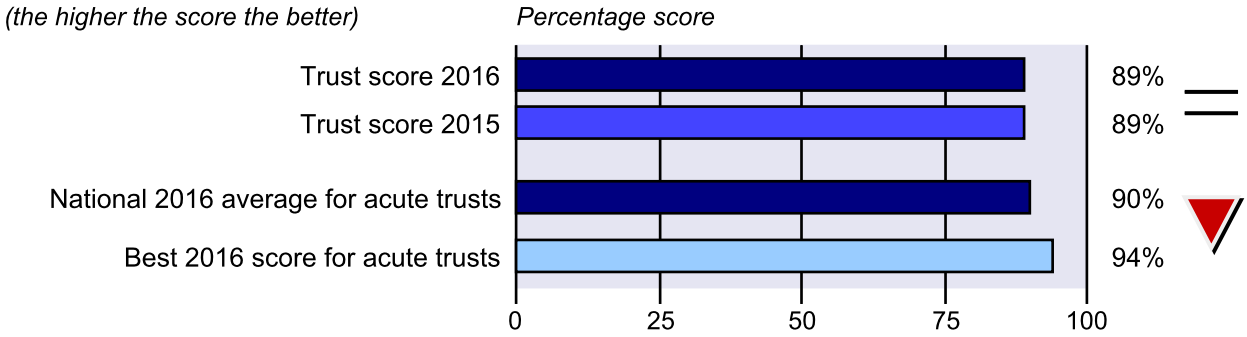


Patient care & experience

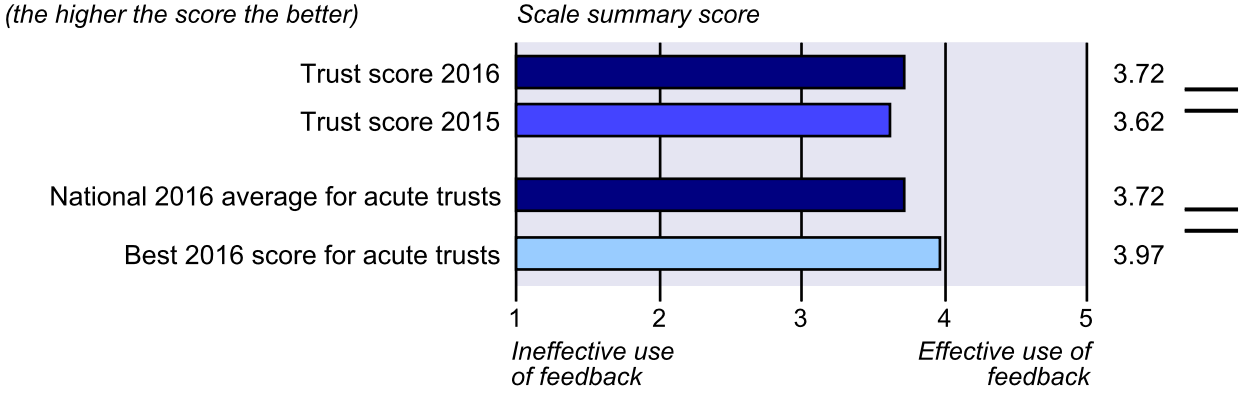
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver



KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users



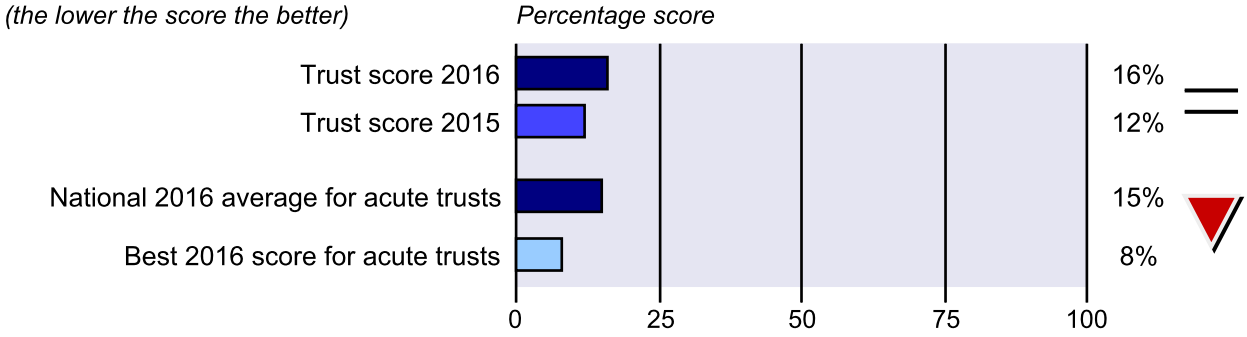
KEY FINDING 32. Effective use of patient / service user feedback



Violence, harassment & bullying

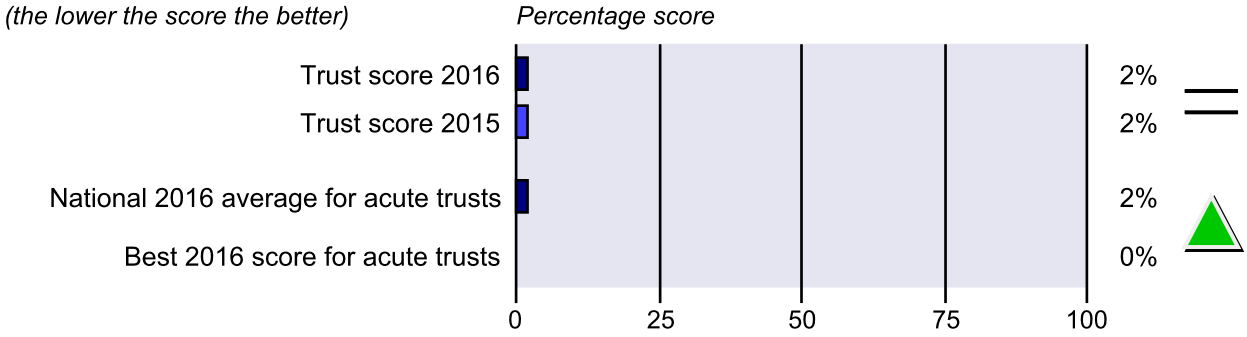
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



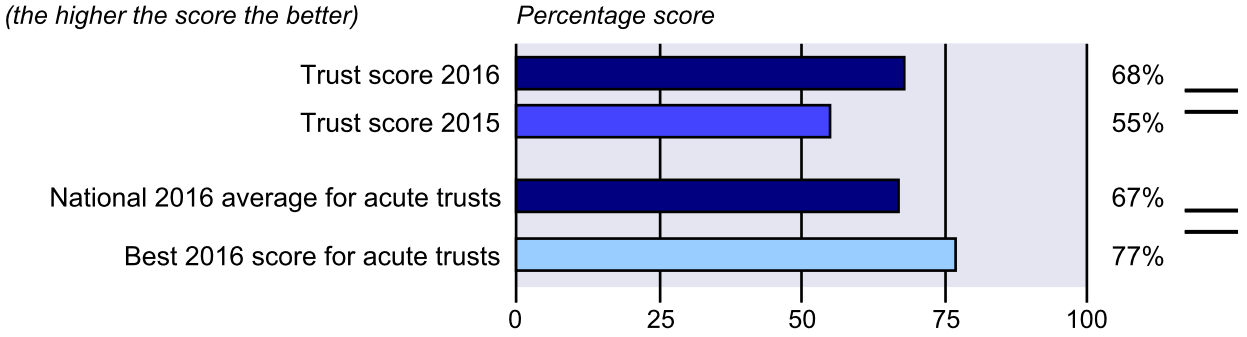
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



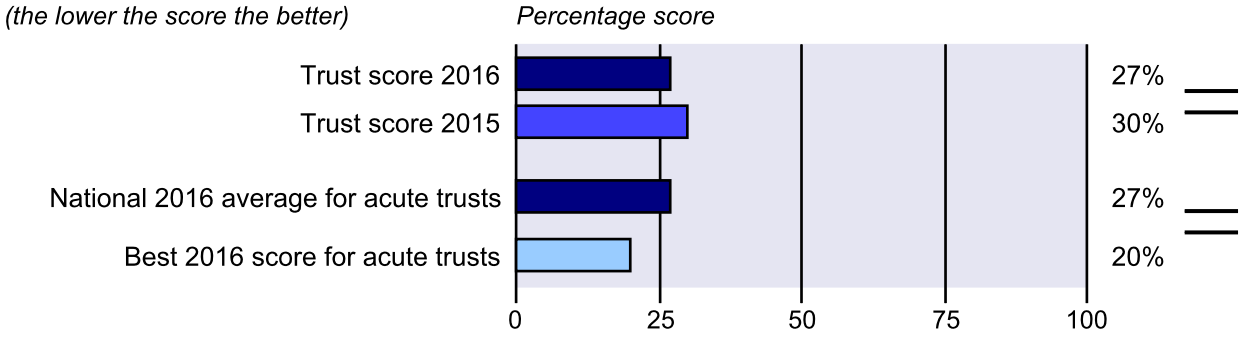
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



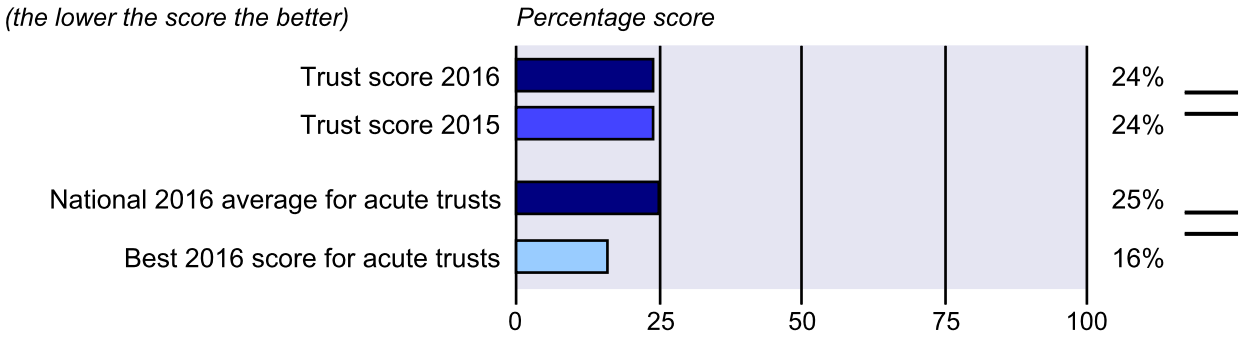
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



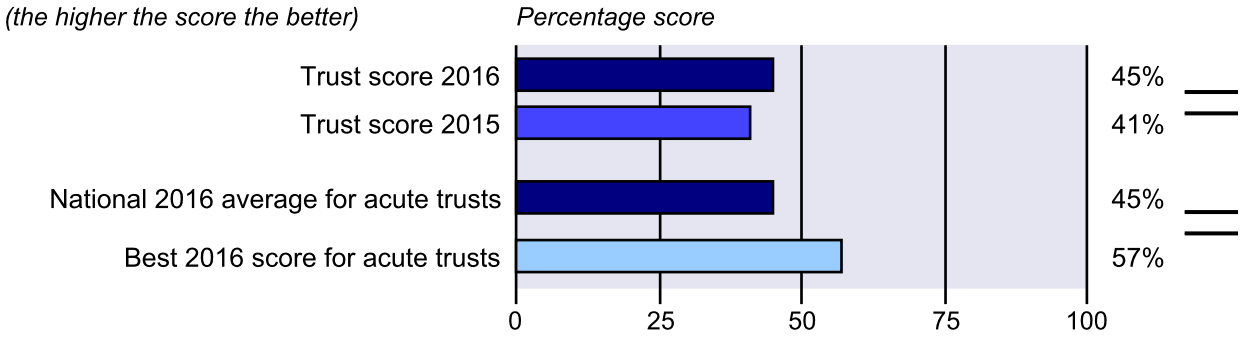
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



2016 STAFF SURVEY RESPONSE

Theme: Colleague Engagement

RESULT	MEASURE	RESPONSE
Colleagues are clear about the Trust's priorities, feel valued; are confident that their voice is heard; and able to take an active part in decisions which affect the Trust, its patients, carers and the community	Increase in staff being able to describe the vision and values of the Trust (based on a baseline survey) Increase in the number of entries for Celebrating Success (based on 2016 figures) KF6 - an increase of 5% of staff reporting that they have good communication with their line manager KF7 - an improvement in staff reporting that they are able to contribute to improvements at work KF10 - an increase of 5% of staff reporting support from their line manager Q17b - in the last 12 months have you personally experienced discrimination at work from any of the following – manager / team leader or other colleagues KF25 - % of staff / colleagues reporting most recent experience of violence KF26 - % of staff experiencing harassment, bullying or abuse from staff in last 12 months	Introduction of 'Go Engage' programme including pulse survey and pilot sites (begin pilots July 2017) Develop and implement new Big Conversation approach across the Trust (June 2017) Building on Big Conversation introduce revised team brief approach mandated across the Trust (September 2017) A 'you said, we did' campaign approach to report back results of Ask Owen and Staff Suggestion Scheme (July 2017) Campaign to support launch of celebrating success Set out clear and helpful guidelines spelling out acceptable/unacceptable behaviour and language (WRES)

Theme: Reward and Recognition

RESULT	MEASURE	RESPONSE
Colleagues feeling that their contribution to delivering compassionate care is rewarded, recognised and valued	Colleagues able to positively describe the Trust's reward offer and the way in which they are recognised for their contribution in the workplace KF1 - staff recommendation of the organisation as a place to work or receive treatment KF4 - staff motivation at work KF5 - recognition and value of staff by managers and the organisation KF11 - % of staff appraised in the last 12 months KF12 - quality of appraisals KF15 - % of staff satisfied with the opportunities for flexible working patterns KF21 - % of staff believing that the organisation provides equal opportunities for career progression or promotion	Brand reward and recognition initiatives Develop the approach to communicating reward and recognition initiatives Promote existing staff benefits and reward Promote the overall reward offer including:- •Health and wellbeing •Learning and development •Pay and conditions •Recognition schemes Further develop the benefits and reward offer Develop and promote the ESR Total Reward Statement Incorporate reward messages in recruitment, on-boarding, induction and probationary periods processes Test and evaluate the reward offer with colleagues

Together we deliver outstanding compassionate care to the communities we serve

compassionate care

Theme: Learning and Development

RESULT	MEASURE	RESPONSE
Colleagues feeling they are invested in and valued by the Trust	100% of eligible colleagues have an appraisal and personal development plan. Colleagues have access to tools and techniques that will help them to succeed and deliver compassionate care Colleagues have the opportunity to develop themselves and their career at CHFT KF5 - recognition and value of staff by managers and the organisation KF9 - effective team working KF11 - % of appraised in last 12 months KF12 - quality of appraisals KF13 - quality of non-mandatory training, learning or development KF21 - % of staff believing that the organisation provides equal opportunities for career progression or promotion	**Appraisal** Appraisal season introduced June to September 2017 with 25% of colleagues participating in their appraisal per month Appraisal e-learning package (June 2017) On-line appraisee assessment for use prior to appraisal (June 2017) **Leadership and management development** Compassionate Leadership In Practice (CLIP) programme for current and aspiring leaders (June 2017) Programme to deliver essentials of management to be developed and implemented Development programme for consultants to be developed in conjunction with Deputy Medical Director **Learning and development opportunities** A review of current offerings and gaps, and creation of a training and OD strategy for the Trust Provide targeted mentoring and coaching for BME colleagues including support to navigate training and development pathways and opportunities for job shadowing (WRES) Develop a comprehensive development programme for Agenda for Change pay bands 2 to 7 (clinical and non-clinical) (WRES)

Theme: Health and Wellbeing

RESULT	MEASURE	RESPONSE
Colleagues feeling their health and wellbeing is supported in the workplace	Q9a - An improvement of 5% points in the number of staff who report that the organisation takes positive action on health and well-being compared to baseline staff survey results or achieve 45% of staff surveyed answering "yes, definitely" Q9b - Achieve an improvement of 5% points in the number of staff experiencing musculoskeletal problems as a result of their work or achieve 85% of staff surveyed answering "no" Q9c - An improvement of 5% points in the number of staff who report that they have felt unwell as a result of work related stress during the last 12 months or achieve 75% of staff surveyed answering "no KF17 - % feeling unwell due to work related stress in the last 12 months KF19 - Organisation and management interest in and action on health and wellbeing	Appraisal Leadership and management development Visible wellbeing programme Moving and Handling risk assessments manage organisational risks Effective Moving and Handling training and information on safe working practices Improved physical fitness of staff Access to swift therapeutic interventions Stress risk assessments to manage organisational risks Information / support in managing stress, building resilience

Timescale for delivery: 1 June 2017 to 30 September 2017 unless otherwise stated

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 6th July 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: CARE OF THE ELDERLY STRATEGY - The Board is asked to receive and approve the Calderdale and Greater Huddersfield 5 Year Strategy for Older and Frail People.	
Action required: Approve	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Transforming and Improving Patient Carre	
Sustainability Implications: None	

Executive Summary

Summary:

Following the Invited Service Review report into Elderly Care a series of workshops were held with system partners, facilitated by a national lead for Elderly Care from Manchester. A strategy was developed that aligned with the principles of the Right Care Right Place with a focus on community care and consolidation of inpatient services that allows development of high quality assessment and inpatient care.

The vision for caring and supporting older or frail people in Calderdale and Greater Huddersfield Health and Social services is that they receive the right care, by the right person, in the right place and at the right time. Care will be accessible, coordinated, timely, compassionate, person centred and goal orientated

In order to achieve this we will focus on:
1. Prevention: Ensure regular assessments of frail older people or people in care homes to detect deterioration in health status early
2. Personalised: Support individuals to enable independent, satisfying, quality of life
3. Integration: Develop multidisciplinary, integrated community ageing teams (ICAT) with trusted assessments and shared care plans to improve coordination
of care and reduce the number of assessments needed
4. Think Home First!: Support and care for people in their own home or environment and reduce referrals to hospital. Develop alternative assessment and care
settings to hospital.
5. Hospital without walls: When hospital care is needed patients will be seen and assessed by staff specialising in caring for older, frail people. In hospital
patients will be encouraged to maintain their usual levels of independence
6. Avoid delays: Each delayed discharge from hospital will be treated as a system failure and managed through an integrated discharge team

All partners are asked to sign off the strategy through their formal governance structures

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 Calderdale and Greater Huddersfield 5 Year Strategy for Older and Frail People.

Appendix

Attachment:

Calderdale and Gtr Huddersfield 5 year Strategy for Older and Frail People.pdf

Calderdale and Gtr Huddersfield 5 year Strategy for Older and Frail People

Introduction

This strategy for older and frail patients was developed following the recommendations of an Independent Service Review (ISR) of older people services by the Royal College of Physicians (RCP). The ISR was commissioned by Calderdale and Huddersfield NHS Foundation Trust (CHFT) in response to a recognition that care of older people in our population could be improved. The RCP spent two days in February 2016 at CHFT interviewing inpatient and community staff and visiting clinical areas. Their final report was delivered in June 2016. The report recognised the broader strategy for health and social services in the locality but concluded that the Trust "lacked an overall strategic direction for how the services to meet the needs of older people across the wider hospital and community should develop." [1]

In response to the report the Acute Medical Directorate at CHFT organised a time out on August 4 2016 to develop a 5 year strategy for older and frail people. Staff from a broad range of community and hospital based services were invited and 65 people attended. The meeting was supported by Dr Sally Briggs, a consultant geriatrician and Associate Medical Director from the University Hospital of South Manchester NHS Foundation Trust. The staff groups represented at the time out were:

- CHFT Ward nursing staff
- Therapists – Inpatient + community
- Primary Care
- Commissioners
- Social Care
- Locala
- YAS
- Consultants
- Middle grades
- RAID/SWYT
- Community matrons
- Emergency Department (ED)
- Acute Medical Staff
- CHFT Dementia lead
- Falls Lead
- Discharge Matron
- Discharge team
- 3rd sector
- Palliative care
- Pharmacy
- QUEST staff
- Community nursing staff

[1] Report of the invited service review to Calderdale and Huddersfield NHS Foundation Trust On 11-12 February 2016

In July 2016 staff from CHFT visited two organisations (Bradford Teaching Hospitals NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust) with strong reputations for elderly care services to understand the opportunities and learn from other's success. The learning was taken to the time out and forms part of this strategy.

This strategy is developed in conjunction with the CHFT 5year strategic plan [2] but specifically focuses on the services for older and frail people. It draws on previous national reports that highlight the strengths and weaknesses of health and social care systems [3][4]. It also draws upon the CHFT 4 pillars and uses them as a foundation to engage with staff and develop services.

It is the beginning of the development of services rather than the end and aims to improve the care for older or frail people, reduce harm and improve the experience for patients and carers delivering a truly integrated service.

There are a number of specialist care pathways in existence that, by the very nature of the condition they are designed to treat, will include caring for older or frail people, for example the heart failure pathway or the management of patients with chronic kidney disease who are unsuitable or decline renal replacement therapy. This strategy does not seek to replace these well-functioning and established pathways of care. Rather, it seeks to enhance them as the vision outlined in this document is aimed to bring holistic integration across our local health and social care systems.

Background

Calderdale and Huddersfield NHS Foundation Trust (CHFT) serves a population of approximately 456,000 across two Clinical Commissioning Groups and two local authorities. Approximately 73,000 people, (16%) are aged 65yrs or older although they constitute 20% of all attendances to the

[2] 5 Year Strategic Plan for Calderdale and Huddersfield NHS Foundation Trust
[3] Building bridges, breaking barriers: Integrated care for older people. CQC report July 2016
[4] Future hospital: Caring for medical patients. A report from the Future Hospital Commission to the Royal College of Physicians September 2013

emergency departments and 43% of all emergency admissions to hospital[5][6]. Within the hospital population 1 in 4 patients admitted as an emergency are over 75yrs and occupy 58% of bed days, table 1. These numbers have increased since 2013.

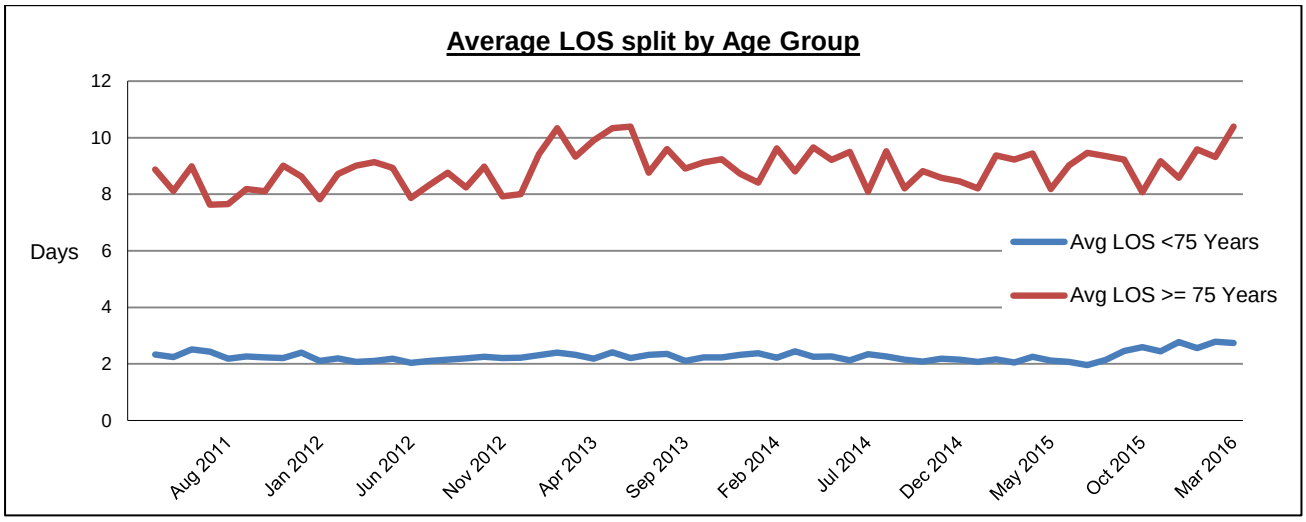
Table 1. Percentage of acute spells in CHFT, 16-74yrs and ≥75yrs. Source: CHFT Knowledge Portal 2016.

	2013-14	2014-15	2015-16	VAR 13-14/15-16	
Acute Spells - >=16 Years	51531	53013	50494	*-1037*	*-2%*
Acute Spells - >75 Years	11893	12493	12664	*771*	*6%*
% of Acute Spells for >75 Years	**23.08%**	**23.57%**	**25.08%**	-	-

Acute Bed Days - >=16 Years	202566	196847	201124	*-1442*	*-1%*
Acute Bed Days - >75 Years	112480	112581	117507	*5027*	*4%*
% of Bed Days - >75 Years	**55.53%**	**57.19%**	**58.43%**	-	-

In CHFT patients aged over 75yrs stay significantly longer in hospital, figure 1, compared to patients under 75yrs. This divide has not changed over the last 5 years. In addition patients over the age of 75yrs are more likely to be readmitted to CHFT within 30days of discharge compared to patients under the age of 75yrs (18% vs 7.3%). Some of this difference may be explained by the increased complexity and coexisting medical conditions in patients over 75years, the extended healing time needed to recover from acute illness and the increased support requirements on discharge. It is also known however that some patients have been admitted unnecessarily to hospital and others have experienced delays in discharge from hospital.

Figure 1. Length of stay in CHFT 2011-2016.



[5] Calderdale CCG Public Equality Report 2016
[6] Gtr Huddersfield CCG Public Equality Report 2016

Compared to our local peer group of hospitals the average length of stay for patients over 75years is longer, Fig 2 and the readmission rate is higher. Fig 3

Fig 2. Comparison of Average length of stay (days) for local peer group 2015/2016

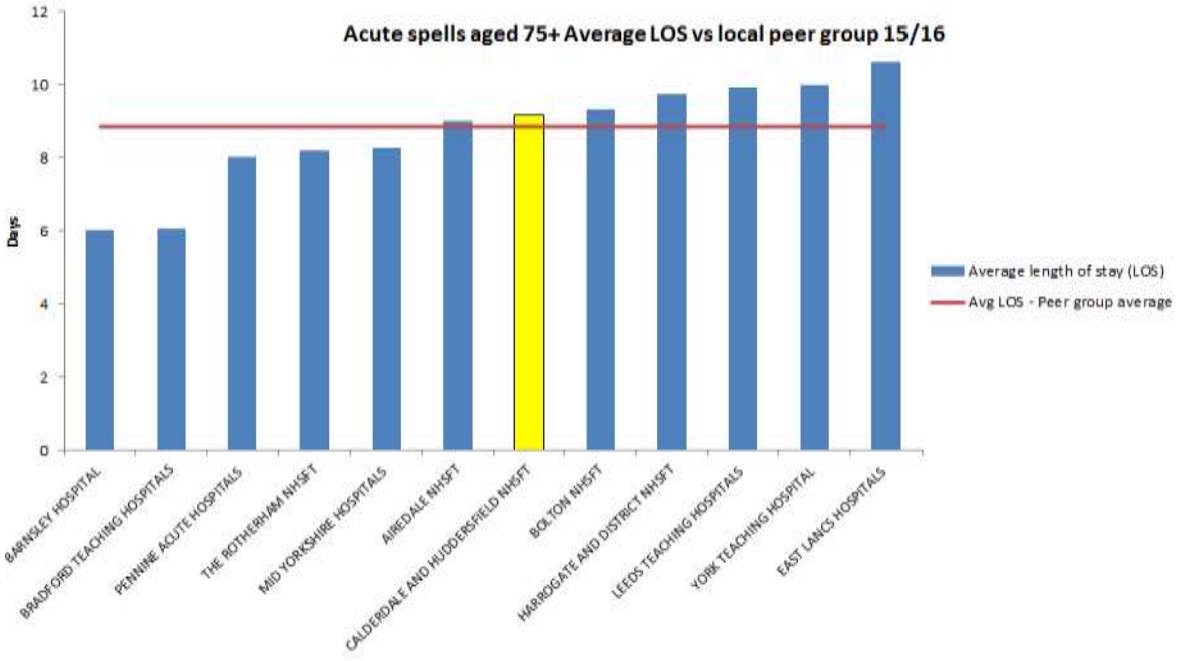
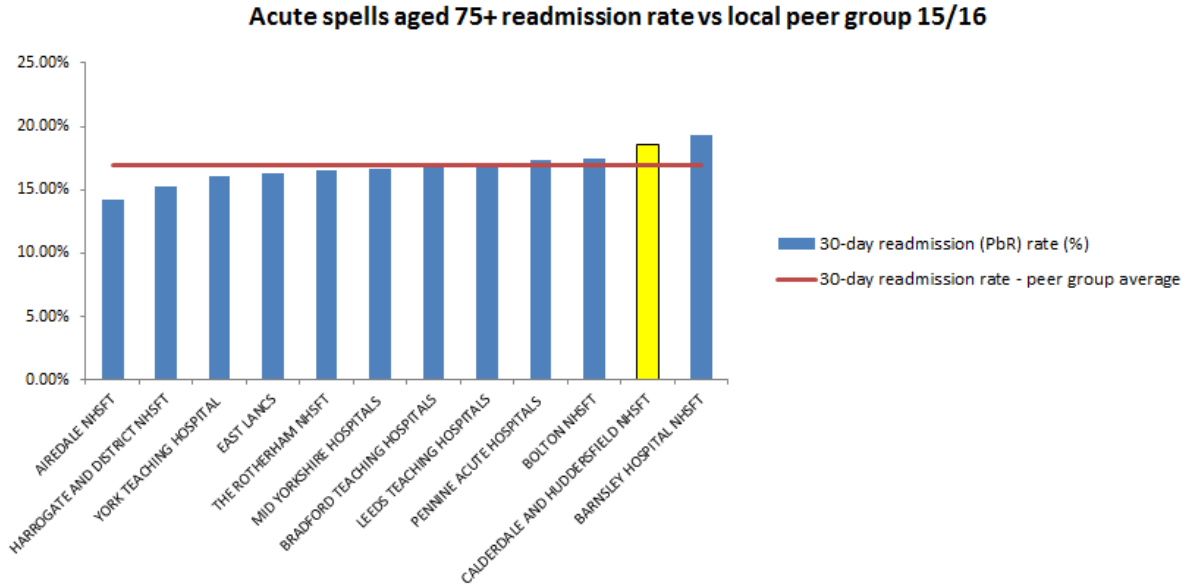


Figure 3. Readmission rate for patients over 75yrs of age, local peer group comparison



On the 16 September 2016 there were 159 patients in hospital who were medically fit and on discharge pathways (18, 11% reportable as DTOC). The majority (123, 77%) were aged 75yrs or older. Of the last 500 medically fit patients on a discharge pathway the average wait in hospital before discharge was 13.9days. Some of this time will have been spent undertaking assessments and organising discharge packages of care. However some proportion of the time spent in hospital on a discharge pathway is avoidable and could be reduced with improvements in coordinated discharge pathways. For example, of those 500 patients on a discharge pathway whose Local Authority was Kirklees, the time spent in hospital on a discharge pathway was 11 days compared to 16.2 days for patients whose Local Authority was Calderdale. This suggests that there are opportunities for shared learning and system changes in order to reduce the time spent by medically fit patients in hospital.

Since October 2016 health and social teams at Huddersfield Royal Infirmary have come together to develop a frailty service to rapidly assess frail patients in ED and, where appropriate, seek to manage patients in their own home. Supported by the national Acute Frailty Network (AFN) members from the social care Hospital Avoidance Team (HAT), CHFT therapists, a consultant geriatrician and staff from the Primary Care Discharge Coordinator team have been working together to undertake a rapid comprehensive geriatric assessment and then “discharge to assess”. The team have worked together through a number of PDSA cycles to shape the service. The team have shared patient stories where, without their intervention, individuals would have been admitted to hospital and risked a prolonged inpatient stay. This service is in the early stages of development and currently based in one of the acute hospitals. In the short time the team has been working together they have improved the experience and care for individuals, avoided hospital admissions and received very positive feedback from the AFN. Their integrated working demonstrates the potential for the frailty service as well the lost opportunities that currently exist for supporting patients in the community as opposed to transfer to ED. Staff within community teams and primary care invest significant time and energy into supporting patients to stay in their own home. This is often on an individual basis; currently there is no system wide integrated process for supporting patients at home and staff lack the broad and timely range of options necessary to support patients at home. With support from community based services including a frailty service focussed on community care rather than just acute hospital care the system would be much better able to support people at home.

Strategy Aims

The issues of high admission rates, length of stay, delays in discharge from hospital and readmission rates highlight that our current services are not fit for older or frail people. Existing systems fail to routinely capture the deteriorating person and do not reliably offer suitable alternatives to hospital based care. The current discrimination between young and old people reflects a system wide failure to address the specific needs of this complex population. It is the aim of this strategy to focus on community and hospital services with the aim that we proactively support older people with holistic integrated services, capture the deteriorating patient, offer alternative to hospital based care and improve the care for patients who need a hospital admission. We aim to ensure that only patients who need hospital based care will be admitted to hospital and only for that time needed before

moving to the next care setting. Success is heavily dependent on developed, specialist supported, integrated pathways of care for older and frail people.

Strategy:

The vision for caring and supporting older or frail people in Calderdale and Greater Huddersfield Health and Social services is that they receive the right care, by the right person, in the right place and at the right time. Care will be accessible, coordinated, timely, compassionate, person centred and goal orientated

In order to achieve this we will focus on:

1. **Prevention:** Ensure regular assessments of frail older people or people in care homes to detect deterioration in health status early
2. **Personalised:** Support individuals to enable independent, satisfying, quality of life
3. **Integration:** Develop multidisciplinary, integrated community ageing teams (ICAT) with trusted assessments and shared care plans to improve coordination of care and reduce the number of assessments needed
4. **Think Home First!:** Support and care for people in their own home or environment and reduce referrals to hospital. Develop alternative assessment and care settings to hospital.
5. **Hospital without walls:** When hospital care is needed patients will be seen and assessed by staff specialising in caring for older, frail people. In hospital patients will be encouraged to maintain their usual levels of independence
6. **Avoid delays:** Each delayed discharge from hospital will be treated as a system failure and managed through an integrated discharge team

The strategy to deliver this vision:

We will work with partner organisations to create Older People's Partnership Board as a subcommittee of the Calderdale and Huddersfield Transformation Board. Membership will consist of senior members from CHFT, Social Services, Locala, Commissioners, YAS and SWYPFT and Primary Care; it will also include patients and their carers and the voluntary sector. The Board will have oversight and responsibility for the care of older people ensuring integration of teams with shared best practice as well as ensuring the delivery of the strategy.

1. **Prevention**

Introduce tools within primary and secondary care to identify patients with frailty or who are at risk of deterioration. Patients with frailty will undergo regular holistic review by a suitable member of

staff to develop an individualised care and support plan. This professional might be the person's general practitioner (GP) or could be a GP with a specialist interest (GPwSI) in older or frail people or a skilled nursing professional such as a specialist community matron. The holistic review would include:

- Identification and Optimisation of medical illnesses plus onward referral to other specialists
- Individualised goal setting
- Drug review (including optimisation if polypharmacy evident)
- Anticipatory care planning (which may include escalation plans, emergency plans, end of life care (EOLC) plans
- Review of social circumstances including housing
- Review of support networks such as friends and family and carers
- Offer appropriate vaccinations/immunisation
- Offer anticoagulation for patients in atrial fibrillation

Following a holistic review, patients with more complex needs will be assessed by a specialist frailty service and undergo a comprehensive geriatric assessment (CGA). CGA is the gold standard for the management of frailty in older people and involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health[7].

Delivery:

Short Term (0-4 months)

Work with existing care home services e.g. QUEST (Calderdale) and Locala Care Home liaison Team to review current service and identify opportunities and resource needs to extend proactive holistic review of care home residents and training for staff working in care homes.

Medium Term (4-12 months)

Introduce tools within Primary and Secondary Care e.g. PRISMA-7 questionnaire, gait speed, Timed Up and Go test (TUGT) to assess and identify frailty in patients over 75yrs of age.

Long-term (12-36months)

Ensure individuals identified as frail are offered regular holistic review with provision of a community based CGA for those with complex needs. Patients in hospital identified as frail will undergo a CGA led by the specialist elderly care team.

2. Personalised

Patients and their family and/or carers will develop and agree goal orientated outcomes which will form the basis of the care they receive.

Delivery:

Short Term (0-6 months)

Review of existing care plans and development of single, shared, patient held emergency care plan. Roll out of the Red Bag initiative. The red bag contains key information, including the emergency

[7] Fit for Frailty: A report by the British Geriatrics Society 2014

care plan, and personal belongings to improve the handover and continuity of care when a person is required to move between different health or social residences e.g. home to hospital.

Medium Term (6-12 months)

Ensure all patients over 75yrs identified with frailty or their carers have agreed goals documented in their care plan

Long-term (12-36months)

Embed a shared proactive and emergency care plan into health and social care systems ensuring that agreed goals are integral in managing and treating chronic conditions and acute deterioration in health status such as an admission to hospital.

3. Integrated

Develop integrated community ageing teams (ICAT): Teams developed with expertise from district nursing, physiotherapy, occupational therapy, community matrons, dietetics, social care, mental health services, pharmacy and 3rd sector services. These would be supported by a community consultant geriatrician, GPwSI or specialist nurse for example a nurse consultant. The ICAT would ensure trusted single assessments of patients with shared care plans to improve interventions and reduce unnecessary assessments. The ICATs would work with specialist staff to support the management of conditions requiring specialist input for example heart failure, Parkinson's and diabetes. The extensivist model has been successfully implemented in other health and social care environments to support people with high intensity demand on multiple agencies.

Existing community locality teams would be enhanced to ensure the skill mix includes staff with the experience and expertise to manage and support older or frail people.

Delivery:

Medium Term (4-12 months)

We will develop system alerts to recognise older adults requiring frequent input from agencies (for example YAS, ED, LCD, Primary Care etc.). These patients will undergo holistic review (and CGA if required) with an agreed care plan to include planning for emergencies.

Long-term (6-12months)

Review of skill mix within community teams and development of GPwSI, nurse specialists and community consultant geriatricians.
Development of an extensivist model of care for high intensity users.

4. Think Home First

Staff will consider the best environment, "right place", at every contact with the patient with the presumption that their home or care home environment is the best place to receive care. Enhanced assessment pathways for YAS will be developed to ensure that only patients who require hospital based assessment will be transported to hospital. The pathways will include rapid support from community teams such as a falls response vehicle. Alternative care settings to hospital will be

developed or enhanced that facilitate rapid diagnosis and treatment care plans such as same day community clinics, acute ambulatory unit or intermediate care. They would also offer an important link between the community and hospital once a patient has been discharged. They would be supported by a GPsWI, community geriatrician or advanced nurse practitioner with access to rapid diagnostics such as point of care testing.

Delivery:

Short Term (0-6 months)

Initiate "Think Home" campaign across health and social care systems to highlight the benefits of supporting people in their own environment

Medium Term (4-12 months)

Incorporate into advanced care planning, patient/carer choice of care environment if condition deteriorates

Development of new pathways for enhanced home based assessments by YAS, supported by community staff

Long-term (12-24months)

Development of alternative assessment and care settings to hospital. This would include community based clinics or units that offer rapid access for assessment and rehabilitation (RADAR; rapid access department for assessment and rehabilitation). Intermediate care services will be enhanced with specialist support to assess and manage older or frail people. It will include rapid diagnostics as well as links with the hospital and community teams to provide continuity of care and a seamless service.

5. Hospital without walls

Develop a 7 day acute service for older or frail that require a hospital based assessment or treatment. The service would be provided by a multidisciplinary team supported by consultant geriatricians. The service would be hospital based and co-located with ED offering rapid CGA and alternatives to hospital based care. The unit would also support community teams and community based clinics/RADARs offering 7 day advice via telephone or video conferencing, same day assessments and "step down" continuity of care for patients recently discharged from hospital. Following assessment patients requiring a period of hospital care would be managed in dedicated short-stay (<72hrs) or longer stay beds for older or frail people.

We will develop a comprehensive inpatient service for all older or frail patients, "hospital without walls" where inpatients will undergo a CGA regardless of which ward or speciality is caring for them.

Delivery:

Medium-term (6-12months)

Work with community teams and virtual ward to improve the continuity of care for patients after discharge from hospital and reduce the need for a readmission to hospital.

Medium Term (6-18 months)

Reconfigure acute elderly cares services within CHFT to create a front end acute older people and frailty unit and dedicated short stay area. Reconfigure inpatient services to ensure dedicated wards for older or frail people with specialist review of patients 7 days a week.

6. **Avoid delays:**

Older or frail patients in ED assessed by the acute frailty service as medically fit will be discharged home without delay and undergo an assessment in their own environment, "Discharge to Assess" (D2A)

For patients requiring a period of intermediate or inpatient care discharge planning will start on admission of the patient. We will introduce trusted assessments in order that individuals avoid unnecessary duplicate assessments. We will develop and agree cross organisational internal standards for managing the discharge of medically fit patients with an agreed dashboard and regular reports on system issues to the Older People's Board and AED Delivery Board

Delivery:

Short Term (0-6 months)

Develop discharge to assess model through PDSA (Plan, Do, Study, Act) test cycles
Use of IT to manage capacity and demand for inpatient therapy services

Medium Term (4-8 months)

Once D2A model design completed we will develop a robust business case to ensure teams have the capacity to meet demand

Medium term (6-18months)

Introduce system wide competence framework for Trusted Assessors. Ensure that individuals undergo one trusted assessment that is shared between partner organisations.
Develop dashboard to monitor delays in patient pathways.
Older and frail patients would be identified on admission and following their CGA have a named discharge coordinator within 48hrs of admission.
Initiate process of discharge planning from first day of admission. Health and social services will work in partnership with the individual and their nominated support to identify care needs and develop discharge plan. This will start at admission rather than once the patient is medically fit.

Operational Delivery of the strategy

To successfully deliver this strategy we must ensure that we continue to accurately plan and account for the financial costs and benefits of each service development. We must also remain cognisant of the existing gaps in skilled staff and carefully consider how we might deliver services in new and innovative ways.

There is also a requirement to train all staff of the issues and challenges that are specific to older people such as dementia or other mental health issues, social isolation, multiple co-morbidities and the risk of rapid deconditioning for patients outside of their usual environment.

Within CHFT the SAFER Board will provide support to delivery of the strategy. The SAFER Board is tasked with driving system change focusing on admission avoidance, better use of hospital beds and 7 day services.

Delivery:

Short Term (4-6 months)

We will undertake a review of demand and capacity within community and hospital services to identify gaps in workforce to deliver new services.
We will develop alternative options for delivering specialist services for example advanced nurse practitioners, nurse consultants, GPwSI and community geriatricians.

Medium term (6-9 months)

We will develop a training programme for all health and social care staff involved in the care of older people.

Measuring success

One of the findings of the Building bridges, Breaking barriers: Integrated care for older people was that monitoring and evaluation of initiatives in place to improve integration was not carried out locally or was insufficient and tended to measure the effectiveness of initiatives or interventions rather than the overall system of care in an area. Locally there are, at present, no specific measurements for assessing the capability or effectiveness of care for older people across the system.

As part of delivering this strategy we will develop cross organisational key performance indicators that monitor and evaluate the whole system of care for older and frail people. This will need to include benchmarking of services against other areas, an evaluation of capacity and demand as well as ensuring the workforce is in place to deliver the necessary care. As part of the ISR response CHFT have started to develop an elderly care dashboard. The dashboard provides data on length of stay, mortality, patients on discharge pathways, staffing levels and the number of falls. CHFT have been working with the AFN and are planning to trial a process for the systematic identification of frail patients presenting acutely to the hospitals to allow surveillance and monitoring of this specific group within the older people population.

Next steps

Following the time out in August 2016 there has already been some early developments and amongst the attendees there has been sharing of innovative ideas and clinical pathways.

Within Huddersfield Royal Infirmary a consultant geriatrician has been released from other commitments to spend time each day working with therapists and the Hospital Avoidance Team (a Kirklees local authority service) to in-reach into the ED, Clinical Decision Unit and Acute Medical Unit

to support a rapid CGA and early discharge of patients from hospital. The Discharge to Assess model has already supported the discharge of a number of patients and is undergoing further PDSA cycles

These innovative changes highlight the potential opportunities with our local systems to make significant change. Their inception also reflects the PDSA approach to developing services with small system testing prior to wider system role out.

This strategic document has been developed in partnership with staff present at the Elderly Care Time Out. The Boards of all partner organisations have also approved the strategy:

	Date of Board Approval
Locala CIC	_____
Calderdale Local Authority	_____
Kirklees Local Authority	_____
South West Yorkshire Partnership NHS Foundation Trust	_____
Calderdale Clinical Commissioning Group	_____
Greater Huddersfield Clinical Commissioning Group	_____
Calderdale and Huddersfield NHS Foundation Trust	_____

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 6th July 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from the sub-committees.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from the sub-committees.

Main Body

Purpose:

The Board is asked to receive the updates and minutes from the sub-committees:-
Quality Committee - minutes of 31.5.17 and verbal update from meeting 3.7.17.
Finance and Performance Committee - minutes of 30.5.17 and verbal update from meeting 4.7.17.
Workforce Well-led Committee - minutes 8.6.17.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive the updates and minutes from the sub-committees.

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES.pdf

QUALITY COMMITTEE

Wednesday, 31st May 2017
Board Room, Sub Basement, Huddersfield Royal Infirmary

PRESENT

Dr Linda Patterson	Non-Executive Director ***(Chair)***
Asif Ameen	Director of Operations – Medical Division
Helen Barker	Chief Operating Officer
Anne-Marie Henshaw	Associate Nurse Director/Head of Midwifery, FSS Division
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Andrea McCourt	Head of Governance and Risk
Dr Cornelle Parker	Deputy Medical Director
Andrew Mooraby	Associate Director of Nursing – Medical Division
Dr David Anderson	Non-Executive Director
Brendan Brown	Executive Director of Nursing
Margaret Metcalfe	Deputy Associate Director of Nursing – Surgical Division
Dr Julie O'Riordan	Divisional Director – Surgical Division
Lindsay Rudge	Associate Director of Nursing
Michelle Augustine	Governance Administrator ***(Minutes)***

084/17 WELCOME AND INTRODUCTIONS

The Chair welcomed members to the meeting.

Introductions were made to two new members to the Trust – Andrew Mooraby and Cornelle Parker.

085/17 APOLOGIES

Dr Ashwin Verma	Divisional Director, Medical Division
Jan Wilson	Non-Executive Director
Vicky Pickles	Company Secretary
Jan Ghee	Community representative
Dr David Birkenhead	Medical Director
Juliette Cosgrove	Assistant Director for Quality and Safety
Peter Middleton	Membership Councillor

086/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note

087/17 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 3rd April 2017 were approved as a correct record.

088/17 ACTION LOG AND MATTERS ARISING

- Issues regarding papers circulated last month
  The Group were happy with the papers that were circulated – there were no issues.

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

089/17 COMMUNITY PSQB DIVISIONAL REPORT

ACTION: The Community PSQB divisional report to be deferred to next month.

090/17 **ESTATES AND FACILITIES PSQB DIVISIONAL REPORT**

Lesley Hill presented the report (Appendix C) and summarised:

- Ongoing work with divisions to ensure robust business continuity plans are in place. Further work has also been undertaken on counter terrorism measures. These will be taken through the Weekly Executive Board meetings.
- Patient-led Assessments of the Care Environment (PLACE) inspections at CRH took place in March 2017, and HRI inspections are planned for the end of May 2017. The results of the inspections will be published nationally and will be presented to the Executive Board.
- Fire Training for 2017 is now online via ESR training.
- Cleaning Industry Management Standard (CIMS) assessment took place in April 2017 and HRI were awarded an honours level award. Only two hospitals received this award in the country, and will be used as the quality management system for HRI cleaning services. Congratulations were conveyed to all staff involved.
- Funding has been agreed for a further 12 months, to help support on-day delivery for equipment service. This will facilitate on-day discharge and prevent hospital admission, reducing excess stay within the hospitals.
- Division now have own Integrated Performance Report (IPR) which is now well-established and reflects health and safety aspects.
- Acre Mills won the award for best refurbishment and best overall project in the annual Huddersfield Civic Society Awards.
- Catering at CRH achieved the Soil Association Food for Life Catering Mark Silver Accreditation (the first team within their group)
- The biggest health and safety staff risk is slips, trips and falls and issue with high heels. This is being followed-up by the Health and Safety Committee.
- Results from the weekly inpatient surveys were highlighted, with car parking being the biggest issue. Discussion ensued on the comments made regarding privacy and dignity needs in relation to survey from linen services.

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

091/17 **FAMILIES AND SPECIALIST SERVICES PSQB DIVISIONAL REPORT**

Anne-Marie Henshaw presented the report (Appendix D) and summarised:

- The funding for the x-ray tube for interventional radiology has now been addressed. The x-ray tube is now on site and working.
- Failure to act on radiology results – an audit carried out on the number of star star alert emails that have not been "read" shows an increase. There were 17 in January, 8 in February, increasing to 33 unread emails in March, and a slight decrease in April to 27. This is being followed up with Divisional and Clinical Directors. Discussion ensued on assurance being needed that there has not been a significant impact or harm being brought to patients whose results were not reviewed. The Committee were in agreement to report on this at the next meeting.

- Risk 6829 – A business case is to be developed to mitigate risks in relation to capacity issues with the pharmacy aseptic dispensing service being able to administer high risk critical injectable medicines with short expiry dates for urgent patient care. The case will be presented at the next Performance Review Meeting in July.

- Serious Incidents – Four incidents were reported during quarter 4, and further discussion took place on two of the incidents; neonatal death and hearing screening incident.

- Stillbirth Reduction Programme – the CHFT stillbirth rate is reducing year on year and results have shown that these have more than halved from 0.52% to 0.24%.

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

092/17 **SURGERY AND ANAESTHETICS PSQB DIVISIONAL REPORT**

Dr Julie O'Riordan presented the report (Appendix E) and summarised:

- Complaints – compliance with timescales had seen some improvement, however performance remains variable. Completion overseen on a temporary basis, but the division will need to work towards a more sustainable long term solution.

- Planning – Issues raised by estates regarding the five year viability of the Intensive Care Unit (ICU) is being worked through, with a revised business continuity plan in the event of any unplanned disruption to services.

- Hand Hygiene - support has been put in place from the Divisional Director to challenge hand hygiene practice in medical staff, which will hopefully see some improvement.

- Delayed discharges from ICU - Very little improvement made with discharges from ICU within 4 hours due to the challenge of operational pressures. Escalation to the patient flow team continues but requires further support to facilitate. PSQB requested that information on delayed admissions is reported to the Divisional Board meeting.

- Incidents – No red serious incidents and six orange incidents closed during quarter 4.

- Complaints – 37 complaints were closed in quarter 4. The division has developed a standard operating procedure to ensure that complaints are manged in a timely way, however this continues to need constant focus to ensure that this remains a priority for complaint investigators.

- Risk register – currently 63 open risks in the division, which are taken to monthly Directorate Management Team (DMT) meetings for discussion. One risk has been added to the register in quarter 4 which relates to the risk of non-compliance with Trust agreed process for completion of clinical assessments, for those patients waiting in excess of three months beyond the due date for allocation of a follow up appointment, as a consequence of capacity shortfalls. Data is being worked on to keep under review.

- Fractured neck of femur (#NOF) – performance has improved through quarter 4:

  - January – 52%
  - February – 80%
  - March – 81%

  Following the visit to Boston Spa NHS Trust, a new clinical lead for #NOF has developed an action plan and developed guidelines for different aspects of care which are being implemented and will improve consistency in the pathway. There is still work to be done on other #NOF actions but progress is being made in the improvement of the Best Practice tariff (BPT).

- Duty of Candour - 13 orange incidents were reported in quarter 4, nine of which required a Duty of Candour sending to the patient / relative. The Division was 100% compliant in quarter 4.

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

093/17 **MEDICAL PSQB DIVISIONAL REPORT**

Andrew Mooraby presented the report (Appendix F) and summarised:

- Sepsis CQUIN – division on track to meet the Emergency Department screening target of 90%. A full report on sepsis is due to be presented at the next meeting.

- Harm falls – Some good work undertaken on falls, however a consistent number still resulting in some harm.

- Friends and Family Test (FFT) – overall response rates for quarter 4 were 27.8%. Would recommend 96.3% and would not recommend was 1.1%. Discussion ensued on whether the survey could be made exempt for chemotherapy patients, and it was agreed that this can be followed up outside the meeting.

- Frailty – the frailty service has joined a network and established a task and finish group with partner organisations to support delivery of recommendations. The new service currently sees around 100 patients per month on the Huddersfield site, and a service is being developed in Calderdale.

- Incidents – reporting has now improved. There are still some issues with green and yellow incidents, however the backlog have decreased significantly.

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

094/17 **QUALITY AND PERFORMANCE REPORT**

Helen Barker presented the report (Appendix G) and summarised April's performance score of 69% for the Trust.

Safe - The domain has a green rating following improvements in harm free care and category 4 pressure ulcers. The responsive domain has returned to amber rating due to missing the 62 day GP referral to treatment target for the first time in over 12 months and continuing to underperform in the diagnostics 6-week target.

Caring – the domain has deteriorated due to the Friends and Family Test (FFT) 'would recommend' score for maternity and Accident and Emergency. Community has agreed to fund and trial a web-based system for FFT, improvements of which will be expected in June and quarter 2. There are still some issues with complaints responses, and discussions are being held with divisions regarding complaints responses.

Effective – The target for emergency readmissions within 30 days has been missed by Calderdale for the last two months, and support is needed with this. There is some work to be done and discussions are underway with commissioners.

Responsive – the Trust's diagnostic waiting list position for April has reduced as a result of an increased waiting list in non-obstetric ultrasound between December and April, which now has an extra 1,500 patient. Work ongoing with division regarding outsourcing.

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

095/17 **CQC END OF YEAR REVIEW**

Brendan Brown presented the report (Appendix H) which provides an end of year review of the Trust's response to the CQC inspection carried out in March 2016. The report also provides information regarding the forthcoming re-inspection, detailed changes to the inspection regime and how the Trust has started to prepare for this.

- Report, ratings and regulatory requirements – the final report sets out 19 must do actions and 12 should do actions

- Trust response to report – a detailed plan was developed for each of the must and should do actions, as well as core service action plans. Progress with plans were regularly updated at the CQC Response Group which focussed on levels of assurance, with challenges as to whether actions taken were embedded and sustained. As of 30th April 2017, all but three actions have been delivered and sustained. They are:

  - MD3 – mandatory and essential skills training and appraisals – this is being monitored through the Well-led Committee
  - MD8 – Medicines – the expected impact has not achieved and a task and finish group has been established to take this forward.
  - SD9 – Seven day working in radiology

  The report also highlights areas with ongoing challenges which have been brought to the attention of the Board of Directors.

- Future inspections – a follow-up inspection is anticipated from the end of quarter 2 onwards, and will include a well-led review. A number of activities have now commenced to enable the Trust to prepare for a re-inspection, and this is being overseen by the Risk and Compliance Group. A series of local mock inspections have also been scheduled.

Extensive work has taken place which now need to be tested, embedded, and demonstrate that there has been a change since the last inspection.

OUTCOME: The Committee received, noted and acknowledged the amount of work put into the report.

096/17 **INFECTION CONTROL COMMITTEE MINUTES**

A copy of the minutes from the Infection Control Committee meeting held on Thursday, 27th April 2017 (Appendix I) were circulated and summarised, including the two MRSA bacteraemia cases reported over the last 12 months, the six avoidable clostridium difficile cases. It was noted that all items will be included in the Infection Control report to be presented at the Board of Directors.

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

097/17 **ANY OTHER BUSINESS**

It was reported that a log of pre and post go-live risks in relation to the implementation of Electronic Patient Record (EPR) are to be combined to demonstrate any potential impact on patient safety. This will be disseminated across divisions, and any details of risks to be brought back to this meeting.

098/17 **MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS**

- Commendation for Cleaning Industry Management Standard (CIMS) cleaning award
- Issues with EPR and any risks to be presented at Quality Committee

099/17 **QUALITY COMMITTEE WORK PLAN**

The work plan (Appendix J) was accepted, and it was agreed that the reporting of the annual complaints report and the quality annual report are moved to 31st July. It was also agreed that the quality annual report is renamed the Quality Committee annual report.

NEXT MEETING

Monday, 3rd July 2017
3:00 – 5:30 pm
Discussion Room 3, Learning Centre,
Huddersfield Royal Infirmary

ACTION LOG FOR QUALITY COMMITTEE FOLLOWING MEETING ON 31st MAY 2017

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

MEETING DATE AND MINUTE REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
DUE THIS MONTH				
31.05.17 (089/17)	**COMMUNITY PSQB DIVISONAL REPORT**	Community Division	**ACTION**: Report to be deferred to next month	Monday, 3rd July 2017
26.04.16 (077/16) 30.01.17 (023/17)	**COMPLIANCE WITH NICE GUIDANCE: QUARTERLY REPORT**	Juliette Cosgrove	▪ Further reports to be received quarterly with the next report due July 2016. ▪ Discussions to take place with CCGs regarding which of the guidelines are not compliant due to commissioning decisions. ▪ **ACTION 26.7.16:** NICE guidance will now be reported on a six monthly basis and CCG issues will be reported at the meeting in January 2017. ▪ **Update 30.01.17:** A request has been made for the NICE compliance report to be deferred to the April meeting (Wednesday, 3rd May 2017) in order for the update to be presented by Mr Martin DeBono, who will be in attendance. There are currently no risks or concerns with NICE compliance. **Update May 2017:** Due to the Quality Committee meeting on Wednesday, 3rd May 2017 being stood down due to EPR implementation, and the meeting on Wednesday, 31st May 2017 being dedicated to PSQB reporting, this will be deferred to the 3rd July 2017 meeting.	Monday, 3rd July 2017
27.02.17 (053/17)	**MORTALITY REPORT**	Dr David Birkenhead	**ACTION 27.02.17:** Report to be submitted at meeting in April to reflect guidance from NHS England **Update May 2017:** Due to the Quality Committee meeting on Wednesday, 3rd May 2017 being stood down due to EPR implementation, and the meeting on Wednesday, 31st May 2017 being dedicated to PSQB reporting, this will be deferred to the 3rd July 2017 meeting.	Monday, 3rd July 2017
27.02.17 (050/17)	**MEDICAL DIVISION PSQB REPORT – FALLS**	Juliette Cosgrove	**ACTION 27.02.17:** That a progress report on falls is presented at the May meeting **Update May 2017:** Due to the Quality Committee meeting on Wednesday, 3rd May 2017 being stood down due to EPR	Monday, 3rd July 2017

ACTION LOG FOR QUALITY COMMITTEE FOLLOWING MEETING ON 31st MAY 2017

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

MEETING DATE AND MINUTE REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
			implementation, and the meeting on Wednesday, 31st May 2017 being dedicated to PSQB reporting, this will be deferred to the 3rd July 2017 meeting.	
29.11.16 (228/16) 27.02.17 (050/17)	**TREATMENT AND PREVENTION OF SEPSIS AT CHFT** **MEDICAL DIVISION PSQB REPORT – SEPSIS**	Juliette Cosgrove	**ACTION 29.11.16:** An update on work done to be given in 6 months' time **ACTION 27.02.17:** That a progress report on sepsis is presented at the June meeting	Monday, 3rd July 2017

CLOSED ACTIONS

No items were closed at the 31st May meeting

APP A

Minutes of the Finance & Performance Committee held on Tuesday 30 May 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
Phil Oldfield	Non-Executive Director (Chair)
Owen Williams	Chief Executive
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Mandy Griffin	Director of Health Informatics
Andrew Haigh	Chair of the Trust
Brian Moore	Membership Councillor
Philippa Russell	Assistant Director of Finance
Betty Sewell	PA (Minutes)

ITEM

WELCOME AND INTRODUCTIONS

079/17 The Chair welcomed attendees to the meeting.

080/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Kirsty Archer – Deputy Director of Finance
Stuart Baron – Associate Director of Finance
David Birkenhead – Medical Director
Richard Hopkin – Non-Executive Director
Vicky Pickles – Company Secretary

081/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

082/17 MINUTES OF THE MEETING HELD 4 APRIL 2017 & 2 MAY 2017

The minutes of the meetings held 4th April and 2nd May were approved as an accurate record.

083/17 MATTERS ARISING AND ACTION LOG

156/16: Community Services – As the CCGs are carrying out a systematic review of community services it was agreed that this would be brought forward and reviewed at the next meeting, the report should include a contract position of future opportunities regarding the accountable care structure, which should encapsulate where we are with regard to mutual with the local authority – **AB/HB (4 July 2017).**

170/16: Benefits Appraisal of External Consultancy Support Investment – The Director of Finance introduced a paper which updated the Committee on the

identified efficiencies and benefits realisation as a result of the Trust's investment in recent consultancy support. The Trust has engaged specialist consultancy support to identify and shape specific efficiency projects as follows:-

- Inverto - Procurement efficiencies
- Newton Europe Ltd - Outpatient and Diagnostic efficiency
- FourEyes Insight - Theatre Productivity project and Clinical Admin redesign

The scope and benefits realisation of each of these projects was discussed in turn.

Inverto - It was noted that the Trust had seen a return on the investment in consultancy support for this project. Additional savings delivered subsequently through internal management action continue to build upon this return.

Newton – Following discussions it was agreed that with regard to the Newton work on Outpatients a question exists around their methodology at the time and from a consultant/operations point of view the efficiencies are difficult to attribute to their work alone. With regard to Diagnostics it is also unclear that efficiencies have been realised following their work and further work is on-going with the FSS Division to increase efficiency in managing demand within funded capacity.

FourEyes Insight – The Theatre Productivity project provided us with individual consultant based targets and this moved us on. However, it is unclear that Theatre productivity efficiencies are a direct result of our investment with FourEyes. With regard to the Clinical Admin opportunity, this is an area where efficiencies have definitely not been delivered.

It was agreed that learning from the above would be that we need to be absolutely clear about the benefit realisation for the expenditure and in the future we should have at least 3 or 4 principles to be applied to the future engagement of consultants to enable us to scrutinise and determine the likelihood of a return in investment.

It was noted that external consultants had brought something to the table using their knowledge base to enable improvement ourselves with mixed results. Our analytical knowledge is much improved and we now have the information and we are using data which is key to influence behavioural change.

It was also noted that some clinicians still do not fully understand the Trust's financial position and this message still has to be communicated successfully. Participation in NHS benchmarking and this needs visibility.

ACTIONS:

- To scope 3 or 4 principle criteria for the engagement of future consultants which is based on a return of investment to be brought back to this forum for agreement **– GB/AB**
- To pursue a "Go-see" with Bolton NHS FT and report back to the Committee – **GB**

The Committee noted the paper.

FINANCE AND PERFORMANCE

084/17 MONTH 01 FINANCE REPORT

The Assistant Director of Finance, took the Committee through the Finance Report for Month 01, the following headlines were noted:

- On balance we were as planned in Month 01, achieving the deficit of £4.04m, however, there were underlying pressures and was only achieved by releasing contingency reserves and the assistance of non-recurrent income.
- Activity was slightly behind plan attributed mainly to case mix which could be linked to EPR.
- Agency expenditure in month was low this could be linked to IR35 negotiations and bank holidays and is unlikely to be a continuing trend.
- EPR revenue costs were low in Month 01 and a higher level of cost is likely to be seen over the next couple of months.
- Cash is on plan for Month 01.
- We are on course to receive our Sustainability & Transformation Funding (STF), however, this year 30% of the funding is linked to our A&E target and the funding is also 'back-ended' and was noted as a risk.
- Forecast position is delivery of the planned £15.9m deficit, however, the risks highlighted in the report, were called out.

In depth discussions took place with regard to QIPP and the Director of Finance informed the Committee that the Trust continues to work with the CCGs with the assistance of both regulators to help bridge the gap and to focus on the items which are achievable. The sharing of SLR data with the CCGs has taken place to start productive conversations.

The Chief Operating Officer reported that following the fire which impacted on the Endoscopy Service the bowel screening programme has taken a hit and a contingency plan is now in place to recover income for the last two quarters of the year. Helen Barker also reported that three specialties had closed two 'out of area' referrals due to IR35, NHS Improvement are aware of our decision. In addition, as a direct result of IR35, we have failed our 2 week wait standard in May and A&E was reported as being turbulent. It was noted that this position is very fluid and steps are taking place to manage the situation.

085/17 REVISED BUDGET BOOK

The Director of Finance presented the Revised Budget Book which would be updated at Board of Directors.

The Committee received the paper for information.

STRATEGIC ITEMS

086/17 CIP UPDATE

The Chief Executive updated the Committee with regard to the 17/18 position. The key headlines were noted as follows:-

- The CIP target reported to NHS Improvement is £20m
- Schemes have been identified to the value of £14.5m
- Over £11k is at GW2 and £2.5m at GW1 and the scoping of additional

schemes stands at £661k.
- A gap of circa £5.5m still exists
- The focus is on GW2 and delivering that target, work continues to get as much as we can to GW2 by 14 June.
- EPR schemes are not included but are not being ignored.
- Depth of coding pre-EPR was good and as part of clinical behaviour post-EPR needs to get back on track as this will help with clinical decisions.

As part of the discussions with regard to CIP it was noted that within the monthly Performance Review Meetings (PRMs), Divisions are being challenged robustly, PRMs for Estates and Corporate will also be scheduled going forward.

087/17 EPR

The Director of Finance reported that this months' report is in line with previous months' financial report. Next month the report will cover the 'go-live' period and should give greater clarity and understanding of the financial position of the project.

The Director of Health Informatics gave a general update and reported that since 'go-live' we have been in what is described as 'early live support' and our transition back into business as usual. It was noted that 'go-live' went well, however, some of the areas which experienced access are still experiencing difficulties and plans are in place to help them through this period. Changes to the structure, now that implementation has taken place, were discussed, it was noted that a review of the resource which is still required at CHFT will be undertaken and some floor walking support has been extended. It was also noted that following the EPR Transformation Board and the Assurance Board a 'go-live' date for Bradford is still to be confirmed. As this is a joint project any delay in the Bradford go-live will have a financial risk for the Trust and a debate about on-going costs and cost association will continue with the Trust, Bradford and Cerner.

The Chief Operating Officer gave an update from an operational point of view to the Committee saying that following a good deployment some departments are finding it hard, ED have struggled to recover post-implementation and ward rounds are taking longer and therefore we are experiencing some productivity flow. However, colleagues who are successfully working with the system like it. Discussions then turned to lessons learnt, it was confirmed that as part of the transformation piece the Operational Readiness Board has been re-instated and the focus of this Board would now change following the implementation the system. It was agreed that a revised Terms of Reference for the Operational Readiness Board and a Transformation Project Plan will come back to the next Committee meeting.

ACTIONS:

- Revised Terms of Reference for the Operational Readiness Board and a Project Plan for Transformation and Benefits Realisation will come back to the F&P Committee – **MG/HB, 4 July 2017**
- With regard to the Bradford go-live a position paper was requested to come to the F&P Committee detailing the ongoing potential exposure and associated costs, risks and mitigations – **GB/MG, 1 August 2017 (Private Agenda)**

The Committee acknowledged the 'go-live' was a significant achievement for the Trust but it was noted that there is still a lot of work to do and that this is the start of the transformation journey. The dedication of all staff during the implementation and post-implementation is commendable. The Committee also thanked Mandy Griffin, Director of Health Informatics and Helen Barker, Chief Operating Officer for their leadership.

GOVERNANCE

088/17 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported as follows:-

It was noted that the Trust's performance score for April was 69%, similar to that of March. It was noted that some changes have taken place this month with regard to the methodology for scoring Finance and Workforce to reflect the emphasis on indicators considered more important. This methodology has been applied to previous months for comparison purposes.

Key points to note:

- Emergency Care Standard for April was better than trajectory at 95%
- Green Cross position has slightly improved
- 62 Day Cancer GP Referral to Treatment target failed in April at 84.2%
- Sickness absence has improved however vacancy rates will be reviewed and an update will come back next month
- More beds have been open than anticipated for April and bank holidays and Norovirus at CRH were sighted as the main reasons for this.
- Re-admission rates are not where they should be – discussions with Locala are taking place.
- Diagnostics target was challenging last month and we failed the indicator in April it is likely that this will continue into May but the hope is to be back on track in June.

In summary it was noted that for the first month of the year it was better than last year bearing in mind the operational focus on EPR implementation.

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

089/17 SELF-ASSESSMENT OF F&P COMMITTEE'S EFFECTIVENESS

The Committee received the paper which provided the results of the Self-Assessment by the members of the Committee.

The Committee noted the action plan to address the feedback.

090/17 MINUTES FROM SUB-COMMITTEES:

Cash Committee – Draft Minutes of meeting held 24 April 2017

Commercial Investment & Strategy Committee – Draft Minutes of meeting held 29 March 2017

Capital Management Group – Draft Minutes of meeting held 13 April 2017

The Director of Finance informed the Committee that the Capital Plan for 2017/18 is being finalised and dialogue continues with the teams, feedback will come to WEB

and Finance & Performance Committee once the programme has been finalised. Discussions took place with regard to the level of increased risk in the delay of our capital plans.

ACTION:
Forward planning and finance risks associated with the backlog of capital schemes to be presented to the Committee at the next meeting – **GB/HB/LH, 4 July 2017**

It was also noted that an up to date picture of the Capital reality for the Trust may be required.

The Committee received the Minutes and noted the contents.

091/17 WORK PLAN
The Work Plan was received by the Committee.

092/17 MATTERS FOR THE BOARD AND OTHER COMMITTEES
The Chair of the Committee summarised the following items which had been discussed during the meeting:-

- Operational Performance – Good for April
- Finance – On plan, however, underlying issues were acknowledged
- Activity – issue with case mix for April
- External Consultants – Discussion/learning, criteria to be developed for next month to be applied for the appointment of consultants in the future
- EPR – Move towards the transformation journey and ToR and project plan of benefits realisation coming back to the next meeting, the delay with any Bradford implementation to be risk assessed and mitigation highlighted
- Commissioner intentions re Community was discussed
- Risk Register to be updated to recognise the revised Capital Plan

093/17 ANY OTHER BUSINESS
Attendance/Membership of the Committee – A discussion took place with regard to re-establishing the core attendance to the Committee meeting following the relaxing of meetings during the EPR implementation. To enable the Executive team to continue to stay visible post-EPR, it was noted that:

Ian Warren, Director of Workforce & Organisational Development
Brendan Brown, Director of Nursing
Lesley Hill. Director of Planning, Estates & Facilities
David Birkenhead, Medical Director

are not expected to attend as core attendees and Mandy Griffin, Director of Health Informatics was given the option to attend for agenda specific items only.

DATE AND TIME OF NEXT MEETING
Tuesday 4 July 2017, 9.00am – 12.00noon,
Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 8 June 2017, 2.00pm – 4.00pm in Room 4, Acre Mill Outpatients, Huddersfield

PRESENT:

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

IN ATTENDANCE:

Kirsty Archer	Deputy Director of Finance
Christine Bouckley	Head of Occupational Health and Wellbeing for agenda item 71/17
Chris Burton	Chair of Staff Side
Lois Mellor	Senior Clinical Midwifery Manager
Jackie Murphy	Deputy Director of Nursing, Modernisation for agenda item 65/17
Cornelle Parker	Deputy Medical Director
Vicky Pickles	Company Secretary
Rachael Pierce	Resourcing Manager for agenda item 74/17
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development
Bev Walker	Associate Director of Urgent Care
Claire Wilson	Assistant Director of Human Resources

60/17 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

61/17 **APOLOGIES FOR ABSENCE:**
Helen Barker, Chief Operating Officer
Rosemary Hedges, Membership Councillor
David Birkenhead, Medical Director

62/17 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

63/17 **MINUTES OF MEETING HELD ON 16 MARCH 2017:**

The minutes of the meeting held on 16 March 2017 were approved as a true record.

64/17 **ACTION LOG (items due this month)**

Workforce (Well Led) Committee Sub Groups
Workforce Strategy Implementation Plan
Workforce Modernisation Programme Board
Medical Division – Assuring the Workforce Plans and Strategy

These items are to be discussed at agenda item 66/17.

Medical Division – Assuring the Workforce Plans and Strategy
Progress plan for deep dive on one Medical Ward

ACTION: BB/IW (This action will be captured in the Right Skills Right Time Programme)

Agency Spend Diagnostic Tool
See item 66/17

Staff Survey Results
See item 69/17

Invite FSS to July Committee meeting - Assuring the Workforce Plans and Strategy

ACTION: IW

MAIN AGENDA ITEMS

FOR ASSURANCE

65/17 **EPR PROGRESS UPDATE**

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

JM highlighted some key points following the go live period.

The high level of engagement was a critical success factor with the good will and commitment of all staff being recognised. Cerner reported CHFT had been the best implementation they had seen.

JM reported on some of the challenges colleagues faced during implementation, for example having no single source of personnel data was the biggest problem at go live. This issue was specifically linked to roles held by the RA team in THIS. Colleagues would have benefitted from more training and more 'on the job' training to help end users. Device functionality will need to be monitored closely for effective day to day running.

Engagement and involvement of EPR friends proved very effective for the Trust.

It was noted the transformation work in terms of job roles needs to be carried out to align current roles to the new EPR roles. This job analysis exercise would be accomplished through The Right Time Right Skills programme.

It was agreed JM, BB, IW and Anna Basford should meet to discuss how the transformation will fit into the workforce plan.

From a finance perspective KA is keen to see the data reports in terms of services provided and how this will support the charging mechanism.

The Committee commended the commitment and hard work of everyone involved in the implementation and go live of EPR.

ACTION: TR to arrange meeting re transformation/workforce plan

ACTION: JM to provide a further update at the September Committee meeting

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

66/17 **WORKFORCE STRATEGY UPDATE**

IW tabled a presentation to outline the governance structure and purpose of the Workforce Modernisation Programme Board (WMPB) and its subgroups.

The first meeting of the WMPB is being arranged to take place in the next 6 weeks.

3 additional short term, temporary resources have been engaged to work with the Trust and will lead on the following specific areas:-

Adrian Ennis - WMPB Lead and Medical Workforce
John Sargent - Right Skills, Right Time
Gary Logan - Nursing Workforce

The subgroups will report to the WMPB which will report monthly to the Workforce (Well Led) Committee.

IW reported significant progress so far:-

- A reduction in sickness
- Lower turnover
- Increase in headcount
- Recruitment to vacancies

The projects will continue to support the delivery of the Workforce Strategy. The Right Time Right Skills programme will involve all service functions. It will involve colleagues in discussions to help them understand their role – are colleagues doing things they don't need to do. Clinical time will be maximised.

A progress update on the Right Skills Right Time programme will be given to the July Committee meeting.

Key focus will be the health and wellbeing of all colleagues. The project groups will ensure that all actions underpin compassionate care for everyone.

KH commented the sub groups would have the time to do the deep dive analysis and give assurance to the Committee.

KH recommended that 2 work streams each month are added to the work plan to present a detailed update to the Committee

Action: TR to amend the Work Plan

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

67a/17 **FLEXIBLE WORKFORCE WEEKLY REPORT**

A copy of the weekly Flexible Workforce Report (produced for the Turnaround Executive) was circulated with papers to the Committee.

IW advised the report had been provided as an example to prompt what the Committee would wish to see in a regular report with regard to agency usage and spend.

The Committee agreed additional information is built into the monthly workforce

report, detailing a 3 month trend for agency spend activity, data with narrative, correlate and identify cause and effect – sickness, head count, safer staffing.

KH is also interested to see the implications to the Trust of the IR35 regulations. IW confirmed a full report is being submitted to the Executive Board on 15 June 2017 and would be brought to the July 2017 Committee Meeting.

ACTION: CW/JE incorporate agency usage information into the Monthly Workforce Performance Report

ACTION: TR revise Work Plan

67b/17 **AGENCY SPEND DIAGNOSTIC TOOL**

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

Work is progressing on how to validate the approach to agency spend and reduction in agency spend. The NHS Improvement diagnostic tool is being considered. JE confirmed the desktop analysis regarding compliance had been completed with 5 domains showing progress made.

Work with Divisional colleagues is being completed with a further paper to be submitted to the Executive Board with recommendations for actions to be signed off.

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

68/17 Implementation of Allocate - E-Rostering

Nursing Work Stream

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

BB gave an overview of the report.

Allocate is the replacement E-rostering system for the nursing workstream. The system went live in May 2017 with a rolling programme for all nursing to be implemented by the end of July 2017.

The Committee noted this e-roster tool has introduced a safe care element which was not available in the previous system.

BB reported that Allocate recently had some cyber viral issues – the business continuity plans were effected successfully.

BB wished to commend Rose Hagreen, E-Rostering Lead, for her input to the successful implementation of the system.

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

Medical Work Stream

CP provided a verbal update re the position of the Medical Work Stream.

CP has now met with Adrian Ennis, external resource, who will be supporting the medical workforce project team in the implementation of Allocate E-systems.

The medical work stream has not used e-rostering previously. An implementation

plan will be developed once certain factors have been determined, examples being the financial position and scoping of signed consultant job plans.

An update will be provided to the July Committee meeting

ACTION: TR to revise Work Plan.

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

69/17 **2016 STAFF SURVEY RESPONSE**

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

Printed copies of Appendix B, Staff Survey response statement were available at the meeting for ease of reading.

The proposed approach to effectively responding to the feedback is to produce an outcome/output/activity (input) statement that identifies a limited number of core themes to focus on ahead of the 2017 staff survey. The themes are consistent with those set out in the 2015 staff survey action plan. The core themes for inclusion in the statement are as follows:-

- Engagement
- Health and wellbeing
- Learning and development
- Reward and recognition
- Workforce race equality

Progress will be monitored through the Workforce (Well Led) Committee with quarterly reports provided to the Board of Directors.

JE reported there has been marginal increase in terms of participation. In order to increase participation a census survey across the Trust is being considered.

The paper will be submitted at the July 2017 meeting of the Board of Directors. The Trust's response statement will be communicated to colleagues by all means available.

The challenge for the Trust is to evidence it has acted on feedback. Colleagues need to feel assured feedback does produce results.

The Committee requested the response be amended so the response is applicable to all colleagues.

KH and IW noted the excellent presentation of the response document.

ACTION: IW to recommend to the Board of Directors the approach to responding to Staff Survey feedback

ACTION: JE to amend response statement

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

70/17 **BOARD ASSURANCE FRAMEWORK**

VP advised the BAF had not been reported at the Board of Directors and is therefore being deferred to the July 2017 Committee meeting.

ACTION: TR to amend the Workplan

71/17 **COLLEAGUE HEALTH AND WELLBEING**

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

CB provided the Committee with an overview of the Trust's approach to colleague health and wellbeing.

The 2017 action plan is based on the requirement of part 1a of the national health and wellbeing CQUIN and incorporates the response to feedback secured through the staff survey.

The national staff survey is the primary source of feedback on staff perception of their wellbeing at work. The national 2017 health and wellbeing CQUIN utilises three specific questions from the staff survey to measure performance improvement with the requirement to demonstrate a positive response in at least two of the three questions of 5% over a rolling 2 years.

Key indicator 1. Staff report that the organisation takes a positive action on health and wellbeing. An improvement of 5% on staff survey question 9a over a rolling 2 year period.

Key Indicator 2. Staff report less musculoskeletal injury and pain. An improvement of 5% on staff survey question 9b over a rolling 2 year period.

Key Indicator 3. Reducing staff experiences of work related stress. An improvement of 5% on staff survey question 9c over a rolling 2 year period.

An annual action plan has been developed detailing key activities in response to the 3 indicators above. Progress against these actions will be reported to the Workforce Modernisation Programme Board.

CB reported that a shift from reactive measures to a focus on a preventative way of life throughout the organisation is necessary to ensure the health and wellbeing of colleagues.

VP confirmed she would raise this issue at the OD and Engagement group.

IW wished to recognise the achievements made and gave credit to all involved. IW asked if the Trust could do more, CB confirmed she was happy with the headline content.

ACTION: CB to provide progress update to the September Committee meeting

ACTION: VP to raise at OD and Engagement group.

OUTCOME: The Committee **RECEIVED, NOTED** and supported the approach

PERFORMANCE

72/17 **WORKFORCE PERFORMANCE REPORT (MAY 2017)**

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

- CW highlighted key points from the report:-

- Sickness absence had continued to improve
- Appraisal season now in place (1 July to 31 October 2017), KPI will be monitored.
- Turnover had increased for the first time this month. This will be closely monitored in next month's trajectory.
- Starters/Leavers – a review of qualified nurses and midwives starting/leaving the Trust had been undertaken dating back to 2014.

BB felt the main reasons for nursing colleagues leaving/returning to the Trust were known and therefore recommended a deep dive into other staff groups leaving the Trust, ie Radiologists, Pharmacists.

Colleague engagement is fundamental in identifying and where possible addressing the reasons colleagues may be thinking of leaving the Trust. IW emphasised the need for strong OD and leadership to ensure managers are engaging with colleagues in support of their health and wellbeing.

ACTION: CW to provide costs by Division re sickness absence

ACTION: CW to align the report more closely to the Workforce Strategy

ACTION: CW to review other staff groups in terms of starters/leavers and provide an update at the July Committee meeting

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

INFORMATION

73/17 **BRIEFING PAPER – WORKFORCE PLANNING AT CALDERDALE AND HUDDERSFIELD NHS TRUST**

A briefing paper had been circulated with papers to the Committee.

CW provided an overview of the approach to strategic workforce planning (availability, utilisation and effectiveness) in the Trust. This being a focused area of the Trust's Workforce Strategy.

The workforce planning journey commenced in 2016 with planning sessions taking place in October and November and a following session in February 2017.

A 'Go See' visit to Imperial College NHS Trust took place in January 2017 to look at their workforce planning process which has been developed over a number of years. CHFT colleagues have been working to localise this process to better manage workforce issues through a 'live' workforce plan for every service area. This is now in the testing stage to ensure it is fit for purpose at 'go live'.

The Workforce and Organisational Development team are developing a set of tools to enhance understanding of workforce planning and capability to design and maintain credible workforce plans across the Trust. The Calderdale Framework, an evidenced based workforce tool, is also built into this localised approach.

The Trust is engaging with NHS Improvements and University of London to support the early implementation of the Trust's model approach.

An Health Education England supported product – 'WRaPT' (The Workforce

Repository and Planning Tool), hosted by Lancashire Care NHS Foundation Trust, is also being looked at to support CHFT's workforce planning toolkit. The aim of this tool is to enable workforce transformation. It works using 3 sets of data; workforce, activity and driver.

A timetable for the activity is outlined in the report.

CW confirmed that this workforce planning model approach will be capable of factoring service change and future demand. The workforce plans will be refreshed annually as part of the Business Planning process. There will be triangulation of service plans, finance (CIPs/developments) and workforce plans. The model will align to the Right Skills Right Time programme.

The Committee endorsed that regular workforce planning discussions and activity needs to embed in the organisation and is not limited to an 'annual' process.

The Committee requested an update is received at its July 2017 meeting.

ACTION: TR update the Workplan to include in the June Committee meeting.

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

74/17 **RECRUITMENT IMPROVEMENT PLAN**

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

RP presented to the Committee the further progress made with regard to the initial 64 recommendations made by StepChange in 2016.

The key notes in terms of progress are:-

More working with divisions
Introduction of conditional and unconditional offer letters
Standard operating procedures in place

In April 2017 StepChange made a follow up review of the recruitment service and made 9 further recommendations. These further recommendations have been built into the Recruitment Improvement plan.

Since the StepChange review in April 2017, the Recruitment and Medical HR departments have implemented a new recruitment system to the Trust. Trac gives recruiting managers visibility to all of their vacancies, right through from authorisation for the advert, through to start date. It also allows them to keep up to date with any communication with candidates.

The new system supports the service in implementing 4 of the 9 recommendations and will allow the Trust to report on a full range of vacancy/recruitment data.

The Committee recognised the good work of the Recruitment Team and wanted to support actions to challenge the current average length of time taking with regard to vacancy approval (14 days), shortlisting (9 days) and notification to Recruitment following interview (7 days) and the resulting time to hire.

The Committee requested a further update on the progress of the Recruitment Improvement plan to be given at its October 2017 meeting. A final report is to be presented in November 2017 following full implementation of the improvement plan.

ACTION: IW to raise with Peter Keogh for discussion with Executive Directors at Divisional Performance Review Meetings

ACTION: All to take messages from report and challenge practice

ACTION: TR to circulate the presentation and add to the Workplan

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

75/17 **2015/2016 CLINICAL EXCELLENCE AWARDS**

A briefing paper had been circulated to the Committee.

IW confirmed the CEA Panel met on 25 April 2017 to consider the 45 applications received. A total of 26 awards were made.

JW was the assigned Chair of the CEA Panel but wished to note that Peter Roberts covered as Chair in the morning as she was unavoidably able to do so.

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

76/17 **WHISTLEBLOWING ANNUAL REPORT – ACTION PLAN PROGRESS REPORT**

A report providing an update on the progress made with regard to raising awareness across the Trust had been circulated to the Committee.

JE requested the Committee note there is a clear CQC Well Led domain and inspection will focus on the Trust's approach to raising concerns and the Freedom to Speak up Guardian.

The actions in the report describe the Trust's approach necessary to ensure the Trust's arrangements for raising concerns continue to be fit for purpose and well known to employees. The Committee is asked to appraise itself of the actions outlined.

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

ITEMS TO RECEIVE AND NOTE

77/17 **ANY OTHER BUSINESS:**

No other business was raised.

ACTION:

78/17 **MATTERS FOR ESCALATION:**

Staff Survey Response Statement to be recommended to the Board of Directors (IW).

DATE AND TIME OF NEXT MEETING:

Thursday 13 July 2017, 2.00 pm – 4.00 pm, Room 3, 3rd Floor, Acre Mill Outpatients