Calderdale and Huddersfield NHS

NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 2 February 2017 from 9:00 am

Venue: Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	Welcome and introductions: Sharon Lowrie. Nominated Stakeholder Peter Middleton, Public Elected Eileen Hamer, Staff Elected Membership Councillors	Chair	**VERBAL**	Note
2	Apologies for absence:	Chair	**VERBAL**	Note
3	Declaration of interests	All	**VERBAL**	Receive
4	Minutes of the previous meeting held on 5 January 2017	Chair	**APP A**	Approve
5	Action log and matters arising:	Chair	**APP B**	Review
6	Staff Story: Tamsyn Grey, Consultant Surgeon to attend to present a paper on 'Role as Guardian of Safe Working'	Executive Medical Director	**Presentation**	Note
8	Chairman's Report a. Membership Council Meeting – 17.1.17	Chair	**VERBAL**	Note
9	Chief Executive's Report:	Chief Executive	**VERBAL**	Note
Transforming and improving patient care – no items				
Keeping the base safe				
10	Risk Register report	Executive Director of Nursing	**APP C**	**Approve**
11	Board Assurance Framework	Company Secretary	**APP D**	**Approve**
12	Governance report - Standing Orders – Membership Council	Company Secretary	**APP E**	**Approve**

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	- Terms of Reference:
	    1. Quality Committee
	    2. Finance & Performance Committee
	    3. Audit and Risk Committee
	    4. Nomination and Remuneration Committees (BOD) and (MC)				

13	Whistleblowing Annual Report	Executive Director of Workforce and OD/Freedom to Speak Up To Guardian	**APP F**	**Note**	
14	Director of Infection, Prevention and Control Update	Executive Medical Director	**APP G**	**Note**	
15	Integrated Performance Report	Chief Operating Officer	**APP H**	**Approve**	
Financial Sustainability					
16	Month 9 – 2016 – Financial Narrative	Executive Director of Finance	**APP I**	**Approve**	
17	Board Resolution conversion of working capital facility to interim revenue support loan	Executive Director of Finance	**APP J**	Approve	
A workforce for the future – no items					
18	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 3.1.17 and verbal update from meeting of 30.1.17 ▪ Finance and Performance Committee – minutes of 3.1.17 and verbal update from meeting 31.1.17 ▪ Draft Membership Council Minutes – 17.1.17 ▪ Audit and Risk Committee – Draft minutes – 18.1.17		**APP K**	**Receive**	
Date and time of next meeting **Thursday 2 March 2017 commencing at 9.00 am** **Venue: Discussion Room 1, Learning Centre, HRI**					

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:	Report Author:
Board of Directors	Kathy Bray, Board Secretary
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	Victoria Pickles, Company Secretary
Title and brief summary:	
PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 5.1.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 5 January 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	

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Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 5 January 2017.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 5 January 2017.

Appendix

Attachment:

There is no PDF document attached to the paper.

Calderdale and Huddersfield
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 5 January 2017 in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

PRESENT

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

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary (minute taker)
Mandy Griffin	Director of The Health Informatics Service
Victoria Pickles	Company Secretary
Juliette Cosgrove	Acting Director of Nursing

OBSERVER

Rosemary Hedges	Public Elected Membership Councillor
Lynn Moore	Public Elected Membership Councillor
George Psomas	dePoel

1/17   WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

2/17   APOLOGIES FOR ABSENCE

Apologies were received from:
Andrew Haigh, Chairman
Owen Williams, Chief Executive

3/17   DECLARATIONS OF INTEREST

There were no declarations of interest to note.

4/17   MINUTES OF THE MEETING HELD ON 1 DECEMBER 2016

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

5/17   MATTERS ARISING FROM THE MINUTES / ACTION LOG
169/16   REVIEW OF PROGRESS AGAINST STRATEGY – PMU/THIS

The Executive Director of Finance reported that this information had been circulated to the Board over the Christmas period and could now be closed on the Action Log.

6/17 **PATIENT / STAFF STORY – MRS ANDREWS RE DELAYED TRANSFER OF CARE**
The Chief Operating Officer advised that the Board were being shown the You-tube presentation https://youtu.be/juu8SmjxQoc following agreement by the A&E Delivery Board that this video would be shown to all Boards during January. The video had been extracted from the Acute Frailty Network presentation by Dr Ian Sturgess.

In summary the presentation highlighted the effect of delayed transfers of care on patients and particularly the effects of deconditioning patients leading to increased falls with decreased mobility. The video included evidence from national studies of the detrimental effects on patients who experienced delays in transfer of care.

It was noted that the Trust continued to strive to challenge staff and partners to reduced delayed transfers, not just in elderly care, but for all patients.

Discussion took place regarding the challenges of ensuring patients did not become deconditioned by delays in discharge and the associated outcomes of this. It was agreed that there was a cultural shift needed and this was a joint challenge for all providers and a matter for all staff. It was agreed that the priorities for the Safer Patient Programme for next year would be reviewed and presented to the Quality Committee/Board in March 2017.

OUTCOME: Safer Patient Programme Priorities for 2017-18 to be reviewed and brought back to the Quality Committee/Board in March 2017.
ACTION: HB/BB/DB – BOD AGENDA ITEM MARCH 2017

7/17 **CHAIRMAN'S REPORT**
a. WYAAT Meeting 12.12.16 Update
The Company Secretary reported that a further meeting of the Company Secretaries was due to take place on the 6 January 2017 to finalise the Committee in Common Terms of Reference and Memorandum of Understanding.

b. MC Workshop re Annual Plan/Quality Accounts 2017
The Acting Chair reported that the Membership Councillors had received an update on the Annual Plan submission and opportunity for the Membership Council to shortlist the indicators for inclusion in the Quality Account for 2017. Members would then be asked to vote against the indicators. It was noted that the closing date for voting was the end of February 2017.

The Executive Director of Planning, Performance, Estates and Facilities reported that the Membership Council had received and approved the Annual Plan.

c. CE/CEO Meeting – 13.12.16
The Acting Chair reported that there was no update to note.

OUTCOME: The Board **NOTED** the update from the Acting Chair.

8/17 **CHIEF EXECUTIVE'S REPORT**
The Acting Chief Executive advised that there was no information to update which was not already included on the agenda.

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

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9/17	**RISK REGISTER**

The Acting Director of Nursing reported on the top risks scoring 15 or above within the organisation.

These were:-

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

Risks with increased score

There was one risk with an increased risk score, risk 6131 regarding service reconfiguration. This risk had reduced in score to 15 but has now increased to a risk score of 20.

Risks with reduced scores

There were no risks with a reduced score on the high level risk register during December.

New risks

There were no risks added to the high level risk register during December.

Closed risks

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

Karen Heaton asked if there had been any impact of Brexit. The Acting Director of Nursing advised that this had been discussed by the Risk and Compliance Group. A risk had been described and was on the risk register but did not score high enough to appear on the corporate risk register as there was currently no no local impact. It was noted that nationally a piece of work was on going but no step change had been seen at this point.

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.

<div align="right">**ACTION: Executive Director of Workforce & OD**</div>

Richard Hopkin queried the heat map Cash Flow risk rating score. It was noted that the score was captured as both 15 and 20 in the paper. Gary Boothby agreed to look into this and rectify it accordingly.

<div align="right">**ACTION: Executive Director of Finance**</div>

OUTCOME: The Board **RECEIVED** and **APPROVED** the corporate risk register subject to amendments to the Cash Flow risk rating.

10/17	**RISK MANAGEMENT STRATEGY**

The Acting Director of Nursing presented the Risk Management Strategy, which had been thoroughly reviewed by the Risk and Compliance Group, Quality Committee, Audit and Risk Committee and Executive Board. The Strategy set out the management of both clinical and non-clinical risk.

It was noted that the Trust had a Risk Management Policy in place which combines largely operational information on risk management and risk registers and the aim of

the Risk Management Strategy was to detail the objectives and organisational framework for risk management systems within the Trust. The document confirms roles, responsibilities and processes for risk management in order to reduce harm, create safer environments for care and achieve the Trust's strategic objectives.

The Board approved the document and expressed their appreciation for the work undertaken in finalising this document.

OUTCOME: The Board **APPROVED** the Risk Management Strategy and the revision of the Risk Management Policy prior to cascading to staff.

11/17   GOVERNANCE REPORT
The Company Secretary presented the Workforce (Well Led) Committee Terms of Reference to the Board. It was noted that the Well Led Workforce Committee Terms of Reference have been reviewed and a number of amendments had been made to reflect the scrutiny of the delivery of the Workforce Strategy. The membership of the Committee had also been reviewed and amended to ensure there was clarity between members of the Committee and attendees.

ACTION: Company Secretary

OUTCOME: The Board **APPROVED** the Workforce (Well Led) Committee Terms of Reference subject to an amendment to the frequency of meetings to monthly.

12/17   CARE OF THE ACUTELY ILL PATIENT REPORT
The Executive Medical Director presented the Care of the Acutely Ill Patient Report.

The progress of the Care of the Acutely Ill Patient (CAIP) programme with its overall aim to reduce mortality in the six themed areas were noted:

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 - HSMR is reducing and currently 102.94

The contents of the report were noted and the positive impact of this programme, demonstrating the aim of the programme to reduce mortality was noted. The Board supported the continuation of the work being undertaken.

OUTCOME: The Board APPROVED the Care of the Acutely Ill Patient Report

13/17   CQC UPDATE
The Acting Executive Director of Nursing presented the CQC Update paper setting out progress against the delivery of the Trust's response to the CQC report. The plan was based on the 19 'must do' and 12 'should do' actions detailed in the CQC report which was published on the 15 August 2016.

The report focuses on the movements of individual actions in line with the 'BRAG' rating methodology.

The Board of Directors were asked to approve the movements in the plan as recommended by the CQC Response Group and which had been approved by the Quality Committee.

It was noted that the links to the evidence files to support the move to a blue rating for action SD4 have been circulated to the Board separately.

OUTCOME: The Board **RECEIVED** the plan and **APPROVED** the closure of action SD4.

14/17 PUBLIC SECTOR EQUALITY DUTY REPORT

The Executive Director of Workforce and Organisational Development presented the public sector equality duty report.

It was noted that the Trust is required to publish an annual report which sets out how the Trust is compliant with the Equality Act 2010. The aims of the Act are to:

- Eliminate unfair discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relationships between different groups

The Board approved the Trust statement for publication on the website. Karen Heaton enquired whether the statement should include the support of the Board of Directors. The Executive Director of Workforce and OD advised that this was not a legal requirement but the Board agreed that this would be good practice and the Executive Director of Workforce and OD agreed that he would ensure that this was amended accordingly.

ACTION: Executive Director of Workforce & OD

OUTCOME: The Board **APPROVED** the Public Sector Equality Duty Report to be published on the Trust website by the end of January 2017.

15/17 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the key points of operational performance for November 2016. 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:-

- November's Performance Score was 65% for the Trust. Norovirus within wards and departments had impacted on flow and staffing.
- Performance had improved in 3 of the 6 domains in month.
- Within the Safe domain, the occurrence of a Never Event had contributed significantly to the rating
- The Trust's HSMR position has improved. Incidence of CDiff continues to be a challenge and is being closely managed
- Regulatory breaches – 62 day referral from screening to treatment – involving 2/3 patients
- Emergency Care Standard 4 hours - November's position was 94.02% which was in the Upper Quartile nationally. An Emergency Care improvement plan has been developed by the Directorate which focusses on the emergenct care standard and quality indicators.
- Stroke Ward – affected by norovirus which could impact on achievement of the target.
- Complaints – significant progress has been made in response times to complaints with the backlog cleared.
- Within Carter dashboard performance against 12 indicators was the same or better
- Community –Reablement pressures were being addressed through the development of a 12 bedded area (max 7 day stay).
- Fractured Neck of Femur – it was hoped that the position would improve with the re-opening of Theatre 6.
- Workforce
  - Mandatory Training – work continues to improve the position. It was noted that further improvements should be seen once the ESR system is

accessible to all staff.
- Staff Survey – Embargoed results had been received. These would be analysed and detailed report brought to a future Board meeting.

OUTCOME: The Board **RECEIVED** the Integrated Board Report and **NOTED** the key areas of performance for November 2016.

16/16 **MONTH 8 – 2016 - FINANCIAL NARRATIVE**
The Executive Director of Finance reported the key financial performance areas. It was noted that this had been discussed in detail at the Finance and Performance Committee held on the 3 January 2017.

The year to date financial position stands at a deficit of £10.60m, a favourable variance of £2.00m from the planned £12.60m of which £1.88m is purely a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The underlying position is a £0.12m favourable variance from year to date plan. This is positive news as the Trust is continuing to maintain the financial position in the second half of the financial year where there was always acknowledged to be a greater challenge in terms of the timing of CIP delivery, alongside seasonal pressures.

Operational performance linked to the STF has also been maintained in the year to date however, in early December the organisation has faced considerable operational challenges including dealing with Norovirus in the face of continued high clinical activity. It continues to be the case that, in order to deliver activity and access standards across the Trust with high vacancy levels, there is reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.47m, an improved position from last month which compares favourably with expenditure in excess of £2.1m each month in the year to August. This improvement brings the agency expenditure beneath the revised trajectory submitted to NHSI.

Summary:-
- EBITDA of £5.98m, a favourable variance of £1.53m from the plan.
- Of this operating performance £1.88m is driven by a timing difference on the accrual of Strategic Transformation Funding versus the planned quarterly profile.
- A bottom line deficit of £10.60m, a £2.00m favourable variance from plan.
- Delivery of CIP of £9.65m against the planned level of £7.62m.
- Contingency reserves of £1.0m have been released against pressures.
- Capital expenditure of £10.66m, this is below the planned level of £17.93m.
- Cash balance of £3.97m; this is above the planned level of £1.94m, supported by borrowing.
- Use of Resources score of level 3, in line with the plan.

OUTCOME: The Board **APPROVED** the Month 8 financial narrative and **NOTED** the continued financial challenges.

17/17 **WORKFORCE STRATEGY**
The Executive Director of Workforce and OD presented the Workforce Strategy and Action Plan. It was noted that this was a live document and would be adjusted as necessary.

He reported that as part of the ongoing need to develop our services, we are further challenged by the need to re-configure our services to meet these increasing demands across a multi-site organisation. It was agreed that our workforce needs to be fully

engaged in developing our approach to meet these futurerequirements. The Workforce Strategy was the key document to draw together the approaches required to attract, retain, support, engage and reward our people in order to meet this challenge.

It was noted that the Strategy themes were:-
• Recruitment
• Retention
• Workforce planning – availability, utilisation and effectiveness
• Agency spend – both in terms of cost and number
• Attendance Management
• Colleague Engagement
• Organisation Development and Leadership.

The Workforce (Well Led) Committee had approved the strategy at its meeting on 8 December 2016.

OUTCOME: The Board **APPROVED** the Workforce Strategy.

18/17   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
Jan Wilson as Acting Chair of the Quality Committee reported on the items discussed at the meeting held on 3 January 2017 which had not been previously covered on the Board's agenda:

- CQC Response Group - review of Action Plan dates
- Integrated Performance Report – received and noted
- Serious Untoward Incident – presentation received from FFS
- GMC Training Letter – had been referred to Workforce Committee – to be circulated to all Board members for information

<div align="right">ACTION: Board Secretary</div>

- Terms of Reference for Quality Committee - approved

OUTCOME: The Board RECEIVED the verbal update and the minutes of the meeting held on 29.11.16.

b. Finance and Performance Committee
Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 3.1.17:
-    Risks and forecast from Commissioners
-
-    Pressures in December/January – bed availability/usage
-    Confirmation of Accelerator Zone funding
-    Challenges of Q4 will be key to targets
-    Presentation on Outpatient Flow and improvements in performance with new technology
-    Cash position and cash management
-    Annual Plan
-    EPR Timeline

OUTCOME: The Board RECEIVED the verbal update and the minutes of the meeting held on 29.11.16.

c. Workforce Committee
OUTCOME: The Board **RECEIVED** draft minutes from the meeting held on 8.12.16.
The key issues currently under discussion included:
- Workforce Strategy – approved
- Review of Terms of Reference - agreed
- Committee Annual Workplan – agreed
- Recruitment Presentation received – shorter timescales

d. Draft Membership Council Minutes – 9.11.16
OUTCOME: The Board **RECEIVED** the draft minutes from the meeting held on
9.11.16. There were no issues of concern.

19/17 **DATE AND TIME OF NEXT MEETING**
Thursday 2 February 2018 commencing at 9.00 am in Discussion Room 1, Learning
Centre, Huddersfield Royal Infirmary.

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

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Calderdale and Huddersfield **NHS**
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	Report Author:
Board of Directors	Kathy Bray, Board Secretary
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	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 February 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 February 2017

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

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

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Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	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.	2.2.16		
168/16 3.11.16	**WELL LED GOVERNANCE ASSESSMENT** As part of new oversight arrangements, NHSI are looking to align their well led governance assessment more closely with the CQC well led assessment. The Company Secretary was due to attend a workshop on this in November and will provide further feedback to the Board at a future meeting.	VP	**1.12.16** It was noted that the workshop had not taken place.			
175/16 3.11.16	**UPDATE FROM SUB-COMMITTEES** **Audit and Risk Committee** 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				
184/16 1.12.16	**FINANCIAL SUSTAINABILITY OF THE NHS REPORT** The Board acknowledged that all stakeholders, Trusts, CCGs and Local Authorities were in this together and this was reflective of the 'Right care, Right time, Right place consultation work. It was agreed that the	OW		March 2017		

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Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	Chairman and Chief Executive should host a conversation with key players to discuss the implications for the future. Consideration would also be given to commissioning an independent think tank organisation to help pull together the outcomes from this.					
6/17 5.1.17	**DELAYED TRANSFER OF CARE – SAFER PATIENT PROGRAMME PRIORITIES 2017-18** It was agreed that the priorities for the Safer Patient Programme for next year would be reviewed and presented to the Quality Committee/Board in March 2017.	**HB/BB/DB**		2.3.17		

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Calderdale and Huddersfield **NHS**

NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	Report Author:
Board of Directors	Andrea McCourt, Head of Governance and Risk
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	Brendan Brown, Executive Director of Nursing
Title and brief summary:	
High level Risk Register - Presentation of the significant risks facing the Trust as at January 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 reviewed the corporate risk register on 17 January 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 corporate 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 January 2017 which identifies the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks.

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

There are no new risks this month.

Discussion of a risk relating to a number of estates risks affecting the Intensive Care Unit at Huddersfield Royal Infirmary took place at the meeting on 17 January. 2017. This risk is being developed further and will be re-presented to the meeting of the Risk and Compliance Group on 14 February 2017 for further consideration as a high level risk.

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 RISK REGISTER REPORT.pdf

HIGH LEVEL RISK REGISTER REPORT

Risks as at 23 January 2017

TOP RISKS
2827 (20): Over-reliance on locum middle grade doctors in A&E 6345 (20): Staffing risk, nursing and medical 6131 (20) : Service reconfiguration 5806 (20): Urgent estates schemes not undertaken 6503(20): Delivery of Electronic Patient Record Programme 6721 (20): Non delivery of 2016/17 financial plan 6722 (20): Cash flow risk
RISKS WITH INCREASED SCORE
There are no risks with an increased risk score in January 2017.
RISKS WITH REDUCED SCORE
There are no risks that have been reduced in score on the high level risk register during January 2017.
NEW RISKS
There are no risks that have been added to the high level risk register during January 2017.
CLOSED RISKS
None

January 2017 Summary of High Level Risk Register by type of risk

Risk ref	Strategic Objective	Risk	Executive Lead	M	O	N	T	H	
		Strategic Risks		Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme - transformation	Director of THIS (MG)	=20	=20	=20	=20	=20	=20
		Safety and Quality Risks							
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	=20	=20	=20	↓15	↑ 20	=20
6886	Transforming & Improving Patient Care	Non compliance with 7 day services standards	Medical Director (DB)	-	-	-	!15	=15	=15
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=20	↓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
6822	Keeping the Base Safe	Not meeting sepsis CQUIN	Medical Director (DB)	-	-	!16	=16	=16	=16
5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	-	-	!16	=16	=16	=16
6829	Keeping the Base Safe	Aspetic Pharmacy Unit production	Director of Nursing	-	-	!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
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=16	=16	↑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
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD	=16	=16	=16	=16	=16	=16
6694	Keeping the base safe	Divisional Governance arrangements	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
6715	Keeping the base safe	Poor quality / incomplete	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	Aug 16	Sept 16	Oct 16	Nov 16	Dec16	Jan 17
		documentation							
6753	Keeping the base safe	Inappropriate access to person identifiable information	Director of THIS (MG)	16!	=16	=16	=16	=16	=16
		Financial Risks							
6721	Financial sustainability	Non delivery of 2016/17 financial plan	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
6722	Financial sustainability	Cash flow risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
6723	Financial sustainability	Capital programme	Director of Finance (GB)	=20	↓15	15 =	=15	=15	=15
		Performance and Regulation Risks							
6658	Keeping the base safe	Inefficient patient flow	Chief Operating Officer (HB)	=20	↓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
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Director of Workforce (IW)		=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

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 23/01/2017

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6693 - Failure to comply with monitor staffing cap = 6715 - Poor quality / incomplete documentation	= 6345 - Staffing risk, nursing and medical	
Likely (4)				= 4783 Outlier on mortality levels = 6658 Inefficient patient flow = 6300 Clinical, operational and estates risks outcome = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 6694 Divisional governance arrangements = 6753 Inappropriate access to patient identifiable data = 5862 Falls risk = 6822 CQUIN sepsis	= 2827 Over reliance on locum middle grade doctors in A&E = 6503 Non delivery of EPR programme = 6721 Not delivering 2016/17 financial plan = 5806 Urgent estate work not complete = 6131 – service reconfiguration = 6722 Cash Flow risk
Possible (3)					= 6814 EPR operational readiness = 6829 Pharmacy Aseptic Unit = 6886 Non compliance with 7 day services standards = 6723 capital programme
Unlikely (2)					
Rare (1)					

High Level Risk Register

Risk No	Div	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6131	Corporate	Oct-2014	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	10 5 x 2	The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks. A change in consultant recruitment process (that commenced during January 2016) will reduce time to appointment. October 2016 update Commissioner approval on 20.10.16. for development to full business case. JOSC decision on 16 November on referral of decision to secretary of state December 2016 Update: On the 16th November the Joint Scrutiny Committee decided that if the CCG's do not satisfactorily address their concerns the Committee will consider referral to the Secretary of State. The Committee will meet in February 2017 to assess progress of the development of the Full Business Case. **January 2017 Update** Public meeting to be held mid-February 2017	Mar-2017	Mar-2017	WEB	Anna Basford	Catherine Riley
2827	Medical	Apr-2011	Developing our workforce	There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints. Locum shifts not being filled by the Flexible Workforce team and gaps not being escalated to the clinical team in a timely manner. ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. FLexible Workforce not able to fill gaps	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time November 2016 Advert out for specialty doctors and ED Consultants December 2016: No changes, the Trust continues to advertise vacancies for specialty doctors and ED consultants. **January 2017:** 1 Substantive Consultant has resigned (Paediatric Emergency Medicine lead) - post advertised. Business case for CESR (Certificate of Eligibility for Specialist Registration), for doctors who meet approved standards but completed their training in alternative programs, for example overseas) posts to cover gaps in middle grade rota.	Mar-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

6345	Trustwide	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
- lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties (A&E, Ophthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology, Gynaecology/Urology Oncology, Acute Oncology Service)
- over-reliance on middle grade doctors meaning less specialist input
- dual site working and impact on medical staffing rotas
- lack of workforce planning / operational management process and information to manage medical staffing gaps
- 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

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.
- revised approvals process for medical staffing to reduce delays in commencing recruitment.
- HR resource to manage medical workforce issues.
- Exit interviews for Consultants being conducted.
- 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:
- workforce plan / strategy for medical staff identifying level of workforce required
- dedicated resource to develop workforce model for medical staffing
- centralised medical staffing roster (currently divisional) / workforce planning for medical staff
- system /process to identify, record and manage gaps in planned medical staffing, particularly for junior doctors
- 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	20	9
4 x 4	4 x 5	3 x 3

Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director)

November 16
Divisions continue to identify opportunities where Specialty Doctors may be able to bridge the gap with Consultant vacancies.
December 16
Active recruitment to vacant nursing, medical and AHP posts continues. From a nursing perspective this includes local, national and international recruitment events.
A confirm and challenge process is now in place at Divisional level, which reviews the quality, professional, safety and financial elements of staffing. A further 'Hard Truths' review of ward nursing establishments is currently underway, alongside the introduction of a peripatetic team to manage the organisations response to the needs of specialising (1:1) nursing improvements to the recruitment process and the Flexible Workforce departments also continue, in line with National and arm's length bodies recommendations.

January 2017 Update
Previous actions continue
Targeted recruitment

Feb-2017	Jan-2018	WLG	David Birkenhead, Brendan Brown, Ian Warren	Lindsay Rudge, Jason Eddleston & Claire Wilson

| 5806 | Estates & Facilities | May-2015 | Keeping the base safe | Risk of the current HRI Estate failing to meet required condition due to condition of the building resulting in failure in achieving compliance. This could result in the closure of areas, stopping of patient care, suspension of vital services,
•Flooring: in ICU at HRI, Ward 19, CCU CRH
•Windows: all elevations of the hospital, A& E Resus, potential closure to services from water affecting core services
•Theatres / Environment ; HRI Main, DSU and Theatre 6 and CRH Theatres & potential for inability to treat patients so missing national targets
•Trust wide roofs which need repairs
•Air Handling Units to prevent any failures in ventilation with a high risk of closing theatre 6, A&E and ICU
•Medical Gas Plant to prevent all gas and air from becoming unavailable to all of HRI
•Electrics upgrade of local distribution boards
•Plant room refurb to meet HSE requirements
• Facet Survey to determine how the Trust meets condition B, a requirement.
• ICU nurse call and fixed life support equipment which could result in harm if it fails
• Deep clean of patient hoists, commodes, wheelchairs, on a regular basis to prevent infection of users and patients
• Pathology Laboratory and Mortuary water supply at HRI to prevent the closure of these departments
• migration of asbestos dust in the service ducts will affect all site | 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 | Nov 16
The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The sub basement area is currently undergoing an environmental clean to enable various projects to recommence after a significant delay in the capital programme.

Dec 16
The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The sub basement area is currently undergoing an environmental clean to enable various projects to recommence after a significant delay in the capital programme.

January 2017 Update
The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The sub basement area is currently undergoing an environmental clean to enable various projects to recommence after a significant delay in the capital programme.

Risk to be re-written during February 2017. | Feb-2017 | May-2018 | RC | Lesley Hill | Paul Gilling / Chris Davies |

| 6503 | Corporate | Dec-2015 | Transforming and improving patient care | RISK of: non - delivery of Electronic Patient Record Programme due to failure to deliver the transformation associated with not achieving the key deliverables around timescales, engagement and financial targets causing CRB to not be realised, significant cost overruns which ultimately could make the programme unsustainable.

The Trust along with its partners BTHFT (Bradford Teaching Hospitals Foundation Trust) and Cerner are implementing an EPR system that will enable service transformation whilst improving patient safety and patient and clinician experience. This is a summary risk, EPR risks escalated at Transformation Group will be brought to R&C by exception.

This will impact on patient care, safety and patient experience and mean the expected financial benefits of EPR programme will not be realised. | A Well-developed Governance Structure in place underpinned by a contract between CHFT and Cerner and a partnership agreement between CHFT and BTHFT.

Management of EPR programme risks using Best Practice MSP (Managing Successful Programmes) methodology and EPR specific risk register

Executive sponsorship of the programme with CEO's chairing the Transformation Board

Separate assurance process in place

Clinical engagement from divisions

Clearly identified and protected funding as identified in the Full Business Case.

All Risk and issues are recorded on the programme risk and issue register and managed by the EPR Risk Review Board. | - Further divisional engagement required - A more in depth understanding of the transformational change is required within the clinical divisions. The impact on activity during go live will be significant and the changes in processes post go live will be equally significant. An understanding, acceptance and support will be essential to success.

- Financial offsetting for 16/17 to mitigate against the reduction in activity during go live and short term post go live.

- Sign off the Operational Readiness plan by division

- Lack of divisional engagement in some areas as raised at the EPR Operational Group. | 20
5 x 4 | 20
5 x 4 | 5
5 x 1 | November Update: Following the re-planning phase referenced above, the timeline for the programme will be based around the successful exit of Trial Load 3 (end of November). If this phase is successful then CHFT will continue to head towards a March go-live, the consequence of failure is the need for a Trial Load 4 (circa 8 weeks). We have met the entry criteria for TL3 and early indicators are positive. The December update will give revised proposed go-live month. The risk score cannot be reduced at this point, further work is required on the Gaps in controls.

December Update: In relation to the process described in the above update, TL3 is now complete and whilst the results were good, we didn't meet the exit criteria (primarily due to OrderComms and E-referrals) There is a need for a Trial Load 4, but not a full TL. It is estimated that this TL will be circa 7 weeks giving a potential go-live date in April 17. This plan is still being worked through and discussed with both the EPR programme and the two trusts involved. Further (more timely) updates via Programme Board, Ops Group and EB with the next risk update in Jan.

January 2017 update:
Situation is still as the update above. TL4 is now planned and gives a go-live date of 29th of April 2017 depending on operational readiness which is also on track. Communications have gone out trust wide detailing the aim of 29th of April. | Feb-2017 | Sep-2017 | RC | Mandy Griffin | Mandy Griffin |

ID				Risk	Controls	Gaps in Control				Update					
6721	Corporate	May-2016	Keeping the base safe	The Trust is planning to deliver a £16.1m deficit in 2016/17. There is a risk that the Trust fails to achieve its financial plans for 2016/16 due to: - clinical activity and therefore income being below planned levels - income shortfall due to commissioner affordability - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - non receipt of Sustainability and Transformation Funding due to performance - failure to deliver cost improvements - expenditure in excess of budgeted levels - agency expenditure and premia in excess of planned and Monitor ceiling level	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach	Further work ongoing to tighten controls around use of agency staffing. For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement. Agency spend must be reduced considerably if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding.	20 5 x 4	20 5 x 4	15 5 x 3	**January 2017 update:** At Month 9, the year end forecast position is to deliver the planned £16.1m deficit (excluding exceptional costs). In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit. Divisional financial recovery plans and additional savings plans must be implemented to ensure delivery of the Trust's forecast financial position. The Trust must drive the necessary reductions in agency expenditure whilst striving to maintain safe staffing levels and deliver standards and access targets. Against the £14m CIP target, £15.11m delivery is forecast and the risk profile of this has been reviewed, £0.7m of schemes remain as high risk. The new EPR system brings heightened risk of lost productivity through the implementation phase, and in a change from planning assumptions, any revenue costs incurred through implementation will have to be included within the £16.1m control total. Commissioner affordability challenges, CQUIN performance and seasonal operational challenges may bring further unplanned pressure. There is a risk that A&E target for Q4 will not be achieved which would reduce the amount of STF funding received by c.£0.3m.	Feb-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer
6722	Corporate	May-2016	Keeping the base safe	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 £5m capital loan from Independent Trust Financing Facility received in April 2016 * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from Monitor * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Working capital loan facility in place (at 3.5% interest rate) for £13.1m to support cash in advance of progression of revenue support loan (at 1.5% interest rate)	The level of outstanding debt held by the Trust is increasing on a monthly basis, the majority of this is owed by other NHS organisations, this has increased the borrowing requirement in the year to date. Capital loan funding not yet approved by NHS Improvement.	15 5 x 3	20 5 x 4	15 5 x 3	**January 2017 update:** Borrowing was drawn down ealier than originally planned to allow settlement of outstanding creditor payments. No further borrowing is now forecast in this financial year following a reduction in the level of planned Capital expenditure and the timing of EPR cash requirements, but a level of debtor and creditor management will still be required in order to maintain the cash position. Cash continues to be a high risk due to the knock on impact of I&E risks; the ongoing reliance on availability of commissioner cash funding; and the fine balance required in managing working capital.	Feb-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer

ID	Division	Date	Objective	Risk	Controls	Gaps/Assurances	Initial	Current	Target	Update	Review Date	Target Date	Committee	Lead	Handler
6753	Corporate	Jun-2016	Keeping the base safe	The Risk of:- Inappropriate access to PID and CHFT Organisational data on some Trust PC's. This risk is increased by the inability to audit access either pre or post any incident. Due to :-Data being saved under Web-station log ins on communal PCs and associated network drives (wards etc) Resulting in:-Breach of confidentiality of patient or staff internally and organisational risk from a CHFT data breach.	- Only trust staff can access the PCs under the web-station login - Only PC's that are a member of a specified group will allow the use of web-station login - Policy mandates that no Data (especially PID) to be saved to local drives - Reduction of generic logons where possible (low impact) - Sophos encryption of disk drives for encrypted local disk data	- Process to wipe the local drive on web-station PCs daily (Begin Comms after audit) - Removal of generic logons through roll out of single sign-on/VDI (Oct 2016) - Password for web-station does not change (currently set in 2010) every 3 months as per other user accounts - Ability to save information to shared network drives associated with web-station account. This information is accessible by all who use the account. - Not all PC's have Sophos Encryption installed (Ongoing)	16 4 x 4	16 4 x 4	4 4 x 1	October Update - As above, no further mitigation to the risk until VDI/SSO is rolled out from November. November/December Update - VDI/SSO project is still on track for this month. Mitigation will be reported in the next update. **January 2017 Update:** SSO timescales have been adjusted to meet the EPR demand and the project will complete mid April. The target date of the risk has been changed accordingly. VDI is no longer in scope but does not affect the mitigation of the risk.	Feb-2017	Apr-2017	RC	Mandy Griffin	Rob Birkett
6822	Medical	Aug-2016	Keeping the base safe	CQUIN target at risk of not being met for 2016/17 based on current compliance for screening for sepsis, time to antibiotic and review after 72 hours and risk of non - compliance in line with new NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of joined up working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treated within the hour and all of the sepsis 6 requirements delivered impact and financial penalties.	Awareness and new controls for ward areas Divisional plan, medical leads identified in all divisions -Improvement action plan in place, improvements seen in data for Q2 -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign to be launched ASAP, introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards NICE guidelines - Cerner currently testing qSOFA and new NICE cut offs	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of joined up working between nursing and medical colleagues Compliance with NICE guidelines - sepsis matron to seek clarity and confirm compliance and noncompliance and add in improvement action plan if needed	15 5 x 3	16 4 x 4	12 4 x 3	November update Deep dive report into the causes of sepsis and barriers to implementing clinical standards completed and now being presented to the quality Committee on 29-11-16 December update. DD/ADN lead for new collaborative, monthly sepsis collaborative with strong medical leadership/involvement. Roll out BUFALO, daily monitoring by performance triggering ward level response/escalation of omissions to CD. Joint working across Medicine and Surgery. Targeted mortality review for sepsis patients to inform quality improvement. Clear communication/education strategy for clinicians. Test of sepsis trolleys in A&E, MAU and Wd 12. Quality improvement support to create culture change sustainability. Co-ordinate action plan with deteriorating patient work. **January 2017 update** Work continues across all areas but data not showing improvements as yet. Focus to continue on delivering the actions identifies above.	Feb-2017	Mar-2017	PSQB	David Birkenhead	Juliette Cosgrove

| 5862 | Medical | Aug-2013 | Keeping the base safe | There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay. | Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. | 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 | Spread of falls improvement work and further staff education and training.
Safety huddles to be embedded on all in patient areas with the co-operation of the whole multi -disciplinary team.
Continue to undertake RCA on harm falls and ensuring learning is embedded.
Embed falls 5 across all areas and monitor quality improvements against this. .

November update
Medical division has undertaken a deep dive into falls, presented at their divisional performance meeting on 25-11-16

Implementing new methods of care delivery to support managing vulnerable patients.

December update.
Deep dive into all areas of Medicine identifying key themes.
Divisional roll out of Falls 5.
Targeted working in high risk areas focusing on intentional rounding, tag bay nursing.
Audit undertaken of quality of safety huddles.
Targeted work on individual areas to improve quality/engagement with Safety huddles.

January 2017 update
Continuing to investigate falls incidents using a rigorous methodology, causes becoming more apparent and these are being acted upon at ward level.
Higher risk areas are developing specific plans to reduce incidence. | Feb-2017 | Mar-2017 | PSQB | Brendan Brown | Maggie Shepley |

| 4783 | Corporate | Aug-2011 | Transforming and improving patient care | Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims.

***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk. | 2 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine 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. August reviews of July deaths (using new process) compliance 70% - highest since Feb'15
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 Aug 2015 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 | Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes
Mortality case notes review may not pick up all factors relating to preventability
Coding improvement work not yet complete
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 | To complete the work in progress
 CQUINS to be monitored by the Trust
 External review of data and plan to take place - assistance from Prof Mohammed (Bradford)
October update
The action plans for the elderly and respiratory ISR's will be presented to the Medical Director this month. Dates for the stroke ISR have been agreed.

November update
The Medical Director to meet with Medicine Division to sign off ISR action plans, the division have appointed a manager to oversee implementation of the plans. A deep dive into sepsis to be taken to Quality Committee in November. A revised care of the Acutely Ill action Plan to be taken to Clinical Outcomes Group in November

December 2016 update:
Care of the acutely ill patient plan agreed by Clinical Outcomes Group in November and will be monitored by the group on a monthly basis. HSMR dropped to 102 based on September data, SHIMII remains outside of expected range.

January 2017 Update
On track with Care of Acutely ill Patient plan.
Mortality Review Protocol updated to include consultant led review process and escalation process for new National avoidability scores.
14 Consultants now trained to perform initial mortality screening.
Joint CHFT and Bradford training for National Mortality Case Record Review Programme arranged for 16th January and to be delivered by the Improvement Academy | Feb-17 | Mar-2017 | COB | David Birkenhead | Juliette Cosgrove |

ID	Category	Date Opened	Title	Risk Description	Controls	Gaps in Controls	Score (Initial)	Score (Current)	Score (Target)	Update	Review Date	Target Date	NA	Lead	Owner
6598	Corporate	Jan-2016	Keeping the base safe	There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation. Further essential skills subjects are been identified and added to the list with increasing frequency. This obviously not only extends the period of time the roll out project will take but also leads to a re-prioritisation exercise around establishing which are the key priority essential skills to focus on first.	There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject - the project timeline extends until February 2017, however the risk will remain after this date as changes to the way essential skills are recorded and reported are presently under discussion and review. 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. The business plan to commission an alternate learning management system has been approved therefore the tendering process is underway, however expected updates to the current system are likely to address many of these issues so interim measures are being established to with a view to keeping the current system if it delivers the planned updates.	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. A manual system to facilitate the actions above will be require1/ Essential skills training data held is inconsistent and patchy. 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.	16 4 x 4	16 4 x 4	12 4 x 3	**January 2017 Update** List reduced to 29 plus 11 specific to maternity areas. FGM now complete, work in progress to complete the priority essential skills and to address the 11 specific to maternity as these require only a small target audience. 14 of the 29 are complete and 9 are in progress. The remaining 6 require increased functionality that will be delivered either by the updates within OLM due in April OR a new LMS. December Update List reviewed by Director of Nursing. Request for further information around renewal periods and relevance to different nursing groups was requested. This has been completed and a meeting for next steps is scheduled for early January. The Trust continues to debate the need for a new learning management system. Until a decision is made, emphasis is been placed on completing TA's for priority identified subjects. These are: female genital mutilation and mental capacity act / deprivation of liberties. November Update A date of 11.11.16 has been agreed to discuss the list of essential skills with the director of nursing.	Feb-2017	Jul-2017	NA	Jason Eddleston	Pamela Wood

ID	Division	Date	Objective	Risk Description	Controls	Gaps in Controls	Risk Scores	Update / Progress	Review	Target	Committee	Lead	Owner
6658	Medical	Mar-2016	Keeping the base safe	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20 4 x 5 / 16 4 x 4 / 9 3 x 3	October 2016 Continued progress on SAFER Programme improvement work. CHFT part of the WYATT Accelerator Zone- to deliver the ECS 95% standard. This is about system resilience, improved patient flow, creating capacity by improved discharge with social care involvement. December 2016 As CHFT continue to experience a high number of patients on a green cross pathway this impacts on flow out of the ED. The A&E Delivery Board, chaired by CCG and all partners has members has made improving discharge and reducing patients on a green cross pathway as their main priority for the system. The accelerator zone funding has been received and actions are bing taken to introduce a frailty team from the begining of January 2017. Staff the Medical Ambulatory Area over 7 days with the necessary equipment purchased. **January 2017 Update** Winter Planning and actions in place. Weekly Cross Divisional Operation Meeting in place. Improved system response to reducing patients on a green cross pathway. Noted slight reduction in patients waiting	Feb-17	Mar-2017	BOD	COO Helen Barker	Bev Walker

| 6300 | Trustwide | May-2015 | Keeping the base safe | As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services. | - 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 Executive
- An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, has been conducted | The inspection report has shown us to be in the "requires improvement" category
An action plan is being developed but not yet approved | 16
4 x 4 | 16
4 x 4 | 8
4 x 2 | CQC compliance Steering Group
Implementation CQC Compliance action plan
 CQC Operational Group
 Further embedding of CQC assurance into the Divisions and Corporate Governance structures

November update
RCOG report has been received and the maternity service are incorporating recommendations into their plans. A number of actions are completed that were due for October. All core services have approved or drafted action plans. Quality summit didn't identify areas for improvement that weren't already included in the action plan. A number of "Go See" visits have occurred including from the CQC and the CCG.

December 2016 Update
Work continues on delivery of actions, "go see" visits and reportting on progress with actions to the CQC response group .Most actions are complete, 3 "embedded" dates for act

January 2017 Update
29 actions are now rated green - completed. 14 actions moving from an amber to a green position and one action (SD4: RCA training for investigations) moving from green to blue – action delivered and sustained / embedded. The remaining 3 actions are on time to deliver. Four actions have received approval to extend their 'embedded' timescales:
• MD6 - Mortality reviews: now 31.1.17 deadline
• MD18 – GI bleed rota: Now 31.1.17 deadline
• SD6a – Children seen by appropriately skilled staff (adult OPD staff – paediatric life support training):Now 31.1.17. deadline.
• SD7 – Signage HRI and Acre Mill: Now 28.2.17 deadline | Feb-2017 | May-2017 | WEB | Brendan Brown | Juliette Cosgrove |

ID	Category	Opened	Area	Risk Description	Controls	Gaps in Controls	Initial	Current	Target	Updates	Review	Target Date	Committee	Exec Lead	Owner
6596	Corporate	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	1. Capacity - recruitment taken place for dedicated investigation resource in Governance and risk team - final stages of recruitment process being completed 1. Ongoing delivery of Effective Investigation Training Course (1 day, monthly) 2. Greater identification and sharing of learning from each SI, sharing within PSQBs and across division through reporting and SI review group November update A training day was held for 14 staff in October. All SI investigations now have a trained investigator allocated. Business case for investigators still being developed. December 2016 Update Plan to explore option to increase investigator capacity with neighbouring organisations. Positive feedback from commissioners and coroner on reports received. Learning survey completed during November with 3 focus groups during December. **January 2017 Update** RCA training day held 3 January with 10 staff trained. CQC "should do" action on staff training in root cause analysis signed off as embedded (delivered and sustained) by CQC response group and Quality Committee. Risk team continues to support staff competency in report writing. Work on Trust wide learning framework continues.	Mar-2017	Mar-2017	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove
6723	Corporate	May-2016	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2016/17 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. NHS Improvement have still not formally approved the Trust's capital programme for 2016/17 due to national funding pressures and there is a risk that elements of the Capital Programme requiring cash support in the next financial year will not be supported, resulting in a failure to develop infrastructure for the organisation.	Agreed £5m capital loan from Independent Trust Financing Facility (ITFF) received in April 2016 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. Discussed with NHS Improvement and planned for distressed cash support.	.	20 5 x 4	15 5 x 3	12 4 x 3	**January 2017 update:** Borrowing was drawn down ealier than originally planned to allow settlement of outstanding creditor payments. No further borrowing is now forecast in this financial year following a reduction in the level of planned Capital expenditure and the timing of EPR cash requirements, but a level of debtor and creditor management will still be required in order to maintain the cash position. Cash continues to be a high risk due to the knock on impact of I&E risks; the ongoing reliance on availability of commissioner cash funding; and the fine balance required in managing working capital.	Feb-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer

ID	Division	Date Opened	Objective	Risk	Controls	Consequence	Initial	Current	Target	Actions	Review Date	Target Date	Lead	Handler	Owner
6829	Family & Specialist Services	Aug-2016	Keeping the base safe	The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately 50,000 pa ready to administer injectable medicines with short expiry dates for direct patient care. Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service on behalf of NHSE. Critical findings would be reported to the MHRA who have statutory authority (under the Medicines Act 1968) to close the unit if it does not comply with the national standards. The 20 year old HRI unit is a maximum life-span up to the end of 2018.capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards. Resulting in the lack of availability of high risk critical injectable medicines for urgent patient care.Non-compliance with national standards with significant risk to patients if unresolved.	Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. Self-audits of the unit External Audits of the units undertaken by the Quality Control Service on behalf of NHSE every 18 months. Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance.	If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance 'rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.	15 3 x 5	15 3 x 5	3 3 x 1	The procurement of manufactured ready to administer injectable medicines when available from commercial suppliers. The first phase will be the procurement of dose- banded chemotherapy as soon as regional procurement contracts have been approved. This will create some capacity. The business case for the future provision of Aseptic Dispensing Services to be produced in January 2017 following the results of the feasibility study at the CRH unit with a view to consideration and approval by the Commercial Investment Strategy Group taking into account commercial procurement of some products. If the business case is approved then the risk will be reduced. The target risk of 0 will be achieved on completion of the refurbishment of the CRH unit. 14.12.16 update - further meeting scheduled for Jan 17 to progress CRH feasibility study. **January 2017 Update** Meeting held with Engie where draft plan for feasibility study was agreed. Engineering costs to be incorporated to provide costings for business case. External audit of current HRI unit planned for 5 April 2017.	Feb-2017	Dec-2018	DB	Brendan Brown	Mike Culshaw

| 6841 | Corporate | Sep-2016 | Keeping the base safe | Risk of: Not being able to go live with the Electronic Patient Record

Due to:
Pre Go-live
Workforce not yet trained and confident in the EPR system, unable to be released for training and lack of basic IT skills as not currently required within staff role.

The potential un-availability of suitable IT equipment in all areas of the Hospitals that need access to EPR.

POST GO LIVE
Inability to use the system effectively once the extended support mechanisms start to reduce following Early Live Support.

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,

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 | 1.   Training – need to monitor uptake of EPR training (EPR team and divisions by Jan 2017)
2.   Need to identify capacity and activity gaps through divisional operational readiness reporting
3.   Number of EPR Friends/effectiveness of EPR friends - Significant improvement (Dec16) | 15
5 x 3 | 15
5 x 3 | 10
5 x 2 | Engagement and operational readiness sign off closer to go live date via operational readiness checklist and EPR passport.

Closely monitor progress around training and staff feedback following the sessions.

Further work with the divisions to clearly communicate the operational groups expectations and measure progress through the divisions reporting back to the ops group.

Dec 2016 Update:
- EPR Friends training underway raising awareness throughout the trust
- Divisional Leads identified to help bridge the gap
- SIM Centres and Demo Days running with good engagement numbers
- Operational meetings back to weekly (divisional specific every 2nd week)
Significant progress has been made against the gaps in controls but not enough to reduce the likely hood yet. A full training plan with dates is likely to help reduce the score pre-go live.N27

January 2017 update:

As above plus the division operational meetings every 2 weeks are split by division to give an update on each area's operational readiness plan in order to monitor progress more quickly. Progress with the other gaps in controls (training and EPR Friends) will not be seen until training is underway. | Feb-2017 | Sep-2017 | RC | Helen Barker | Mandy Griffin |

ID	Division	Date Opened	Objective	Risk Description	Controls	Gaps in Controls / Assurance	Initial	Current	Target	Action Plan / Updates	Review Date	Target Date	Committee	Lead	Owner
6715	Corporate	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication and multidisciplinary working.	Monthly clinical record audits (CRAS) with feed back available form ward to board A further qualitative audit is undertaken monthly by Matrons that includes patient understanding . Medical audits are undertaken Analysis and action planning is managed through divisional patient safety and quality board A multi professional clinical documentation group meets bi monthly to ensure new documentation is ratified, standards on documentation are addressed. This group also receives reports and audits with regard to documentation and identifies to the divisions areas (teams, wards departments) of concern as well as any specific areas of concern within a specific standard. Clinical records group monitors performance, highlighting best and worst performing wards and action plans are developed and managed through the divisions, including specific areas for improvement.	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	20 4 x 5	15 3 x 5	6 3 x 2	The Trust is developing an electronic patient record that will enable reports to be run in real time, audits can be undertaken by the ward or department lead when they deem it necessary (daily, weekly, monthly) There are alerts and stops within the system to prevent the user skipping documentation. November Update The Clinical Record Audits remain suspended with the divisions focusing on improving falls and fluid balance documentation. Progress will be reported through divisional Patient Safety and Quality Boards The senior nurse team are reviewing the ward assurance framework which will include documentation; the anticipated timeframe to test the revised assurance is January 2017. December Update The improvement work and ward assurance remains in development. **January 2017 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.	Feb-2017	May-2017	QC	Brendan Brown	Jackie Murphy

ID	Division	Date Opened	Strategic Objective	Risk	Controls	Gaps in Controls	Initial	Current	Target	Updates	Review Date	Next Review	Committee	Lead	Owner
6693	Corporate	Mar-2016	Keeping the base safe	Risk of financial penalties and reputational damage due to non compliance with NHSI cap rules resulting in tighter control and scrutiny by regulatory bodies (special measures) and negative media coverage (name and shame).	Weekly reporting of all off-cap breaches Assurance via Finance, Performance & Well-led Group Centralisation of agency bookings via FWD to ensure governance of SOP Prioritising bank cover over agency use Adhering to a Preferred Supplier List (PSL) of framework agencies Executive control of off-cap engagements Divisional action plans to replace all medium/long-term agency contracts with alternative cover Ongoing implementation of NHS-I agency spend toolkit recommendations and Safer Staffing, Workforce Utilisation & Efficiency Programme initiatives.	Unable to report on wage cap breaches to NHS-I Lack of data capture hindering the Trust's ability to manage and report demand effectively Current FWD Vendor Management System (VMS) not sending vacancy requirements to agencies in timely manner - increasing risk of higher agency cost. Evidence that some agency bookings are going outside of SOP, i.e. not going through FWD Agency workers being engaged despite adequate bank cover for short-term demand/pressures Agencies not on PSL being engaged to meet short-term demand/pressures High cost agency workers being engaged to meet short-term demand/pressures No robust action plan yet to replace medium/long-term agency use	15 3 x 5	20 4 x 5	9 3 x 3	**January 2017 Update** Recruitment of short term / temporary project manager to assist with FWD workstreams Procurement of additional Allocate (Bank Staff) licences to replace current VMS and data capture system Evaluate benefits from moving to PSL to Managed Service Provider (MSP) Introduction of Agency Control Panel Align agency cap levels with region and set policy for Trustwide adherence to cap Co-ordinate regional approach to determine regional bank solution Implement Trust wide e-rostering to automate booking processes and embed rostering efficiencies Complete NHS-I agency spend toolkit recommendations and Safer Staffing, Workforce Utilisation & Efficiency Programme initiatives.	Feb-2017	Mar-2017	WLG	Ian Warren,	Mark Borrington, Programme Manager

ID	Area	Date Opened	Title	Description	Action Plans	Reasons for Non-Achievement	Initial	Current	Target	Impact and Response	Review Date	Target Date	Committee	Lead	Handler
6886	Corporate	Nov-2016	Transforming and improving patient care	The seven day service compliance is a part of one of the five categories that the Single Oversight Framework is judged on. As the trust is an early adopter of the four priority standards (2, 4, 5 and 8) it is expected that full compliance will not be achieved by March 2017. At present the impact of not meeting this is not clear as NHS Improvement have not stated what (if) penalties are in place for un met targets. The panel discussed the likely outcomes of not meeting this deadline (financial? Monitoring? Greater oversight?). It was also mentioned that nationally the target is September 2020, and whether we would expect to be able to meet the standards by this date also. This is due to split site acute services, no additional investment for the extra consultants needed, consultant workforce vacancies and difficulties in recruiting. This will result in inconsistent service delivery over the 7-days and especially at weekends. In turn this may impact on clinical outcomes, patient flow and patient experience. Currently there is no contractual obligation or penalty in not achieving compliance with the four priority standards by March 2017. This may also impact on local and national reputational loss and be focus of future enquiry.	High level action plans are being reviewed with the aim of developing more detailed plans to review what can be achieved within current resources and current configuration of acute services. This will include details of workforce and skill mix, financial implications and full benefits such LOS and patient experience. This will need to take into account what can realistic be achieved with the scope of the 5-year plan. 7DS reports via the Safer Programme.	reasons for not achieving compliance include: • Lack of funding to recruit additional consultants to meet compliance • difficulties in retaining and recruiting to consultant posts within certain specialties, completion of a detailed action plan will help identify possible solutions to achieving compliance it is doubtful that with 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	Impact and response to non-compliance from NHS I will require further monitoring. **January 2017** CHFT remains non-compliant against the four priority standards in relation to 7DS. Cumulative 7 day services national surveys demonstrate near compliance with standards 2 and 6. Compliance with standards 5 and 8 remain a challenge. A detailed action plan is being developed to mitigate against this risk that is within current configuration of acute services and resources. It is likely that we will remain non-compliant against these standards by March 2017. The consequence of remaining non-compliant is still not known.	Feb-2017	Mar-17	BOD	David Birkenhead	Sal Uka

Calderdale and Huddersfield **NHS**

NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	**Report Author:**
Board of Directors	Kathy Bray, Board Secretary
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	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:

Over the last month the Board Assurance Framework has been reviewed at the Risk and Compliance Group and each of the Board's sub-committees. The Quality Committee and Finance and Performance Committee are the same week as the Board meeting and therefore a verbal update on any further proposed changes will be given at the meeting.

There are two risks with an increased score; four risks with a decreased score; and no closed or opened risks.

In addition, aits last meeting, the Board tasked the Audit and Risk Committee with reviewing the Board Assurance Framework to check whether it was in line with other Trust Assurance Frameworks.

Main Body

Purpose:

Over the last month the Board Assurance Framework has been reviewed at the Risk and Compliance Group and each of the Board's sub-committees. The proposed amendments to the BAF resulting from these discussions are presented to the Board for approval. In addition at its last meeting, the Board tasked the Audit and Risk Committee with reviewing the Board Assurance Framework to check whether it was in line with other Trust Assurance Frameworks. A number of areas are proposed for further consideration as part of the annual review of the BAF.

Background/Overview:

Please see attached

The Issue:

Current Board Assurance Framework
Over the last month the Board Assurance Framework has been reviewed at the Risk and Compliance Group and each of the Board's sub-committees.

The proposed changes are outlined below for consideration by the Board. As the Finance and Performance Committee and the Quality Committee meet the week of the Board meeting, a verbal update on any other proposed changes will be given at the Board.

There are two risks with an increased score; four risks with a decreased score; and no closed or opened risks.

Risks with an increased score:

• Risk 10: Failure to achieve local and national performance targets and levels required for STF
This risk has been increased from 16 to 20. This is due to the fact that the STF funding is dependent on achievement of performance targets. To date the Trust has been achieving the Emergency Care standard within the 1% tolerance. In Q4, this has been incredibly challenging and while continuing to perform well, and within the top decile of Trusts nationally, performance has fallen and the tolerance is not applied in Q4. That means the Trust is unlikely to achieve the required performance for Q4.

• Risk 11: Failure to maintain current estate and equipment and to develop future estates model to provide high quality patient care.
The risk score has been increased from 16 to 20. This is as a result of the continued squeeze on the capital budget and the resources available to carry out the work required to maintain the HRI site.

Risks with a decreased score:

• Risk 1: 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.

At the Risk and Compliance Group, it was suggested that the risk score be moved from a 20 to 16. The Trust's HSMR position has shown a sustained decrease over a number of months and in September fell below 80 for the first time in a single month. It is expected that we should start to see a similar reduction in SHMI, as there is a six-month lag between the two figures.

• Risk 6: Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the Trust.

The risk has been reduced from a 9 to 6 as processes for patient and public involvement have been strengthened to ensure there is clarity between the Trust, Clinical Commissioning Groups and Overview and Scrutiny Committees around who is responsible for undertaking PPI in relation to transformational change. A network of engagement champions has been recruited and are provided with development and support on a quarterly basis. The requirement to undertake robust PPI has been built into the business case and PMO paperwork.

• Risk 8: Failure to implement robust governance systems and processes across the Trust

The score has been reduced from 12 to 8. The risk was originally identified following the Trust's Well Led review and as part of the preparations for the CQC inspection in March last year. Since that time the Trust has implemented the Well Led actions; strengthened risk management and performance management across the Trust; implemented divisional performance review meetings and is on plan to deliver its cost improvement plans.

• Risk 13: Failure to attract and develop appropriate clinical leadership across the Trust.

The score has been reduced from 16 to 12 as a result of the actions taken to develop the job planning framework and strengthen the job roles. There remains further work to develop the organisational development plans for medical staffing and to implement the education proposal.

Board Assurance Framework review

At its last meeting, the Board tasked the Audit and Risk Committee with reviewing the Board Assurance Framework to check whether it was in line with other Trust Assurance Frameworks.

The review looked at two areas:
- How the Trust BAF compares in terms of candour. The review demonstrated that the Trust takes and open and honest approach in its BAF in line with some but not all Trusts.
- Other risks to be considered for inclusion on the BAF. A number of areas for consideration were identified:
  Inequalities
  Stakeholder and contractual relationships
  Partner arrangements and conflicts of priorities across health economies
  Delayed transfers of care; patient flow

It is recommended that these will be looked at as part of its annual refresh process alongside the refresh of the 1 Year Plan and brought back to the Board in May.

Next Steps:

It is proposed that the BAF comes back to the Board in May 2017 for its next formal review.

Recommendations:

The Board is asked to approve the update to the Board Assurance Framework and comment on the proposed areas identified for inclusion on the BAF as part of the annual review.

Appendix

Attachment:

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NHS

Calderdale and Huddersfield
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2016/17

Contents:

compassionate care

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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.	16 ⬇	DB	4783 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	Failure 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.	15 =	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 =	MG	6503 6841
006	Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust	6 ⬇ TARGET	BB	
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	8 ⬇ TARGET	OW	6694
009	The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement	20 =	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 =	JE	
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 =	GB	6721 6828 6723 6822 6721
017	Failure to progress and agree a five year strategic turnaround plan across the local health economy	15 =	AB	6131 2827 4783
019	Failure to maintain a cash flow	20 =	AB	6722

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LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly likely (5)			4. Seven day services =	10. National and local targets ⬆ 11. Estate fit for purpose ⬆ 19. Cash flow =	
Likely (4)				1. Mortality ⬇ 15. Financial delivery 16/17 =	2. Large scale transformation = 3. Service reconfiguration = 9. Compliance with NHS Improvement = 12. Staffing levels =
Possible (3)				13. Clinical leadership ⬇ 14. Staff engagement =	5. EPR = 7. Compliance with quality standards = 17. Five year turnaround plan =
Unlikely (2)			6. PPI ⬇	8. Governance ⬇	
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 as become CQC outlier - 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 being implemented • Mortality review process redesigned and rolled out with clinical leads appointed to address the gaps in capacity / capability to undertake reviews • 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 • Mortality reviews in respiratory and stroke not showing any themes • Three level 2 reviewers trained • Work with GP lead on post-discharge deaths within 30 days	First line 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 Second line Care of the Acutely Ill patient report to Board PSQB reports to Quality Committee Mortality review updates to Quality Committee Third line HSMR has fallen to 108.6. Predicting modest further reductions Independent review of cases by Professor Mohammed	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. Mortality reviews not yet undertaken consistently. Carried out for 40% of all deaths. Job plans for 2017/18 will include requirement to undertake mortality reviews	• SHMI position remains high 113	**Initial** 5x4 = 20	**Current** 5x4 = 20	**Target** 4x4 = 16

Action	Timescales	Lead
Awaiting review of mortality review guidance to implement process further Post-discharge deaths wtihin 30 days work being carried out Job plans for 2017/18 being developed	November COMPLETE March	JC DB

Links to risk register:
Risk 4783 - Outlier on Mortality
Risk 2827 - Clinical decision making in A&E
Risk 6313 - Inability to progress service transformation
Risk 6596 - SI reporting

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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		
								Initial	Current	Target
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, 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	First line Modernisation WEB held every 6 weeks CIP plan on track for 16/17 EPR implementation programme Fortnightly CQC response group Second line Integrated Board Report EPR report to Finance and Performance Committee / Board Turnaround Executive scrutiny weekly Monthly report on turnaround to Finance and Performance Committee Board approval of 5 Year Strategic Plan Third line PRM meetings with NHS I demonstrate progress Well Led Governance Review showed some areas of good practice EPR Gateway assurance report	EPR continues to be risk with training timetable to be fully developed and implemented	CQC assessment of requires improvement	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
Implementation plan for CQC actions Training plan for EPR to be developed and delivered	March May	BB MG

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

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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 Monitor • 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. • Monitor support for development of 5 Year Strategic plan approved by the Trust Board and updated to take account of 16/17 planning guidance. • 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	First line Vanguard work in Calderdale showing an impact Second line 5 Year plan progress report to Finance & Performance Committee and Board Urgent Care Board and System Resilience Group in place Third line Recent Trauma review shows positive position for CHFT PRM meeting with NHS I and roundtable meeting tracks progress	• 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 • High sickness rates among staff	**Initial** 5x5 = 25	**Current** 4x5 = 20	**Target** 3x5 = 15

Action	Timescales	Lead
Particpation in JOSC meeting	~~16 November 2016~~ 30 January 2017	AB
Develop understanding of FB requirements with CCG / NHSI / NHS E	COMPLETE	AB
Plan for development of FBC	March 2017	AB
Develop FBC	June 2017	AB

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

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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 • Capacity brought in to support programme • New gastro rota implemented	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	• Gap analysis and action plan to be followed up • National consultant contract negotiations outcomes awaited • Capacity to deliver 7 day service action plan • Medicine action plan to be implemented	• 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** 5x3 =15 / **Target** 2x3 = 6

Action			Timescales	Lead
7 day service action plan to be finalised ~~Hospital @ Night phase 1 roll out~~			~~October / November~~ April COMPLETE	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 has 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	<u>First line</u> Regular reporting showing progress against plan CHFT has met exit criteria for the majority of areas <u>Second line</u> 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 <u>Third line</u> 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				Ongoing starting in September	MG
Training plan to be completed and delivered				~~September~~ May	MG
~~Go-live date to be agreed~~				COMPLETE	

Links to risk register:
Risk 6503 - Non delivery of EPR
Risk 6841 - EPR go-live
BAF risk 2.1516

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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**		
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 in communication and engagement strategic oversight 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 Third line OSC oversight and approval of 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		**Initial** **Current** **Target** 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: 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**
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. - 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 • Fortnightly CQC Response Group in place overseeing implementation of actions and assurance of completion• Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures • Leadership walkrounds implemented • Policies reviewed • Process tightened around review and compliance with NICE guidance	First line Staffing levels reported to WEB CQC Steering Group reports Clinical audit plan reviewed Assessment of compliance with NICE guidance Second line 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 DIPC report to Board Care of the Acutely Ill Patient plan report to Board Slight improvement in HSMR Vacancy and agency use reporting Third line 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 CQC	• Mandatory training compliance • CQC report identified a number of areas requiring action both at Trust-wide and divisional level including medicines management, complaints handling, mandatory training and staffing levels. • Operational priorities impacting on capacity • Standard of serious incident investigations needs to be improved • 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			March				BB		

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

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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**
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 undertakend 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 approved and being implemented	<u>First line</u> Divisional governance arrangements in place with Executive attendance Improved PSQB reporting Self assessment undertaken against Board Governance Assurance Framework template Maintaining compliance against financial plan including CIP for 16/17 <u>Second line</u> Well Led Governance Review action plan delivered and monitored by the Board Performance Management Framework arrangements reviewed by the Board <u>Third line</u> PRM meeting with NHS I showing progress - moved to Quarterly meetings Well Led Governance Review identified no red flags Partnership Board meeting with CCGs	• Risk management arrangements to be strengthened at divsional level and below • Mandatory training and appraisal not yet at full compliance	• CQC assessment as requires improvement including some areas linked to well led such as divisional governance arrangements • CIP profile for 16/17 back-loaded which may prove challenge towards the end of the year	**Initial** **Current** **Target** 3x4 = 12 2x4 = 8 2x4= 8
Action					**Timescales**		**Lead**	
CQC response implementation plan to be delivered Performance management framework implementation update to be brought to the Board					March COMPLETE		BB	
Links to risk register: Risk 6694 Divisional governance								

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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**
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	• PRM 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 EY independent assessment of 5 Year Plan	• Performance against 4 Hour EC standard • Achievement of year end financial position remains challenging	• 17/18 CIP plan not yet finalised • Delivery of 16/17 CIP more challenging towards year end	**Initial** 5x5 = 25 / **Current** 4x5 = 20 / **Target** 2x5 = 10

Action	Timescales	Lead
CQC response implementation plan to be delivered Assessment of impact of Single Oversight Framework to be presented to Board	March ~~October~~ COMPLETE	BB

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

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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 in three key areas
• Over delivering on outpatient and daycase and under delivering on electives
• Achievement of 4 hour emergency care standard requires micro-management.
• Demand increased by 4.4%
Continued delays with non-reportable discharge delays | • A&E target remains below STF and there is no tolerance for Q4
• Clear that won't receive SRG funding for 16/17 winter period
• Lack of operational response to system surge plans. | **Initial** 4x4 = 16 / **Current** 5x4 = 20 / **Target** 2x3 = 6 |

Action				Timescales		Lead	
Continued work on SAFER programme QIA for system resilience funding Deployment of WYAZ funding to be agreed Case to be developed setting out why STF trajectory won't be achieved				Ongoing ~~December~~ COMPLETE ~~December~~ COMPLETE February		HB 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**
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.	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.	• 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	Initial 4x4 = 16 / Current 5x4= 20 / Target 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							

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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 insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **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 multifaceted 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. • Framework for identifying 'at riak' wards which are under resourced or under performing in place. • Risk assessments in place • Nursing recruitment and retention strategy in place	<u>First line</u> 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 Trust wide review of Ward Nurse staffing levels completed by DoN July 2016 Weekly meeting on agency spend <u>Second line</u> 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 <u>Third Line</u> Plans discussed with NHS I	Current hotspots are: Emergency Care; Radiology; Hisotpathology; vascular surgery; opthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; therapies; clinical administration 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.	• Not yet clear of the impact of agency figures on the new Single Oversight Framework assessment • Need clear workforce plan • Need recruitment and retention strategy for medical and therapy	4x4 = 16	4x5 = 20	3x3 = 9

Action				Timescales		Lead			
Workforce strategy for medical staff to be developed Implementing revised guidance on safer staffing				December COMPLETE		DB B			

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

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	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**		
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.	<u>First line</u> 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 <u>Second line</u> Integrated Board Report Revalidation report to board <u>Third line</u> IIP Accreditation Internal Audit report and Turnaround Director report on PMO arrangements and inclusion of clinicians and Quality Imapact Assessment processes in governance arrangements.	• Education proposal not yet finalised • OD plan for medical workforce to be developed • Divisional structures including time for clinical leadership to be finalised	• Acquire independent assessment of clinical leadership arrangements • Staff FFT / Survey results deteriorating • Appraisal compliance away from target	**Initial** 4x4 = 16	**Current** 3x4 = 12	**Target** 3x3 = 9

Action	**Timescales**	**Lead**
Divisional structures work to be completed	March	HB
OD plan for medical workforce to be developed	March	IW
Education proposal to be reviewed and implemented	~~December~~ February	IW
Restructure of medical director's office to be completed	~~December~~ February	DB

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

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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
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	• Colleague engagement plan signed off by WEB • Leadership visibility increasing • Quarterly staff FFT in place • Work together get results programme in place • 'Ask Owen' button launched and being responded to • Good evidence of colleague engagement in SOC / OBC development • Celebrating success annual awards • Staff survey action plan • Health and wellbeing strategy • Implemented star award • Leadership walkaround and feedback process in place	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	• 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	3x4 = 12	3x4 = 12	1x4 = 4

Action	Timescales		Lead
Staff survery and Workforce Race Equality Scheme action plan to be implemented Analysis of 2016 Staff Survey results to be undertaken and any additional actions identified	~~September~~ March March		ALL IW

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

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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
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 regulatory 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	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 Monthly return to NHS I PRM meeting with 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.	**Initial** 4x4 = 16 **Current** 4x4 = 16 **Target** 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

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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

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TRUST GOAL: 4. FINANCIAL SUSTAINABILITY

Ref	OWNER		RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE &	GAPS IN CONTROL	GAPS IN ASSURANCE	RATING		
								Initial	Current	Target
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 £5m capital loan from Independent Trust Financing Facility received in April 2016 * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from Monitor * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Working capital loan facility in place (at 3.5% interest rate) for £13.1 m to support cash in advance of progression of revenue support loan (at 1.5% interest rate) * 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.	First line WEB financial performance report Cash Management Committee Second line Finance and Performance Committee reports Third line 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	Distressed cash support through "Revenue Support Loan" not yet formally approved by NHS Improvement	5x3 = 15	5x4=20	5x3=15

Action		Timescales	Lead
Further work to raise profile of cash management across the Trust		COMPLETE	

Links to risks register:
Risk 6722- Cash management

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
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 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
STP	Sustainabiility and Tranformation Plan

WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts

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
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:	**Report Author:**
Board of Directors	Kathy Bray, Board Secretary
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	Victoria Pickles, Company Secretary
Title and brief summary:	
GOVERNANCE REPORT - FEBRUARY 2017 - This report brings together a number of governance items for review and approval by the Board.	
Action required:	
Approve	
Strategic Direction area supported by this paper:	
Keeping the Base Safe	
Forums where this paper has previously been considered:	
Appropriate level committee	
Governance Requirements:	
Keeping the base safe	
Sustainability Implications:	
None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:
- Standing Orders for the Membership Council
- Terms of Reference
  - Quality Committee
  - Finance and Performance Committee
  - Audit and Risk Committee
  - Nomination and Remuneration Committees (BOD) and (MC)

Main Body

Purpose:

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

Background/Overview:

As part of the annual review of governance the Standing Orders for the Membership Council and the terms of reference of each of the sub-committees have been reviewed.

The Issue:

The Membership Council reviewed its standing orders at its meeting in January and have approved them for ratification by the Board of Directors. The amendments made reflect the change from Monitor to NHS Improvement; clarity on expenses; and a number of minor changes to bring them more in to line with the model arrangements.

There were no significant amendments made to the terms of reference of either Nominations and Remuneration Committee or the Audit and Risk Committee.
The Quality Committee and Finance and Performance Committee were amended to reflect the revised sub-group governance arrangements and to clarify membership and attendance at the meetings.

Next Steps:

The remaining areas of governance for review are the Board of Directors standing orders, scheme of delegation and the constitution. These will be presented at a future meeting.

Recommendations:

The Board is asked to approve the Standing Orders and Terms of Reference.

Appendix

Attachment:

COMBINED GOV REPORT.pdf

A Public Benefit Corporation

STANDING ORDERS

MEMBERSHIP COUNCIL

Version:	2.0 Review and update including: - Expenses clarification - References to Monitor / NHS Improvement - Typographical amends
Approved by:	Membership Council
Date approved:	
Date issued:	
Next Review date:	

CONTENTS

INTERPRETATION

In these Standing Orders, the provisions relating to interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning and, in addition:

"**The Act**" shall mean the National Health Service Act 2012.

"**Terms of Authorisation**" shall mean the Authorisation of the Trust issued by Monitor with any amendments for the time being in force.

"**Corporation**" means Calderdale & Huddersfield NHS Foundation Trust, which is a public benefit corporation.

"**Board of Directors**" shall mean the Board of Directors as constituted in accordance with the Trust's constitution.

"**Chairman**" means the person appointed to be Chairman of the Trust under the terms of the constitution.

"**Chief Executive**" shall mean the chief officer of the Trust.

"**Constitution**" shall mean the constitution attached to the Authorisation with any variations from time to time approved by Monitor.

"**Council Member**" shall mean a member of the Membership Council as defined in section 12 of the constitution.

"**Deputy Chair"** is the Non-Executive Director who deputises for the Chair of the Board of Directors.

"**Director**" shall mean a member of the Board of Directors as defined in section 13 of the constitution.

"Lead Governor" shall mean the publically elected Membership Councillor who has been selected to be the Lead and who will deputise as Chair if neither the Chairman or the Deputy Chair is present.

"**Membership Council**" shall mean the Council of Members as constituted in accordance with the corporation's constitution.

"**Membership Councillor"** shall mean those persons elected or appointed to sit on the Trust's Membership Council.

"**Monitor**" is the previous name of the Independent Regulator for NHS Foundation Trusts. This changed to NHS Improvement on 1 April 2016.

"**Motion**" means a formal proposition to be discussed and voted on during the course of a meeting.

"**NHS Improvement**" is the new Independent Regulator for NHS Foundation Trusts which came into being on 1 April 2016 formed from Monitor and the NHS Trust Development Authority.

"**Officer**" means an employee of the Trust.

"**Vice-Chairman**" means the Vice-Chairman of the Trust pursuant to the terms of the constitution who will preside at meetings of the Membership Council in the Chairman's absence.

"**Secretary**" means the Board Secretary of the Trust or any other person appointed to perform the duties of the Secretary to the Board of Directors.

SECTION A: CONDUCT OF MEETINGS

1. **Admission of the Public and the Press**

   1.1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Membership Council but shall be required to withdraw upon the Membership Council resolving as follows:

   "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with 12.24 of the Constitution."

   1.2. The Chairman (or Vice-Chairman) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Membership Council's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the Membership Council may resolve as follows:

   "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Membership Council to complete business without the presence of the public in accordance with 12.24 of the Trust's Constitution."

   1.3. Nothing in these Standing Orders shall require the Membership Council to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without prior agreement of the Membership Council.

2. **Calling and notice of meetings**

   2.1. The Membership Council is to meet at least three times in each financial year. Meetings shall be determined at the first meeting of the Membership Council or at such other times as the Membership Council may determine and at such places as they may from time to time appoint.

   2.2. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least **ten working** days written notice of the date and place of every meeting of the Membership Council to all Council Members. Notice will also be published on the Trust's website.

   2.3. Meetings of the Membership Council may be called by the Secretary, by the Chairman, by the Board of Directors or by eight Council members (including two appointed Council Members) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Council Members as soon as possible after receipt of such a request giving at least **ten working days'** notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or four Council Members, whichever is the case, shall call such a meeting.

   2.4. In the case of a meeting called by Council Members in default of the Chairman, the notice shall be signed by those Council Members and no business shall be transacted at the meeting other than that specified on the notice.

2.5. All meetings of the Membership Council are to be general meetings open to members of the public unless the Membership Council decides otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds. The Chairman may exclude any member of the public from a meeting of the Membership Council if they are interfering with or preventing the proper conduct of the meeting

2.6. The Membership Council may invite the Chief Executive or through the Chief Executive any other member or members of the Board of Directors, or a representative of the Trust's auditors or other advisors to attend a meeting of the Membership Council. The Chief Executive and any Executive of the Trust nominated by the Chief Executive shall have the right to attend any meeting of the Membership Council provided that they shall not be present for any discussion of their individual relationship with the Trust

2.7. The Membership Council may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

2.8. All decisions taken in good faith at a meeting of the Membership Council, or of any of its committees, shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Council Members attending the meeting.

2.9. Following notice of the meeting (as set out in SO 2.3) an agenda for the meeting, specifying the business proposed to be transacted at it shall be sent to every Council Member, , so as to be available to him/her at least **five working** days before the meeting.

2.10. The agendas will include all supporting papers available at the time of posting. Further supporting papers will be received no later than **three (3)** working days before the meeting.

2.11. Lack of service of the notice on any one person above shall not affect the validity of the meeting, but failure to serve such a notice on more than six Council Members will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3. **Quorum**

3.1. Ten Membership Council members (including not less than six Public Council Members, not less than two Staff Council Members and not less than two Appointed Council Members – in line with the Constitution) present in person or by proxy under arrangements approved by the Membership Council shall form a quorum

4. **Setting the agenda**

4.1. A Council Member desiring a matter to be included on an agenda shall make the request in writing to the Chairman at least **ten working** days before the meeting. Requests made less than fourteen clear days before a meeting may be included on the agenda at the discretion of the Chairman or the Secretary.

5. **Chairmanship of meeting**

5.1. The Chairman of the Trust or, in his/her absence, the Deputy Chair, or in his/her absence the Lead Governor will chair meetings of the Membership Council.

5.2. The Lead Governor will be appointed from the Public Membership at a general meeting. He/she will act as Chairman of the meeting should the Chairman and the Deputy Chair be in conflict. The Lead Governor will hold the casting vote when he/she is acting as Chairman.

6. **Notices of motion**

6.1. A Council Member desiring to move or amend a motion shall send a written notice thereof at least **ten working** days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to preceding provisions.

7. **Withdrawal of motion or amendments**

7.1. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

8. **Motion to rescind a resolution**

8.1. Notice of motion to amend or rescind any resolution (or general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Council Members who give it and also the signature of four other Council Members, of whom at least two shall be Public Council Members. When any such motion has been disposed of by the Trust, it shall not be competent for any Council Member other than the Chairman to propose a motion to the same effect within six months, although the Chairman may do so if he/she considers it appropriate.

9. **Motions**

9.1. The mover of a motion shall have the right of reply at the close of any discussions on the motion or any amendment thereto.

9.2. When a motion is under discussion or immediately prior to discussion it shall be open to a Council Member to move:
   a) An amendment to the motion.

   b) The adjournment of the discussion or the meeting.

   c) That the meeting proceed to the next business. (*)

   d) The appointment of an ad hoc committee to deal with a specific item of business.

   e) That the motion be now put. (*)

   [*In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Council Member who has not previously taken part in the debate.]

9.3. No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

10. **Chairman's ruling**

10.1. The decision of the Chairman of the meeting on the question of order, relevancy and regularity shall be final.

11. **Voting**

11.1. Questions arising at a meeting of the Membership Council requiring a formal decision shall be decided by a majority of votes. In case of an equality of votes the Chairman shall decide the outcome. No resolution of the Membership Council shall be passed if it is unanimously opposed by all of the Public Council Members.

11.2. All questions put to the vote shall, at the discretion of the Chairman, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Council Members present so request, or the Secretary deems it advisable or necessary.

11.3. If at least one third of the Council Members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Council Member present voted or abstained.

11.4. If a Council member so requests his vote shall be recorded by name upon any vote (other than by paper ballot).

11.5. In no circumstances may an absent Council Member vote by proxy. Absence is defined as being absent at the time of the vote.

12. **Minutes**

12.1. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting

12.2. No discussion shall take place upon the minutes, except upon their accuracy, or where the Chairman considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

12.3. Minutes shall be circulated in accordance with Council Members' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust Website (required by the Code of Practice of Openness in the NHS).

SECTION B: COMMITTEES

13. **Appointment of Committees**

13.1. Subject to paragraph 40 below and such directions as may be given by NHS Improvement, the Membership Council may and, if directed to do so, shall appoint committees of the Membership Council, consisting wholly or partly of Council Members. In all cases, each committee shall have a majority of Public Council Members.

13.2. A committee appointed under SO 13.1 may, subject to such directions as may be given by NHS Improvement or the Membership Council, appoint sub-committees consisting wholly or partly of members of the committee.

13.3. These Standing Orders, as far as it is applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Membership Council.

13.4. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Membership Council), as the Membership Council shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

13.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Membership Council.

13.6. The Membership Council shall approve the appointments to each of the committees which it has formally constituted. Where the Membership Council determines that persons who are neither Council Members, nor directors or officers, shall be appointed to a committee, the terms of such an appointment shall be determined by the Membership Council subject to the payment of travelling and other allowances being in accordance with such sum as may be determined by the Board of Directors or NHS Improvement (in line with SO 20).

13.7. Where the Membership Council is required to appoint persons to a committee or to undertake statutory functions as required by NHS Improvement, and where such appointments are to operate independently of the Membership Council or the Board of Directors, such appointment shall be made in accordance with the any regulations laid down by the Chief Executive or his nominated officer or any directions or guidance issued by NHS Improvement from time to time.

14. **Confidentiality**

14.1. A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Membership Council or shall otherwise have concluded on that matter.

14.2. A Council Member or a member of a committee shall not disclose any matter reported to the Membership Council or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Membership Council or committee shall resolve that it is confidential.

14.3. In relation to patient confidentiality, the provisions at paragraphs 42 and 43 above for disclosure of information by Council Members or members of committees established by

the Membership Council shall not apply, and such information shall not be disclosed under any circumstances.

15. **Appointment of the Chairman, Vice-Chairman and Non-Executive directors**

15.1. The Membership Council shall appoint a Chairman of the Trust. The Board of Directors will appoint one Non-Executive Director to be Vice-Chairman of the Trust. This individual may, through agreement with the Chair, also take on the role of SINED (Senior Independent Non-Executive Director). The Membership Council shall ratify the appointment of the Vice Chairman at a general meeting.

15.2. Non-Executive Directors are to be appointed by a sub-committee (not exceeding four persons) of the Membership Council using the procedures set out under paragraph 13 of the constitution.

SECTION C: REGISTER AND DISCLOSURE OF INTERESTS

16. **Register and disclosure of interests**

16.1. If Council Members have any doubt about the relevance or materiality of an interest, this should be discussed with the Chairman or the Secretary.

16.2. Any Council Member who has a material interest in a matter as defined below and in the constitution shall declare such an interest to the Membership Council and it shall be recorded in a register of interests and the Council Member in question:

a) Shall not be present except with the permission of the Membership Council in any discussion of the matter, and

b) Shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

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

16.4. At the time the interests are declared, they should be recorded in the minutes of the Membership Council. Any changes in interests should be officially declared at the next meeting as appropriate following the change occurring.

16.5. It is the obligation of a Council Member to inform the Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the register upon receipt within three working days.

16.6. The details of Council Members' interests recorded in the register will be kept up to date by the Secretary, and reviewed at each meeting of the Membership Council.

16.7. Subject to the requirements of the Public Benefit Corporation (Register of Members) Regulations 2006 and the Data Protection Act 1998, the register will be available for inspection by the public free of charge and will be published on the Trust's website.

16.8. Copies or extracts of the register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the register.

16.9. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Council Member, or their spouse or partner, in any firm or business which, in connection with the matter, is trading with the trust, or is likely to be considered as a potential trading partner with the trust. The exceptions which shall not be treated as material interests are as follows:

a) Shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

b) An employment contract held by staff Council Members;

c) A contract with their Clinical Commissioning Group (CCG) held by a CCG Council Member;

d) An employment contract with a Local Authority held by a Local Authority Council Member;

e) An employment contract with any organisation listed at paragraph 12.3.5 of the constitution.

16.10. If, in relation to 47, the Chairman has a conflict of interest, the Vice-Chairman will exercise the casting vote. If the Vice-Chairman has a conflict of interest, the Deputy Chairman will preside and exercise the casting vote, the nomination to be approved by a majority vote of those present at the meeting.

16.11. An elected Council Member may not vote at a meeting of the Membership Council unless, before attending the meeting, they have made a declaration in the Membership Council Charter as specified by the Membership Council as to the basis upon which they are entitled to vote as a member. The Constitution provides guidance. An elected Council Member shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Membership Council, and every agenda for meetings of the Membership Council will draw this to the attention of elected Council members.

16.12. Members of the Membership Council must meet the requirements of the Fit and Proper persons test.

SECTION D: TERMINATION OF OFFICE AND REMOVAL OF COUNCIL MEMBER

17. **Termination of office**

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

   a) They resign by notice in writing to the Secretary;

   b) They fail to attend two meetings in any Financial Year, unless the other Council Members are satisfied that the absences were due to reasonable causes, and they will be able to start attending meetings of the trust again within such a period as they consider reasonable;

   c) In the case of an elected Council Member, they cease to be a Member of the constituency by whom they were elected;

   d) In the case of an appointed Council Member, the Appointing Organisation terminates the appointment;

   e) They have failed to undertake any training which the Membership Council requires all Council Members to undertake;

   f) They have failed to sign and deliver to the Secretary a statement in the form required by the Membership Council confirming acceptance of the Code of Conduct for Council Members/Membership Council Charter;

   g) They refuse to sign a declaration in the form specified by the Membership Council that they are a Member of a specific public constituency and are not prevented from being a Member of the Membership Council. This does not apply to Staff Members;

   h) They are removed from the Membership Council under the following provisions.

18. **Removal of Council Member**
   18.1. A Council Member may be removed from the Membership Council by a resolution approved by not less than three-quarters of the remaining Council Members present and voting at a general meeting of the Membership Council on the grounds that:

   a) They have committed a serious breach of the Code of Conduct; or

   b) They have acted in a manner detrimental to the interests of the Trust; and

   c) The Membership Council considers that it is not in the best interests of the Trust for them to continue as a Council Member.

   18.2. Where a person has been elected or appointed to be a Council Member and he/she becomes disqualified for appointment, under SO 17.1 above, he/she shall notify the Secretary in writing of such disqualification.

   18.3. If it comes to the notice of the Secretary that a person elected or appointed to be a Council Member may be disqualified, under SO 17.1 above, from holding that office and the Secretary has not received a notice, under paragraph 59, from that person, the Secretary will make such inquiries as he/she thinks fit and, if satisfied that the person may be so disqualified, the Secretary will advise the Chairman so that the Chairman can

make a recommendation for disqualification to the Membership Council. The recommendation will either be made to a general meeting or to a meeting called specifically for the purpose.

18.4. The Secretary shall give notice in writing to the person concerned that the Trust proposes to declare the person disqualified as a Council Member. In this notice, the Secretary shall specify the grounds on which it appears to him/her that the person is disqualified and give that person a period of fourteen days in which to make representations, orally or in writing, on the proposed disqualification.

18.5. The Chairman's recommendations and any representations by the Council Member concerned shall be made to the Membership Council. If no representations are received within the specified time, or the Membership Council upholds the proposal to disqualify, the Secretary shall immediately declare that the person in question is disqualified and notify him/her in writing to that effect. On such declaration the person's tenure of office shall be terminated and he/she shall cease to act as a Council Member.

SECTION E: REMUNERATION AND PAYMENT OF EXPENSES

19. **Remuneration**

   19.1. Council Members are not to receive remuneration.

20. **Payment of expenses**

   20.1. The return cost of travel from the Council Member'
   a) The actual bus or rail fare using the most direct route.

   b) Travel by private car or taxi at the Trust's usual pence per mile rate (currently 23p per mile) using the most direct route.

   c) Necessary parking charges.

   20.2. Membership Councillors claiming expenses may be required to provide tickets, receipts or other proof of expenditure alongside a completed and signed expenses form.

   20.3. Expenses will be authorised through the Secretary's office and details of all expenses claimed by Membership Councillors will be recorded and published in the Trust's Annual Report and Accounts.

SECTION F: STANDARDS OF CONDUCT OF COUNCIL MEMBERS

21. **Policy**

21.1. In relation to their conduct as a member of the Membership Council, each Council Member must comply with the same standards of business conduct as for NHS staff. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Council Members are expected to be impartial and honest in the conduct of official business.

22. **Interest of Council Members in contracts**

22.1. If it comes to the knowledge of a Council Member that a contract in which he/she has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust, he/she shall, at once, give notice in writing to the Secretary of the fact that he/she has such an interest.

22.2. A Council Member shall not solicit for any person any appointment in the Trust.

22.3. Informal discussions outside appointment committees, whether solicited or unsolicited, should be declared to the committee.

SECTION G: MISCELLANEOUS PROVISIONS

23. **Suspension of Standing Orders**

    23.1. Standing Orders may be suspended at any general meeting provided that:

    a) at least two-thirds of the Membership Council are present, including at least six elected Council Members and one appointed Council Member, and

    b) the Secretary does not advise against it, and

    c) a majority of those present vote in favour.

    23.2. But Standing Orders cannot be suspended if to do so would contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution.

    23.3. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting and any matters discussed during the suspension of Standing Orders shall be recorded separately and made available to all members of the Membership Council.

    23.4. No formal business may be transacted while Standing Orders are suspended.

24. **Variation and amendment of Standing Orders**

    24.1. Standing Orders may only be varied or amended if:

    a) the proposed variation does not contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution;

    b) unless proposed by the Chairman or the Chief Executive or the Secretary, a notice of motion under paragraph 19 has been given;

    c) at least two-thirds of the Membership Council are present, including at least six elected Council Members and one appointed Council Member, and at least half of the Council Members present vote in favour of amendment.

25. **Review of Standing Orders**

    25.1. Standing Orders shall be reviewed bi-annually by the Membership Council. The requirement for review shall extend to all and any documents having effect as if incorporated in Standing Orders.

QUALITY COMMITTEE

TERMS OF REFERENCE

Version:	**1.1** (first draft circulated for review to Chair / Director of Nursing) **1.2** Amendments prior to Board **1.3** Amendments after submission to Quality Committee **1.4** Further amendments **1.5** Further amendments
Appendices	**1.** Named list of members **2.** Sub groups **3.** Reports aligned to CQC domains
Approved by:	Board of Directors
Date approved:	
Date issued:	
Review date:	

QUALITY COMMITTEE TERMS OF REFERENCE

1. **Constitution**

    1.1. The Trust Board hereby resolves to establish a Committee to be known as the Quality Committee. The Quality Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. **Authority**

    2.1. The Quality Committee is constituted as a Standing Committee of the Board. Its constitution and terms of reference are subject to amendment by the Board.

    2.2. The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

    2.3. The Committee is authorised by the Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

    2.4. The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. **Purpose**

    3.1. The purpose of the Quality Committee is:
    - To provide assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care
    - To ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

    3.2. The Quality Committee is responsible for:
    - Reviewing proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account.
    - Seeking assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.
    - The ongoing monitoring of compliance with national quality standards and local requirements.

4. **Duties**

    The duties of the Committee, given below, cover quality improvement, governance and risk, quality and safety reporting and audit and assurance.

    Quality improvement

    4.1. To review proposed quality improvement priorities and monitor progress and compliance against defined quality priorities.

    4.2. To maintain a focus on patient experience through a number of data sources including stories; friends and family test; national surveys and seek assurance that the Trust is learning from experience.

4.3. To oversee the development of the Quality Accounts to ensure accuracy of data and compliance with timescales for publication and review progress against these.

4.4. To review the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding progress with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

4.5. To receive, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

4.6. To establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessments, standards or criteria.

Governance and risk

4.7. Ensure all quality risks are appropriately managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the high level risk register and Board Assurance Framework

4.8. Promote a just and open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

4.9. Seek assurance on the process for reviewing and reporting incidents and serious incidents and sharing the learning from these.

4.10. Seek assurance against compliance with NICE guidelines / guidance and any rationale for non or partial compliance

4.11. Seek assurance that there are effective systems of governance, performance and internal control in relation to clinical services, research and development through an annual governance review.

4.12. Review performance against the quality and safety aspects of the Integrated Performance Report

4.13. Undertake an annual review of the quality impact assessment process to gain assurance that the risks to any impact on quality arising from proposed cost improvements have been managed and mitigated.

4.14. Ensure any procedural , policy or strategy documents which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with the Policy for Development and Management of Procedural Documents (Policy for Policies) and any key national standards and best practice

4.15. Receive a quarterly report from each of the sub-groups to the Committee.

4.16. Establish an annual work plan which the Committee will review annually.

4.17. Produce an annual report against delivery of the terms of reference of the Quality Committee.

Quality and safety reporting

4.18. In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

Audit and assurance

4.19. To approve and oversee delivery of the clinical audit plan and a review of its findings.

4.20. To receive all reports regarding the Trust produced by the Care Quality Commission and other external bodies, e.g. Royal Colleges, and seek assurance on the delivery of actions to address recommendations

4.21. Receive reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions

4.22. To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken to address these.

4.23. Gain assurance from divisions that they implement the activity required to achieve compliance with service quality and governance standards.

5. Membership and attendance

5.1. The Committee shall consist of the following members:-
- Three Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee.
- Chief Nurse
- Chief Operating Officer
- Medical Director
- Executive Director of Planning, Estates and Facilities

5.2. The following shall be required to attend all meetings of the Committee:
- Assistant Director of Quality
- Deputy Director of Nursing
- Head of Governance and Risk
- Membership Councillor
- Governance administrator (notes)

5.3. The following shall be required to attend the meetings focused on divisional performance (one meeting per quarter):
- Divisional Director, Surgical & Anaesthetics
- Divisional Director, FSS (or Divisional Director of Operations)
- Divisional Director, Medicine (or Divisional Director of Operations)
- Divisional Director, Community Services & Operations
- Associate Nurse Director, Community Services
- Associate Nurse Director, FSS
- Associate Nurse Director, Medicine
- Associate Nurse Director, Surgery and Anaesthetics

5.4. Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.5. A quorum will be four members and must include at least one Non-Executive and one Executive Director.

5.6. Attendance is required at 75% of meetings. Members unable to attend should indicate in writing to the Committee Secretary at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.7. A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1. The Committee shall be supported by the Secretary, whose duties in this respect will include:-
- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting
- Maintaining a record of attendance.

7. Frequency of meetings

7.1. The Committee will meet every month and at least nine times per year.

8. Reporting

8.1. The Committee Secretary will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2. An action schedule will be articulated to members two working days following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers.

8.3. The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4. Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next board of directors meeting.

8.5. A summary report will be presented to the next board meeting.

9. Review

9.1. As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2. The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

Quality Committee Terms of Reference
V1.5

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10. Monitoring effectiveness

10.1. In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:
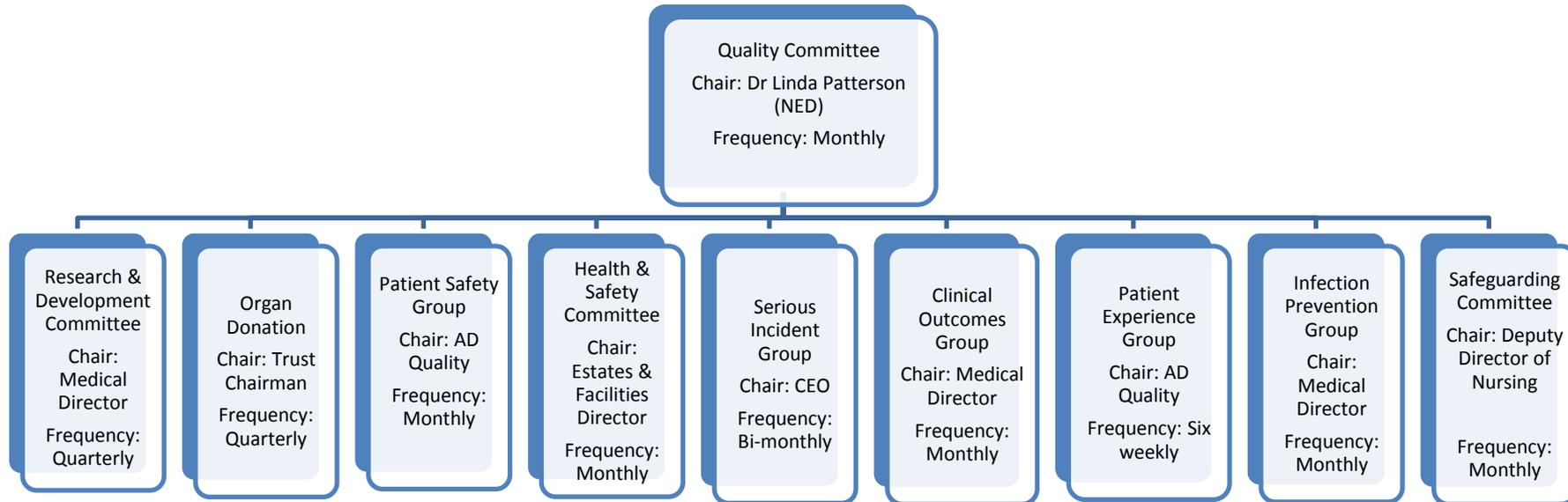
- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 5 working days prior to the meetings;
- The action point from each meeting are circulated within two working days, on 80% of occasions

Appendix 1

Members and required attendees of the Committee

Job Title	Name	Required at
Non-Executive Director *(Chair)*	Dr Linda Patterson	All meetings
Non-Executive Director *(Vice Chair)*	Dr David Anderson	All meetings
Non-Executive Director	Jan Wilson	All meetings
Membership Councillor	Peter Middleton / George Richardson	All meetings
Executive Director of Nursing	Brendan Brown	All meetings
Chief Operating Officer	Helen Barker	All meetings
Executive Director of Planning, Estates & Facilities	Lesley Hill	All meetings
Assistant Director of Nursing and Quality *(until July 2017)*	Juliette Cosgrove	All meetings
Head of Risk & Governance	Andrea McCourt	All meetings
Medical Director	Dr David Birkenhead	All meetings
Deputy Director of Nursing - Corporate	Lindsay Rudge	All meetings
Divisional Director (Surgical)	Dr Julie O'Riordan	Divisional focus meeting (1 in 3)
Divisional Director (FSS)	Mr Martin DeBono	Divisional focus meeting (1 in 3)
Divisional Director (Medicine)	Dr Ashwin Verma	Divisional focus meeting (1 in 3)
Divisional Director (Community) or Clinical Lead	Nicola Sheehan	Divisional focus meeting (1 in 3)
Associate Director of Nursing (Surgery)	Joanne Middleton	Divisional focus meeting (1 in 3)
Associate Director of Nursing (FSS)	Anne-Marie Henshaw	Divisional focus meeting (1 in 3)
Interim Associate Director of Nursing (Medicine)	Juliette Cosgrove	Divisional focus meeting (1 in 3)
Associate Director of Nursing (Community)	Diane Catlow	Divisional focus meeting (1 in 3)
Governance Administrator	Michelle Augustine	All meetings

Appendix 2
Sub-groups

Quality Committee

Chair: Dr Linda Patterson (NED)

Frequency: Monthly

Research & Development Committee	Organ Donation	Patient Safety Group	Health & Safety Committee	Serious Incident Group	Clinical Outcomes Group	Patient Experience Group	Infection Prevention Group	Safeguarding Committee
Chair: Medical Director	Chair: Trust Chairman	Chair: AD Quality	Chair: Estates & Facilities Director	Chair: CEO	Chair: Medical Director	Chair: AD Quality	Chair: Medical Director	Chair: Deputy Director of Nursing
Frequency: Quarterly	Frequency: Quarterly	Frequency: Monthly	Frequency: Monthly	Frequency: Bi-monthly	Frequency: Monthly	Frequency: Six weekly	Frequency: Monthly	Frequency: Monthly

CQC domain	Reporting to Quality Committee via
Safe	Safeguarding via quarterly and annual reports Patient Safety Group reports (2 months per quarter) Health and Safety (2 months per quarter) Board Assurance Framework (quarterly) Corporate risk register (2 months per quarter) As required: Prevention of future death reports, incident reports / action plans.
Effective	Organ donation via quarterly and annual reports NICE guidance compliance once a quarter Clinical audit plan, twice a year Clinical Outcomes Group – two reports per quarter Mortality Surveillance Group – two reports per quarter Care of the Acutely Ill Programme – report every other month Service specific reports / invited service reviews as required – detailed in workplan
Experience	Report from Patient Experience and Caring Group (minutes)
Responsive	Quarterly quality report Quality Account Quality annual report Integrated performance report (monthly)
Well-Led	CQC response group report (monthly) Research and development 6 monthly report Workforce Committee twice per quarter Quality impact assessment process – once per annum Divisional patient safety quality board reports Serious Incident Review Group – minutes Infection Control Committee - minutes

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Version:	1.1 - first draft circulated for review to Chair / CE / DoF / DDof 1.2 - comments received OW / CB / AH 1.3 - Amendments from the Board of Directors 2.1 – Reviewed and updated for membership and to reflect planning cycle
Approved by:	Board of Directors
Date approved:	
Date issued:	
Review date:	

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

1. Constitution
The Trust Board hereby resolves to establish a Committee to be known as the Finance and Performance Committee. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose
The Finance and Performance Committee has delegated authority from the Board to oversee, coordinate, review and assess the financial and performance management arrangements. This includes monitoring the delivery of the 5 Year Plan and supporting Annual Plan decisions on investments and business cases.

The Committee will assist in ensuring that Board members have a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

3. Authority
The Finance and Performance Committee is authorised by the Board, to which it is accountable, to investigate or approve any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request for such information.

4. Role and duties of the Committee
The Finance and Performance Committee will provide the Board with assurance that finance and performance is being monitored and managed across the organisation and that progress is being made in the implementation of the Annual Plan. The Committee will also make recommendations on investment.

The duties of the Committee can be categorised as follows:

4.1. Finance and Financial Performance
- Provide assurance that the finance and performance reporting systems of the organisation are robust through detailed review of the financial section of the Integrated Board Report on a monthly basis.
- Keep the content of the Trust's Integrated Board Report under review, ensuring that it includes appropriate performance metrics and detail of exceptions to provide assurance to the Board on all aspects of organisational performance against its Strategic Objectives.
- Seek assurance from the executive that any appropriate management action has been taken to return the trust performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored.
- Provide assurance to the Board that cost improvement plans to support organisational changes are being delivered through the receipt of regular reports from the Turnaround Executive.
- Review the Trust's Long Term Financial Model and any NHS Improvement submissions to test assumptions and provide assurance that the returns represent a true and fair view of the financial performance for the period under review.
- Review all significant financial risks on the high level risk register and the Board Assurance Framework.
- Review the Single Oversight Framework finance and use of resources metric, in light of overall financial performance.
- Examine any matter referred to the Committee by the Trust Board.

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

4.2. **Business and commercial development**
- Ensure compliance with Monitor's Risk Evaluation for Investment Decisions (REID) guidance and Treasury Management guidance.
- Approve and set control limit for capital
- Review the Trust's Annual Business Plan, 5 Year Plan, 5 Year Capital Plan and Financial Model and recommend to the Board for approval.
- Prioritise capital programme under discrete headings (based on high level business case proposals from divisions):
    - Equipment replacement
    - Unavoidable major schemes
    - IM&T
    - Significant strategic importance
    - Estates (maintenance/ upgrades)
    - Aspirational
- Understand and agree revenue consequences of schemes and monitor cash flow implications
- Receive an update from Commercial Investment Strategy Group on business case approvals ensuring that outcomes and benefits are clearly defined, are measurable and support the delivery of key objectives for the Trust. Ensuring only those below £5M are approved by the Group and those above £5M are recommended to the Board for approval.
- Review post-implementation investment audits undertaken by or on behalf of the Trust. These should be carried out 12 months after business case approval.
- Approve and keep under review the Trust's investment and borrowing strategy and policies.
- Review the Trust's Commercial Strategy and individual bids and acquisitions to ensure proper financial and performance impact evaluation and make recommendations to the Board.
- Review progress against the Commercial Strategy action plan
- Periodically review the market analysis for the Trust.
- Approve the establishment of joint ventures or other commercial partnerships/relationships including the incorporation of start-up companies. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, etc. related to joint ventures, commercial partnerships or incorporation of start-up companies.
- Agree investment / dis-investment in services (with full understanding of financial and service implications of these decisions e.g. overheads)

4.3. **Treasury Management**
- Maintain an oversight of the Trust's Treasury Management activities, ensuring compliance with Trust's policies.
- Monitor the application of safeguards on investment of funds including:
    - List of institutions within which funds can be placed
    - Appointment of bankers and brokers
    - Investment limits for each institution
    - Investment types
- Review the performance of treasury management investments.
- Review borrowing arrangements and liabilities
- Review and monitor the Trust's Treasury Management Policy *(approval is through the Audit & Risk Committee)*.

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FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

5. **Membership and Attendees**
   5.1. The Committee shall consist of the following members:
   - Non – Executive Director (Chair)
   - Non – Executive Director (Vice Chair)
   - Non – Executive Director
   - Chief Executive
   - Executive Director of Finance
   -
   - Executive Medical Director or Executive Director of Nursing
   - Chief Operating Officer
   - Director of Transformation and Partnerships.

   5.2. The Deputy Director of Finance and the Company Secretary will regularly attend. All other non-executive and executive directors will be invited to attend along with a Membership Councillor. Executive Directors and other senior management staff may be required to attend discussions when the Committee is discussing areas of performance or operation that are their responsibility.

6. **Attendance**
   6.1. Attendance is required by members at 75% of meetings. Members unable to attend should indicate in writing to the Committee secretary, at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances, any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

   6.2. A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardies the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

7. **Administration**
   7.1. The Committee shall be supported by the Secretary to the Executive Director of Finance, whose duties in this respect will include:
   - In consultation with the Chair develop and maintain the reporting schedule to the Committee
   - Collation of papers and drafting of the agenda for agreement by the Chair of the Committee;
   - Taking the minutes and keeping a record of matters arising and issue to be carried forward;
   - Advising the group on scheduled agenda items;
   - Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
   - Maintaining a record of attendance.

8. Meetings
8.1. Meetings will be held on a monthly basis and arranged to meet the requirements of the corporate calendar;
8.2. Items for the agenda must be sent to the Committee Secretary a minimum of 8 days prior to the meeting: urgent items may be raised under any other business;
8.3. An action schedule will be circulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers; and
8.4. The agenda will be sent out to the Committee members one week prior to the meeting date, together with the updated action schedule and other associated papers.

9. Reporting
9.1. The minutes of the Committee meetings formally recorded by the Committee Secretary will be submitted to the Trust Board and Audit and Risk Committee when approved.
9.2. The Chair of the Finance and Performance Committee shall, at any time, draw to the attention of the Trust Board any particular issue which requires their attention.
9.3. The Capital Management Group and the Commercial Investment Strategy Group will provide minutes of its meetings to the Committee along with reports as agreed.

10. Quorum
A quorum is determined as being four of the members in attendance but must include the Chair or Vice-Chair and one Executive Director.

11. Review
The Terms of Reference shall be reviewed on an annual basis and ratified by the Board.

12. Monitoring Effectiveness
In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 7 days prior to the meetings;
- The action schedule was circulated within 48 hours, on 80% of occasions

CALDERDALE AND HUDDERSFIELD
NHS FOUNDATION TRUST

AUDIT & RISK COMMITTEE

TERMS OF REFERENCE

Version:	1.1 (first draft circulated for review to Chair / DoF / DDof)
Approved by:	Board of Directors
Date approved:	? 3.11.16 – BOD 18.10.16 - ARC
Date issued:	18.10.16
Review date:	October 2017

AUDIT & RISK COMMITTEE TERMS OF REFERENCE

1. Authority

1.1 The Audit and Risk Committee is constituted as a standing sub committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors meetings. The Audit & Risk Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Audit & Risk Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit & Risk Committee.

1.3 The Audit & Risk Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The Audit & Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls corporate governance and assurance frameworks.

2.2 The Audit and Risk Committee will have close working relationships with Quality Committee which has responsibility for oversight and monitoring of clinical risks.

2.3 The Board of Directors is responsible for ensuring effective internal control including:
- Management of the foundation trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Audit & Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control. In addition the Audit & Risk Committee shall:

- Ensure independence of External and Internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Audit & Risk Committee; and
- Monitor corporate governance (e.g. Compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

3. Membership

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3.1 The Committee shall be composed of not less than three Non-Executive Directors, at least one of whom should have recent and relevant financial experience. The Trust Chair will <u>not</u> be a member of the Audit & Risk Committee.

3.2 A quorum shall be two members.

4. Attendance

4.1 Only members of the Committee have the right to attend. The Director of Finance, Deputy Finance Director, Company Secretary and Head of Internal Audit of the Foundation Trust shall generally be invited to routinely attend meetings of the Audit & Risk Committee.

4.2 A representative of the External Auditors may normally also be invited to attend meetings of the Audit & Risk Committee.

4.3 The Chief Executive should be invited to attend at least annually to discuss the assurance supporting the Annual Governance Statement and when considering the Internal Audit plan. Other Directors are expected to attend as required by the Audit and Risk Committee and where items relating to their areas of risk or responsibility are being considered.

4.4 The Foundation Trust Chair may be invited to attend meetings of the Audit & Risk Committee as required.

4.5 A representative of the Local Counter Fraud Service is invited to attend all meetings of the Audit & Risk Committee.

4.6 The Chair of the Board of Directors will appoint a Membership Councillor to attend the public meetings of the Audit and Risk Committee. The appointment will be reviewed each year.

4.7 Attendance is required by members at 75% of meetings. Members unable to attend should inform the Board secretary as soon as possible in advance of the meeting except in extenuating circumstances.

4.8 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

5. Administration

5.1 The Board Secretary shall be the secretary to the Audit & Risk Committee and will provide administrative support and advice. The duties of the Board Secretary in this regard include but are not limited to:

- Agreement of the agenda with the chair of the Audit & Risk Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and

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- Maintaining a record of attendance.

6. Frequency of meetings

6.1 Meetings shall be held at least three times per year, with additional meetings where necessary. The Committee must consider the frequency and timing of meetings required to discharge all of its responsibilities on a regular basis.

6.2 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit & Risk Committee without Executive Directors present.

7. Duties

7.1 Governance, internal control and risk management

7.1.1 To ensure the provision and maintenance of an effective system of integrated governance, risk identification and associated controls, reporting and governance.

7.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

7.1.3 To review processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other board committees in relation to the Trust's overall internal control and risk management position

7.1.4 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

7.1.5 To review the adequacy of the Foundation Trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

7.1.6 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

7.1.7 The adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

7.2 Internal audit

7.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

7.2.2 To oversee on an ongoing basis the effective operation of Internal Audit including:

- Adequate resourcing;
- Its co-ordination with External Audit;

Complying with the public sector Internal Audit Standards

- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and

- Meeting the internal audit needs of the Foundation Trust.

7.2.3 To consider the major findings of Internal Audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

7.2.4 To consider the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal. The appointment/dismissal of Internal Audit remains the responsibility of the Director of Finance.

7.2.5 To conduct an annual review of the Internal Audit function.

7.3 External audit

7.3.1 To make a recommendation to the Membership Council in respect of the appointment, re-appointment and removal of an External Auditor. To the extent that that recommendation is not adopted by the Membership Council, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.3.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the foundation trust associated impact on the audit fee.

7.3.3 To assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Membership Council with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.3.4 To oversee the conduct of a market testing exercise for the appointment of an Auditor at least once every five years and, based on the outcome, make a recommendation to the Membership Council with respect to the appointment of the Auditor.

7.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.3.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

7.3.7 To consider the provision of the External Audit Service, the cost of the audit and any questions of resignation and dismissal.

7.4 Annual accounts review

7.4.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;

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- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.2 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

7.4.3 To seek assurance from the Quality Committee that the Trust's Quality Account and opinions of External Audit have been scrutinised in detail.

7.4.4 To review all accounting and reporting policies and systems for reporting to the Board of Directors.

7.5 Standing orders, standing financial instructions and standards of business conduct

7.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct. Standards of Business Conduct and Declarations of Interest; including maintenance of Registers.

7.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

7.5.3 To review the Scheme of Delegation.

7.6 Other

7.6.1 To review performance indicators relevant to the remit of the Audit & Risk Committee.

7.6.2 To examine any other matter referred to the Audit & Risk Committee by the Board of Directors and to initiate investigation as determined by the Audit & Risk Committee.

7.6.3 To ensure that the Quality Committee performs at least an Annual Review of the clinical audit plan and considers the findings and recommendations of in-year reports, ensuring the plan and extras are consistent with the strategic direction of the Trust.

7.6.4 To develop and use an effective assurance framework to guide the Audit & Risk Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

7.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

7.6.6   To review the work of all other Board sub-committees as part of the Audit and Risk Committee assurance role. The Audit and Risk Committee will receive a self assessment and annual report from each of the committees for approval.

8.   Reporting

8.1   The minutes of all meetings of the Audit & Risk Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Audit & Risk Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes.

8.2   The Audit & Risk Committee will report annually to the Board of Directors in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the governance statement; the assurance framework; the effectiveness of risk management within the foundation trust; the integration of and adherence to governance arrangements; its view as to whether the self-assessment against standards for better health is appropriate; and any pertinent matters in respect of which the Audit & Risk Committee has been engaged.

8.3   The Foundation Trust's Annual Report shall include a section describing the work of the Audit & Risk Committee in discharging its responsibilities.

9.   Review

9.1   The Terms of Reference of the Audit & Risk Committee shall be reviewed by the Board of Directors at least annually.

Reviewed: 18.10.16

NOMINATION AND REMUNERATION COMMITTEE (BOARD OF DIRECTORS)

TERMS OF REFERENCE

Version:	1.1 (first draft circulated for review to Chair / Non-Executives) 1.2 Draft submitted to Board for approval
Approved by:	Board of Directors
Date approved:	08.09.15 30.6.16
Date issued:	30.6.16
Review date:	June 2017

NOMINATION AND REMUNERATION COMMITTEE TERMS OF REFERENCE

1. **Constitution**

   1.1   The Trust hereby resolves to establish a Committee to be known as the Nomination and Remuneration Committee. The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. **Authority**

   2.1   The Nominations and Remuneration Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

   2.2   The Nominations and Remuneration Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Nominations and Remuneration Committee.

   2.3   The Nominations and Remuneration Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from both within and outside the Trust with relevant experience and expertise if it considers this necessary to the exercise its functions.

3. **Purpose**

   3.1   To be responsible for identifying and appointing candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service. When appointing the chief executive, the committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006. When appointing the other executive directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

4. **Nominations role**

   The Committee will:

   4.1   Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board and make recommendations to the Board with regard to any changes.

   4.2   Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors, taking into account the challenges and opportunities facing the Foundation Trust and the skills and expertise needed, in particular on the Board in the future.

   4.3   Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

   4.4   Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.

   4.5   When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search; consider

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candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

4.6 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise.

4.7 Be responsible for identifying and nominating a candidate for approval by the Membership Council, to fill the position of Chief Executive (in line with the Constitution).

4.8 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

4.9 Consider any matter in line with Trust procedures relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Foundation Trust.

5. Remuneration role

5.1 Establish and keep under review a remuneration policy in respect of Executive Board Directors (and senior managers on locally determined pay).

5.2 Consult with the Chief Executive about proposals relating to the remuneration of other executive directors.

5.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors (and senior managers on locally-determined pay), including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses; and compensation payments.

5.4 In adhering to all relevant laws, regulations and Trust policies:-

- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose and at a level which is affordable for the trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors (and senior managers on locally determined pay) while ensuring that increases are not made where trust or individual performance do not justify them.
- Be sensitive to pay and employment pay and conditions elsewhere in the trust.

5.5 Monitor and assess the output of the evaluation of the performance of individual directors, and consider this output when reviewing changes to remuneration levels.

5.6 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments (including redundancy), taking account of national guidance where appropriate, always ensuring that poor performance is not rewarded.

5.7 Delegate responsibility to the Chief Executive and Director of Workforce and OD

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for the determination of the Trust's Pay and Reward Strategy as it affects all other staff – working within national frameworks where required.

6. Membership and attendance

6.1 The membership of the committee shall consist of:
- The Trust Chair
- The other non-executive directors on the Board (excluding the Chair of the Audit and Risk Committee for remuneration business)
- The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding his/term terms of condition and remuneration.

6.2 The Trust Chair shall chair the committee.

6.3 A quorum shall be three members which must include either the Chair or Deputy Chair.

6.4 The Executive Director of Workforce and OD shall normally be invited to attend meetings in an advisory capacity.

6.5 Other members of staff and external advisers may attend all or part of a meeting by invitation of the committee chair where required.

6.6 Members unable to attend should inform the Committee Secretary at least 7 days in advance of the meeting.

6.7 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

7. Administration

7.1 The Board Secretary shall be the secretary to the Committee and will provide administrative support and advice. The duties of the Board Secretary in this regard include but are not limited to:
- Agreement of the agenda with the chair of the committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

8. Frequency of meetings

8.1 Meetings shall be held as required but at least twice in each financial year,

9. Reporting

9.1 Formal minutes shall be taken of all Committee meetings. Once approved by the committee, the minutes will go to the next Board of Directors meeting unless it would be inappropriate to do so.

9.2 A summary report will be presented to the next board meeting.

9.3 The Committee shall receive and agree a description of the work of the committee, its policies and all Executive Director emoluments in order that these are accurately reported in the Trust's Annual Report.

10. Review

10.1 As part of the Trust's annual committee effectiveness review process, the committee shall review its collective performance.

10.2 The terms of reference of the committee shall be reviewed by the Board of Directors at least annually.

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NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)

TERMS OF REFERENCE

Version:	1.1 First draft circulated for review to Chair – 13.10.15 1.2 Draft submitted to Membership Council for approval – 4.11.15 1.3 Draft submitted to Board for approval – 26.11.15
Approved by:	Board of Directors & Membership Council
Date approved:	4.11.15 and 26.11.15
Date issued:	13.10.15 21.7.16
Review date:	October 2017

NOMINATION AND REMUNERATION COMMITTEE TERMS OF REFERENCE (MEMBERSHIP COUNCIL)

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Nomination and Remuneration Committee (Membership Council). The Committee has no executive powers other than those specifically delegated in these terms of reference.

1.2 Please note that all references in these terms of reference to Non-Executive Directors are to be taken to include the Chair, unless specifically indicated otherwise.

2. Authority

2.1 The Membership Council Nomination and Remuneration Committee (the Committee) is constituted as a standing committee of the Membership Council. Its constitution and terms of reference shall be as set out below, subject to amendment at future Membership Council meetings.

2.2 The Nomination and Remuneration Committee is authorised by the Membership Council to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Nomination and Remuneration Committee.

2.3 The Nomination and Remuneration Committee is authorised by the Membership Council, subject to funding approval by the Board of Directors, to request professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2.4 The Nomination and Remuneration Committee is also authorised to request such internal information as is necessary and expedient to the fulfilment of its functions.

3. Conflicts of Interest

3.1 The Chair of the Trust, or any Non-Executive director present at committee meetings, will withdraw from discussions concerning their own re-appointment, remuneration or terms of services.

3.2 In order to sit as a member of the committee participants must sign a declaration that they have no intention to apply for a Non-Executive Director appointment in the 12 months following attendance at the meeting of the Nomination and Remuneration Committee.

4. Nominations role

The Committee will:

4.1 Periodically review the balance of skills, knowledge, experience and diversity of the Non-Executive Directors and, having regard to the view of the Board of Directors and relevant guidance on board composition, make recommendations to the Membership Council with regard to the outcome of the review.

4.2 Review the results of the Board of Directors' performance evaluation process that relates to the composition of the Board of Directors.

4.3 Review annually the time commitment requirement for Non-Executive Directors.

4.4 Give consideration to and succession planning for Non-Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and

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expertise needed on the Board of Directors in the future.

4.5 Make recommendations to the Membership Council concerning plans for succession, particularly for the key role of Chair.

4.6 Keep the leadership needs of the Trust under review at Non-Executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.7 Keep up-to-date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.

4.8 Agree with the Membership Council a clear process for the nomination of a Non-Executive Director.

4.9 Take into account the views of the Board of Directors on the qualifications, skills and experience required for each position.

4.10 For each appointment of a Non-Executive Director, prepare a description of the role and capabilities and expected time commitment required.

4.11 Identify and nominate suitable candidates to fill vacant posts within the Committee's remit, for appointment by the Membership Council.

4.12 Ensure that a proposed Non-Executive Director's other significant commitments are disclosed to the Membership Council before appointment and that any changes to their commitments are reported to the Membership Council as they arise.

4.13 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest as well as with compliance with 'Fit and Proper Person' requirements are reported.

4.14 Ensure that on appointment Non-Executive Directors receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside Board of Directors Meetings.

4.15 Advise the Membership Council in respect of the re-appointment of any Non-Executive Director. Any term beyond six years must be subject to a particularly rigorous review.

4.16 Advise the Membership Council in regard to any matters relating to the removal of office of a Non-Executive Director.

5. Remuneration role
The Committee will:
5.1 Recommend to the Membership Council a remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the Chair (except in respect of his own remuneration and terms of service) and the Chief Executive and any external advisers.

5.2 In accordance with all relevant laws and regulations, recommend to the

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Membership Council the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors.

5.3 Receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

5.4 In adhering to all relevant laws and regulations establish levels of remuneration which:

5.4.1 are sufficient to attract, retain and motivate Non-Executive Directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable to the Trust;

5.4.2 reflect the time commitment and responsibilities of the roles;

5.4.3 take into account appropriate benchmarking and market-testing, while ensuring that increases are not made where Trust or individual performance do not justify them; and

5.4.4 are sensitive to pay and employment conditions elsewhere in the Trust.

5.5 Oversee other related arrangements for Non-Executive Directors.

6. **Membership and attendance**
6.1 The membership of the committee shall consist of Membership Councillors appointed by the Membership Council.

6.2 The Committee will normally be chaired by the Trust Chair. Where the Trust Chair has a conflict of interest, for example when the Committee is considering the Chair's re-appointment or remuneration, the Committee will be chaired by the Deputy Chair/Lead Membership Councillor.

6.3 A quorum shall be three members, two of whom must be public Membership Councillors.

7. **Secretary**
7.1 The Board Secretary shall be the secretary to the Committee

8. **Attendance**
8.1 Only members of the Committee have the right to attend Committee Meetings.

8.2 At the invitation of the Committee, meetings shall normally be attended by the Chief Executive and Director of Workforce.

8.3 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

9. **Frequency of Meetings**
9.1 Meetings shall be held as required, but at least twice in each financial year.

10. **Minutes and Reporting**
10.1 Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to all members of the Membership Council unless a conflict of interest, or matter of confidentiality exists.

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10.2   The Committee will report to the Membership Council after each meeting.

10.3   The Committee shall receive and agree a description of the work of the Committee, its policies and all Non-Executive Director emoluments in order that these are accurately reported in the required format in the Trust's Annual Report.

11.   Performance Evaluation
11.1   The Committee shall review annually its collective performance.

12.   Review
12.1   The Terms of Reference of the Committee shall be reviewed by the Membership Council at least annually.

/KB/MC-NOMREM-TOR
NOVEMBER 2015

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, 2nd February 2017	**Sponsoring Director:** ian warren, Executive Director of Workforce and OD

Title and brief summary:
Whistleblowing Annual Report - See attached

Action required:
Note

Strategic Direction area supported by this paper:
Keeping the Base Safe

Forums where this paper has previously been considered:
Audit and Risk Committee - 18 January 2017

Governance Requirements:
See attached

Sustainability Implications:
None

Executive Summary

Summary:

See attached

Main Body

Purpose:

see attached

Background/Overview:

see attached

The Issue:

See attached

Next Steps:

See attached

Recommendations:

The Board is asked to note the content of the report.

Appendix

Attachment:

Whistleblowing Annual Report January 2017.pdf

BOARD OF DIRECTORS	
PAPER TITLE: WHISTLEBLOWING ANNUAL REPORT	**REPORTING AUTHOR:** Mr Barry Mortimer, Senior Human Resources Adviser
DATE OF MEETING: 2 FEBRUARY 2017	**SPONSORING DIRECTOR:** Dr David Anderson, Freedom To Speak Up to Guardian
STRATEGIC DIRECTION – AREA: • Keeping the base safe	**ACTIONS REQUESTED:** • To note

PREVIOUS FORUMS: 18 January 2017 - Audit and Risk Committee

IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link: http://nww.cht.nhs.uk/index.php?id=12474**

EXECUTIVE SUMMARY: The national NHS Whistleblowing Policy includes a reference to Board oversight and an annual whistleblowing report. To this end this report contains a review of effectiveness of the Trust's Raising Concerns Policy and the Trust's general approach to whistleblowing, together with a work plan for further key work on developing the Trusts whistleblowing processes.

FINANCIAL IMPLICATIONS OF THIS REPORT: None

RECOMMENDATION: The Board is asked to note the content of the report.

APPENDIX ATTACHED: YES

BOARD OF DIRECTORS

2 FEBRUARY 2017

WHISTLEBLOWING ANNUAL REPORT

1. Introduction

The Trust introduced its Raising Concerns (including whistleblowing) Policy on 21 January 2016 following comprehensive input from leading whistleblowing charity Public Concern at Work (PCaW). The national NHS whistleblowing policy introduced by NHS Improvement sets out a requirement for Board oversight and an annual report. To this end this report sets out a review of the effectiveness of both the policy and the Trusts general approach to whistleblowing, together with a work plan for further key work on developing the Trust's approach to whistleblowing.

2. National context

The impact of the failings at Mid Staffordshire NHS Trust is well documented and the subsequent report by Sir Robert Francis QC gave a very clear steer to the NHS for wholescale improvement in its approach to whistleblowing. The establishment of the National Guardians Office (hosted by the CQC) and the introduction of a national NHS whistleblowing policy have given further impetus to the Governments plans for improving the reporting culture in the NHS.

3. Background

Since 2014 the Trust has taken action to improve and assure its whistleblowing arrangements as set out below.

Date	Activity	Outcome
1 November 2014 to 31 October 2015	Formal one year contract with Public Concern at Work to guide the Trust's approach to whistleblowing.	• Availability of PCaW Freephone and advice line for CHFT staff • Review of existing Trust policies:- - Freedom of Speech(whistleblowing) - Grievance Procedure - Bullying/Harassment • Advice on appointment of Freedom To Speak Up (FTSU) Guardian • General support for whistleblowing arrangements • Annual review of Trust's whistleblowing arrangements • Membership of PCaW "First 100"campaign designed to persuade organisations to sign up to its Code of Practice on whistleblowing
2014 2015	Inclusion of local whistleblowing questions in national NHS staff survey.	Direct feedback from Trust staff (see section 4 below for further details). Ability to track progress.

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Date	Activity	Outcome
June 2015	Appointment of Dr David Anderson, Senior Independent NED, as FTSU Guardian.	Availability of independent source of advice/help for CHFT staff. (Note: all Trusts are required to have FTSUG by 1 October 2016).
August 2015 to date	Membership of NHS Employers Raising Concerns Expert network.	Networking opportunity through meetings with other Raising Concerns leads.
15 December 2015	PCaW annual review of CHFT's whistleblowing arrangements.	- Impetus for introducing revised policy - Reassurance that CHFT's approach to whistleblowing is largely positive.
21 January 2016	Revised policy approved at Executive Board.	New Raising Concerns (including whistleblowing) Policy developed with support from PCaW.
January and February 2016	Key communications activities:- - Letter from Chief Exec attached to payslips - Various articles in CHFT Weekly and Line Manager Bulletin - Reference in Big Brief - Posters for display in wards/departments	Increased awareness of policy and the channels open to staff to raise concerns.
January 2016 onwards	Development of Raising Concerns intranet site.	More comprehensive guidance for Trust staff.
March – May 2016	Awareness sessions run in some areas of the Trust for managers.	Increased awareness.
1 April 2016	Introduction of national NHS Whistleblowing Policy.	Requirement for all Trusts to adopt this policy.
September/October 2016	Participated in Internal Audit Review of Trusts whistleblowing arrangements.	Ensure Trust policy is compliant with national NHS Policy.
20 October 2016	Introduction of new NHS reporting template by NHS Employers.	More comprehensive system for capturing key data.
November 2016	Clarify relationship between Raising Concerns Policy and Incident Reporting, Management and Investigation Policy.	Amendments proposed to Incident Reporting, Management and Investigation Policy to reflect the relationship.

4. Staff survey feedback 2014/2015

A decision was taken to test the Trusts approach to raising concerns with the inclusion of the following local questions in the national staff surveys for 2014/2015 (the 2016 results were not available at the time this report was written).

- In the past 3 years have you been aware of an incident at work which was not addressed through the normal management process and which led you to consider being a whistleblower?

- Are you aware of the Trust's whistleblowing arrangements?

- Did you raise your concerns?

- If yes, who did you raise your concern with? (line manager/supervisor/Trade Union/HR/other please specify).

- Did you receive any feedback?

- How do you think your concerns were handled? (not at all, not very well, well).

- Did you suffer any negative repercussions?

- Going forward how confident are you that your concern will be addressed by the Trust? (unsure/not confident/reasonably confident/very confident).

A snapshot of key data from the 2015 and 2015 surveys has been outlined in the following slide:
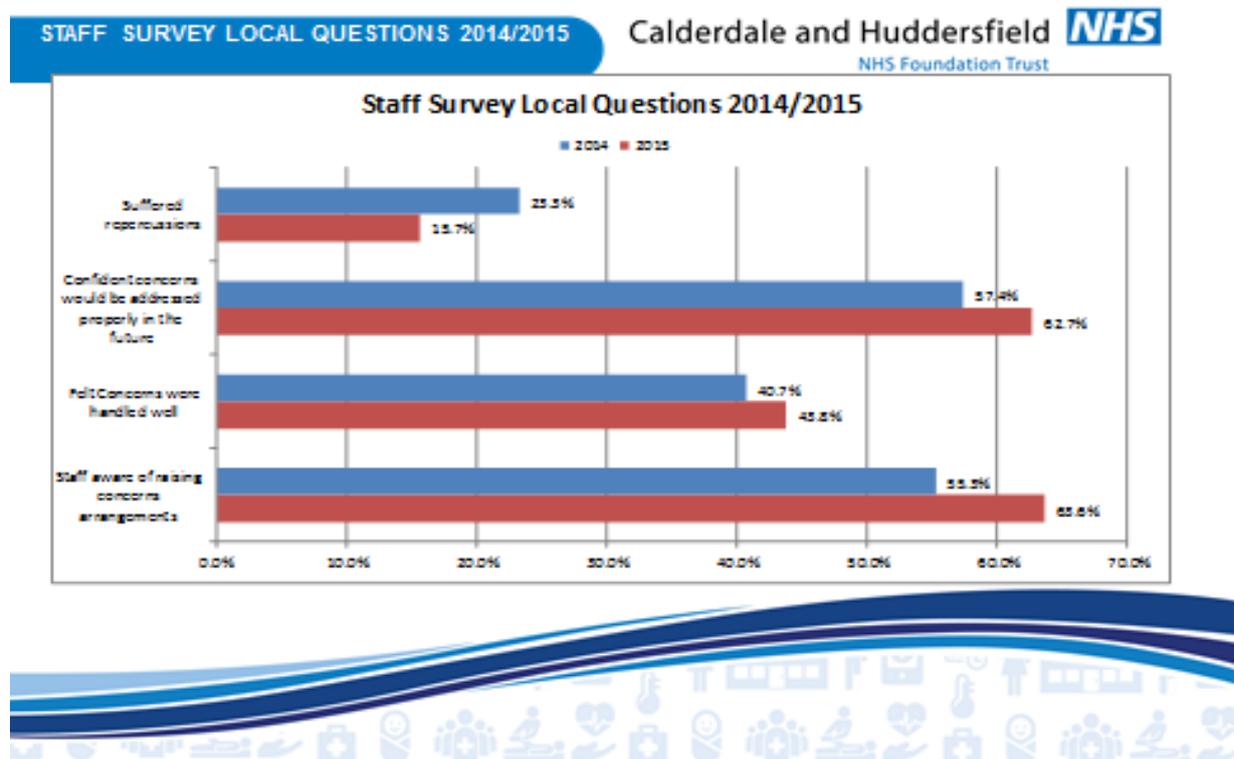
The data for 2014/15 suggests, inter alia, an encouraging increase in awareness of staff regarding the Trust's whistleblowing arrangements (albeit from a small sample size). The data for the 2016 survey will be added to this when it is available to help the Trust to track progress.

5. Areas requiring further action

A review of the effectiveness of the policy suggests that further work is required to ensure the Trusts arrangements for raising concerns continue to be fit for purpose and this is set out in the future work plan.It should be recognised however that the Trust has a very well established incident reporting system and it is understood that this may account for the absence of any concerns raised formally under the Raising Concerns Policy,as evidenced by the absence of any issues raised via the e-mail inbox set up for this purpose.

6. Future Work Plan

Activity	Planned Outcome	Timescale	Lead
Complete work on reviewing Raising Concerns Policy to incorporate national policy.	CHFT policy compatible with national whistleblowing policy.	31 January 2017	Senior HR Adviser
Ensure CHFT policy includes link to new NHS Employers reporting template.	More comprehensive facility for reporting/recording concerns.	31 January 2017	Senior HR Adviser
Consider recommendations from Internal Audit review	Compliance with national NHS Whistleblowing Policy.	31 January 2017	Senior HR Adviser
Promote use of Health Education England e-learning sessions for line managers.	Increased awareness for line managers on how to receive and respond to a concern.	Throughout 2017	Senior HR Adviser
Examine possibility of substantive FTSU guardian appointment on a joint basis with another West Yorkshire Trust.	Increased capacity for FTSU guardian to develop comprehensive Trust approach.	To be determined	Senior HR Adviser
Ensure concerns raised are suitably recorded.	All complaints are logged on the Trust's Raising Concerns reporting system	From 1 March 2017	Freedom to Speak Up Guardian
Review 2016 staff survey local question results.	Continue trend analysis from 2014/15. Identify weak spots/areas for improvement.	Early 2017	Senior HR Adviser

Activity	Planned Outcome	Timescale	Lead
Review local staff survey questions to see whether they continue to serve the purpose they were designed for.	Identify improvements in questions where necessary.	Early 2017	Senior HR Adviser.
Maintain and improve the Intranet Raising Concerns site.	Enhanced resources available for Trust staff.	31 March 2017	Senior HR Adviser
Continue membership of national networks (e.g. NHS Employers Expert network and National Guardians network).	Enhanced knowledge base.		Senior HR Adviser (Expert network) Guardian (NGO network)
Re-launch efforts to develop raising concerns champions network.	Establishment of 20 – 30 Trust staff willing to act as 'champions'.	30 April 2017	Senior HR Adviser

7. **Action required**

The Board of Directors is asked to note the content of this report.

Dr David Anderson
Freedom to Speak Up Guardian

Calderdale and Huddersfield NHS

NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	**Report Author:**
Board of Directors	Jean Robinson, Lead Infection Prevention and Control Nurse
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	David Birkenhead, Medical Director
Title and brief summary:	
Quarterly DIPC report - The Board is asked to receive the report on the position of healthcare associated infections.	
Action required:	
Note	
Strategic Direction area supported by this paper:	
Keeping the Base Safe	
Forums where this paper has previously been considered:	
Executive Board	
Governance Requirements:	
Keeping the base safe	
Sustainability Implications:	
None	

Executive Summary

Summary:

The board is asked to receive the report on the position of healthcare associated infections

Main Body

Purpose:

None

Background/Overview:

None

The Issue:

None

Next Steps:

None

Recommendations:

The board is asked to receive the report on the position of healthcare associated infections

Appendix

Attachment:

Quarterly DIPC Report January 2017.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Report from the Director of Infection Prevention and Control to the Weekly Executive Board
1st October to 31st December 2016

Performance targets

Indicator	End of year ceiling	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**1**	
C.difficile (trust assigned)	21	**23**	5 avoidable and 18 unavoidable cases
MSSA bacteraemia (post admission)	9	**11**	Local ceiling – 15/16 outturn
E.coli bacteraemia (post admission)	25	**34**	Local ceiling – 15/16 outturn
MRSA screening (electives)	95%	95.14%	Nov validated
Central line associated blood stream infections (Rate per 1000 cvc days)	1	**0.5**	Rolling 12 months, December validated data.
ANTT Competency assessments (doctors)	95%	77.2%	4% increase in last 3 months
ANTT Competency assessments (nursing and AHP)	95%	84.4%	3% increase in the last 3 months
Hand hygiene	95%	99.06%	

Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	**95%**	**90.63%**	Data cleansing of MRSA emergency screening to commence as some admissions may fall into the exclusion criteria for screening.
Isolation breaches	**Non set**	195	Compared to 247 for same time period last year
Cleanliness	**Non set**	97%	

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MRSA bacteraemia:

Unfortunately in December we had our first MRSA bacteraemia in over 449 days.

A 69 year old gentleman was admitted during November 2016, having been found at home by his neighbor on the floor naked. He was in a very unkempt state on arrival to hospital and had declined medical and social input for many years. The patient had sacral pressure sores and cuts to skin which were inflamed, he also had multiple bruising and lesions to legs, moisture lesions to both groins, cuts to toes, he was also doubly incontinent.

The patient became unwell 2 weeks after admission with a pyrexia of 40.1. The sepsis bundle was followed as per protocol. There was no MRSA colonization screening completed on the admission ward, nor the ward to which he was subsequently transferred.

The patient has since made a full recovery with social care input.

Total Number of MRSA Bacteraemia
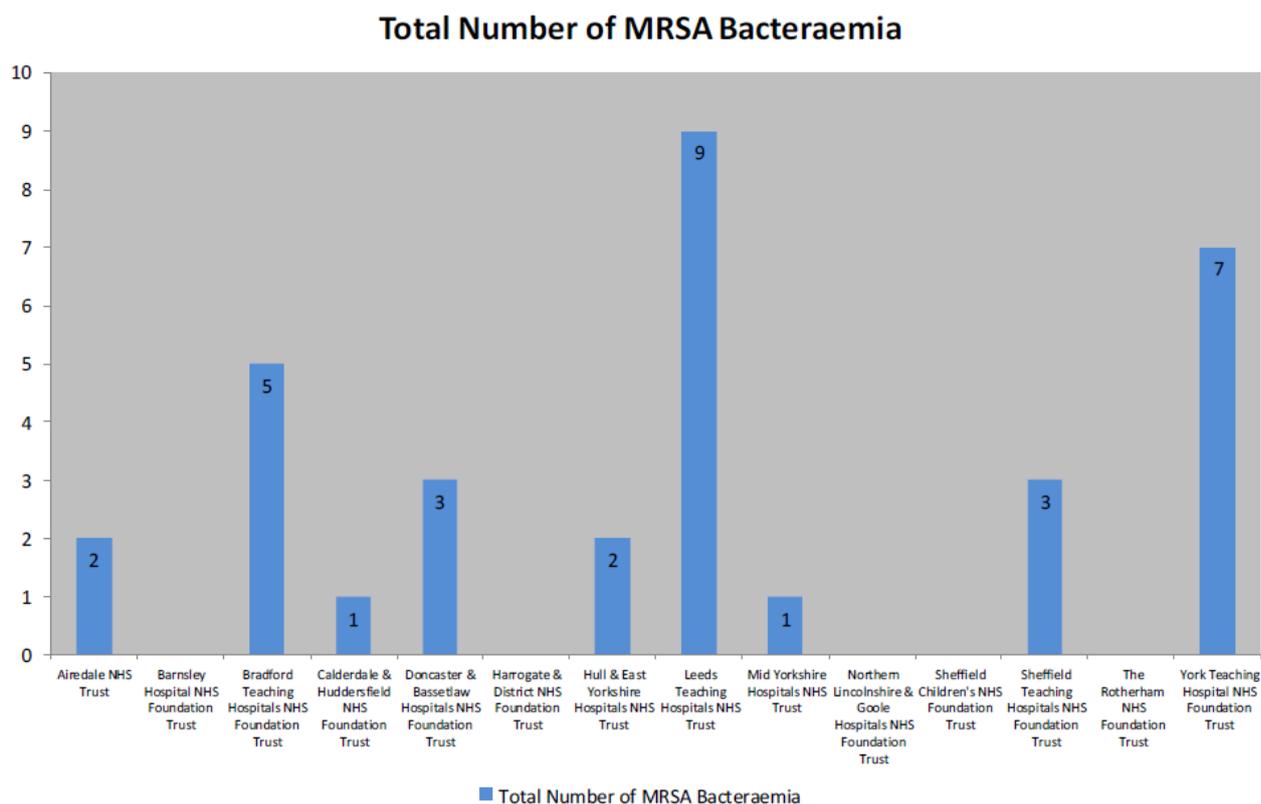
MSSA bacteraemia: there have been 11 post-admission MSSA bacteraemia cases during quarter one, against the internal objective of 9.

MRSA - Hospital-Acquired Infections (HAIs):
There have been 21 acquisitions this year compared to 18 for the same time period last year.
Wards are informed of any HAIs that occur within their area and are asked to carry out a ward-led investigation; these are presented to the PSQBs. These will be monitored throughout the year.

Clostridium difficile: the ceiling for 2016/17 is for no more than 21 post-admission cases as of 31st December there have been 23 cases.
Key themes from the C-diff cases are:
- Delay in obtaining stool specimen
- Completion of the Bristol Stool Chart and assessing patient bowel habits.
- Delay in isolation – wards awaiting specimen results before isolation
- Antibiotic prescribing
- All cases a sporadic in nature with no dominant strain being identified.

Work is ongoing to improve compliance with the above issues.

Total Number of C difficile infection

Trust	Value
Airedale NHS Trust	12
Barnsley Hospital NHS Foundation Trust	8
Bradford Teaching Hospitals NHS Foundation Trust	28
Calderdale & Huddersfield NHS Foundation Trust	23
Doncaster & Bassetlaw Hospitals NHS Foundation Trust	22
Harrogate & District NHS Foundation Trust	26
Hull & East Yorkshire Hospitals NHS Trust	33
Leeds Teaching Hospitals NHS Trust	82
Mid Yorkshire Hospitals NHS Trust	32
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust	17
Sheffield Children's NHS Foundation Trust	4
Sheffield Teaching Hospitals NHS Foundation Trust	80
The Rotherham NHS Foundation Trust	12
York Teaching Hospital NHS Foundation Trust	26

Legend: Total Number of C difficile infection — Acute Trust target objective (16/17)

Escherichia-coli (E-coli) bacteraemia:

There have been 34 post-admission E-coli bacteraemia cases against the internal objective of 25; the HAI health economy meeting has been reinstated and the focus for the forthcoming 12 months will be collaborative work with an aim reduced the incidence of E-coli bacteraemia.

Outbreaks & Incidents:-

- During November and December there have been several wards affected at CHFT with Norovirus as follows:-

CRH Ward Closures:	• 8 closed wards, 4 of these being initially restricted. • Norovirus was confirmed on 7 of the above wards • 2 of the wards were cohorted due to capacity issues • 75 patients were affected • 16 staff were affected • 115 Bed days lost (BDL)
HRI Ward Closures:	• 3 closed wards • Norovirus was confirmed on 2 of the above wards • 1 ward had 1 bay closed • 23 patients were affected • 11 staff were affected • 19 BDL
CRH Restricted wards:	• 6 restricted wards/bays. • Norovirus was confirmed on 2 wards • 25 patients were affected • 3 staff were affected
HRI Restricted Wards:	• 9 restricted wards/bays • Norovirus was confirmed on 1 ward • 30 patients were affected • 0 staff was affected.

Central Vascular Access Device related bacteraemia

The internally set target for CVAD related bacteraemia is 1 per 1000 CVAD line days, the current rate is 0.5%

Isolation Breaches

There have been 195 isolation breaches since 1st April 2016 compared to 236 breaches for the previous year. The majority of breaches are patients with a previous history of MRSA acquisition on the medical admission units.

The IPCT will continue to monitor isolation breaches; actions to reduce breaches have been included in the HCAI annual action plan, this includes ongoing work with the medical division where the majority of breaches occur.

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Audits:
45 Quality improvement environmental audits have been carried out since the beginning 1ˢᵗ April 2015 to 31ˢᵗ December 2016.
Compliance scores: <75% = red rating; 76% - 90% = amber rating; 91%+ = green rating.
- 22 of the areas achieved a green rating.
- 21 of the areas achieved an amber rating; actions plans are produced by the ward/department following the audit in order to address any issues or concerns identified.
- One area's received a red rating in September this will be re-audited in October and is now an Amber.
- One of the areas the report is pending.

CPE audit: - a random selection of patient notes were auditing during November against compliance with CPE risk assessment, of the 101 notes checked 100% were fully compliant compared to the previous audit in July when it was 94%. This plays a vital part in keeping both our patients, staff and environment free from CPE.

CJD audit: - a random selection of 30 patient's notes was audited for compliance against the CJD risk assessment; 100% is consistently achieved every quarter.

Commode audits: these are carried out by the IPCT on a monthly basis. Commodes on all ward areas are inspected to ascertain whether they have been cleaned according to CHFT policy and are ready for use. The average compliance rate is 88% over the 3 month period Oct-Dec 2016.
Cleaning compliance issues include urine splashes to the commodes, including some dried urine and faeces.
Results are discussed with ward staff at the time that the audit is carried out and are included on the IPC monthly reports.

Hand hygiene:

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. The table below shows a year on year percentage increase of compliance with 'Bare Below Elbow'.
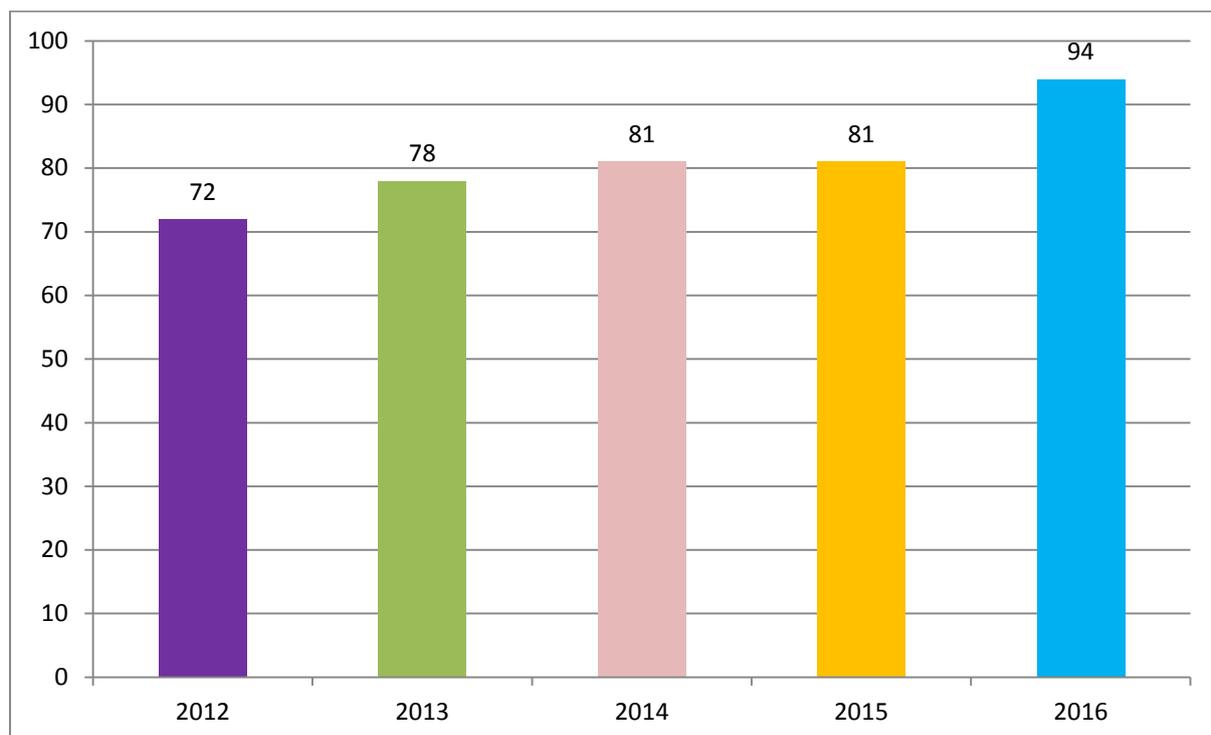
Wards and departments continue to audit hand hygiene compliance and staff are encouraged to report actual practice so that any problems can be identified. A meeting has been held with GOJO our current alcohol gel supplier with the intention being that we pilot the use of an Observational APP which focuses on the WHO '5 moments' of hand hygiene and can we used on hand held devices. We aim to pilot this in the next few months on a couple of areas to ensure it meets the organisation's needs.

Link Infection Prevention & Control Practitioners (LIPCPs):
The IPCT continue to provide 4 workshops per year for the LIPCPs for each ward area and department, plus one aimed specifically at community staff, in order to address specific IPC issues and provide relevant information and support.

Training:
Micro teaching sessions on the wards has commenced on areas identified as having training needs, this will be rolled out proactively to all wards over the next 12 months.

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The IPCT continue to deliver 'right from the Start' and 'Beyond the Basics' training session.   Bespoke sessions have been provided to areas identified either during incidents or at the Ward Srs/Matrons requests; 2655 staff has attended training in the last 2 years, this includes 97 medics.

ANTT (Aseptic Non-Touch Technique) training for Assessors:
There are 123 new assessors have been trained since October 2015.
Competency rate is now at 84.4% for nursing staff (previously 81.69%) and 77.2% (previously 73.35%) for Doctors; Trust overall 82.79% (previously 78.72%). Plans to improve performance includes:- ANTT competency matrix on all divisional PSQBs; additional support provided to ANTT assessors by the IPCNs; new assessors identified and trained on ward/departments are being supplied with their individual clinical area matrix so that they can target those staff who are not ANTT assess, this is proving to have a positive effect.

IPCT:
The on-call cover has restarted as of 1st October.
2 IPCNs have completed and successfully passed the IPC master module at Sheffield University.
2 members of the team are EPR friends.
IPCT continue to work both proactively and reactively.

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Antimicrobial Stewardship Report 2016

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.

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 aimed at trying to meet the CQUIN targets:

- **Part A of the national CQUIN**
  Reduction in antibiotic consumption per 1000 admissions

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

Although there was a steady rise in the consumption of all antibiotics between 2013/14 and 2015/16, this is beginning to plateau and 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.

Total consumption of antibioitcs per 1000 admissions (PHE data)
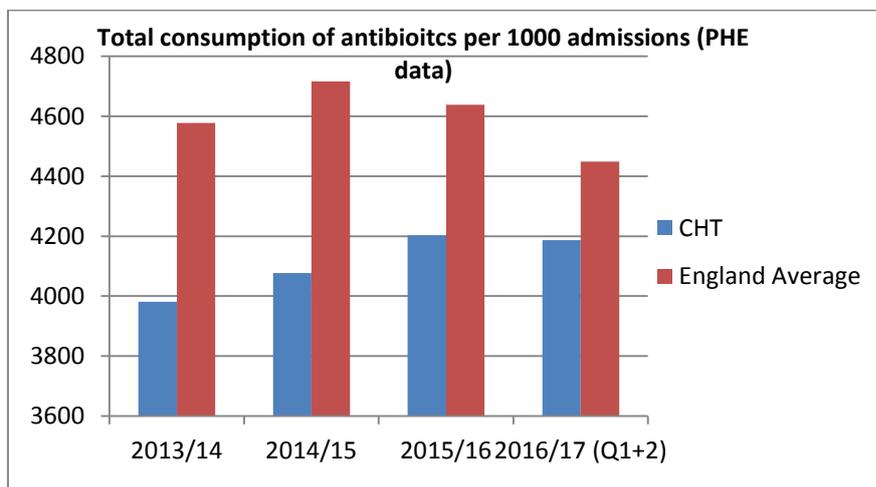
- *Reduction of 1% or more in piperacillin-tazobactam consumption against the baseline 2013/4.*

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.

Total consumption of Piperacillin-Tazobactam per 1000 admissions (PHE data)
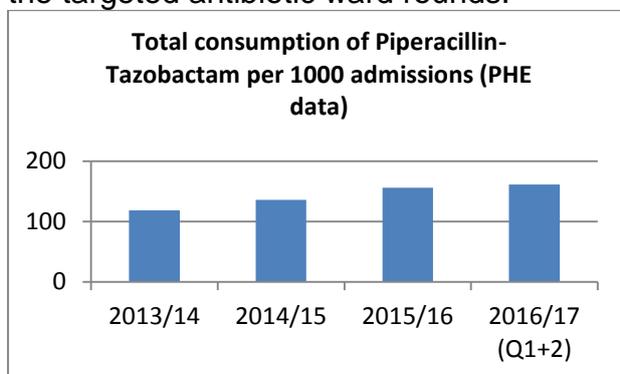
- *Reduction of 1% or more in Carbapenem consumption against the baseline 2013/4.*

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 Carbapenemase producing Organisms (CPOs). 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.

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Total consumption of Carbapenems per 1000 admissions (PHE data)
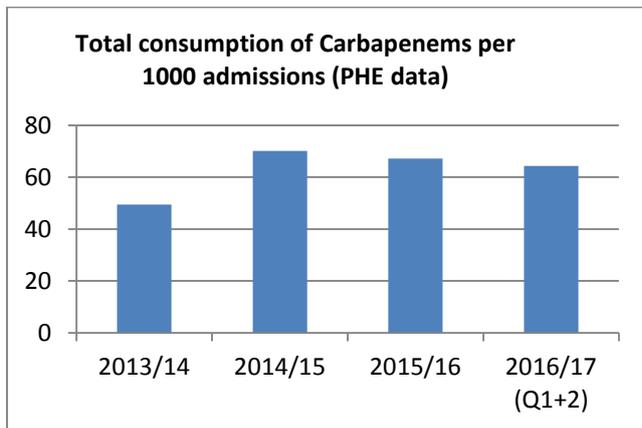
The target reductions for part A of the CQUIN were not met at Q1 and 2. Discussions are ongoing with the CCG with the aim of setting more realistic and achievable targets.

- **Part B of the national CQUIN**
  Empiric review of antibiotic prescriptions within 72 hours
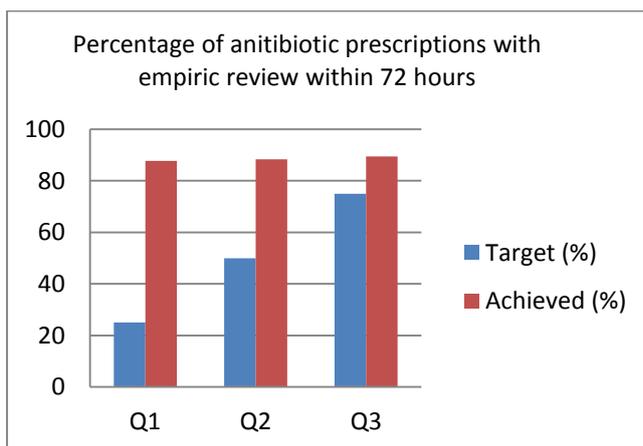
Targets were met at Quarters 1-3 and plans are in place to meet the target at Q4 (90% of antibiotic prescriptions should be reviewed within 72hours).

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.

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.

Between Sept – Dec 2016, as part of the targeted ward rounds, 112 antibiotic prescriptions were reviewed. 27.7% of these were stopped, 10.7% were de-escalated to an alternative antimicrobial with a narrower spectrum of activity and 8.9% were switched from an IV antibiotic to an oral antibiotic.

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.
Review of Datix incidents concerning antimicrobials
This is done 6 monthly and any trends are investigated

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Electronic Prescribing

The Consultant Microbiologists and Antibiotic Pharmacist have advised the team developing the Electronic Patient Record. An indication and review date will be mandatory for all inpatient prescriptions and further information is required to be documented when prescribing a restricted antimicrobial. Additional wording has been added to electronic prescriptions of Linezolid to remind prescribers that FBC monitoring is required. The aim is to improve safety and reduce outpatient waiting times that have been reported to occur when FBCs have not been ordered.

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

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

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Calderdale and Huddersfield **NHS**

NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	Report Author:
Board of Directors	Sue Laycock, PA to Chief Operating Officer
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	Helen Barker, Chief Operating Officer
Title and brief summary:	
INTEGRATED BOARD REPORT - The Board is asked to receive and approve the Integrated Board Report for December 2016	
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, Quality Committee and Finance and Performance Committee	
Governance Requirements:	
Keeping the base safe	
Sustainability Implications:	
None	

Executive Summary

Summary:

December's Performance Score is 65% for the Trust, with SAFE achieving a Green rating following improvement in Harm Free Care and without the impact of November's never event. CARING and RESPONSIVE domains are just short of the Green rating.

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 December 2016

Appendix

Attachment:

Board Report Dec 16.pdf

Board Report

December 2016
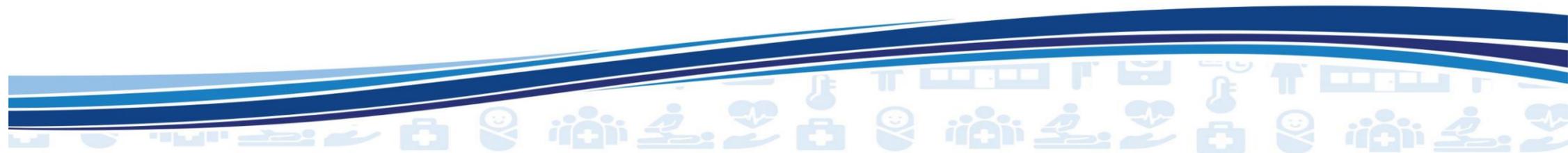
Performance Summary

December

RAG Movement

December's Performance Score is 65% for the Trust with SAFE achieving a Green rating following improvement in Harm Free Care and no never event. CARING and RESPONSIVE domains are just short of Green rating.

CHFT

Performance Score 65%

(wheel segments: Efficiency & Finance, Safe, Caring, Effective, Responsive, Workforce)

Total performance score

Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
55%	54%	64%	64%	64%	69%	66%	65%	65%

December Score by Domain

Domain	Score	Trend
Safe	82%	↑
Caring	70%	↔
Effective	60%	↓
Responsive	70%	↑
Workforce	55%	↓
Efficiency & Finance	60%	↓
Performance Score	**65%**	↔

SINGLE OVERSIGHT FRAMEWORK

SAFE	Emergency C-Section Rate
VTE Assessments	Never Events
CARING	FFT A&E FFT OP
FFT Community	FFT Inpatients FFT Maternity
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	97.7%	97.6%	⬆	96%
Inpatient Complaints per 1000 bed days	2.1	2.4	⬆	TBC
EFFECTIVE				
Average Length of Stay - Overall	5.2	5.2	⬆	5.17
Delayed Transfers of Care	1.36%	2.07%	⬆	5%
Green Cross Patients (Snapshot at month end)	109	83	⬇	40
Hospital Standardised Mortality Rate (12 months Rolling Data)	102.94	105.00	⬆	100
Theatre Utilisation (TT) - Trust	83.4%	85.1%	⬇	92.5%
RESPONSIVE				
% Last Minute Cancellations to Elective Surgery	0.49%	0.68%	⬆	0.6%
Emergency Care Standard 4 hours	92.49%	94.02%	⬇	95%
% Incomplete Pathways <18 Weeks	95.64%	96.13%	⬇	92%
62 Day GP Referral to Treatment	90.4%	89.1%	⬆	85%
SAFE				
% Harm Free Care	95.17%	93.92%	⬆	95.0%
Number of Outliers (Bed Days)	779	284	⬇	495
Number of Serious Incidents	8	8	⬅➡	0
Never Events	0	1	⬆	0

MOST IMPROVED

Improved: Average Diagnosis per Coded Episode. Achieved target for first time in the last 12 months.

Improved: Inpatient Complaints per 1000 bed days. Lowest rate since February 2016.

Improved: Delayed Transfers of Care. Lowest rate for over 12 months.

MOST DETERIORATED

Deteriorated: Stroke Indicators. All stroke indicators deteriorated in December. Unfortunately stroke units were closed due to Norovirus from 2nd to 19th December. This reduced the access for patients on to the unit. Also 7A was closed from 30th November until 17th December which did prevent discharges and bed availability.

Deteriorated: Number of MRSA Bacteraemias – Trust assigned. There has been one case of MRSA Bacteraemia in the Medical division in December. Admission screening was not evident in the records as such the case cannot definitively be confirmed as community or hospital acquired and therefore will be assigned to the Trust.

Deteriorated: A and E 4 hour target - No patients waiting over 8 hours.

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

ACTIONS

Action: A four bedded HASU area was set up on one of the Rehabilitation wards and staff were moved accordingly however this did not prevent the fact that the number of useable beds on the unit were reduced.

Action: The importance of the documentation of MRSA swabs on admission has been reiterated to all relevant staff.

Action: ED escalation SOP is in place and being followed to ensure that any ED delays are addressed in a timely manner.

Arrow direction count ⬅➡ 1 ⬆ 10 ⬇ 8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.7	7.9	⬇	
Sickness Absence Rate	4.54%	4.27%	⬇	4.0%
Turnover rate (%) (Rolling 12m)	12.25%	12.41%	⬆	12.3%
Vacancy	355.20	355.07	⬇	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q2	80%	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	61%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	£4.01	£2.80	🟢
Expenditure vs Plan var (£m)	-£4.45	-£3.29	🟡
Liquidity (Days)	-15.85	-16.71	🟢
Variance from Plan	-£0.22	£0.12	🟡
Variance from Plan excl exceptional (£m)	£0.01		🟢
CIP var (£m)	£2.00	£2.03	🟡
UOR	3	3	🔴
Temporary Staffing as a % of Trust Pay Bill	15.53%	15.79%	🟢

Executive Summary

The report covers the period from December 2015 to allow comparison with historic performance. However the key messages and targets relate to December 2016 for the financial year 2016/17.

Area	Domain
Safe	• **Number of Category 4 Pressure Ulcers Acquired at CHFT -** there was one Category 4 ulcer in December.
Caring	• **Complaints closed within timeframe** - 55 complaints were closed in December, which is a 50% decrease from November; this decrease in number of complaints closed was expected due to the significant closure of overdue complaints in November. However, of the 55 complaints closed only 49% of these were closed within target timeframe. Now that overall complaints numbers have decreased, complaints processes within Divisions need to be reviewed and tightened up to ensure timeliness of responses. • **Friends and Family Test Community Survey** - FFT reports 4% of people would not recommend services. There was support at the Community PRM to change the way FFT responses are collected in the next year and expect that this will provide more robust information.
Effective	• **Number of MRSA Bacteraemias – Trust assigned -** There has been one case of MRSA Bacteraemia in the Medical division in December. Admission screening was not evident in the records as such the case cannot definitively be confirmed as community or hospital acquired and therefore will be assigned to the Trust. The importance of the documentation of MRSA swabs on admission has been reiterated to all relevant staff. • **Number of E.Coli - Post 48 Hours – Trust assigned** - There were 4 E-coli infections in December, 1 in Surgical division and 3 in Medicine. RCA's are awaited to establish why they occurred but initial findings indicate that they are not related. • **Hospital Standardised Mortality Rate** (12 months Rolling Data November 15 - October 16) - has increased slightly to 103.74. October was higher in month at 105.75. The weekday/weekend split shows a 6 point difference. • **Mortality Reviews** - The completion rate for Level 1 reviews stands at 36% and improvements are beginning to be seen now that the renewed consultant review process is developed. • **Crude Mortality Rate** has increased to its highest rate since May. This increase fits into an expected seasonal pattern. The timing and extent of the winter rise in crude mortality has varied year to year and 2015/16 showed an unusually late rise. This figure for December is more in keeping with the norm but will be reviewed more closely at the Mortality Surveillance Group to ensure that there are no underlying concerns.

Background Context

During December A&E has seen activity continue to over-perform but at a higher level than seen in month 8. Activity is 4.5% above the month 9 plan and cumulatively 3.4% above plan and peaks on Sundays and Mondays continue. Discharges at a weekend and Monday are causing pressure points in relation to bed capacity.

Non-elective activity overall is 1.8% below the month 9 plan. This is an increase in activity when compared to month 8 when activity was 3.5% below plan. The in-month improvement is mainly due to a reduction in emergency long stay (EMLS) under-performance mainly by Stroke Medicine and Medical Oncology. Cumulatively activity is 0.9% below planned levels due to EMLS.

Flow across the Health and Social care system remains a challenge and the Trust continues to embed the SAFER programme, particularly through matron presence on the wards. The new AAU facility opened at HRI in early January and the Acute Frailty Network provided exceptionally positive feedback on the progress made by the frailty team to date following their visit in December.
Several specialties are being supported with improvement including Invited Service Reviews. Action plans are in place for Respiratory and Elderly, with the Stroke IPR completed in December receiving excellent informal feedback.

There remained high numbers of patients fit for non-acute care but unable to be discharged. YTD the number of green cross patients has increased, however more materially the LOS of these patients is increasing resulting in a beds pressure of 16 beds. Additional capacity was also required due to the impact of Norovirus on both sites.

AZ funding is supporting increased medical cover out of hours in Q4 to support delivery of the ECS. Other AZ schemes should help support delivery of ECS and improved flow/reduced bed base in the form of increased primary care streaming and packages of care in social services.

Planned day case (DC) and elective activity (EL) has improved in month 9 with activity 20% above plan. This is driven by an over-performance in day cases offset by a slight under-performance within elective activity. The improvement from month 8 is most significant within Gastroenterology and General Surgery, but overall has improved across a number of specialties. Gastroenterology DC has continued to over-perform, while Interventional Radiology continues to be above plan with a corresponding reduction within elective. EL under-performance has improved in month mainly within General Surgery, Paediatrics and Gynaecology. T&O is slightly below planned levels in month and Interventional Radiology is a continued under-performance due to the shift to day case activity.

A mock external CQC inspection took place within Maternity services 10th January. Verbal feedback was generally positive, this will be followed up by a written report in the next few weeks.

Executive Summary

The report covers the period from December 2015 to allow comparison with historic performance. However the key messages and targets relate to December 2016 for the financial year 2016/17.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** - December's position was 92.49% however the Trust remains one of the highest performing organisations nationally. ED escalation SOP is in place and being followed to ensure that any ED delays are addressed in a timely manner. Over the festive period and into the New Year timely flow out of ED for the admitted pathways has been particularly challenging which significantly affected performance. The department has worked hard to ensure the non-admitted pathways (notably 'minors') has continued to function effectively through the deployment of flex-up capacity (plaster rooms) and bolstering middle grade staffing in the department during peak times. Accelerator Zone funding is supporting increased medical cover into AAU and admission avoidances OOHs and plans are in place to deliver this recurrently from April 2017. • **Stroke -** All stroke indicators deteriorated in December. Unfortunately stroke units were closed due to Norovirus from 2nd to 19th December. This reduced the access for patients on to the unit. A four bedded HASU area was set up on one of the Rehabilitation wards and staff were moved accordingly however this did not prevent the fact that the number of useable beds on the unit were reduced. Also 7A was closed from 30th November until 17th December which did prevent discharges and bed availability. • **RTT pathways over 26weeks** - numbers increased to 126 in month, highest since August. During December Surgery division experienced a number of cancelled operations, both on the day (related to bed availability) and patients cancelling due to illness which impacted on the numbers. • **38 Day Referral to Tertiary** continues to underperform. In Surgery every breached pathway has an independent review with the general manager, patient pathway manager and senior clinician to establish avoidable causes that create breaches. In FSS an action plan is in place.
Workforce	• **Sickness Absence rate** - Short and long term sickness have deteriorated slightly in month. Both Medicine and FSS divisions have contributed to the increase. All staff involved are being managed within Trust policy. • **Return to work Interviews** have fallen below last month's peak. However still some way short of 100% target. Medicine and Surgery divisions are both < 60% whilst FSS and Community divisions are both > 80%. Poor performing areas are being targeted and a supportive letter focusing on the importance of Return to Work Interviews has been circulated and a video has been produced. This will be available on the intranet before the end of January 2017. • **Mandatory Training and Appraisal -** Mandatory training compliance has changed to a rolling 12 month reporting period and is RAG rated against performance at the same point last year. Only Information Governance is below last year's performance. A Workforce Summit (comprising Human Resources Business Partners, Workforce Development and Workforce Business Intelligence) was held in December 2016. The outcome was to inform an action plan to introduce an appraisal season linked to pay progression model which will be instigated in 2017/2018.
Efficiency/ Finance	• **Finance:** Year to date: The financial position stands at a deficit of £13.11m (excluding exceptional costs), a favourable variance of £0.01m from the planned £13.12m. This is positive news as the Trust is continuing to maintain the financial position in the second half of the financial year where there was always acknowledged to be a greater challenge in terms of the timing of CIP delivery, alongside seasonal pressures. Operational performance linked to the Sustainability Transformation Funding has also been maintained in the year to date despite operational challenges in December including dealing with Norovirus in the face of continued high clinical activity. It continues to be the case that, in order to maintain safety and secure and regulatory access standards across the Trust with high vacancy levels, there is a reliance upon agency staffing. Total agency spend in month was £1.55m; a similar level to the previous month which compares favourably with expenditure in excess of £2.1m each month in the year to August. This improvement brings the year to date agency expenditure beneath the revised trajectory submitted to NHSI. The impact of this operational position is as follows at headline level: • EBITDA of £5.63m, an adverse variance of £0.44m from the plan. • A bottom line deficit (excluding Exceptional costs relating to property disposals) of £13.11m, a £0.01m favourable variance from plan. • Delivery of CIP of £11.08m against the planned level of £9.07m. • Contingency reserves of £1.0m have been released against pressures. • Capital expenditure of £12.45m, this is below the planned level of £20.61m. • A cash balance of £4.98m, this is above the planned level of £1.94m, supported by borrowing. • A Use of Resources score of level 3, in line with the plan. • **Theatre Utilisation** has fallen slightly across all theatres in December. On day cancellations have impacted upon Theatre Utilisation. Across all areas this has been related to patients cancelling due to illness on the day of surgery, or late the day before. Bed pressures have impacted upon the CRH utilisation with delays experienced even when no cases were cancelled while bed availability has been secured, prior to a case commencing.
Activity	• **Activity** In month is above planned levels in all of the main points of delivery apart from elective and non-elective inpatients. Cumulatively elective inpatients and daycase combined are above plan however waiting lists are still high reflecting ongoing demand.

Background Context

December has been a challenging month with the Community division supporting patients with increasing acuity out of hospital and responding to the challenges that the acute hospital faces to maintain flow. Backlogs within reablement impacted on flow with a large volume of patients waiting for packages of care.

A bid response to the 0-5 early years tender in Calderdale was submitted in early December with results expected in early February.

Cancer waiting times continue to be challenging, a mixture of early pathway pressures with increased referral via fastrack, MDT arrangements and diagnostic pressures. The Divsions are working together on improvements and closer support to the Patient Flow team.

Surgery colleagues visited Pilgrim hospital in Boston to look at how they run their #Neck of Femur pathway. The key messages were standardising patient care so that every patient receives the same service regardless of the team on duty. They also prioritised this group of patients above any other patient other than life or limb threatening. The team are busy developing an action plan following the visit and will be sharing this with WEB colleagues 23rd February.

Community Place Intermediate Care ward opened 3rd January 2017 with 12 beds - this space needs to be fully utilised and embedded to support the retraction of outliers and the medical bed base.

Direct access and unbundled outpatient imaging has continued to perform above plan and has seen a further increase in month 9 to 19.7% from 13% above plan last month reflecting referral demand. Diagnostic testing has seen a significant decrease from month 8 when tests were 5.4% above plan. This decrease is driven by a change in Biochemistry from 5.8% above plan in month 8 to 1.7% above plan in month 9.
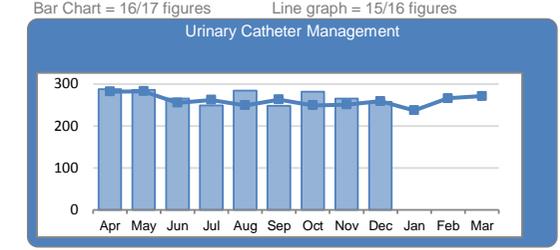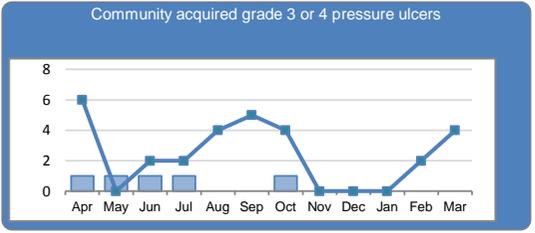
Outpatient (OP) activity overall has continued to over-perform and has seen a further increase compared to month 8 of 11.5% above the month 9 plan. The over-performance in-month is across both first and follow-up attendances including procedures. The specialties with higher over-performances within first attendances are General Surgery, ENT, Paediatrics, Gynaecology and Dermatology. General Surgery has shifted to an over-performance, while Breast Surgery has seen a material under-performance in-month. Cumulatively outpatient activity is now 4.3% above plan however with demand continuing at high levels this is not resulting in a reduced waiting list size.

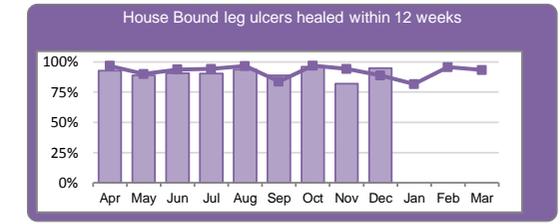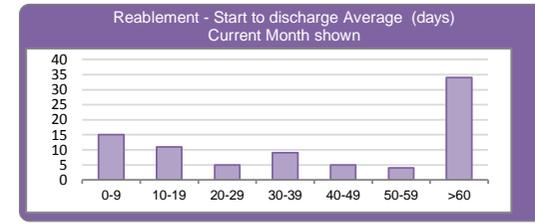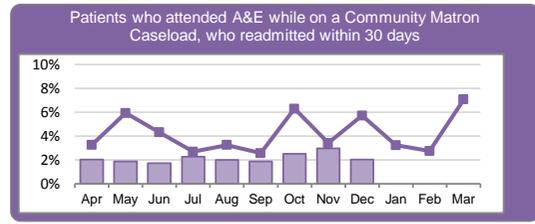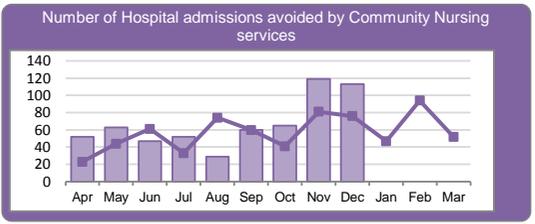# Safe, Effective, Caring, Responsive - Community Key messages

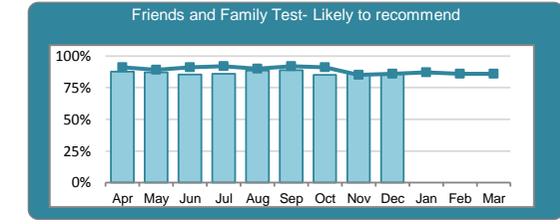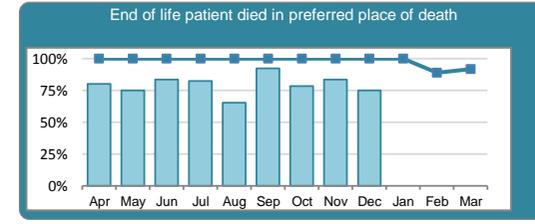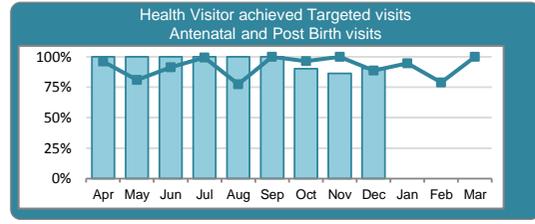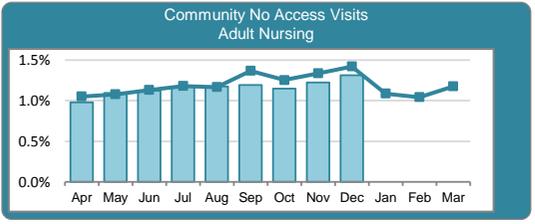| Area	Reality	Response	Result
Safe	Falls reduction , reduction cat 3/4 community acquired PU's, Early Detection of Sepsis: The team continue to focus on these 3 areas to improve outcomes - Work on the sepsis model within community is the area that now requires further development and model design.	The orange incident panel meets weekly to review orange and red incidents. Robust PU pathway in place. Falls prevention and collaboration work continues. Mel Johnson from the Patient Safety Collaborative is working with the QUEST team around AKI, the work will focus on supporting care homes with early identification of issues impacting on AKI, starting with hydration and nutrition. The impact of this work will hopefully be to reduce admissions to acute settings, reduce sepsis and improve patient experience - this work is currently being scoped, the expectation will be that the learning will be shared across other community services.	Maintained reduction in 3/4 pressure ulcers. Learning from falls investigation fed into the division via PSQBs. QUEST matrons to work collaboratively to identify tools and develop education packages for care homes and community staff and develop training packages for community staff to support the quality agenda. By when: March 2017 Accountable: Associate Director Nursing
Effective	Flow through intermediate services: There are continued challenges across Calderdale, particularly in upper valley, for access to packages of care. This continues to impact on the flow through reablement and intermediate care services.	Flow through intermediate services: Additional packages of care have been commissioned by social care in December and January to support flow though reablement. The division is undertaking a review of all parts of the intermediate tier to understand where the blockages are and what can be done differently. A proposal for running a rapid process improvement intervention has been developed and looking for support from social care senior managers to undertake this jointly.	Flow through intermediate services: To have an agreed redesign intermediate tier process following the rapid process improvement intervention and an agreed action plan for implementing changes. By when: February 2017 Accountable: Karen Barnett
Caring	Health Visitor core contact visits: During Q3 the health visiting service has been working with the data team to find a more accurate way of recording whether the antenatal and birth visits have been offered by health visitors to clients in Calderdale: Antenatal contacts - 91% of antenatal contacts were completed: a further 2% were not delivered because parents declined the contact; 2% were not delivered because the HV had no access visits; 4% were not delivered because the baby was born prematurely; 1% was not delivered because the health visiting service was not aware that the family were living in Calderdale. Birth Visits - completed between 10-14 days old - 93% of birth visits were completed within the given time frame. Outside the 14 day time frame: 1% was not completed on time due to no access visits; 2% were not completed because parents declined the contact; 4% were not completed on time because the baby remained in hospital.	Health Visitor core contact visits: The service lead is aware of all clients that have not received the core contact within the mandated timeframe. She is following these up with individual Health Visitors to understand if there are practice issues or other reasons and then will develop actions that can improve performance.	Health Visitor core contact visits: The performance of mandated visits will improve month on month. Expect target to be achieved by end March 2017. By when: March 2017 Accountable: Karen Barnett
Responsiveness	ASI's for MSK: Issue is generally in spinal pathway. Whilst capacity has remained there has been an increase in demand for this service in the last year. MSK responsiveness - Typing turnaround: There has been an issue identified where letters that have been typed are backed up waiting for the practitioner to sign them.	ASI's for MSK: The spinal MSK post has been recruited to. The person leaving post has agreed to bank shifts. Additional MSK practitioners to be appointed following business case approval for 2017/18. MSK responsiveness - Typing turnaround: New typist has started within team. A template is being agreed within the service. A plan has been implemented with the MSK practitioners to reduce backlog by end January 2017.	ASI's for MSK: Reduce the number of ASI's in MSK. Accountable: Head of Therapies By when: February 2017 MSK responsiveness - Typing turnaround: There are 78 letters that require sign off from clinics in October/November/December. DO has requested urgent action for these to be completed by end January. By when: End January 2017. Accountable: Head of Therapies

Dashboard - Community

Bar Chart = 16/17 figures   Line graph = 15/16 figures

Safe

Community acquired grade 3 or 4 pressure ulcers

One month in arrears

Falls that caused harm whilst patient was in receipt of Community Services

One month in arrears

Incidents Harm free care

Urinary Catheter Management

Effective

Number of Hospital admissions avoided by Community Nursing services

Patients who attended A&E while on a Community Matron Caseload, who readmitted within 30 days

Reablement - Start to discharge Average (days) Current Month shown

House Bound leg ulcers healed within 12 weeks

Caring

Community No Access Visits Adult Nursing

Health Visitor achieved Targeted visits Antenatal and Post Birth visits

End of life patient died in preferred place of death

Friends and Family Test- Likely to recommend

Responsive

Average time to start of reablement (days)

Appointment Slot Issues for MSK & Podiatry

MSK   Podiatry

Waiting Times - 18 week RTT

MSK Responsiveness Backlog -days

Well Led

% Complaints closed within target timeframe

Staff sickness rate

One month in arrears

Finance - Planned variance against actual (£'000)

Finance - Planned CIP saving against actual savings (£'000)

Glossary of acronyms and abbreviations

- **A&E** - Accident & Emergency
- **ADN** - Associate Director of Nursing
- **AED** - Accident & Emergency Department
- **ASI** - Appointment Slot Issue
- **ASU** - Acute Stroke Unit
- **AZ** – Accelerator Zone
- **BPT** - Best Practice Tariff
- **CCG** - Clinical Commissioning Group
- **CCU** - Critical Care Unit
- **CD** - Clinical Director
- **CDiff** - Clostridium Difficile
- **CDS** - Commissioning Data Set
- **CDU** - clinical decision unit
- **CEPOD** - National Confidential Enquiry into Patient Outcome and Death
- **CHPPD** - Care hours per patient day
- **CIP** - Cost Improvement Programme
- **CQC** - Care Quality Commission
- **CQUIN** - Commissioning for Quality and Innovation
- **CRH** - Calderdale Royal Hospital
- **CT** – Computerised tomography
- **DH** - Department of Health
- **DNA** - did not attend
- **DSU** - Decision Support Unit

- **DTOC** - Delayed Transfer of Care
- **EBITDA** - Earnings before interest, tax, depreciation and amortisation
- **ECS** - Emergency Care Standard
- **EEA** - European Economic Area
- **EPR** - Electronic Patient Record
- **ESR** - Electronic Staff Record
- **FFT** - Friends and Family Test
- **FSRR** - Financial Sustainability Risk Rating
- **FSS** - Families and Specialist Services
- **GM** - General Manager
- **GP** - General Practitioner
- **GH** - Greater Huddersfield
- **HAI** - Hospital Acquired Infection
- **HCA** - Healthcare Assistant
- **HDU** - High Dependency Unit
- **HOM** - Head of Maternity
- **HRG** - Healthcare Resource Group
- **HR** - Human Resources
- **HRI** - Huddersfield Royal Infirmary
- **HSMR** - Hospital Standardised Mortality Rate
- **I&E** - Income and Expenditure
- **ICU** - Intensive care unit
- **IT** - Information Technology

- **KPI** - Key Performance Indicator
- **LOS** - Length of Stay
- **LTC** - Long Term Condition
- **MAU** - medical admission unit
- **MRI** - Magnetic resonance imaging
- **MRSA** - Methicillin-Resistant Staphylococcus Aureus
- **MSK** - Musculo-Skeletal
- **MSSA** - Methicillin Susceptible Staphylococcus Aureus
- **NHSE** - NHS England
- **NHSI** - NHS Improvement
- **NICU** - Neonatal Intensive Care Unit
- **NoF** - Neck of Femur
- **OD** - Organisational Development
- **PAS** - Patient Administration System
- **PbR** - Payment by Results
- **PHE** - Public Health England
- **PHSO** - Parliamentary and Health Service Ombudsman
- **PPH** - Postpartum Haemorrhage
- **PRM** - Performance Review Meeting
- **PTL** - Patient Tracking List
- **PU** – Pressure Ulcer
- **QIPP** - Quality, Innovation, Productivity and Prevention

- **RAG** - Red Amber Green
- **RCA** - Root Cause Analysis
- **RN** - Registered Nurse
- **RTT** - Referral to Treatment
- **SACT** - Systemic Anti-Cancer Treatment
- **SAU** - surgical admission unit
- **SH** - Safety Huddle
- **SHMI** - Summary Hospital-level Mortality Indicator
- **SI** - Serious Incident
- **SITREPs** - Situation reports
- **SSNAP** - Sentinel Stroke National Audit Programme
- **SOP** - Standard Operating Protocol
- **SRG** - Systems Resilience Group
- **SUS** - Secondary Uses Service
- **UCLAN** - University of Central Lancashire
- **UTI** - Urinary Tract Infection
- **UoR** – Use of Resources
- **Var** - Variance
- **VTE** - Venous Thromboembolism
- **WLI** - Waiting List Initiative
- **WTE** - Whole Time Equivalent
- **YAS** - Yorkshire Ambulance Service

Calderdale and Huddersfield **NHS**

NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	**Report Author:**
Board of Directors	Kathy Bray, Board Secretary
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	Gary Boothby, Deputy Director of Finance
Title and brief summary:	
FINANCIAL COMMENTARY TO NHS IMPROVEMENT - MONTH 9 - The Board is asked to approve Month 9 Financial Commentary	
Action required:	
Approve	
Strategic Direction area supported by this paper:	
Financial Sustainability	
Forums where this paper has previously been considered:	
Finance and Performance Committee - 31.1.17	
Governance Requirements:	
Financial Sustainability	
Sustainability Implications:	
None	

Executive Summary

Summary:

The Board is asked to approve Month 9 Financial Commentary

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve Month 9 Financial Commentary

Appendix

Attachment:

NHSI Financial Commentary Month 9 1617 for Board.pdf

MONTH 9 DECEMBER 2016, 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 December 2016.

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 year to date financial position stands at a deficit of £13.34m, an adverse variance of £0.22m from the planned £13.12m of which £0.23m are exceptional costs relating to the disposal of properties and are therefore excluded from the position for control total purposes. The underlying position is a £0.01m favourable variance from year to date plan. This is positive news as the Trust is continuing to maintain the financial position in the second half of the financial year where there was always acknowledged to be a greater challenge in terms of the timing of CIP delivery and in the face of increasing operational pressures including dealing with Norovirus in December whilst managing continued high clinical activity.

Operational performance linked to the STF has also been maintained in the year to date although early indications for January are that the challenge has stepped up considerably, with 48 additional beds open and increased Delayed Transfers of Care due to higher demand and system wide challenges outside of our control. It continues to be the case that, in order to deliver activity and access standards across the Trust with high vacancy levels, there is reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.55m, a similar level to Month 8 and an improvement compared to the average for the first six month of the year which was in excess of £2.0m a month. This improvement brings the agency expenditure comfortably beneath the revised trajectory submitted to NHSI.

Month 9, December Position (Year to Date)

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	277.64	281.66	4.01
Expenditure	(271.57)	(276.03)	(4.45)
EBITDA	**6.07**	**5.63**	**(0.44)**
Non-Operating items	(19.19)	(18.97)	0.23
Deficit	**(13.12)**	**(13.34)**	**(0.22)**

- EBITDA of £5.63m, an adverse variance of £0.44m from the plan.
- A bottom line deficit of £13.34m, a £0.22m adverse variance from plan;
- Of which £0.23m relates to the disposal of properties and a further £0.14m relates to restructuring costs.
- Delivery of CIP of £11.08m against the planned level of £9.07m.
- Contingency reserves of £1.0m have been released against pressures.
- Capital expenditure of £12.45m, this is below the planned level of £20.61m.
- Cash balance of £4.98m; this is above the planned level of £1.94m, supported by borrowing.

- Use of Resources score of level 3, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

The year to date activity over performance sits alongside strong CIP delivery, achieving £2.00m in advance of the planned timescale. The combined benefit has not flowed through in full to the bottom line but has rather absorbed the activity and performance related expenditure pressures and one off issues such as the Junior Doctors' strike action.

In summary the main variances behind the year to date position, against the plan are:

Operating income	£4.01m favourable variance
Operating expenditure	(£4.45m) adverse variance
EBITDA	**(£0.44m) adverse variance**
Non-Operating items	£0.36m favourable variance
Restructuring costs	(£0.14m) adverse variance
Total	**£0.22m adverse variance**

Operating Income

There is a £4.01m favourable variance from the year to date plan within operating income. This includes STF funding of £8.47m as planned, representing full achievement of financial and operational criteria in the year to date. There has been a slight under-performance against the A&E trajectory in individual months but this is overridden by the cumulative year to date achievement.

Achievement of the A&E trajectory will be increasingly challenging for the Trust in the final quarter due to increases in A&E attendances and pressures on non elective capacity. This is exacerbated by the volume of 'Green Cross' (medically fit for discharge) numbers, leading to an additional 48 beds being open in January versus the December level and forcing a level of elective cancellations. Performance in late 2016 through to January 2017 has been impacted by a combination of factors outside of the control of the Trust. A local community hospital site has had a period of ward closures in response to CQC inspection; a system failure in the local council impacted the Trust by slowing discharges; and particularly high A&E attendances have been seen over the last four weeks.

The Trust are part of the West Yorkshire Accelerator Zone and have implemented the initiatives described in the funding application, however these were confirmed later than initially planned affecting the impact as recruitment remains challenging with continued reliance on some adhoc staffing. Recognising the step change required from Q4 15/16 delivery, this will add to the challenge.

NHS Clinical Income

Within the £4.01m favourable income variance, NHS Clinical income shows a favourable variance of £2.28m. As described above, overall activity has again had a strong performance in month which augments the position seen in the year to date. The breakdown by point of delivery is as follows:

- Planned day case and elective inpatient performance is 20% (631 spells) above the month 9 plan which is an improved position from month 8. Cumulatively, the aggregate performance across day case and electives is also above plan, driven by strong day case activity.

- Non-elective activity overall is 1.8% (83 spells) below the month 9 plan. In the year to date non elective activity just slightly below planned levels by 0.9% with fluctuation in individual months.

- A&E activity has continued to over-perform with activity at a higher level than month 8. The month 9 activity is 4.5% (553 attendances) above plan and cumulatively is 3.4% (3,763 attendances) above plan.

- Outpatient activity overall has seen a further increase with activity 11.5% (2,655 attendances) above the month 9 plan. The over-performance in month is across both first and follow-up attendances, including procedures. Cumulatively activity is 4.3% (10,816 attendances) above plan.

- Adult critical care bed day activity and NICU activity are both above plan in the year to date, most significantly the latter by 14.3% (634 spells).

The clinical contract PbR income position is driven by these areas of activity over performance as well as Rehabilitation and Diagnostic testing & imaging. The non-elective activity level belies the favourable income position which is boosted by case mix.

This position continues to reflect an over-performance against the Trust's year to date plan and a greater over-performance against contracts with the Trust's Commissioners. The 2016-17 contracts with the Trust's commissioners incorporated a lower level of activity and income to the Trust plan in the main due to the CCG QIPP plans, Trust CIP plans and a differing view of baseline activity levels. The Trust remains in close contact with commissioners in order to guard against unexpected challenges and has so far been successful in securing cash relating to overtrades. However the Trust remains mindful of the affordability pressures to the health economy as a whole and the risk that PbR overtrades exceed Commissioner resources by year end. Some provision has been made in forecast to reflect likely commissioner challenge to changes to counting and coding practices that have been driven through the Trust's CIP, but further mitigating action may be required in order that the forecast delivery of the control total can be sustained.

The 2016-17 plan was inclusive of £1.97m of System Resilience funding. Whilst the Trust is continuing to pursue this full value, commissioners are looking likely to withhold this funding on the grounds of affordability. The projects that are supported within the Trust with this funding are committed and embedded recurrently to aid improved patient flow and capacity in the context of pressures in the social care sector placing the health economy risk entirely with the Trust.

Other income

Overall other income is below plan by £1.86m in the year to date. There are three key areas of variance: the transfer of the West Yorkshire Audit Consortium to another host provider, which has reduced income by £0.76m cumulatively; the Trust planned for Bowel Scope income as part of non-NHS Council funding which changed contractually to be funded through NHS England, a cumulative variance of £0.65m (offset within NHS Clinical Income); and growth in Pharmacy Manufacturing Unit income has been slower than planned with a year to date variance of £0.44m.

Operating expenditure

There was a cumulative £4.45m adverse variance from plan within operating expenditure across the following areas:

Pay costs	(£1.93m) adverse variance
Drugs costs	£1.76m favourable variance
Clinical supply and other costs	(£4.29m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £1.93m higher than the planned level in the year to date. The high vacancy levels in clinical staff groups continues causing reliance on agency staffing with the associated premium rates driving the overspend.

For 2016/17 the Trust was originally given a £14.95m ceiling level for agency expenditure by NHSI. In the course of the year, the Trust was given the opportunity to restate the agency trajectory with the clear expectation that this would form a commitment by the Trust to reducing the agency costs. The revised full year position is to reduce the run rate in the second half of the year and contain spend within a £24.31m total. The Trust understands that it will now be held to this commitment.

The drive to recruit staff is ongoing including advertising new types of roles to aid recruitment potential. The work to push down the contractual rates paid to Medical agencies and develop a tiered approach to bookings is now beginning to impact. The actions to curb agency usage are of the highest priority to the Trust with a weekly Executive Director level meeting focussing purely on this agenda and continuing to work with colleagues in NHSI to ensure the implementation of best practice. Total agency spend in month was £1.55m, a similar level to Month 8 and an improvement compared to the average for the first six month of the year which was in excess of £2.0m a month. This improvement brings the agency expenditure comfortably beneath the revised trajectory submitted to NHSI.

It should be noted that £2.0m of contingency reserves were planned against pay across the first six months of the financial year. This contingency has been released against the pay position; meaning that the underlying divisional year to date pay overspend is almost £4.0m. In overall terms, there has been a year to date benefit from releasing reserves of £1m to the bottom line, a provision has been made against the £1m balance of the available contingency for potential future risks. The accounting treatment for provisions is as a non-pay cost and as such this drives an over spend against this element of the plan.

Drug costs

Year to date expenditure on drugs was £1.76m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £1.73m below plan. Underlying drug budgets are therefore further underspent by £0.03m.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £4.29m above the plan. This overspend reflects activity related factors such as ward consumables and diagnostic test costs, as well as technical issues such as provisions. There has been a considerable increase in MRI usage driving hire costs and outsourced reporting charges, with growth in internal diagnostics demand outstripping the overall activity increase. Another factor is high cost devices which are 'pass through' costs are £0.39m above the planned level, compensated directly by income.

As was the case last month, an element of the overspend in this area is driven by purely technical reasons. A provision has been made against the £1m balance of contingency reserves for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.23m below the planned level. This is driven by a combination of lower than planned depreciation charges and Public Dividend Capital payable. The adoption of a different valuation method for the PFI site and a review of equipment asset lives have reduced the asset value upon which both depreciation and PDC are chargeable.

The year to date has also seen a net loss on disposal of £0.23m: £0.06m gain on disposal against the sale of the old Occupational Health building which was surplus to Trust requirements, and a loss on disposal £0.29m relating to Princess Royal Hospital due to the sale price being lower than the carrying Net Book Value. This technical accounting movement is excluded from the measurement against the control total.

The year to date benefits are offset in part by higher than planned interest payable due to higher than planned interest rates. The greater impact of this interest pressure is included in the full year forecast where continuing to bear the current interest rate of 3.5% for a Working Capital Loan as opposed to the planned switch to a Revenue Support Loan at 1.5% will cost £0.4m more than plan, despite a reduction in our forecast borrowing requirements for 1617.

Restructuring costs of £0.14m have been incurred in the year to date to fund redundancy costs which will deliver savings in the future periods.

Cost Improvement Programme (CIP) delivery

In the year to date, £11.08m of CIP has been delivered against a plan of £9.07m, an over performance of £2.00m. As was highlighted in previous months, whilst the level of over performance is positive news it should be noted that the over performance in early months is counterbalanced by under delivery in the latter half of the year. The £2.00m over performance against CIP plans in the year to date has not translated to an equivalent benefit to the Trust's bottom line financial performance but has rather offset other pressures. The issue that has been foreseen as a result of this is budgetary pressure in the remainder of the year, which requires mitigation through the divisional recovery plans. This recovery has been realised in-month, with the lower CIP delivery versus plan in December having been sufficiently offset to maintain the overall financial position.

The year end forecast CIP delivery remains stable from last month at £15.11m. This over performance against plan is offsetting other pressures and therefore does not translate to an improvement in the overall year end forecast. It should also be noted that £4.5m of the total forecast CIP has been identified non-recurrently and this is creating an additional burden which has had to be accommodated in next year's financial plans.

Work is ongoing to ensure that CIP delivery in the latter part of the year can be secured, this is where the highest risk schemes are due to commence in earnest, for example the complex SAFER programme focussing on operational productivity through improved patient flow which remains under close review. Additional savings opportunities also need to be delivered in support of the divisional recovery plans that are required to deliver the overall financial control total of £16.1m deficit.

Statement of Financial Position and Cash Flow

At the end of December 2016 the Trust had a cash balance of £4.98m against a planned position of £1.94m, a favourable variance of £3.04m. In month the variance was higher than forecast due to: one of our main Commissioners paying their Month 10 invoice early, Commissioner overtrade invoices that were paid quicker than expected and lower than expected Capital expenditure in Month 9. The key cash flow variances for the year to date compared to plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	(0.22)
	Non cash flows in operating deficit	(0.29)
	Other working capital movements	(5.32)
	Sub Total	**(5.82)**
Investing activities	Capital expenditure	8.26
	Movement in capital creditors	1.22
	Sub Total	**9.48**
Financing activities	Drawdown of external DoH cash support	(0.12)
	Other financing activities	(0.50)
	Sub Total	**(0.62)**

Operating activities

Operating activities show an adverse £5.82m variance against the plan. The adverse cash impact of the I&E position of £0.51m (£0.22m adverse I&E variance plus £0.29m non-cash flows in operating deficit) is coupled with a £5.32m adverse working capital variance from plan. The working capital variance reflects the catch up of payments to suppliers, coupled with the accrued STF for Quarter 3. The performance against the Better Payment Practice Code has seen further improvement in month with 97.91% of invoices paid within 30 days against the 95% target, as many of the older outstanding invoices have flushed through in previous months and we are now paying recent invoices in the main.

Total aged debt based on invoices raised is £4.71m which is a reduction on last month as some material invoices have been settled, the remaining value includes; charges for Care Packages to local CCGs; contract overtrade invoices to local and other commissioners; and System Resilience Funding. As previously described, with the exception of the System Resilience Funding, these do not represent a risk of non settlement but rather a timing delay.

Investing activities (Capital)

Capital expenditure in the year to date is £12.35m which is £8.26m below the planned level of £20.61m.

Against the Estates element of the total, year to date expenditure is £3.91m against a planned £7.84m. The main area of spend in month was on the continuation of the Theatre refurbishment programme with a year to date spend of £1.89m, this is coupled with spend on backlog maintenance including Asbestos removal, Medical Air plant, fire detection and roofing work.

IM&T investments total £5.32m against a plan of £6.37m. The main areas of spend in month were the continuation of the Electronic Patient Record (EPR), and EDMS projects. The main reason for the underspend against plan is the delay in go live of EPR.

Expenditure on replacement equipment in the year to date is also lower than plan.

Forecast capital expenditure is currently expected to be £26.13m, £2.09m below the planned full year value of £28.22m. The delay in the go live date for EPR has resulted in an increase in the forecast spend against this element of the original plan of £6.08m, which has been offset by some further re prioritisation of the capital plan.

A level of capital expenditure on EPR has now been pushed back to month 12 and a proportion of this expenditure is now forecast to be paid in cash terms the next financial year. This has reduced our loan drawdown requirements for 2016/17, but has been included in the cash / borrowing requirements as detailed in final 2017/18 Plan submitted in December.

Financing activities

Financing activities show a £0.62m adverse variance from the original plan, of which £0.12m is due to lower than planned cash support through borrowing.

Continuing to borrow at the current planned levels at an interest rate of 3.5% for the remainder of the year will bring a pressure of £0.4m, included in forecast, against the original plan which assumed a switch to the lower interest rate in-year. The latest understanding from discussions with NHSI to convert our loan from a Working Capital Facility (at 3.5% interest) to a Revenue Support loan (at 1.5% interest), is that we will only move to the lower rate loan once the working capital facility has reached the level equivalent to 30 days operating costs. The current forecast shows that this level of draw down will be reached early in the next financial year.

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3. **Use of Resources (UOR) rating and forecast**

UOR

Against the UOR the Trust stands at level 3 in both the year to date and forecast position, in line with plan. This is equivalent to the Trust's previous rating of 2 against the Financial Sustainability Risk Rating, on the new inverted rating scale.

Forecast – Income and Expenditure

The year end forecast position continues to be delivery of the planned £16.1m deficit and control total.

As described last month, the reported forecast year end deficit is £16.32m but includes exceptional costs relating to the disposal of property of £0.22m. These exceptional technical accounting costs are excluded from the deficit for control total purposes and therefore have no impact on our STF allocation or UOR metric.

This position assumes delivery of £15.11m CIP and that recovery plans are delivered to offset ongoing pressures and risks. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m STF which is intrinsic to and contingent upon delivery of the planned deficit.

It has previously been acknowledged in discussion with NHSI, that the £16.1m control total excluded any I&E or cash pressures for EPR 'go live'. However, recent communications have indicated that any revenue costs incurred as a result of EPR implementation and training will now have to be included within the £16.1m Control Total. It has previously been assessed that the additional costs incurred would be c.£5m, but it is likely that some of these costs will fall into the next financial year and a proportion of the remaining costs can absorbed within the forecast Capital plan. Further work is underway to fully understand the Capital / Revenue split of these costs and to assess the remaining risk to the Control Total.

There have inevitably been other areas of underlying pressure and risk emerging in year, including areas that have impacted in the year to date which are beyond the organisation's direct control, such as the assumed loss of £1.97m of System Resilience funding to the Trust, against which expenditure commitments cannot be released, Junior Doctor's strike action and the higher than planned rate of interest being borne on current borrowing. This pressure intensifies in the remainder of the financial year as the Trust plans to deal with the combination of EPR implementation; delivery of complex CIP schemes with greater returns; managing winter pressures alongside quelling agency staff usage; and likely loss of income due to commissioner challenges to counting and coding practices.

The Trust has made good progress in implementing recovery plans to mitigate these risks. These include a range of divisional plans, rigorous budgetary control and innovative solutions. Under the latter heading the Trust has sought to negotiate with the soft FM provider on the PFI site to secure a favourable agreement. This is currently being tested independently to ensure value for money. The Trust will progress this initiative subject to best value being evidenced. In addition, the risk previously identified against full achievement of CQUIN targets has diminished having achieved the challenging staff flu immunisation target.
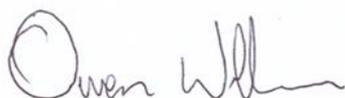
Forecast – Capital and cash

In overall terms the capital expenditure is currently forecast at £26.13m, £2.09m below the planned full year value of £28.22m. Delays in the go live date for EPR and the requirement to capitalise as

much of the implementation cost as possible has increased forecast spend against this element of the original plan by £6.08m, there has however been some further re prioritisation of the capital plan, resulting in reduced spend on the Estate and Equipment and some slippage which has been captured in the 1718 Capital Plan.

The majority of capital expenditure on EPR has now been pushed back to month 12 and a proportion of will be accounted for as a movement in Capital Creditors as this is now forecast to be paid in cash terms the next financial year. This has reduced our loan drawdown requirements for 2016/17, but has been added to the assessment of 2017/18 borrowing. Alongside this, in year, the cash benefit of the sale of Princess Royal Hospital at £1.2m is offsetting the non-cash I&E benefit of lower than planned depreciation and supporting working capital pressures.

The Trust is mindful of the limited availability of capital funding nationally. On this basis, the organisation continues to constantly review our capital programme whilst taking into account operational, and legislative compliance requirements.

Owen Williams
Chief Executive

Gary Boothby
Executive Director of Finance

Calderdale and Huddersfield **NHS**

NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	**Report Author:**
Board of Directors	Philippa Russell, Senior Finance Manager
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	Gary Boothby, Deputy Director of Finance

Title and brief summary:
Interim Revenue Support Facility - Board Resolution required to support transfer of existing Working Capital Facility into an Interim Revenue Support Facility.

Action required:
Approve

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:

The Board are asked to approve a resolution required to support the Interim Revenue Support facility application.

Main Body

Purpose:

A Board Resolution is required to support the transfer of existing our Working Capital Facility into an Interim Revenue Support Facility.

Background/Overview:

Integral to the Trust's 16/17 financial plan was the requirement to secure interim support funding to support our working capital needs. This borrowing has been secured from Department of Health in the form of a Working Capital Facility with a current balance of £26.90m at an interest rate of 3.5%. The Trust has now been given the opportunity to transfer this borrowing to an Interim Revenue Support Facility at a lower interest rate of 1.5%. This will reduce our interest payments by circa £0.04m per month (£0.54m per year).

The Issue:

Interim Revenue Support Facility:

This is a three year facility to cover the working capital requirements of the Trust, with a repayment date of 18th January 2020. Interest is calculated at a rate of 1.5% and paid 6 monthly. The facility requires that the Trust maintains a minimum cash balance of £1.9m.

Working Capital Facility:

This transaction will result in the closure of our existing Working Capital Facility. Any future borrowing requirements will require the agreement of a new loan facility. The Trust forecast assumes that no further borrowing will be required in this financial year, but borrowing arrangements are yet to be agreed for 17/18.

Next Steps:

Board Resolution:

The Board are asked to approve the following resolution required to support the Interim Revenue Support facility application,(reference DHPF/ISWBL/RWY/2017-01-12/A):
(a) Approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;
(b) Authorise the Chairman and Director of Finance to execute the Finance Documents to which it is a party on its behalf; and
(c) Authorise the Chairman and Executive Director of Finance, on behalf of the Trust, to sign and despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.
(d) Confirm the Borrower's undertaking to comply with the Additional Terms and Conditions.

Recommendations:

The Board are asked to approve the above resolution required to support the Interim Revenue Support Facility.

Appendix

Attachment:

There is no PDF document attached to the paper.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	Report Author:
Board of Directors	Kathy Bray, Board Secretary
Date:	**Sponsoring Director:**
Thursday, 2nd February 2017	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 each of the sub-committees	
Action required:	
Approve	
Strategic Direction area supported by this paper:	
Keeping the Base Safe	
Forums where this paper has previously been considered:	
As appropriate	
Governance Requirements:	
Keeping the base safe	
Sustainability Implications:	
None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from each of the sub-committees:-
- Quality Committee - 3.1.17 and verbal update from 30.1.17
- Finance and Performance Committee - 3.1.17 and verbal update from 31.1.17
- Workforce Well Led Committee - draft minutes from 19.1.17
- Membership Council Meeting - draft minutes - 17.1.17
- Audit and Risk Committee - draft minutes - 18.1.17

Main Body

Purpose:

The Board is asked to receive the updates and minutes from each of the sub-committees:-
- Quality Committee - 3.1.17 and verbal update from 30.1.17
- Finance and Performance Committee - 3.1.17 and verbal update from 31.1.17
- Membership Council Meeting - draft minutes - 17.1.17
- Audit and Risk Committee - draft minutes - 18.1.17

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 each of the sub-committees:-
- Quality Committee - 3.1.17 and verbal update from 30.1.17
- Finance and Performance Committee - 3.1.17 and verbal update from 31.1.17
- Membership Council Meeting - draft minutes - 17.1.17
- Audit and Risk Committee - draft minutes - 18.1.17

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES.pdf

Calderdale and Huddersfield **NHS**

NHS Foundation Trust

QUALITY COMMITTEE
Tuesday, 3rd January 2017
Board Room, Sub Basement, Huddersfield Royal Infirmary

PRESENT

Jan Wilson	Non-Executive Director **(Chair)**
Helen Barker	Chief Operating Officer
David Birkenhead	Medical Director
Brendan Brown	Executive Director of Nursing
Juliette Cosgrove	Assistant Director of Quality
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Andrea McCourt	Head of Governance and Risk
Julie O'Riordan	Divisional Director, Surgical Division
Peter Middleton	Membership Councillor
Vicky Pickles	Company Secretary
Michelle Augustine	Governance Administrator **(Minutes)**

ITEM NO	
001/17	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
002/17	**APOLOGIES** Dr David Anderson — Non-Executive Director Rob Aitchison — Director of Operations, FSS Division Asif Ameen — Director of Operations, Medical Division Karen Barnett — Assistant Divisional Director, Community Division Gary Boothby — Deputy Director of Finance Diane Catlow — Associate Nurse Director, Community Division Martin DeBono — Divisional Director, FSS Division and Associate Medical Director Tracy Fennell — Associate Nurse Director, Medical Division Anne-Marie Henshaw — Associate Nurse Director/Head of Midwifery, FSS Division Maggie Metcalfe — Matron for Operating Services Joanne Middleton — Associate Nurse Director, Surgery and Anaesthetic Services Jackie Murphy — Deputy Director of Nursing, Modernisation Linda Patterson — Non-Executive Director George Richardson — Membership Councillor Lindsay Rudge — Associate Director of Nursing Kristina Rutherford — Director of Operations, Surgical Division Sal Uka — Divisional Director, 7 Day Service/Hospital at Night Ian Warren — Executive Director of Workforce and Organisational Development
003/17	**DECLARATIONS OF INTEREST** There were no declarations of interest to note
004/17	**MINUTES OF THE LAST MEETING** The minutes of the last meeting held on Tuesday, 29th November 2016 were approved as a correct record.

005/17	**ACTION LOG AND MATTERS ARISING**
	▪ Terms of Reference
	Following the last meeting, a revised copy of the terms of reference (Appendix C) was circulated with amendments made to the membership of the committee, and the required attendees needed at each committee meeting. It was stated that the terms of reference of all executive committees have now been reviewed in order to remove duplication and discussion of issues at multiple meetings, and the expectation that board members of each committee have carried out an assurance role at their respective committees. The revised terms of reference will be submitted to the next Board of Director's meeting on Thursday, 5th February 2017, and the terms of reference will come into effect from the following Quality Committee meeting on Monday, 27th February 2017.
	It was also suggested that the terms of reference of all executive committees are shared with members.
006/17	**CARE QUALITY COMMISSION (CQC) REPORT**
	Brendan Brown (Executive Director of Nursing) reported on the circulated paper (Appendix D) which focuses on the movements of individual actions in line with the 'BRAG' rating methodology: 16 actions have moved from amber (on track to deliver) rating to a green (action complete) rating, and one action has moved from a green to blue (delivered and sustained) rating. The evidence and proposal form to support the green to blue rating was also attached.
	Extension requests were made for four actions' embedded dates, which the CQC Response Group considered, and recommended that further actions be taken. The Quality Committee was requested to approve the movements in the plan and support the revised completion dates as recommended by the CQC Response Group.
	ACTION: That a copy of the action plan is also attached with future reports.
	OUTCOME: The Quality Committee noted the content of the report and agreed the changes and recommendations made by the CQC Response Group.
007/17	**QUALITY AND PERFORMANCE REPORT**
	Helen Barker (Chief Operating Officer) reported on the circulated paper (Appendix E1 and E2) and summarised that November's performance score is 65% for the Trust.
	3 of the 6 domains improved in month. Within the Safe domain, the Never Event has contributed significantly to the red rating. Regulatory targets scoring red this month were due to Emergency Care Standards (ECS) 4 hours performance scoring 94.02% against a target of 95%, and Cancer 62 day screening to treatment scoring 85.7% against a target of 90%.
	Safe
	− *Percentage of Post-partum Haemorrhage (PPH) greater than or equal to 1500 mls:* performance has improved in month to 1.3%. This is the best performance this year and takes the year to date performance to 3.1%, just above the internally set target of 3%.
	Caring
	− *Complaints*: 109 were closed in November, with 38% being closed within target timeframe. The total number of overdue complaints has been reduced to 5 which is an impressive 93% reduction from October. At the beginning of the New Year, the complaints department will start to look at themed analysis of complaints. This work will be fed into wider groups to ensure learning from complaints.
	− *Friends and Family Test Outpatients Survey*: 91% would recommend performance has

been maintained from last month's performance, but is still below the target of 95%.
− *Friends and Family Test Community Survey*: 4% of people would not recommend services.

Effective
− Clostridium Difficile - There was 1 case reported in month with none avoidable. This takes the total number of cases to 21 as at the end of November against last year's total of 25 which is a higher run rate however the number deemed avoidable at 5 is well below the full year tolerance of 21.
− Non-elective fractured neck of femur (#NOF): the number of patients operated on within 36 hours of admission for fragility hip fracture was 36 out of a total of 46. The use of Theatre 6 is expected to progress this position with the introduction of 3 additional Trauma lists per week. A 'go-see' is planned to Pilgrim Hospital Boston in Lincolnshire in January 2017 to identify best practice elements that can be introduced at CHFT.

Responsive
− *Stroke*: Patients admitted to a stroke ward within four hours has maintained the 70% performance in November. Patients scanned within one hour of arrival however, dropped in month. Discussions are ongoing between the medicine and Families and Specialist Services (FSS) divisions to improve scanning, with FSS agreeing to prioritise stroke patients. The stroke Invited Service Review (ISR) took place in December 2016 and early reports are positive regarding the quality of the service with areas for improvement identified.

CQUN
− The flu vaccine Commission for Quality and Innovation (CQUIN) has been achieved, with the sepsis CQUIN still a concern and the antimicrobial resistance CQUIN needing more data. A plan has been set forward to the Clinical Commissioning Group (CCG) and awaiting a response. Other CQUINs are on track for delivery.

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

008/17	**PATIENT SAFETY GROUP REPORT**
	Andrea McCourt (Head of Governance and Risk) reported on the circulated paper (Appendix F) which summarised the issues reported at the Patient Safety Group meeting held on Thursday, 1st December 2016:

− *Venous Thromboembolism* – low compliance is being targeted for improvement work, and the medical division are yet to allocate a representative to attend the Thrombosis Committee meeting. This is being escalated to Divisional Directors.
− *Pressure Ulcers* - Definitions of roles and responsibilities of the TV link practitioner (TVLIP) have been approved, and training sessions are due to take place in January 2017. Learning from pressure ulcers will also be shared at the group.
− *Medical Division's Deep Dive* – heat maps and action plans have been created for each directorate following the deep dive, along with a change to dashboards for all divisions.
− *Terms of Reference* – The terms of reference for the group are also due to be reviewed.

Discussion ensued on learning and how this is shared. It was stated that significant pieces of work are taking place looking at themes and trends and putting together a learning framework, following staff surveys and focus groups on the different ways in which colleagues learn. It was also stated that the 'What happened next…?' newsletter will be developed into a quarterly bulletin focussing on specific areas of adverse events.

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

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009/17	**SERIOUS INCIDENT REPORT**
	Andrea McCourt (Head of Governance and Risk) reported on the circulated paper (Appendix G) which summarises new, completed and de-logged incidents from October and November 2016:
	▪ *New serious incidents* - There were 16 new incidents reported to the Clinical Commissioning Group (CCG) in October and November 2016:
	− 14 occurring within the medical division − 2 occurring within the surgery and anaesthetics division
	Discussion ensued on one of the incidents within the surgery and anaesthetics division involving a retained swab. This is the second never event within 2016/17, the first being a misplaced naso-gastric tube.
	▪ *Completed Serious Incident Reports* - There were seven serious incident reports submitted to commissioners; four in October 2016 and three in November 2016. A case summary of each incident was attached, which are disseminated to all divisions via Patient Safety and Quality Boards meetings, and added to the Effective Investigations intranet page. Discussion ensued on the case summaries relating to the incidents in the FSS division concerning the neonatal death (Datix 132380) and intrauterine death (Datix 133875). It was agreed that a short presentation on the monitoring of the recommendations from both incidents should be delivered to the Quality Committee at the meeting in February.
	ACTION: To invite the Associate Director of Nursing and the Deputy Head of Midwifery to the February meeting to give a presentation on the monitoring of recommendations from the neonatal and intrauterine deaths
	▪ *De-logged incident* - During October 2016 one incident was de-logged as a serious incident by the Clinical Commissioning Group (CCG). The incident had been flagged from a mortality review where both first and second level reviews identified a patient's death as probably preventable due to lack of documented medical review on the two days immediately after surgery. A full investigation was undertaken which concluded that the death was slightly preventable, as the lack of formal medical review did not contribute to the patient's death. This investigation has identified the need to analyse the mortality review process to ensure expert opinions are sought prior to a Hogan score being agreed by the second level reviewer.
	OUTCOME: The Quality Committee received and noted the content of the report.
010/17	**RISK REGISTER (CORPORATE)**
	Andrea McCourt (Head of Governance and Risk) reported on the circulated papers (Appendix H1 and H2) which gave a summary of changes in the risk register from November and December 2016:
	▪ There were seven risks scoring 20 or over ▪ One risk with an increased score from 15 to 20 during December 2016 due to ongoing scrutiny ▪ One new risk was agreed at the 8th November 2016 Risk and Compliance Group and was added to the high level risk register, and ▪ No risks were closed in November or December 2016
	A copy of the risk register was also available.
	OUTCOME: The Quality Committee received and noted the content of the report.

011/17	**HEALTH AND SAFETY COMMITTEE REPORT** Lesley Hill (Executive Director of Planning, Performance, Estates and Facilities) reported on the circulated paper (Appendix I) which summarised key business at the last Health and Safety Committee meeting on 21st December 2016 including: ▪ *Medical Devices* – There has been a noticeable improvement in the management of medical devices and maintenance planning. Training attendance in the use of medical devices is low in some divisions and departments, and colleagues are reminded that if they are not trained they must not use the medical device. ▪ *Conflict resolution training* – Colleagues have highlighted a need for a more practical form of training with patients with dementia, including restraint. The East Lancashire Trust will provide six taster sessions of this type of training as an initial step forward. **OUTCOME**: The Quality Committee received and noted the content of the report.

012/17	**CLINICAL OUTCOMES GROUP REPORT**
	
	Dr David Birkenhead (Medical Director) reported on the circulated paper (Appendix J) and the key issues discussed at the last Clinical Outcomes Group meeting held on Monday, 21st November 2016:
	
	▪ *Safety Huddles* – These are now implemented on all wards within surgery, medicine and maternity. There is a plan to introduce in paediatrics and gynaecology. There are 10 wards using 'code purple' to identify patients that are flagged as a concern by any member of staff.
	
	▪ *Sepsis* – A deep dive into sepsis is being conducted, and working on the processes to include the use of BUFALO instead of sepsis 6, as this is what junior doctors' use in other trusts in the area. Sepsis trolleys have been introduced to the Emergency Department and looking at a Patient Group Directive (PGD) to administer first dose of antibiotics in a timelier manner.
	
	▪ *Hospital Standardised Mortality Ratios (HSMR) / Summary Hospital-level Mortality Indicator (SHMI)*
	  − HMSR (July 15- June 16) = 105 (latest HSMR published is 102.94)
	  − SHMI (April 15- March 16) = 113
	
	▪ *Care of the Acutely Ill Patient (CAIP) action plan* – this is an update on progress of the following elements:
	  − Investigating mortality- Mortality reviews are to be included in the consultant's job plans and training to be provided. Consultants to be invited to join the mortality review process ahead of their appraisal.
	  − Reliability – overall bundle compliance remains variable. Meetings are being arranged with each of the bundle leads. Sepsis work is being prioritised
	  − Deteriorating Patients – The Deteriorating Patient Group is focusing on improvement work on timeliness of observations. There are 10 wards identified to use 'code purple'.
	  − Frailty – two of the elderly care consultants are working with community partners to avoid admission of frail people. This is part of work lead by the Safer Patient work stream.
	  − CAIP Dashboard – the format has changed to be more in line with the Trusts Quality and Performance Report to show trend data over a greater period of time. Further quality measures need to be identified for frailty and deteriorating patients.
	
	OUTCOME: The Quality Committee received and noted the content of the report.

013/17	**MORTALITY SURVEILLANCE GROUP REPORT**
	Dr David Birkenhead (Medical Director) reported on the circulated paper (Appendix K) and the key issues discussed at the last Mortality Surveillance Group meeting held on Monday, 7th November 2016:
	▪ Mortality Review Protocol – This has been revised to include process for child death reviews and the LeDeR (Learning disabilities).
	▪ Healthcare Evaluation Data (HED) alerts - Acute cerebrovascular disease had been alerting for some time but had reduced in October. The current alerts include 'Deficiency and other anaemia' and 'Urinary tract infections'. Further reviews on these groups were agreed and to be presented at the next meeting.
	▪ Mortality review update - 49% of deaths have been reviewed in the last 12 months. The number of reviews each month has been declining.
	▪ Consultant level reviews - Preparation work has been ongoing to include changes from the Hogan preventability score to the new national mortality review avoidability score. Changes have been made to the review form, the database and the knowledge portal and ready to go live from December 2016. Consultants have been invited to join the team of reviewers ahead of the job planning process.
	▪ 30-day deaths - A small cohort of six deaths from one GP practice showed four deaths were expected and not much learning gained. A further meeting has been arranged to discuss how the process for reviewing deaths that occur within 30 days of discharge can be expanded. Consideration to given for admission and readmission avoidance.
	▪ Clinical coding – Co-morbidity form completion significantly below expected levels. The Electronic Patient Record (EPR) will probably help with this. The clinical coding team is really stretched and difficult to recruit to.
	OUTCOME: The Quality Committee received and noted the content of the report.
014/17	**PATIENT EXPERIENCE AND CARING REPORT**
	Juliette Cosgrove (Assistant Director of Quality) reported on the circulated paper (Appendix L) which highlights discussions at the Patient Experience and Caring Group (PE&CG) meetings in October and November 2016. The October meeting took the form of a workshop to identify the improvement priorities for the 2017 work plan, and the November meeting included a review of the Group's terms of reference:
	▪ Agreed PE&CG improvement priorities – which include patient experience opportunities being picked up through other initiatives, research projects, learning opportunities and a campaign approach on customer care standards. Further details of the programme will be provided in the quarter 3 report to the Quality Committee.
	▪ Revised PE&CG terms of reference – The annual review of the terms of reference include the proposed move to eight meetings a year (previously monthly), one assurance and one improvement meeting per quarter; and that the End of Life and nutrition groups now reporting to Clinical Outcomes Group.
	▪ The EQUIP process - A strengthened approach to reviews of policies and service changes in relation to any equality and diversity impact has been introduced - these will now be subject to questions related to the nine protected characteristics. Responses will be reviewed by the Engagement and Inclusion team.

	▪ Complaints – a much improved position has been achieved following a significant drive to deal with the backlog. Each Division is now required to sustain the position, with an escalation process if off-track. A position of 'green' for the CQC must do action was reported to the CQC Response Group. It was reported that the Patient Experience and Caring Group is working well, and it was asked whether a membership councillor could be in attendance at this meeting, which was agreed. **OUTCOME**: The Quality Committee received and noted the content of the report.
015/17	**QUALITY ACCOUNT – PRODUCTION TIMELINE** Andrea McCourt (Head of Governance and Risk) reported on the circulated paper (Appendix M) which gives the key dates for the production of the 2016/17 Quality Account and discussion of quality priorities for 2017/18. **OUTCOME**: The Quality Committee received and noted the content of the report.
016/17	**ANY OTHER BUSINESS** ▪ Safe storage of food for patients on wards This issue was previously discussed at the Board of Directors meeting in December 2016, where a membership councillor asked for advice on the Trust's policy regarding relatives bringing in food for patients and the safe storage of this. It was confirmed that relatives were able to bring food in for patients as in some cases it was beneficial to the health and wellbeing of the patient, however, it was not possible to store food for patients on the ward. This view was also taken by the Quality Committee, and it was agreed that the Executive Director of Nursing and Executive Director of Planning, Performance, Estates and Facilities would further discuss the matter with the membership councillor. ▪ General Medical Council (GMC) Training A letter from the GMC regarding the quality of medical education and training provided by trusts across the UK was circulated (Appendix N). The letter stated that concerns reported from the GMC's annual survey of doctors, and the need for those responsible for the delivery of medical education to take the appropriate steps to ensure the medical training of doctors remains protected. The Quality Committee reviewed the national training survey results as outlined in the letter and were in agreement with the comments in the letter. It was also agreed that this should be discussed at the Workforce (Well-led) Committee.
017/17	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** ▪ CQC Response Group Report - The Quality Committee was asked to approve the movements in the plan from November 2016 and December 2016 as recommended by CQC Response Group, and support the revised completion dates for the actions currently not delivering against the plan. ▪ Quality and Performance Report – The Quality Committee looked closely at the quality metrics in the report. The safe element has moved to red, however, there are no underlying issues. ▪ Serious Incident Report – The Quality Committee will request a short presentation from the FSS division (at February meeting) with regard to their response to monitoring of recommendations from case summary learning involving neonatal and intrauterine deaths ▪ GMC Training – The Quality Committee have requested that the Workforce (Well-Led) Committee take forward a letter from the GMC regarding the quality of medical education training. ▪ Terms of Reference – The Quality Committee recommended the revised terms of reference for Board approval

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018/17	**QUALITY COMMITTEE WORK PLAN**
	A copy of the Quality Committee's work plan for 2017 was circulated (Appendix O) for information.
	OUTCOME: The Quality Committee received and noted the content of the report

NEXT MEETING

Monday, 30th January 2017
3:00 – 5:30 pm
Board Room, Sub-basement
Calderdale Royal Hospital

Minutes of the Finance & Performance Committee held on Tuesday 3 January 2017 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer (on part)
Anna Basford	Director of Transformation & Partnerships
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)
Ian Warren	Director of Workforce & Organisational Development
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance
Mandy Griffin	Interim Director of Health Informatics (in part)
Brian Moore	Membership Councillor
Victoria Pickles	Company Secretary
Betty Sewell	PA (Minutes)

ITEM

001/17 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

002/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
David Birkenhead – Medical Director
Brendan Brown – Director of Nursing
Andrew Haigh – Chair of the Trust
Lesley Hill – Director of Planning, Performance and Estates & Facilities
Owen Williams – Chief Executive

003/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

004/17 MINUTES OF THE MEETING HELD 29 NOVEMBER 2016

The minutes of the last meeting were approved as an accurate record subject to a minor change to attendees noting that Richard Hopkin was not present at the meeting.

005/17 MATTERS ARISING AND ACTION LOG

113/16: Annual Review of Contracts - The Company Secretary confirmed that a Board Workshop is in diaries and that the Committee in Common Terms of Reference are not yet finalised, a meeting would be taking place later this week to review the final amend. Following submission to the West Yorkshire Chief Executive meeting they will go to Board – **action closed**.

172/16: Strategic Item – It was agreed that a revised chart (Page 21 of the 5 Year

Strategic Plan) will come to the next meeting which will compare with the Plan and the Actual position – **KA/GB**

173/16: EPR – It was confirmed that there would be value in having a pre go-live baseline review in March 2017 – **SB**

FINANCE AND PERFORMANCE

006/17   MONTH 8 FINANCE REPORT

The Deputy Director of Finance, Kirsty Archer, took the Committee through the Finance Report for Month 8, year to date:

- The I&E position remains slightly ahead of plan with a favourable variance of £0.12m against a planned deficit of £12.60m, which is in line with Month 7. We are continuing to forecast the Control Total of £16.1m (excluding Exceptional Costs).
- We continue to over deliver CIP, however, it is envisaged this will slow down in the latter part of the financial year. The over delivery of CIP and the Income over performance allows us to report a favourable position whilst absorbing operational pressures.
- Planned reserves of £1m have been held back to mitigate against pressures in the latter part of the year.
- The Cash balance is above plan at £3.97m this was due to the late receipt of STF on the last day of the month, which did not allow us to make further payments to suppliers. The uncertainty of the timing of the receipt of the STF is leading to indecisions with regard to the release of cash.
- Capital is under-spent in month.

007/17   FINANCIAL FORECAST AND RECOVERY PLANS AT MONTH 8

The Director of Finance introduced a paper which will also be discussed at Turnaround Executive later today.

At Month 5 a detailed forecast was shared that identified a need for a further £2m of recovery schemes in order for the Trust to deliver against the agreed £16.1m Control Total. The paper detailed the progress made since Month 5 and updates the forecast position.

Work undertaken between Months 5 and 8 and the favourable in month position suggests that the Control Total of £16.1m can be delivered. However, there remains a material risk particularly regarding receipt of SRG and the funding of the Accelerator Zone. In addition, there is now a heightened risk around the likelihood of Commissioner challenge to counting and coding and achievement of CQUIN targets, crystallisation of one or both of these will require further remedial action to secure the Control Total. Discussions took place with regard to our coding principles which is improving year on year, it was also noted that with the introduction of EPR our level of coding will significantly improve.

Gary Boothby informed the Committee that there are 3 or 4 main areas of the contract negotiations which leaves us with a significant gap and at an escalation meeting prior to the deadline date of 31 December, it was agreed that due to the level of the gap we would seek formal arbitration.

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Discussions then took place with regard to the Soft FM opportunity and it was confirmed that a revised written offer had been received from ISS and confirmation from Catalyst that if they received confirmation of the offer by the end of January they should be able to push something through in this financial year. Following discussions with KPMG they suggested contacting Citrica who are in receipt of our data and are hoping to report back mid-January to confirm whether or not the offer is value for money.

In summary, there are challenges but at this point of time the forecast of £16.1m is still deliverable.

With the arrival of the Director of Operations an update was received by the Committee with regard to the latest operational position, it was noted that there were 48 extra beds open and authorisation had been given to staff those beds with agency staff to keep patients safe.

012/17 **INTEGRATED PERFORMANCE REPORT**
Due to the availability of the Chief Operating Officer the agenda was adjusted accordingly and the key points of the IPR, from a finance and performance perspective, were noted as follows:-

- Within month there was a slight deterioration in performance, however, it was noted that an adjustment to the data to take account of CDiff reporting has been amended.
- Within 'Safe' a Never Event contributed significantly to the RED rating.
- Emergency Care Standard and Cancer 62 day screening had had an effect on 'Responsiveness'.
- From a performance perspective, we did deliver within the 1% tolerance in Month and in Qtr 3.
- The norovirus had an impact on our Stroke capacity which also has an impact on our Best Practice Tariff
- Work is being focused on our emergency re-admission with particular focus on the potential of losing funding next year, challenges are with Greater Huddersfield (managed by Locala) and triangulation with Commissioners is key.
- We are delivering on RTT, however, our waiting lists remain high.
- SAFER programme – the Community Place was due to open today, however, with the influx of admissions over the weekend the 'correct' type of patient needs to be identified.

Discussions took place with regard to the excess bed days and the fact that this situation is driven by the system. It was noted that with the Kirklees local authority IT systems went down over the Christmas period which lead to patients not being assessed and discharged. There was also an issue with Calderdale CCG prior to Christmas following the closure of Holme Valley.

The Committee agreed that with the 48 extra beds being open we should identify how many patients could have been discharged and were not for us to understand the impact.

Following discussions it was noted that our admission numbers are one of the best in the area.

With regard to the Accelerator Zone, it was noted confirmation has been requested that funding is in place and is being spent. Internally patients who are accessing the funding are being tracked. It was also noted that money will not be released to the CCGs unless it is evidenced. It is understood that a letter has been sent from WYATT to the Secretary of State to request that the Accelerator Zone funding continue into next year.

In terms of Workforce it was noted that the pressure is agency staffing and short term sickness and the downward 13 month trajectory will be tested.

The Committee noted the contents of the report.

170/16: Outpatient Follow-up Appointment benchmarking information – The Chief Operating Officer took the Committee through a presentation which had been presented by Katharine Fletcher, General Manager, Outpatients and Records at a national outpatient improvement event which received positive feedback and at WEB.

Helen Barker described the work done to improve the technology and culture which included a reminder service via SMS, calls and interactive voice messaging. The use of check-in kiosks have also improved data quality; partial booking which has reduced DNAs and cancellations; and the Knowledge Portal which provides real time accurate information at specialty, consultant and clinical level.

Discussions took place with regard to the number of patients and the number of clinics and whether this is tracking through to a financial benefit. Helen Barker agreed to provide an Outpatient Productivity slide.

The Director of Health Informatics commented that with the success of this work, benefits realisation will need to be re-assessed for EPR.

The Chief Operating Officer left the meeting.

008/17   CASH REPORT
The Deputy Director of Finance introduced the Cash Report, the key points were noted as follows:-

- As previously reported to the committee, delivery of the 2016/17 financial plan was dependent on cash support of £37.6m which is in addition to existing borrowing from previous years of circa £30.0m.
- The various elements of borrowing are based on differing payment terms and interest rates.
- As at the end of November 2016, £60.41m had been borrowed against a plan of £58.32m made up of different types of borrowing.
- The reason for the additional borrowing in YTD above plan, is made up of a number of factors, mainly non-cash I&E benefit and the re-payment of the

capital loan being set at a shorter profile than anticipated in the plan which is out of our control.

- The pressure in year, has been off-set by the receipt of cash from the sale of Princess Royal.
- The working capital position is also driven by the aged debt position which has improved in month but still remains over £5.12m at Month 8.
- The majority of the debt relates to 20 customers/ organisations of which three quarters of the value is owing from other NHS organisations.
- Of the £5.12m, £1.5m relates to invoices in relation to SRG funding against which there is a risk of non-payment based on the current commissioner stance, which we continue to invoice month on month.
- One of the actions taken to resolve the aged debt position was to establish Assistant Directors of Finance as Account Managers which has enabled some success.

Discussions took place with regard to our 'credit control' arrangements, particularly for the Pharmacy Manufacturing Unit (PMU) and how the Cash Committee could enter the next phase which will enable us to tap into good practice.

The Director of Finance confirmed that a loan approval will need to go to Board before the end of March 2017.

ACTIONS:

- The Cash Report to be updated on a monthly basis to year-end – **KA**
- To split the breakdown of aged debt between PMU/Non-Contract Activity with other NHS Organisations/Oversea Visitors and Staff Overpayments - **KA**

The Committee noted the current cash challenges and the actions underway to improve cash flow.

009/17   **FINANCIAL PLANNING UPDATE**

The Director of Finance and the Deputy Director of Finance introduced a presentation which detailed the Trust's response to the feedback from NHS I following receipt of our draft plan.

The Deputy Director of Finance focussed the Committee on the changes which came from the instructions from NHS I to the Trust to **include** the estimated impact of the **EPR implementation** and provide an assessment of what action the Trust can take to minimise impact and to **exclude** the requested **reconfiguration capital expenditure**, in context of constrained national capital funding. In addition to the Trusts response to the above instructions, additional challenges which total approx., £2m were also identified within the presentation and the Trusts response to those challenges were highlighted.

It was noted that in terms of CIP the deadline for submission of plans was the end of December and these will be taken to next weeks' Turnaround Executive meeting noting that the first cut will be less than £17m which is recognised as extremely high risk and challenging.

The Committee noted the contents of the presentation and it was agreed this should be shared with Board within the 'Private' session.

STRATEGIC ITEMS
010/17 CIP UPDATE

The Director of Transformation & Partnerships confirmed there was nothing more to add to the Month 8 position reported and the progress being made on 2017/18 which will be reported fully at the next meeting.

011/17 EPR

The Associate Director of Finance highlighted the key point from the paper that the financial forecast to support a go-live date of March 2017 for CHFT requires review to support an April/May go-live date which is currently being planned. It was noted that conversations have taken place with KPMG and with Bradford Teaching Hospital Foundation Trust (BTHFT) with regard to the accounting treatment of the asset and the intention to impair it to the value of the contract with Cerner. With regard to the timing of the 50/50 payment, we have proposed that in the 3 months build up to our go-live date we will incur 100% of the costs and for Bradford to pick up 100% of the costs post our go-live date. It is our intention to accrue the final payment to Cerner. It was also noted that with regard to VAT costs, conversations have taken place with EY with regard to the potential VAT liability of £900k relating to agency costs which will also be accrued in the last month of this financial year.

The Director of Health Informatics referenced a position statement which would be going to Board which captures the reason for needing a Trial Load 4. It was noted that all activity is pointing to a 'go-live' date of 29th April, Bank Holiday weekend and confidence is high in achieving this date. Plans are being put in place to mitigate manual data migration if this is required. With agreement with BTHFT and Cerner communication will be issued advising the go-live date subject to achieving certain milestones.

GOVERNANCE
012/17 INTEGRATED PERFORMANCE REPORT

Item covered earlier in the meeting.

013/17 MONTH 8 COMMENTARY TO NHS IMPROVEMENT

The Committee received the paper for information which provides the Management Commentary on the financial position of the Trust at the end of November 2016 which has been submitted to NHS I.

The Committee noted the contents.

014/17 REVIEW FINANCE & PERFORMANCE TERMS OF REFERENCE

The Company Secretary confirmed that the Terms of Reference for the Committee had been revised and are with Finance for review, they will be available for discussion at the next meeting.

015/17 WORK PLAN

The Work Plan was received and noted by the Committee.

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016/17 **MATTERS FOR THE BOARD AND OTHER COMMITTEES**
The Chair of the Committee highlighted the following items which had been discussed during the meeting:-

- Risk in the forecast relating to the Commissioner challenges, CQINS etc.
- Winter challenges
- Performance Report – we are on track at the end of Qtr 3. Strong performance with signs of increasing pressures, with December being a challenging month.
- Value excess bed days in relation to local authority issues for future NHS I PRMs
- Accelerator Zone investments to help with performance targets.
- Outpatient Follow-up System – the challenge is to verify the level of savings of a much improved operational performance.
- Financial Plans for 17/18 and the risks and changes from the initial submission
- Cash – further breakdown requested with regard to aged debt and discussions with regard to a Credit Controller.
- Taking the Annual Plan to the private session of the Board
- TOR next meeting
- Performance in month – recognising risks going forward on plan.
- EPR will go the private session of the Board

017/17 **ANY OTHER BUSINESS**
There were no further items for discussion.

DATE AND TIME OF NEXT MEETING
Tuesday 31 January 2017, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL MEMBERS MEETING HELD ON TUESDAY 17 JANUARY 2017 IN THE BOARDROOM, SUB-BASEMENT, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Chair
Di Wharmby	Public elected – Constituency 1
Rosemary Hedges	Public elected – Constituency 1
Veronica Maher	Public elected – Constituency 2
Peter Middleton	Public elected – Constituency 3
Nasim Banu Esmail	Public elected – Constituency 4
Stephen Baines	Public elected – Constituency 5
George Richardson	Public elected – Constituency 5
Brian Moore	Public elected – Constituency 8
Charlie Crabtree	Staff-elected – Constituency 13
Cath O'Halloran	Nominated Stakeholder - University of Huddersfield

IN ATTENDANCE:

David Birkenhead	Executive Medical Director
Kathy Bray	Board Secretary
Brendan Brown	Executive Director of Nursing
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Peter Keogh	Assistant Director of Performance
Ruth Mason	Associate Director of Engagement & Inclusion
Victoria Pickles	Company Secretary
Philippa Russell	Acting Director of Finance
Ian Warren	Executive Director of Workforce & OD
Jan Wilson	Non-Executive Director/Deputy Chair - Trust
Owen Williams	Chief Executive

1/17   APOLOGIES:

Apologies for absence were received from:

Katy Reiter	Public elected – Constituency 2
Dianne Hughes	Public elected – Constituency 3
Grenville Horsfall	Public elected – Constituency 4 (Reserve Register)
Annette Bell	Public elected – Constituency 6
Brian Richardson	Public elected – Constituency 6
Lynn Moore	Public elected – Constituency 7
Kate Wileman	Public elected – Constituency 7
Michelle Rich	Public elected – Constituency 8
Mary Kiely	Staff-elected – Constituency 9
Nicola Sheehan	Staff-elected – Constituency 10
Eileen Hamer	Staff-elected – Constituency 11
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
Dawn Stephenson	Nominated Stakeholder – SWYPFT
Sharon Lowrie	Nominated Stakeholder – Locala
Dr David Anderson	SINED/Non-Executive Director
Helen Barker	Chief Operating Officer

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Gary Boothby   Executive Director of Finance
Anna Basford   Director of Transformation and Partnerships
Mandy Griffin   Director of The Health Informatics Service

The Chair welcomed everyone to the meeting.

2/17   DECLARATION OF INTERESTS
There were no declarations of interest at the meeting.

3/17   MINUTES OF THE LAST MEETING – 9 NOVEMBER 2016
The minutes of the last meeting held on 9 November 2016 were approved as an accurate record.

4/17   MATTERS ARISING
77/16 - CARE OF THE ACUTELY ILL PATIENT & SAFER PATIENT PROGRAMME
Peter Middleton asked if the Membership Councillors could receive regular updates on the progress with these two programmes. It was agreed that the Executive Medical Director and Chief Operating Officer would be asked to ensure that these two items are included on the MC Agenda for the meeting to be held on 5 April 2017 and would be added to the Membership Council work plan.

ACTION: DB/HB/KB

72/16   REGISTER OF INTERESTS/DECLARATION OF INTERESTS
It was noted that all Membership Councillors with the exception of Sharon Lowrie had returned their completed declarations.   The Chairman asked the Board Secretary to send a further reminder to Sharon Lowrie.

ACTION: KB

76/16 - IPR – METHODOLOGY FOR CALCULATING PERFORMANCE SCORES
The Chairman reported that the Chief Operating Officer had agreed to circulate the methodology for calculating the performance score. This was circulated to Membership Councillors on the morning of Wednesday 18 January 2017 by the Board Secretary.

79/15 - MC/BOD WORKSHOP – WEDNESDAY 16 NOVEMBER 2016
The Chairman reported that there had been a disappointing turnout from the Membership Council with only 7 Membership Councillors in attendance at this Workshop. The Chairman requested that, particularly when meetings involve the Board, the Membership Councillors make every effort to ensure good attendance.

73/16b – **CQC INSPECTION – ACTION PLAN**
The Executive Director of Nursing presented the latest version of the CQC Action Plan.

It had been agreed at the last meeting that an update be given to provide assurance to the Membership Councillors on the delivery of the Trust's response to the CQC report.   The plan was based on the 19 must do and 12 should do actions detailed in the CQC report which was published on 15th August 2016.

The report focuses on the movement of individual actions in line with the 'BRAG' (Blue, red, amber and green) rating methodology; these had been approved by the Trust Quality Committee on 3rd January 2017.

It was noted that a mock CQC inspection had been held by NHS England the previous week to look at Maternity Services and this had received positive feedback. Further mock CQC inspections were planned for Paediatrics and ICU. The Executive Director of Nursing reported that it was important to review all evidence to ensure performance and improvements continued.

OUTCOME: The Membership Council **RECEIVED AND NOTED** the CQC Action Plan.

5/17   CHAIRMAN'S REPORT

a.   ANNUAL MEMBERSHIP COUNCIL MEETINGS WORK PLAN 2017

The Annual Workplan had been brought to the meeting for approval and give opportunity for the Membership Council to include any other items. No matters were raised.

Peter Middleton requested that 'Quality' be embedded within the Workplan. Discussion took place regarding the various meetings/reports where quality is included which are already included on the Workplan. It was agreed that the Company Secretary would review this.

ACTION: VP

OUTCOME: The Membership Council **RECEIVED AND APPROVED** the MC Workplan for 2017 and it was agreed that the Company Secretary would review 'Quality' on the Workplan.

b.   UPDATE FROM CHAIRS INFORMATION EXCHANGE MEETING – 19.12.16

The Minutes from the Chairs Information Exchange Meeting held on the 19 December 2016 were received and noted.

The Chairman updated the Membership Council on developments regarding some of the issues which had been raised at the meeting. This included:-

Communications

Discussion had taken place at the Chairs Information Exchange regarding communication between staff and patients. It had been suggested that Sal Uka be invited to attend a future MC meeting again.

The Executive Medical Director advised that Sal Uka's portfolio had changed since he last attended the Membership Council and suggested that it would be more appropriate for Juliette Cosgrove to come to a future meeting to update on 'Communications' from both a general and clinical perspective.

ACTION: DB/KB/JC
Juliette Cosgrove to be invited to meeting on 5.4.17

OUTCOME: The Membership Council **RECEIVED AND NOTED** the Chairs Information Exchange Minutes – 19.12.16 and it was agreed that Juliette Cosgrove be invited to a future meeting.

c.   MEMBERSHIP COUNCIL WORKSHOP – 14.12.16

It was noted that a Membership Council Workshop had taken place on the 14 December 2016 to discuss the Annual Plan and priorities for the Quality Accounts in 2017.   It was noted that this had been well attended and was a helpful meeting.

The Chairman reported that the Membership Councillors present had received an update on the Annual Plan submission and were given the opportunity to shortlist the indicators for inclusion in the Quality Account for 2017. It was noted that Members would then be asked to vote against the indicators and the closing date for voting was the end of February 2017.

The Executive Director of Planning, Estates and Facilities had also attended the meeting and the Membership Council had received and approved the Annual Plan.

All presented had reported that this had been a very helpful and productive meeting.

OUTCOME: The Membership Council **NOTED** the feedback from the MC Workshop held on 14.12.16

d. FEEDBACK FROM MATTERS ARISING AT PRE-MEETING HELD 9.1.16
The Chairman updated the Membership Council on the actions which had been undertaken to address the issues raised at the private pre-meeting held on 9.1.16. This included:-
- Good News Stories/Benchmarking – This had now been included within the Performance Paper and would be discussed later in the meeting.
- EPR Communications – A communications plan was in place to ensure that developments are cascaded to both staff and the public in due course.
- Celebrating Success Video – Arrangements were being made for this to be displayed at appropriate events.

OUTCOME: The Membership Council **NOTED** the feedback from the private pre-meeting.

e. A/E PERFORMANCE
Discussion took place regarding the recent national media reporting regarding A/E performance and the view that some patients might be better treated outside of hospital. It was reported that the percentage of these patients within the Trust averaged between 48-49%. It was reported that the A/E pathway had been reviewed and actions had been undertaken by the senior staff to improve triaging in the department. It was reported that the Trust was one of the higher performers nationally but the Chief Executive reported that this came at a cost to the Trust being in deficit by £27m pre STF funding. The Medical Director reported that ultimately reconfiguration of services would give assurance of quality care.

The Chairman and Chief Executive reported on the various data within the Trust which was available to the Executive team and the Non-Executive Directors by which would assure themselves that Trust staff were doing all they could despite the challenges facing them. Some of the data available included:-
- Data in the Integrated Performance Report
- Quality Committee reports
- Benchmarking performance reports
- SITreps reports
- Safer Patient Programme outcomes
- Complaints information

Discussion took place regarding the good performance of the Trust in meeting the targets and the work undertaken to achieve this. Thanks were given by the Membership Council to staff in achieving the position, despite the challenging position.

The Chairman reported that NHS Improvement had circulated a letter in December regarding broadening our oversight of A/E and further monitoring of services were being introduced.

OUTCOME: The Membership Council **NOTED** the performance of the Trust against the Emergency Care standard.

CONSTITUTION

6/17   MEMBERSHIP COUNCIL REGISTER
The updated register of members as at 1 January 2017 was received.
OUTCOME: The Membership Council **APPROVED** the updated Register.

7/17   REGISTER OF INTERESTS/DECLARATION OF INTERESTS
The updated Register of Interests/Declarations was received. Any amendments were requested to be notified to the Board Secretary as soon as possible. Only one declaration remained outstanding from Sharon Lowrie and this had been requested.

OUTCOME: All Membership Councillors present **APPROVED** the Register of Interests.

8/17   CONSTITUTIONAL AMENDMENTS
The Company Secretary reported that the two issues requiring clarification had not been finalised and therefore further information was awaited on the impact of the development of a Committee in Common across the West Yorkshire Association of Acute Trusts (WYAAT) and secondly the consultation being undertaken by NHS England on standardising all Trust declarations of interests from staff.

Brian Moore reported that there was some confusion between the titles 'Membership Council' and 'Council of Governors'. Discussion took place and a majority vote in favour of changing the title was agreed, although it was noted that the meeting was not quorate. It was agreed that the Company Secretary would seek the views of the Board and NHSI and bring a recommendation back to the Membership Council and Board as part of the sign off of the changes to the Constitution in April.

OUTCOME: It was **AGREED** that further information would be brought to the Membership Council Meeting on 5 April 2017.

ACTION: Agenda item 5.4.17 – Company Secretary

9/17   REVIEW OF STANDING ORDERS – MEMBERSHIP COUNCIL
The Company Secretary presented the tracked amendments to the Review of Standing Orders for the Membership Council. The amendments included:-
- Expenses clarification
- References to Monitor / NHS Improvement
- Typographical amends

It was noted that this document would be reviewed again in January 2019.

OUTCOME: The Membership Council **APPROVED** the amendments to the Standing Orders for the Membership Council subject to the amendment to the title 'Council of Governors' being approved by the Board and NHSI

ACTION: Company Secretary

10/16 UPDATE FROM BOARD SUB COMMITTEES

10/17a – AUDIT AND RISK COMMITTEE
Peter Middleton reported that the Audit and Risk Committee were progressing well and the next meeting was scheduled for the following day.

10/17b – ELECTRONIC PATIENT RECORD

Brian Moore reported that the 'Go Live' date for implementation of the EPR system within CHFT had now been agreed for the bank holiday weekend of the 28 April to 2 May 2017. Arrangements were still being made for Bradford which was likely to be some time during July 2017.

10/17c – FINANCE AND PERFORMANCE COMMITTEE
Brian Moore reported that the Committee discussion reflected the report given in the Acting Assistant Director of Finance's presentation.

10/17d - QUALITY COMMITTEE
Peter Middleton reported that revised, comprehensive Terms of Reference had been agreed by the Committee. It was noted that a Patient Experience and Caring Group was being established and it was suggested that a MC representative be invited to sit on this group. Jan Wilson reported that she had approached Lynn Moore on this. The Associate Director of Engagement & Inclusion advised that Juliette Cosgrove was to be invited to a future MC event to update on the work of this group and that further consideration of Membership Council involvement be given at that meeting.

ACTION: ASSOCIATE DIRECTOR OF ENGAGEMENT & INCLUSION

10/17e – CHARITABLE FUNDS COMMITTEE
The Chairman reported that the Charitable Funds Committee was looking to rationalize funds in order that they could be used for the benefit of the Trust. Discussions continue with two providers to explore the opportunities of a cash lottery system and as part of this a self-financing Fund Raiser would be appointed.

10/17f – WORKFORCE WELL-LED COMMITTEE
Ian Warren reported that the next Workforce Well-Led Committee was due to meet on Thursday 19 January 2017. The previous meeting had focused on developing the new Workforce Strategy which had been signed off by the Board of Directors in January 2017.

10/17g – ORGAN DONATION COMMITTEE
The Chairman reported that there had been no Organ Donation Committee meetings held since the last Membership Council meeting.

10/17h – MC/BOD JOINT ANNUAL GENERAL MEETING – FEEDBACK FROM TASK AND FINISH GROUP
The Company Secretary presented a paper outlining a proposal:-
- To bring the meeting forward in the year to July, just prior to the start of the school holidays. There are a number of benefits to this including the ability to hold the elections slightly earlier in the year to address some of the current vacancies we are holding; lighter nights and hopefully better weather.
- To hold the meeting on Thursday 20 July 2017 from 5pm.
- To run a small 'health fair' from 5pm to 6pm consisting of:
  - A stand from each division setting out their successes from 2016/17 and plans for 2017/18
  - A successes communication stand celebrating the good work of the Trust
- To hold the formal AGM meeting at 6pm.

The associated implication of this were discussed and the Chairman advised that although the AGM and election process would be brought forward, the new members and existing

members would not change until September as originally planned. This would give opportunity for induction and training to take place before September.

Discussion also took place regarding the 9 November meeting and it was agreed that this should be brought forward to October. (Outside of the meeting this was notified to the Membership Councillors as 4.00 pm on Thursday 26 October 2017 in the Large Training Room, Learning Centre, CRH).

OUTCOME: The Membership Council **APPROVED** the proposed changes for the AGM and Health Fair to be held on the 20 July 2017 and it was agreed that the Board Secretary would confirm the date along with the amended Membership Council Meeting which was to be brought forward from November to October.

ACTION: BOARD SECRETARY

11/17 STRATEGIC PLAN & QUALITY PRIORITIES 2016-17 UPDATE
a. 7 DAY SERVICES
The Executive Medical Director reported on the work being undertaken by Dr Sal Uka to implement 7 day services. It was noted that this work had been led from Sir Bruce Keogh setting 10 standards in emergency/acute care to drive seven-day services across the NHS. Currently the Trust was currently working towards the following 4 standards:-
- Emergency Admissions seen by a consultant within 14 hours of admission to hospital
- Diagnostic Services – timeliness of access to scans and reports
- Timely 24 hour access, seven days a week, to consultant-directed interventions
- All patients on the AMU, SAU, ICU and other high dependency areas to be seen and reviewed by a consultant twice daily.

The Trust was one of the early implementers and was receiving help and support from the NHS Improvement Team.

b. H&S ACTION PLAN
The Executive Director of Planning, Performance, Estates and Facilities outlined the work undertaken within the Trust regarding Health and Safety issues. In summary these included:-
- Appointment of new Health and Safety Manager
- Internal Audit and external audits undertaken
- Fire Training – face to face training being undertaken. Currently achieved 65% compliance.
- COSHH Guidance – Database established. Review of information and training on going.
- Health and Safety Committee – re-established with good attendance from Trust staff.
- Security – further work being undertaken with advice being received from Leeds Teaching Hospital.
- Emergency Planning – Officer currently on sick leave but interim looking at reviewing MAJAX system.
- Estates Capital Work – Fire alarm system at HRI reviewed and work continues on compartmentalization.
- Performance Information – Report to H&S Committee – key themes being looked at – slips, trips and falls

OUTCOME: The Membership Council **RECEIVED** the updates.

12/17 TRUST PERFORMANCE
a. Integrated Performance Report (IPR)
The Assistant Director of Performance gave an overview of the key themes. It was noted that

7

185

November's Performance Score is 65% for the Trust. 3 of the 6 domains improved in month. Within the Safe domain the Never Event has contributed significantly to the RED rating. In terms of Performance Achievements the Trust continues to maintain a significant number of its regulatory targets as 'Green' and of particular note is Hospital Standardised Mortality Rate (HSMR) which has fallen below 80 for the first time in month (September).

The Assistant Director of Performance had also supplied the Membership Council with presentation detailing the Trust's performance as at 17 January 2017 in order that this could be shared with the public if required.

b. Month 6 – September 2016 Finance Report
The Executive Director of Finance presented the overview of the financial position in the year to date and the financial forecast for year end 2016/17.

The key issues included:-

Summary Year to Date:
- The year to date deficit is £12.48m versus a planned deficit of £12.60m.
- Year to date Elective activity remains behind plan but is offset by higher than planned Outpatient, A&E and Day case activity
- Capital expenditure year to date is £10.66m against a planned £17.93m.
- Cash balance is above plan at £3.97m against a planned £1.94m.
- The Trust has drawn down loans earlier than planned. The total loan balance is £60.41m against a planned £58.32m.
- CIP schemes delivered £9.65m in the year to date against a planned target of £7.62m.
- The revised NHS Improvement performance metric Use of Resource (UOR) stands at 3 against a planned level of 3. This is the equivalent of a Financial Sustainability Risk rating of 2 as previously measured.

Summary Forecast:
- The forecast year end deficit is £16.35m against a planned deficit of £16.10m, but includes exceptional costs of £0.3m relating to the disposal of Princess Royal. These exceptional costs are excluded from the deficit for Control Total purposes and therefore have no impact on our STF allocation or UOR metric. This position assumes delivery of £15.19m CIP and that recovery plans are delivered to offset ongoing pressures and risks.
- Cash forecast is in line with plan at £1.90m.
- The Trust cash position relies on the Trust borrowing £30.53m in this financial year to support both Capital and Revenue plans, lower than the £37.63m planned.
- Forecast capital expenditure is £0.56m below plan at £27.64m. Capital expenditure on EPR has now been pushed back to M12 and a proportion of this expenditure is now forecast to be paid in the next financial year. This has reduced our loan drawdown for 2016-17, but will need be added to the 2017-18 borrowing requirement.
- The year-end UOR metric is forecast to be at level 3 as planned.

OUTCOME: The Membership Council **RECEIVED** the update on Trust performance.

13/17   INFORMATION TO RECEIVE
The following information was received and noted:

a.   Updated Membership Council Calendar – updated calendar received and contents noted.

b. Extract from Quarter 2 Quality Report re Complaints and PALs
The Executive Director of Nursing reported that this information had been supplied to the Membership Council for information and offered an overall view of the Trust's management of the current position with regard to complaints and PALs contacts received during Quarter 2.

14/17   ANY OTHER BUSINESS
The Associate Director of Engagement and Inclusion reminded the Membership Councillors of future diary dates to which all were welcome to attend:-

a.   Training Session "Holding to Account" – Monday 30 January 10.30 – 12.30

b.   Walkabouts to Simulation Suite – Tuesday 17.1.17 – 10.30 – 12.00 noon and Friday 3 February.

15/17   DATE AND TIME OF NEXT MEETING
Wednesday 5 April 2017 commencing at 4.00 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital

The Chair thanked everyone for their contribution and closed the meeting at 6.15 pm.

Calderdale and Huddersfield **NHS**

NHS Foundation Trust

**Minutes of the Audit and Risk Committee Meeting held on
Wednesday 18 January 2017 in Acre Mill, 3rd Floor commencing at 11:00am**

MEMBERS
Prof Peter Roberts   Chair, Non-Executive
Richard Hopkin   Non-Executive Director
Phil Oldfield   Non-Executive Director (Teleconference)

IN ATTENDANCE
Gary Boothby   Executive Director of Finance
Kathy Bray   Board Secretary (minutes
Michael George   Internal Audit Manager
Andrew Haigh   CHFT Chairman as Observer
Adele Jowett   Local Counter Fraud Specialist
Helen Kemp-Taylor,   Head of Internal Audit
Andrea McCourt   Head of Governance and Risk
Peter Middleton   Membership Councillor
Alistair Newall   Senior Manager, KPMG (for agenda item 10)
Victoria Pickles   Company Secretary

Ian Warren   Executive Director of Workforce and OD (for agenda item 4)
Sarah Parkin   Payroll and Pensions Manager (for agenda item 4)
Barry Mortimer   Senior Workforce and OD Advisor (for agenda item 5)

Item
1/17   **APOLOGIES FOR ABSENCE**
Apologies for absence were received from:
Brendan Brown, Non-Executive Director
Clare Partridge, External Auditor

2/17   **DECLARATIONS OF INTEREST**
There were no conflicts of interest declared at the meeting.

3/17   **MINUTES OF THE MEETING HELD ON 18 OCTOBER 2016**
The minutes of the meeting held on 18 October 2016 were agreed as a correct record.

4/17   **ACTION LOG AND MATTERS ARISING**
     b. 46/16 - Payroll Internal Audit
As agreed at the previous meeting Ian Warren, Executive Director of Workforce and OD, together with Sarah Parkin, Payroll and Pensions Manager attended the Committee to give an update on the progress made to address the issues identified in the Audit of the payroll function. To date most items on the Action Plan had been rated green and completed and Sarah highlighted the following actions:-

- A review of the BACs system to ensure double checking had been implemented
- Backlog of filing had now been cleared.
- Leeds Teaching Hospital had offered to help giving advice on the processes and training gaps in the department, along with giving recommendations of any best practice.

It was noted that Internal Audit would be undertaking a full follow-up Audit and a report would be presented at April's Audit and Risk Committee Meeting.

Discussion took place regarding the support from Leeds Teaching Hospital and Phil

1

Oldfield requested that the Committee receive an update on the benefits realised from this at the next meeting.

<div align="right">**ACTION: IW – AGENDA ITEM 19.4.17**</div>

OUTCOME: The Committee noted the work undertaken to date and agreed to receive a further update at the meeting on 19 April 2017**.**

b. SAFEGUARDING FOLLOW-UP REPORT
The Company Secretary presented a follow-up report which highlighted the actions which had been undertaken with regard to:-

- E-Expenses actions - which will be implemented by March 2017
- Safeguarding which detailed the 8 actions undertaken and the 1 outstanding issue with regard to Adult Training – Restraint Theory Training - which was due to be completed in March 2017.

It was noted that a new process was being developed whereby Trust representatives will follow-up on outstanding reports which are escalated by the Internal Audit team and this would be put in place before the next meeting on 19 April 2017.
OUTCOME: The Committee **NOTED** the follow-up report and welcomed a process for follow-up on outstanding audits.

5/17   **ANNUAL REPORT ON WHISTLEBLOWING**
Barry Mortimer, Senior Workforce and OD Advisor attended the meeting to present the Annual Whistleblowing Report.

It was noted that the report had been prepared by Barry Mortimer, in liaison with Dr David Anderson, Freedom To Speak Up to Guardian and Non-Executive Director. The report contained a review of effectiveness of the Trust's Raising Concerns Policy and the Trust's general approach to whistleblowing, together with a work plan for further key work on developing the Trusts whistleblowing processes. Barry highlighted that the staff survey feedback in the report was from 2014-15 as the most recent staff survey data had not been received at the time of writing.

Barry outlined the actions which had been undertaken to promote the Whistleblowing and Raising Concerns policy within the Trust.

Head of Internal Audit reported that she would be happy to share with Barry Mortimer the issues which had arisen across other Trusts with regard to Whistleblowing and expressions of concern.

<div align="right">**ACTION: HKT**</div>

Discussion took place regarding the Internal Audit Report on Whistleblowing which had received an overall 'significant' audit opinion, although concern was expressed at the low number of reported issues. The Committee discussed the various ways in which staff could raise concerns (i.e. Ask Owen, Datix, Divisional meetings) but there was no linkage of the available reporting pathways to the Whistleblowing process.

Peter Middleton felt that he was assured that there were systems in place but there was no clarity or cohesion.   Barry Mortimer agreed to let Peter Middleton have a copy of the Trust Policy for information.

<div align="right">**ACTION: BM**</div>

OUTCOME: The Committee **NOTED** the Whistleblowing report and the actions undertaken to further develop the process. It was noted that this annual report would be presented to the Board of Directors at its meeting on 2 February 2017.

6/17   **COMPANY SECRETARY'S BUSINESS**

The Company Secretary presented a number of reports relating to governance within the Trust.

1. REPORT ON CURRENT REGULATORY COMPLIANCE ISSUES

The Audit and Risk Committee were asked to receive the updated Regulatory Compliance Register and note that no breaches have arisen in meeting the deadlines.

The Committee received a verbal update on the outcome of the discussions at the Risk and Compliance Group meeting held the previous day when it was agreed that in future HR and Quality regulatory compliance issues would be included on the Corporate report.

OUTCOME: The Audit and Risk Committee **RECEIVED** the regulatory compliance register and **NOTED** that all appropriate submissions had been made within the deadlines.

2. REVIEW OF BOARD ASSURANCE FRAMEWORK

The Company Secretary presented the most up to date version of the Board Assurance Framework and discussion took place regarding movement on the framework. It was noted that the heat-map required amending and this was in hand.

The Chair raised the fact there was an increased risk of the construction price index rising due to Brexit and any delays in the reconfiguration process could affect the overall costs, and suggested that this should be included in the Risk Register.

Following discussion at previous meetings the Company Secretary gave a powerpoint presentation on the candour of the BAF and after reviewing and benchmarking a number of Trusts' a deep dive into the top themes.

The review confirmed that the Trust was in line with the top 10 themes of other Trusts and in providing candour of reporting but had identified a number of gaps. The gap issues identified were:-
- Business development and growth
- Inequalities
- Stakeholder and contractual relationships
- Partnership arrangements and conflict of priorities across health economies
- Delayed transfers of care; patient flow

It was noted that these findings would be presented to the Board of Directors Meeting on 2 February for consideration.

OUTCOME: The Committee **RECEIVED** and **NOTED** the updated Board Assurance Framework.

3. ARC WORKPLAN 2017

The Audit and Risk Committee reviewed and agreed the 2017 work plan. No amendments were requested.

OUTCOME: The Committee **RECEIVED** and **AGREED** the ARC work plan for 2017

4. SELF-ASSESSMENT OF COMMITTEES EFFECTIVENESS

The Company Secretary presented the Self-Assessment template. It was noted that as part of the strengthened governance arrangements, the Trust had implemented an annual review of effectiveness for each of the Board sub-committees. The results of the self-assessments will identify improvement actions, and an annual report of its work over the year will be brought to the Audit and Risk Committee.

OUTCOME: The Committee **AGREED** to **COMPLETE and RETURN** the Self-

Assessment questionnaire by close of play on **Wednesday 1 February 2017** in order that a composite, action plan and draft annual report can be taken to the 19 April 2017 ARC Meeting.

ACTION: ALL

5. REVIEW OF ARC ATTENDANCE REGISTER
The Committee received the draft attendance register and subject to two amendments it was approved.

OUTCOME: The Committee **RECEIVED and APPROVED** the ARC Attendance Record

7/17   EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS
1. Review Waiving of Standing Orders
The Deputy Director of Finance presented a report detailing the waving of Standing Orders during the third financial quarter of 2016/2017. During this quarter, 7 were placed as a result of standing orders being waived, at a total cost of £301,585.26. No amendments to earlier single sources were made this quarter.

There were 9 tender over the second quarter, the value of spend was £10,751,176.90

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

2. Review of Losses and Special Payments
In accordance with the Standing Financial Instructions, the Deputy Director of Finance presented the losses and special payments for the quarter ending 31 December 2016.

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

3. AGREE FINAL ACCOUNTS PROCESS AND PLANS
This item was included in the discussions held regarding the External Audit papers. It was noted that the Annual Report timetable for 2017-18 had been prepared in consultation with the Finance Team and Auditors. The Chairman asked that the meeting date for April ARC be amended to 19 April 2017.

OUTCOME: The Committee **AGREED** the Annual Report timetable subject to the amendment to the April ARC meeting to read 'Wednesday 19 April 2017'.

4. BAD DEBT WRITE OFF AND DEBT COLLECTION
The Deputy Director of Finance presented the Bad Debt Write Off and Debt Collection report. The Total debt recommended for write off was £14,436 comprising:-
Overseas Visitors x 3 £10,537
Overpayments x 2 £2,260
Other £1,238

The Committee discussed the item relating to two visits by one overseas visitor and the Executive Director of Finance assured the Committee that the Trust was doing everything possible to comply with the government directives.

OUTCOME: The Committee **APPROVED** the proposed write-offs.

5. DE-CONSOLIDATION OF CHARITABLE FUNDS FROM TRUST ACCOUNTS
The Deputy Director of Finance presented the paper which set out the rational for de-consolidating Charitable Funds from the Trust Annual Accounts numbers on the grounds of materiality.

It was noted that discussions had been held with the Trust's external auditors with regard to de-consolidating the Charitable Funds Accounts on the grounds that the

values consolidated for Charitable Funds are deemed not to be material from an audit point of view. It was noted that this would help improve the annual accounts process as the consolidation of the Charitable Funds accounts makes the process more complex and therefore heightens the chance of error.

The Charitable Funds Committee prepare Annual Accounts every year in their own right which are also audited by external audit and are submitted to the Charity Commission and so are available to the public

OUTCOME: The Committee recommended to the Board of Directors, as Trustees, the de-consolidation of Charitable Funds from Trust Accounts.

ACTION: PR – BOD 2.2.16

8/17   **INTERNAL AUDIT**

1. Review of Internal Audit Follow-up Report
The Internal Audit Manager presented the report and the highlighted the progress made around the recommendations. As discussed earlier in the meeting arrangements were being made for a process to be established whereby the Company Secretary will follow up outstanding audit recommendations as identified by Internal Audit and these will be re-audited.

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

2. Review of Internal Audit Progress Report
The Internal Audit Manager reported that since the last report to the Committee in October 2016 the following reports had been issued to and discussed with management:

Report No	Report	Opinion
CH/07/2017	ISO Compliance Programme, Phase 1	Significant
CH/08/2017	ISO Compliance Programme, Phase 2	Significant
CH/09/2017	Charitable Funds	Significant
CH/10/2017	Raising Concerns/ Whistleblowing	Significant
CH/11/2017	Winter Planning	Significant
CH/12/2017	Discharge Planning	Limited

The Committee discussed the one limited assurance report in more detail:

CH/12/2017 - Discharge Planning
The audit considered the internal processes that are necessary to facilitate the discharge of a patient. Issues were identified with the preparation of medication for the patient to take out. This process is based on a paper Drug Chart. This chart must be either reviewed by a pharmacist making a visit to the ward or delivered to them – usually at the end of the day, when it is more difficult to discharge someone. Any subsequent queries with the doctor writing the prescription can delay the process. The adoption of the EPR system will provide an on-line method of handling this process which should address these problems.

There are also delays in ordering equipment, to facilitate the patients discharge, as there is some confusion as to who is responsible and unnecessary or incomplete referrals for occupational therapy assessments are made which used limited resources, when not required.

The implementation of discharge co-ordinators has been a positive development and training is now in place for new appointees.

Discussion took place regarding the opportunities which could be available to the Trust in providing community care for patients and it was noted that work was underway through

a number of forums to address this issue.

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

3. INTERNAL AUDIT CHARTER
The Head of Internal Audit presented the Internal Audit Charter. It was noted that the Internal Audit Charter establishes the internal audit function's position within the Trust, confirming its purpose, ethics, and authority and describes how internal audit will fulfil its function. The need for an Internal Audit Charter is set out in the Public Sector Internal Audit Standards and this had been issued to all NHS Audit Yorkshire clients.

The Charter was approved, subject to amendments to terminology and reporting arrangements being reflected in the diagram.

OUTCOME: The Committee **APPROVED** the Internal Audit Charter subject to amendments.

9/17   LOCAL COUNTER FRAUD
1. Local Counter Fraud Specialist Progress Report
The Local Counter Fraud Specialist (LCFS) presented the progress report, based on the 2016/2017 Key Framework of Duties and which was approved by the Audit and Risk Committee in April 2016.

Progress has been made towards the delivery of the work plan, notably:-
- Regular talk at Nurse Induction mandatory training
- Liaison with the Director of WOD
- Guided tour around HPS with publicity and photos in newsletter
- Closer working with WOD including the introduction of a new protocol
- Implementation of new NHS Protect guidance regarding Agency Fraud.

In addition she updated the Committee on the live investigations being undertaken and progress being made.

The Chairman asked that the issue of reminding all staff regarding declarations of interests being returned be included in any induction/training meetings attended by the LCFS.

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

10/17   EXTERNAL AUDIT
1. TECHNICAL UPDATE
The Senior Manager for KPMG explained that the Technical Update was for information and highlighted areas of particular interest.

It was noted that this document would be circulated to the remaining Board Members for information.

ACTION: KB

OUTCOME: The Committee **RECEIVED AND NOTED** the Technical Update.

2. EXTERNAL AUDIT PLANS AND FEES
The Senior Manager for KPMG presented the External Audit Plan which outlined the approach and key risks covered by the KPMG External Audit plan for the 2016/17 financial year, covering the audit of the financial statements, use of resources and quality report. The Audit fee assumptions were expected to remain as the previous year at £56,000.

Discussion took place regarding:
- Going Concern Statement - The Executive Director of Finance suggested that the

narrative would follow the same guidelines as the previous year.
- EPR costs and capitalisation – The Committee welcomed feedback from External Audit following the February visit.

OUTCOME: The Committee **APPROVED** the External Audit Plans and Fees.

11/17   INFORMATION TO RECEIVE
The Committee **RECEIVED** the following minutes:
1. Quality Committee Minutes – 31.10.16 and 29.11.16
2. Risk & Compliance Group Draft Minutes – 13.12.16
3. THIS Executive Meeting Summary Notes – 10.10.16 and 23.11.16
4. Information Governance & Records Strategy Committee Minutes – 17.11.16
5. Nomination and Remuneration Committee (MC) Minutes – 18.10.16

Richard Hopkin suggested that periodically it would be helpful for the Committee to receive an update from the Risk and Compliance Group. The Head of Governance and Risk agreed that she would prepare a report twice per annum to outline the work of the RCAG.

It was noted that the work of the Quality Committee would be included in the Annual Report containing updates from all the Board Sub-Committees prepared by the Company Secretary.
ACTION: AM & ARC WORKPLAN

12/17   ANY OTHER BUSINESS
There was no other business raised.

13/17   MATTERS TO ESCALATE TO BOARD
The Committee noted the following items to be brought to the attention of the Board at its meeting on 2 February 2017:
- Payroll Progress Report – on-going
- Whistleblowing Report – cohesion of reporting
- BAF – review of candour, themes and gaps
- Waving of SOs
- Losses and Special Payments
- De-consolidation of Charitable Funds
- Internal Audit Report
  - Follow-up process
  - IA Progress report - (1 Limited – 5 Significant)
  - Internal Audit Charter
- LCFS report – focus on return of declarations of interest
- External Audit – Technical Update
- External Audit Plan and fees
- Minutes from sub-committees – two yearly reports from RCAG to ARC.

14/17   DATE AND TIME OF NEXT MEETING
Wednesday 19 April 2017 at 10.45 am – 3rd Floor Acre Mills Outpatient Building.

15/17   REVIEW OF MEETING
All present were content with the issues covered and the depth of discussion.

KB/VP/ARC-18.1.17