Calderdale and Huddersfield NHS

NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 2 March 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: Dawn Stephenson, Nominated Stakeholder Michelle Rich, Publicly Elected Veronica Maher, Publicly 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 2 February 2017	Chair	**APP A**	Approve
5	Action log and matters arising:	Chair	**APP B**	Review
6	Staff Story: To receive 'Patient Story through a Staff Lens' From Karen Melling, Matron – Pain Service and Endoscopy Units.	Executive Director of Nursing	**Presentation**	Note
7	Chairman's Report a. NAO Report – Health & Social Care Integration and Kings Fund - Key Messages	Chair	**APP C**	Note
8	Chief Executive's Report: a. Health Service Context	Chief Executive	**APP D**	Note
Transforming and improving patient care – no items				
9	EPR Operational Readiness	Chief Operating Officer	**Presentation**	Note
Keeping the base safe				
10	High Level Risks Register	Executive Director of Nursing	**APP E**	**Approve**

11	Governance report - Membership Council Elections Timetable - Performance Management Framework – update on work from Sub Committee Workplans	Company Secretary	**APP F**	**Approve**
12	Care of the Acutely Ill Patients Report	Executive Medical Director	**APP G**	**Approve**
13	Review of progress against strategy (quarterly update)	Director of Transformation and Partnerships	**APP H**	**Approve**
14	CQC Update on Action Plan	Executive Director of Nursing	**APP I**	**Approve**
15	Integrated Performance Report	Chief Operating Officer	**APP J**	**Approve**
Financial Sustainability				
16	Month 10 – 2016-2017 – Financial Narrative	Executive Director of Finance	**APP K**	**Approve**
A workforce for the future – no items				
17	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – verbal update from meeting of 27.2.17 and draft minutes of 30.1.17 ▪ Finance and Performance Committee – verbal update from meeting 28.2.17 and minutes of 31.1.17 ▪ Workforce Well Led Committee draft minutes of 19.1.17 and 16.2.17 meetings ▪ Health and Safety Policy - Updated		**APP L**	**Receive**
Date and time of next meeting Thursday 6 April 2017 commencing at **8.30 am** **Venue: Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary**				

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 2nd March 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 2.2.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 2 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 minutes of the last Public Board of Directors Meeting held on Thursday 2 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 minutes of the last Public Board of Directors Meeting held on Thursday 2 February 2017.

Appendix

Attachment:

draft BOD MINS - PUBLIC - 2.2.17.pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 2 February 2017 in the Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary.

PRESENT

Andrew Haigh	Chairman
Owen Williams	Chief Executive
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
Jan Wilson	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

OBSERVER

Peter Middleton	Public Elected Membership Councillor
Eileen Hamer	Staff Elected Membership Councillor
Tamsyn Grey	Consultant Surgeon (for item 25/17 - Staff Story)

20/17 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

21/17 APOLOGIES FOR ABSENCE

Apologies were received from: Sharon Lowrie, Nominated Stakeholder

22/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

23/17 MINUTES OF THE MEETING HELD ON 5 JANUARY 2017

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

OUTCOME: The minutes of the meeting were approved

24/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG

9/17 – International Staff – The Executive Director of Workforce and OD reported that information was still awaited from NHS Protect.

9/17 – Risk Register - Heat Map – The Executive Director of Finance advised that the heat map Cash Flow risk rating score had now been amended as discussed at the last meeting.

11/17 – Governance Report – The Company Secretary reported that clarity between members of the Workforce Well-led Committee and attendees had been undertaken on the Terms of Reference.

14/17 - Public Sector Equality Duty Report – The Company Secretary reported that the Public Sector Equality Duty Statement had now been uploaded to the Trust Website.

168/16 - Well Led Governance Assessment – The Company Secretary advised that the workshop scheduled for December had not taken place. She explained that NHS Improvement were consulting on the format of the Well-Led Governance Assessment and the closing date for feedback was the 14 February. A teleconference on this was due to take place the following week. it was agreed that this remain open on the Action Log for a report to come back in March 2017.

ACTION: BOD Agenda – 2.3.17

175/16 - Update From Sub-Committees – Declarations of Interests – The Company Secretary advised that Guidance was still awaited. It was requested that this remain open on the Action Log for a report to come back in March 2017.

ACTION: BOD Agenda – 2.3.17

184/16 - Financial Sustainability of the NHS Report
It was noted that Individual meetings between the Chair and Chief Executives of Locala, SWYPFT and Calderdale and Kirklees Councils had been arranged to take place during March/April 2017.

25/17 STAFF STORY – ROLE AS GUARDIAN OF SAFE WORKING

Tamsyn Grey, Consultant Surgeon attended the meeting to update the Board on her role as Guardian of Safe Working, a role she had been undertaking since October 2016.

The background to the setting up of this role following the introduction of the revised contracts for junior doctors was noted. It was noted that the Guardian was responsible for overseeing the exception reports and reporting to the Local Negotiating Committee and Board via Well-led Committee. A report will also be included in the Trust's Annual Report and Accounts. It was within the Guardian's remit to issue fines where required. To date no fines had been issued.

The ongoing issues within the Trust were discussed and the Chief Executive asked about pressures and where the Board could offer support. It was noted that work was being undertaken to link the role into the operational management of the Trust rather than being seen as a stand-alone role. Medical workforce/agency was being reviewed to ensure that safe working is embedded in the organisation. It was noted that there was no administrative support available with this post and the Executive Director of Workforce and OD agreed to look into this.

Discussion took place regarding rota/work plan software used in the organisation and it was agreed that the Executive Medical Director/Executive Director of Workforce and OD/Executive Director of Nursing, Director of THIS and Chief Executive would discuss this outside the meeting.

ACTION: DB/IW/BB/OW/MG

OUTCOME: It was agreed that Medical Workforce would be raised at the Workforce Well-Led Committee to be held on 16.2.17 to clarify the role of the Guardian on Safe Working and the responsibility of both educational supervisors and General Managers in ensuring this is an effective process and is embedded into the organisation. This

would be brought back to the Board through the Workforce Well-led Committee minutes in March 2017.

26/17 CHAIRMAN'S REPORT

a. Membership Council Meeting – 17.1.17

The Chairman updated the Board on the key highlights from the Membership Council Meeting held on 17.1.17. This included agreement through discussion of the Membership Councillors present to change the name from 'Membership Council' to 'Council or Governors'. However, it was noted that the meeting had not been quorate at this point. The Company Secretary was reviewing this amendment, along with other amendments required to the Constitution and would be presented to the Membership Councillors at their next meeting on the 5 April 2017.

b. NHSI Improvement Meeting

The Chairman reported that the Non-Executive Directors had been encouraged to get involved in the Model Hospital Portal and interest from any Non-Executive Directors willing to champion this were welcome.

OUTCOME: The Board **NOTED** the update from the Chairman.

27/17 CHIEF EXECUTIVE'S REPORT

The 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 Chief Executive.

28/17 RISK REGISTER

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

These were:-
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Staffing risk, nursing and medical
6131 (20) :Service reconfiguration
5806 (20): Urgent estates schemes not undertaken
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 scores

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

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

Discussion took place regarding the challenging period during the pre and post EPR implementation time and it was suggested that consideration be given to the risk rating

regarding this, taking into account the possibility of a CQC re- inspection.

ACTION: Executive Director of Nursing

OUTCOME: The Board agreed that a review of the narrative of the Risk Register be undertaken at year-end in order to archive risks as appropriate and identify tolerance ratings for endemic risks. It was agreed that this would be undertaken by the Executive Director of Nursing and Company Secretary and would be taken through the Audit and Risk Committee for review before returning to Board in May 2017.

ACTION: BB/VP/ARC and BOD Agenda item May 2017.

29/17 BOARD ASSURANCE FRAMEWORK

The Company Secretary reported that 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 were presented to the Board for approval.

It was noted that in addition, at the 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. This work had been undertaken and a number of areas were proposed for further consideration as part of the annual review of the BAF.

It was noted that there are two risks with an increased score; four risks with a decreased score; and no closed or opened risks.

The 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.

The Chief Operating Officer added that a Patient Flow risk should also be included in the BAF with relation to STF funding and the reflection of not potentially getting funding in March 2017.

- 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.

The Chief Executive asked that the Finance and Performance Committee consider whether it was still relevant to reflect non-compliance with the NHS Improvement/Regulator now that the Trust was on a normalised reporting regime. It was felt that this would be reviewed through the Single Oversight Framework.

ACTION: F&P Committee

OUTCOME: The Board **APPROVED** the Board Assurance Framework and proposed areas for further consideration.

30/17 GOVERNANCE REPORT

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

a. Standing Orders for the Membership Council

The Membership Council had reviewed its Standing Orders at its meeting in January and had approved them for ratification by the Board of Directors. The amendments made reflected 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.

b. Terms of Reference

- Quality Committee
- Finance and Performance Committee
- Audit and Risk Committee
- Nomination and Remuneration Committees (BOD) and (MC)

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 had been amended to reflect the revised sub-group governance arrangements and to clarify membership and attendance at the meetings.

OUTCOME: The Board **APPROVED** the Governance Report.

31/17 WHISTLEBLOWING ANNUAL REPORT

The Executive Director of Workforce and OD together with Dr David Anderson, Non-Executive Director and Freedom to Speak Up to Guardian presented the Whistleblowing Annual Report. It was noted that this had been discussed in detail at the Audit and Risk Committee held on 18 January 2017.

The Board agreed that it was important to ensure that staff have a variety of routes to raise concerns/whistle-blow. It was acknowledged that some data was outside of this report and the Executive Director of Workforce & OD agreed to look into this.

It was agreed that a greater awareness of the Raising Concerns/Whistleblowing process was required in the Trust and this would be taken through the Workforce Well-led Committee and actions reported back to the Board in 3 months' time.

ACTION: Executive Director of Workforce & OD
BOD Agenda item May 2017

OUTCOME: The Board **APPROVED** the Annual Whistleblowing Report.

32/17 DIRECTOR OF INFECTION, PREVENTION AND CONTROL UPDATE

The Executive Medical Director presented the DIPC quarterly report. The contents were noted and the highlights were:-

- Overall performance of the Trust was quite strong.
- C.difficile - Year to date 25 cases (5 avoidable and 18 unavoidable cases)
- MSSA - Year to date performance 11
- E.coli Bacteraemia (post admission) Year to date 34 MRSA screening (electives) 95.14%
- ANTT competency assessment (doctors) - Year to date 77.2% - 4% increase in last 3 months.
- ANTT assessments (nursing and hand hygiene) YTD 84.4% - 3% increase in the last 3 months. Overall compliance with ANTT was improving within the Trust.

Linda Patterson suggested that thought be given as to whether there was sufficient capacity for Outpatient Parenteral Antibiotic Therapy (OPAT) antibiotics services. It was noted that the OPAT communications within the organisation would be undertaken

through the Ambulatory service and further awareness of this service would be communicated as appropriate.

OUTCOME: The Board **NOTED** the contents of the DIPC quarterly report

33/17 **INTEGRATED PERFORMANCE REPORT**

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

- December's Performance Score is 65% for the Trust
- High number of patients – issues with capacity due to norovirus at Calderdale Royal Hospital(CRH).
- Challenging over the Christmas period with two occasions of instigating silver command.
- SAFE was achieving a green rating following improvement in Harm Free Care and without the impact of November's never event.
- CARING and RESPONSIVE domains were just short of the green rating.
- Stroke Patients – deterioration on CRH site due to norovirus.
- A/E Dept breaches – compounded by norovirus.
- Complaints – Focussed piece of work on going around investigation reviews
- Workforce – Recruitment on going for nursing and bank staff with an incentive of weekly paid staff system being put in place.
- Mandatory Training – The Chief Executive reported that WEB had discussed the possibility of identifying which, if any, mandatory training could be deferred until after the EPR training has been undertaken. The outcome would be brought to the Board in March.

ACTION: EXECUTIVE DIRECTOR OF WORKFORCE & OD AND BOARD AGENDA ITEM – MARCH 2017

- Emergency Care – The Trust had continued to deliver good performance against the Emergency Care Standard (ECS) and despite narrowly missing the 95% target had secured access to Sustainability and Transformation funding to the end of quarter 3 by complying with the agreed trajectory.
  The A/E Department had seen a higher attendance rate than last year and assurance given that all patients were being dealt with in a safe and caring environment.
  Work continued with Calderdale and Kirklees Councils to reduce delayed transfers in care.
  On behalf of the Membership Council Peter Middleton wished to thank all staff particularly the A/E team for their work over the Christmas period.

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

34/17 **MONTH 9 – 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 31 January 2017.

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 the Trust's 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. Operational actions that have been put in place to curb the use of agency have started to impact positively. The 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 months 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.

Summary

- 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.

OUTCOME: The Board **APPROVED** the Month 9 financial narrative and **NOTED** the continued financial challenges.

35/17 BOARD RESOLUTION – CONVERSION OF WORKING CAPITAL FACILITY TO INTERIM REVENUE SUPPORT LOAN

The Executive Director of Finance updated the Board on the conversion of the working capital facility to an interim revenue support loan. It was noted that this had been discussed in detail at the Finance and Performance Committee meeting held on the 31 January 2017.

It was noted that 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 the interest payments by circa £0.04m per month (£0.54m per year).

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.

The Board approved the following resolution 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.

OUTCOME: The Board **APPROVED** the conversion of working capital to an interim revenue support loan in accordance with the above resolution.

36/17 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

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

a. Quality Committee

Dr Linda Patterson, Chair of the Quality Committee reported on the items discussed at the meeting held on 30 January 2017 which had not been previously covered on the Board's agenda:

- Organ Donation Presentation – it was suggested that this presentation might be used for a future Board agenda 'Patient Story'.
- Quality Report – the format had been revised with highlights.
- Safeguarding Report – Assurance with safeguarding Mental Health Goals. Training on going.
- CQC Report – update on actions completed received.
- Research and Development portfolio – Thanks were given to the R&D team for their work in raising the profile of both clinical and non-clinical research and development within the organisation.

OUTCOME: The Board **RECEIVED** the verbal update and the minutes of the meeting held on 3.1.17.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 31.1.17:

- Terms of Reference approved
- EPR implementation and risks discussed.
- Discussion regarding financial performance to date and forecast risks.
- Cash position and work of Cash Committee – to be brought to future meeting.
- Diagnostics – further report on capacity to be brought to future meeting.
- 2017/18 CIP position risks acknowledged.

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

c. Draft Membership Council Minutes – 17.1.17

The Board **RECEIVED** the draft Membership Council Meeting minutes from the meeting held on 17.1.17 and referred to earlier in the Chairman's report.

e. Audit and Risk Committee

The Board **RECEIVED** the draft Audit and Risk Committee Minutes from the meeting held on 18.1.17. The key issues were:-

- Whistleblowing Report – Coherence of reporting an issue.
- Internal Audit Reports – 1 with limited assurance – 'Discharge Planning'; 5 with significant assurance.
- De-consolidation of Charitable Funds – recommended for approval by the Board and approved.

f. Workforce Committee

Karen Heaton, Chair of the Workforce Well-led Committee reported on the items discussed at the meeting held on 19.1.17:-

- Workforce Strategy received and continues to be refined.
- Medicine Division invited to next meeting re Agency Plan to offer support.
- EPR Training – update/discussion regarding mandatory training requirements.
- Staff Survey – presentation expected to next meeting along with WRES Action Plan.
- Equality and Diversity Training for Non-Executive Directors - discussed. It was noted that the Company Secretary was proposing an annual (as required) Development Session all Non Executives to complete their mandatory training.
- Sickness and absence targets reviewed. Discussion took place regarding the sickness and absence targets and it was agreed that these would be brought to the next meeting.

OUTCOME: The Board **RECEIVED** the verbal update from the meeting held 19.1.17.

37/17 DATE AND TIME OF NEXT MEETING

Thursday 2 March 2017 commencing at 9.00 am in Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary.

The Chair closed the public meeting at 11:00 am.

DRAFT

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 2nd March 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 March 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 March 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 March 2017

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 March 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
165/16 3.11.16	**BOARD ASSURANCE FRAMEWORK** It was agreed to bring the Board Assurance Framework to the Board in February and for the Company Secretary to review other organisations' BAFs to assess the types of risks included	VP	**1.12.16** It was agreed that the Company Secretary would undertake a deep dive of the top themes and bring back to the Board anything which would benefit changing on the BAF in February 2017. **2.2.17** Compliance with NHSI was discussed and the Board questioned whether this was still relevant. It was agreed that this would be further discussed through the Finance and Performance Committee.	2.3.16		
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. **2.2.17** A teleconference was due to take place the w/c 6.2.17 and therefore it was requested that this remain open on the Action Log.	2.3.17		
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	**2.2.17** The Company Secretary advised that Guidance was still awaited. It was requested that this remain open on the Action Log for a report to come back in March 2017.	2.3.17		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 March 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
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 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.	OW	**2.2.17** Individual meetings between the Chair and Chief Executives of Locala, SWYPFT and Calderdale and Kirklees Councils had been arranged to take place during March/April 2017.			2.2.17
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		
25/17 2.2.17	**STAFF STORY – ROLE AS GUARDIAN OF SAFE WORKING** Discussion to take place around the rota / work plan software used in the Trust	IW / DB / BB / MG		2.3.17		
31/17 2.2.17	**WHISTLEBLOWING ANNUAL REPORT** It was agreed that a greater awareness of the Raising Concerns/Whistleblowing process was required in the Trust and this would be taken	IW		4.5.17		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 March 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	through the Workforce Well-led Committee and reported back to the Board in 3 months' time.					
28/17 2.2.17	**RISK REGISTER** Board agreed that a review of the EPR risk and its relation to a potential CQC re-inspection be considered alongside a review of the narrative at year-end in order to archive risks as appropriate and identify tolerance ratings for endemic risks. It was agreed that this would be undertaken by BB and VP and would be taken through the Audit and Risk Committee for review before returning to Board in May 2017.	BB/VP/ARC		4.5.17		
33/17 2.2.17	**MANDATORY TRAINING** OW reported that WEB had discussed the possibility of identifying which, if any mandatory training could be deferred until after the EPR training has been undertaken. Outcome would be brought to the Board in March.	OW/IW		2.3.17		

National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health, Department for Communities and Local Government and NHS England

Health and social care integration

HC 1011 SESSION 2016-17 8 FEBRUARY 2017

Key facts

£5.3bn
total pooled budget in the first year of the Better Care Fund

£511m
Departments' and partners' estimated savings from the first year of the Better Care Fund

2020
target date for integrated health and social care services across England

87,000	actual increase in emergency admissions to hospitals between 2014-15 and 2015-16, against a planned reduction of 106,000, as reported in Better Care Fund metrics
185,000	actual increase in delayed transfers of care between 2014-15 and 2015-16, against a planned reduction of 293,000, as reported in Better Care Fund metrics
628	permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population in 2015-16, exceeding the target of 659 per 100,000
82.7%	of older people who were still at home 91 days after discharge from hospital receiving reablement or rehabilitation services in 2015-16, exceeding the target of 81.9%
£900 million	NHS England's expectations of savings from the roll-out of new care models by 2020
90%	proportion of local areas that agreed or strongly agreed that the delivery of the Better Care Fund plans had a positive impact on integration locally
£2.1 billion	NHS Sustainability and Transformation Fund for 2016-17, of which £1.8 billion was allocated to covering NHS deficits rather than transformation

Summary

1 Integration is about placing patients at the centre of the design and delivery of care with the aim of improving patient outcomes, satisfaction and value for money. Rising demand for care services, combined with restricted or reduced funding, is putting pressure on the capacity of both local health and social care systems. The Department of Health, the Department for Communities and Local Government (the Departments) and NHS England are trying to meet the pressures on the systems. They are doing this through a range of ways intended to transform the delivery of care, one of which is to integrate health and social care services at the local level.

2 Integration aims to overcome organisational, professional, legal and regulatory boundaries within the health and social care sectors, to ensure that patients receive the most cost-effective care, when and where they need it. Some barriers to integrated care are substantial. England has legally distinct health and social care systems. The NHS is free at the point of use, while local authorities typically only pay for individual packages of care for adults assessed as having high needs and limited means. Both systems are in turn made up of a complex range of organisations, professionals and services.

3 The Department of Health is responsible for health and adult social care policy in England. The Department for Communities and Local Government has responsibility for the local government finance and accountability system. NHS England is responsible for supporting clinical commissioning groups and for the commissioning of NHS services overall. The two Departments and NHS England are trying to address funding and demand pressures by supporting local authorities and NHS bodies to integrate services.

4 The Departments and NHS England do not prescribe how organisations in a local area should integrate services. Local areas can choose to integrate services in a broad range of ways and how they do so depends on the needs of the local population, and on existing care services and structures. Integration is not about organisations merging and can cover a range of types of cooperation. For example:

- at patient level, local areas can introduce joint assessments of a patient's care needs across more than one service and involving more than one care professional;
- at service level, local areas can bring together several services into one place for people with a single condition, such as diabetes; and
- at organisational level, local areas can pool budgets or jointly commission services.

5 The Departments and NHS England have made a number of commitments concerning integration.

- The 2010 Spending Review announced the transfer of £2.7 billion from the NHS to local authorities over the four years to 2014-15, to promote better joined-up working.
- The 2013 Spending Review announced that, in 2015-16, the Departments, NHS England and the Local Government Association would create the Better Care Fund. The Fund requires local health bodies and local authorities to pool existing funding and produce joint plans for integrating services and reducing pressure on hospitals. In 2015-16, the Fund's minimum pooling requirement was £3.8 billion. This comprised a pre-existing transfer of £1.1 billion from the NHS to social care, an additional transfer to the pooled budgets of £1.9 billion from the NHS, and £0.8 billion of other health and care funding streams. Some local areas chose to pool more than the minimum requirements, resulting in a total pooled Fund of £5.3 billion.
- In 2013, the Department of Health launched the five-year Integrated Care and Support Pioneers Programme to support its commitment for "urgent and sustained action" to make joined-up and coordinated health and care the norm by 2018.
- In 2014, NHS England published its *Five Year Forward View*, setting out how it aims to achieve a financially sustainable health and care system by 2020 including through integration.
- The government reiterated its commitment to joining up health and social care in the Spending Review and Autumn Statement 2015. It stated that locally led transformation of health and social care delivery has the potential to improve services for patients and unlock efficiencies. It delayed until 2020 its target date for health and social care to be integrated across England, with local areas required to produce a plan by April 2017 for how they would achieve this.

Scope of our report

6 We looked at how integration is progressing within and between the separate adult social care and health systems and the extent to which it has benefitted patients. We examined:

- the case for integrating health and social care (Part One);
- the progress of national initiatives, including the first year of implementation of the Better Care Fund (Part Two); and
- the plans for increased integration (Part Three).

7 Our report focuses on services providing direct care to patients and does not cover other public services that affect people's wellbeing, such as housing and leisure services.

Key findings

The Departments' case for integrating health and social care

8 **Rising demand for services, combined with restricted or reduced funding, is putting pressure on local health and social care systems.** Between 2011-12 and 2015-16, spending by NHS trusts and NHS foundation trusts increased by 11%, while local authority spending on adult social care has reduced by 10% since 2009-10. However, the number of people aged 65 and over in England is increasing at more than twice the rate of increase of the population as a whole. This number is projected to increase by 21% between 2015 and 2025. Key measures of the performance of health and social care sectors are worsening. For example, between November 2014 and November 2016, delays in discharging patients from hospital increased by 37%. The two main reported reasons for this increase were patients waiting for a care package in their own home and patients waiting for a nursing home placement. These trends indicate that an ageing population is putting pressure on hospitals and social services (paragraphs 1.5 and 1.6).

9 **Nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services.** Since the Health Act 1999 allowed local authorities and the NHS to pool budgets and merge care services, the Departments have supported local bodies to collaborate and trial various approaches to integrating care. However, shifts in policy emphasis and reorganisations which promote competition within the NHS, such as the move from primary care trusts to clinical commissioning groups in 2013 and the Health and Social Care Act 2012 have complicated the path to integration (paragraphs 1.10 to 1.12).

10 **The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients.** The Departments have not tested integration at scale and are unable to show whether any success is both sustainable and attributable to integration. International examples of successful integration provide valuable learning but their success takes place in a context of different statutory, cultural and organisational environments (paragraphs 1.11 to 1.13, 2.13, 2.15, 2.18 and 2.19).

11 **There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity.** While there are some positive examples of integration at the local level, evaluations of initiatives to date have found no evidence of systematic, sustainable reductions in the cost of care arising from integration. Evaluations have been inhibited by a lack of comparable cost data across different care settings, and the difficulty of tracking patients through different care settings. As we stated in our November 2014 report *Planning for the Better Care Fund*, providers of health and social care have fixed costs. Therefore reductions in activity do not necessarily translate into sizeable savings unless whole wards or units can be decommissioned (paragraphs 1.11, 1.12, 2.5, 2.18 and 3.23).

Progress with national integration initiatives

12 The Departments' expectations of the rate of progress of integration are over-optimistic. Embedding new ways of working and developing trust and understanding between organisations and their leaders are vital to successful integration. This can take many years because the cultures and working practices in the health and local government sectors are very different. Local areas that have achieved more coordinated care for patients from closer working between social care and NHS organisations have been doing so for up to 20 years. An April 2016 review of integration across England commissioned by the government found that local areas had made limited progress with integration. Local areas need to know that the Departments have a sustained commitment to integration given the length of time that it takes to establish and the investment required (paragraphs 2.5, 2.13, 2.17 and 3.22).

13 Nationally, the Better Care Fund did not achieve its principal financial or service targets over 2015-16, its first year. The principal financial goal for 2015-16 was that the Fund would achieve savings of £511 million, based on local plans. The principal service measure was the reduction of demand for hospital services as a clear indicator of the effectiveness of integrated local health and social care services. Local areas planned to reduce emergency admissions by 106,000, saving £171 million. However, in 2015-16 the number of emergency admissions increased by 87,000 compared with 2014-15, costing a total of £311 million more than planned. Furthermore, local areas planned to reduce delayed transfers of care by 293,000 days in total, saving £90 million. However, the number of delayed days increased by 185,000 compared with 2014-15, costing a total of £146 million more than planned. The Departments and partners did not monitor or track the achievement of savings at the local level as they had no mandate to do so. In our November 2014 report *Planning for the Better Care Fund*, we cautioned that the Fund made bold assumptions about the financial savings expected that were based on optimism rather than evidence. The Departments recognise that the Fund's performance metrics are affected by factors that are outside of the Fund's influence (paragraphs 2.6 to 2.11).

14 Local areas achieved improvements in two areas at the national level. They reduced permanent admissions of older people (aged 65 and over) to residential and nursing care homes. They also increased the proportion of older people still at home 91 days after discharge from hospital receiving reablement or rehabilitation services. The Better Care Fund has been successful in incentivising local areas to work together: more than 90% of local areas agreed or strongly agreed that delivery of their plan had improved joint working (paragraphs 2.6 to 2.11).

15 The Departments are simplifying the Better Care Fund's assurance arrangements and will provide more funding from 2017-18. In response to feedback from local areas the Departments plan to reduce the number of national conditions that local areas must meet from eight to three. Between 2017-18 and 2019-20, the Departments are supplementing the Fund with £2.4 billion of additional resources. From 2017-18, the Departments plan to allow areas with more advanced integrated working to graduate from the Fund's programme management. The Departments have not yet published guidance for Fund planning for 2017–2019 (paragraphs 2.11, 3.7, 3.8 and 3.22).

16 The Integrated Care and Support Pioneers Programme has not yet demonstrated improvements in patient outcomes or savings. An early evaluation of the programme found little evidence of major service change being implemented or of measurable impacts on local services, such as improved cost-effectiveness or patient experience of care. The evaluation was predominantly focused on describing the setting up of local programmes and individual projects. It concluded that it was too early to identify potential improvements at this stage in the implementation process (paragraphs 2.12 to 2.15).

17 NHS England's ambition to save £900 million through introducing new care models may be optimistic. The *Five Year Forward View* describes seven new care models that integrate services around the patient, including, where relevant, social care. NHS England is developing these models across England, including at 50 'vanguard' test sites. NHS England hopes to reduce growth in hospital activity from 2.9% to 1.3% by 2020-21, in part through the new care models. It expects the new care models to achieve savings of £900 million by 2020-21. However, the new care models are as yet unproven and their impact is still being evaluated. NHS England plans to have evaluated the effectiveness and value for money of the new care models programme by the end of 2018. Despite this, the NHS mandate requires NHS England to roll out the new care models rapidly; achieving 20% coverage by the end of 2016-17 and 50% by 2020 (paragraphs 1.13 and 2.16 to 2.19).

The Departments' plans for integration

18 The Departments and their partners are still developing their understanding of how to measure progress in integrating health and social care. They plan to agree a definition of integrated care focused on patient experience. The Departments are planning to publish an integration standard describing the core elements of an integrated health and care system, although a review of the draft standard found important gaps. The Departments plan to build on the standard with a proposed integration scorecard to measure the impact of integration on patients, their health and care outcomes, and the financial savings for organisations (paragraphs 1.9 and 3.16 to 3.18).

19 The Departments' governance and oversight across the range of integration initiatives is poor. The Departments and their partners have set up an array of initiatives examining different ways to transform care and create a financially sustainable care system. However, the Integration Partnership Board receives updates on progress of the Better Care Fund only with no reporting from other integration initiatives. The ministerial Health and Social Care Integration Implementation Taskforce did not meet regularly and has now been disbanded. The lack of comprehensive governance is leading to uncoordinated effort across central bodies and the Department of Health has now initiated a review of governance arrangements. The Department of Health has not clarified how the Better Care Fund aligns with the new sustainability and transformation planning process (paragraphs 3.20 and 3.21).

20 The Departments are not systematically addressing the main barriers to integration that they have identified. The Departments do not have specific work streams to bring together, monitor and evaluate findings from various integration initiatives and emerging best practice. The three barriers – misaligned financial incentives, workforce challenges and reticence over information-sharing – are long-standing and ones which we have identified in our reports dating back to 2003. The misalignment of financial incentives arises in part from the difference between the separate health and social care systems, which are free and means-tested respectively. It also arises in part from the creation of payment systems in the NHS that promote competition and drive activity in hospitals. Creating an integrated workforce is inhibited in many local areas by difficulty in recruiting and retaining staff, particularly in community care. In our fieldwork we found a lack of understanding at the local level about whether and how patient data could be linked (paragraphs 2.14, 3.6, 3.23 and 3.24).

21 Without full local authority engagement in the joint sustainability and transformation planning process, there is a risk that integration will become sidelined in the pursuit of NHS financial sustainability. There is general agreement across the health and social care sectors that place-based planning is the right way to manage scarce resources at a system-wide level. However, local government was not involved in the design and development of the NHS-led sustainability and transformation planning process. The engagement of local authorities has improved for the local planning and decision-making phase of the process, with four of the 44 local sustainability and transformation plan footprint areas led by local authority officials, but overall engagement to date has been variable (unlike their more structured engagement with the Better Care Fund). The process is widely regarded as NHS-led and NHS-focused. The Departments have dropped requirements for local areas to produce a separate plan by April 2017 showing how they would integrate health and social care by 2020. Instead, local areas must demonstrate this through their 2017–2019 Better Care Fund plans, and sustainability and transformation plans. Research commissioned by the government in 2016 concluded that local areas are not on track to achieve the target of integrated health and social care across England by 2020 (paragraphs 3.12 to 3.14 and 3.22).

22 NHS England has not assessed how pressures on adult social care may impact on the NHS. NHS England has noted that the widening gap between the availability of, and need for, adult social care will lead to increases in delayed discharges and extra pressure on hospitals. However, we did not see any estimate of the impact on NHS bodies of pressures on social care spending (paragraph 3.4).

23 NHS England is diverting resources away from long-term transformation to plug short-term financial gaps. NHS England has set up the Sustainability and Transformation Fund to pay for transformation between now and 2020, including work to integrate local care services. However, so far most funding is being used to address the deficits of NHS trusts. NHS England has used £1.8 billion (86%) of the £2.1 billion available in the Sustainability and Transformation Fund for 2016-17 to meet provider deficits. It has said it will continue to use the Sustainability and Transformation Fund to meet provider deficits in 2017-18 and 2018-19. The £0.3 billion of the Sustainability and Transformation Fund left for transformation in 2016-17 includes funding for new care models 'vanguard' sites and is available only where organisations meet control totals and performance trajectories (paragraphs 3.10 and 3.11).

Conclusion on value for money

24 Joint working between the NHS and local government to manage demand and support out-of-hospital care through integration could be vital to the financial sustainability of the NHS and local government. The Better Care Fund has increased joint working and the provision of integrated services. However, in the face of increased demand for care and constrained finances, the Fund has not yet achieved its potential to manage demand for healthcare; support out-of-hospital care; improve outcomes for patients; or save money. A key assumption of the Fund – that funding could be transferred from the health sector to social care without adverse impact on the NHS – has proved not to be the case because the health service itself is under financial pressure. As a result, the Fund has not achieved the expected value for money, in terms of savings, outcomes for patients or reduced hospital activity, from the £5.3 billion spent through the Fund in 2015-16.

25 Sustainability and transformation plans could be, but are not yet, a vehicle for joint health and care planning. Unless the Departments decide to formally align local health and adult social care planning, there is a significant risk of sidelining the Better Care Fund and missing the goal of integrating health and social care services across England by 2020. To support that process we would reiterate our 2014 emphasis on the need for robust evidence on how best to improve care and save money through integration and for a coordinated approach. The Departments do not yet have the evidence to show that they can deliver their commitment to integrated services by 2020, at the same time as meeting existing pressures on the health and social care systems.

Recommendations

26 The Departments, NHS England and NHS Improvement are all working on integrating health and social care services. They face two main challenges: providing the environment within which integrated services can succeed and benefit patients; and creating a robust evidence base demonstrating the scalability and replicability of cost-effective integration initiatives. The Better Care Fund has not led to the intended improvements over its first year and the other current integration initiatives are making slow progress. Nevertheless, the government has underscored its commitment to integration through announcing additional contributions to the Better Care Fund from 2017-18. We recommend that the Departments and their national partners:

a **Confirm whether integrated health and care services across England by 2020 remains achievable.** Progress with integration has, to date, been slower and less successful than expected. Financial pressures are increasing for both health services and local government and it is not clear that integration will alleviate these pressures or improve services for patients. The Departments should therefore assess the achievability and benefits from seeking integrated services by 2020.

b **Establish the evidence base for what works in integrating health and social care as a priority.** The existing evidence base does not yet support the proposition that integration saves money, reduces hospital activity or improves patient outcomes. There is much work under way to evaluate current initiatives and the timely dissemination of the outcome of evaluations will support local decision-making and allocation of resources.

c **Review whether the current approaches to integrated health and social care services being developed, trialled and implemented are the most appropriate and likely to achieve the desired outcomes.** While popular approaches, such as multi-disciplinary teams focusing on patients with multiple and complex needs, may improve the care experience for a minority of patients, the evidence to date does not suggest that they will achieve the widespread efficiencies and outcomes needed in the current financially constrained times. The Departments and their partners should support local areas by identifying, from the available evidence, which forms of integration are most likely to lead to the desired outcomes at this time. This might include focusing on particular cohorts of patients, particular pathways of care or particular groupings of health and care services.

d **Bring greater structure and discipline to their coordination of work on the three main barriers to integration – misaligned financial incentives, workforce challenges and reticence over information-sharing.** Local areas are finding these barriers difficult or impossible to overcome at the local level, and the Departments recognise that national approaches are required. The Departments and their partners should consider whether local areas need increased support and guidance to find local solutions, for example to overcome difficulties in recruiting and retaining care workers or to facilitate data-sharing and governance; or whether effort is needed at the national level, such as changes to financial arrangements to better align incentives across the health and care systems.

e **Set out how planning for integration will be on a whole-system basis, with the NHS and local government as equal partners.** Currently, the Better Care Fund is widely regarded as an initiative that primarily benefits local government, and consequently health bodies can become disengaged. At the same time the sustainability and transformation planning process is widely regarded as an initiative to support NHS financial planning, and local authorities can become disengaged. Both initiatives have integration of health and social care services as central to reform across local areas. The Departments and partners should set out clearly how the two initiatives align and support one another, how both local government and health bodies should contribute to achieving mutually agreed goals, and how they will support local bodies where local relationships are not working well.

f **Put in place appropriate national structures to align and oversee all integration initiatives as a single, coordinated programme.** Currently, there is no single body or board with oversight of all the ongoing initiatives, which may mean that learning is not being shared quickly and effectively, and that effort is being duplicated. Given the speed with which local areas need to move towards integrated health and social care systems, the current slow pace of progress, and the seeming intractability of some barriers to progress, it is essential that the Departments and their partners improve their central role in overseeing integration in a holistic way and in providing support to local areas.

g **Complete their development of measures that capture the progress of implementing more patient-centred integrated care.** The Departments are expecting local areas to roll out integrated services rapidly over the three remaining years to 2020, and it is essential that they have accurate and up-to-date information on the progress being made. Local areas need to have a clear definition of what they are working towards to achieve integrated health and care services.

Key messages

- The *NHS five year forward view* set a direction for the future of the NHS that has been widely supported.
- Sustainability and transformation plans (STPs) – the local plans for delivering the Forward View based on 44 geographical 'footprints' in England – offer the best hope for the NHS and its partners to sustain and transform the delivery of health and care.
- The context in which STPs have emerged is much more challenging than when the Forward View was published, with the NHS now facing huge financial and operational pressures.
- The changes outlined in STPs could help address these pressures, but there is a risk that work to sustain services will crowd out efforts to transform care.
- Proposals set out in the 44 STPs submitted in October 2016 need to be developed into coherent plans, with clarity about the most important priorities in each footprint.
- A high priority is to use existing services in the community more effectively to moderate demand for hospital care, which is a major cause of current NHS pressures.
- New care models being developed by the vanguards and in related initiatives demonstrate how services are being transformed, and need to be supported and spread to other areas.
- Proposals to reconfigure hospitals could improve the quality and safety of care, and need to be considered on their merits to ensure that a convincing case for change has been made.
- Proposals to reduce capacity in hospitals will only be credible if there are robust plans to provide alternatives in the community before the number of beds is cut.
- Cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement their plans.

- A more realistic timescale should be adopted for the implementation of STPs, given the time it takes for innovations in care to become established and deliver results.
- Changes to the law are needed to amend aspects of the Health and Social Care Act 2012 that are not aligned with the Forward View, particularly those relating to market regulation.
- The NHS should engage meaningfully with staff, patients and the public, local authorities and the third sector in discussing the proposals contained in STPs.
- The NHS should also strengthen the governance and leadership of STPs and put in place the capacity and capability required to support implementation.
- National bodies should work together in supporting the NHS and local authorities in the implementation of STPs and send out consistent messages on what they now expect.
- The government should reiterate its commitment to STPs as the means for implementing the Forward View; it should support proposals to improve services where the case for change has been made, and recognise the need for additional resources for the NHS and social care.

compassionate care

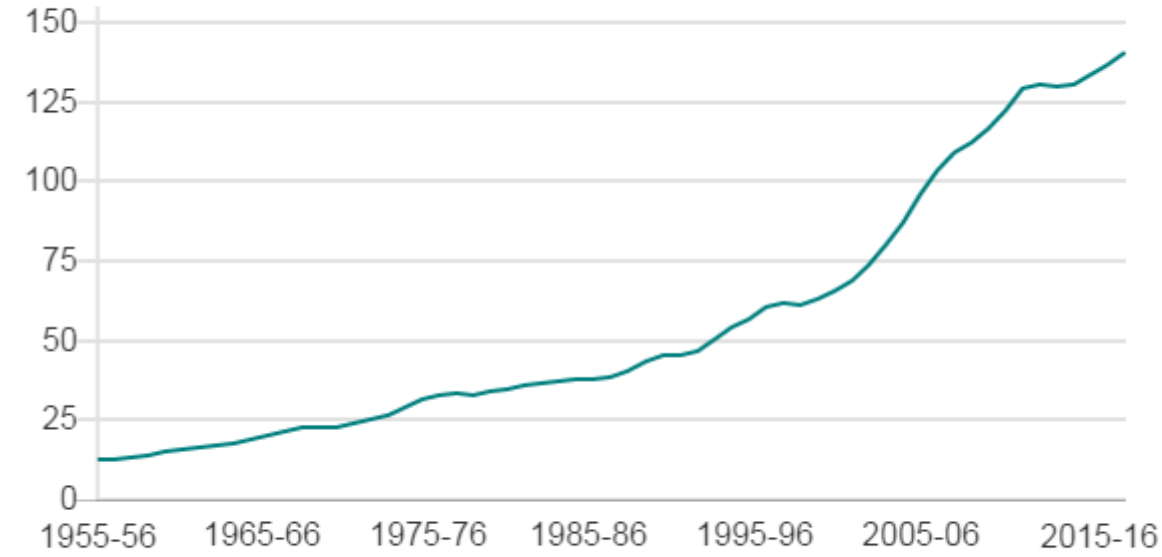
Calderdale and Huddersfield NHS Foundation Trust

Health System Context

March BoD 2017

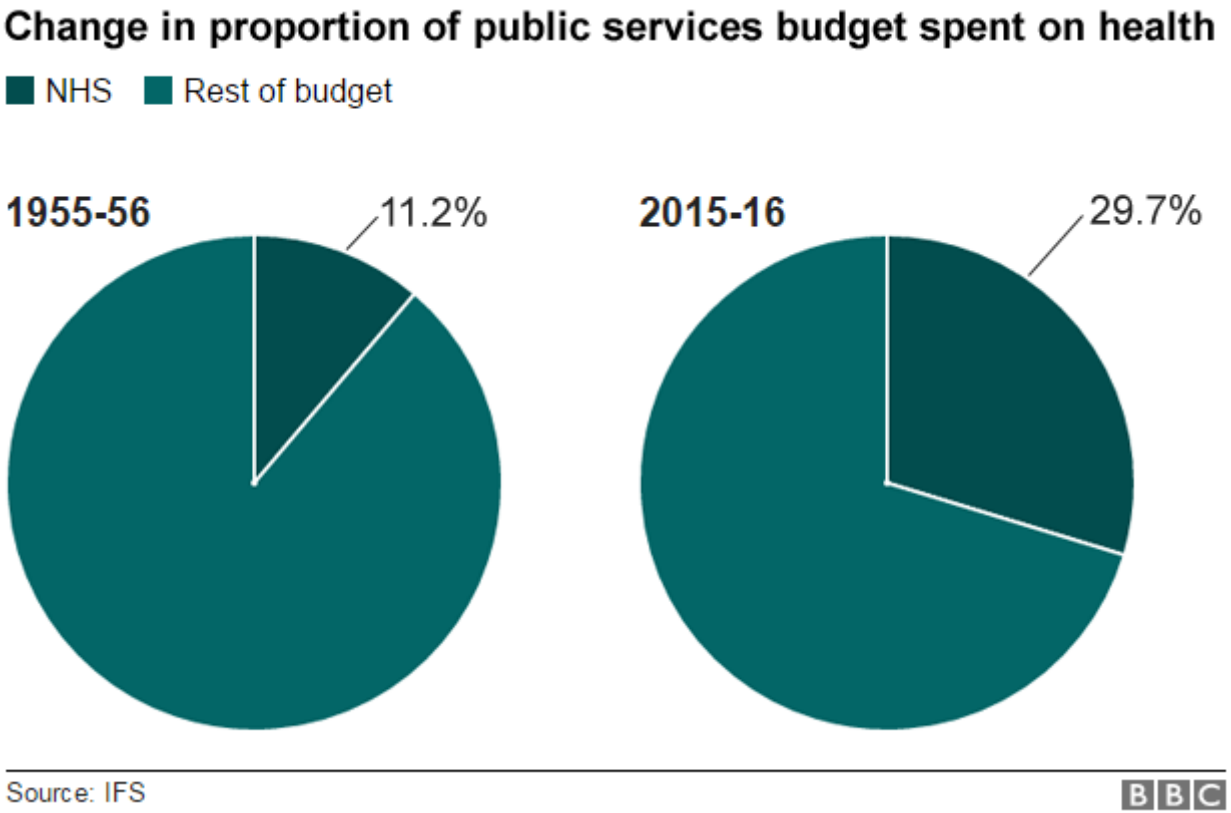
How the NHS budget has grown

Health spending in the UK (£bn in 2016-17 prices)



Source: IFS

BBC


Change in proportion of public services budget spent on health
NHS
Rest of budget
1955-56
11.2%
2015-16
29.7%
Source: IFS
BBC

A&E performance in England against four-hour targets

Percentage of patients dealt with at A&E within four hours

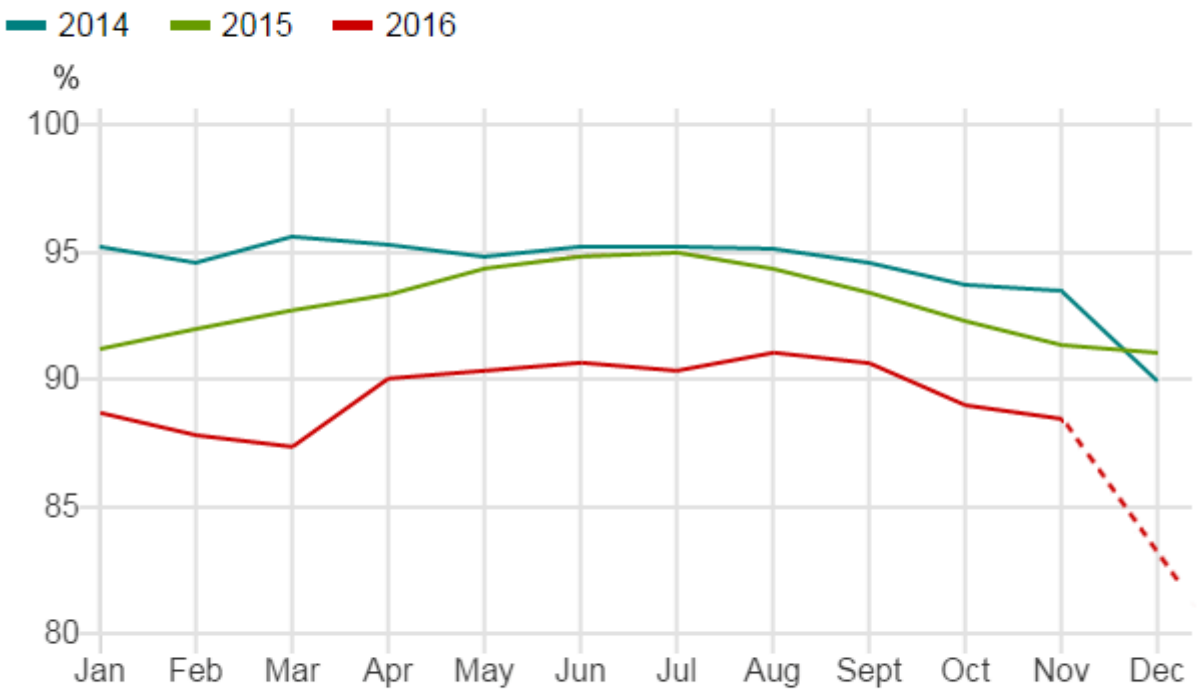
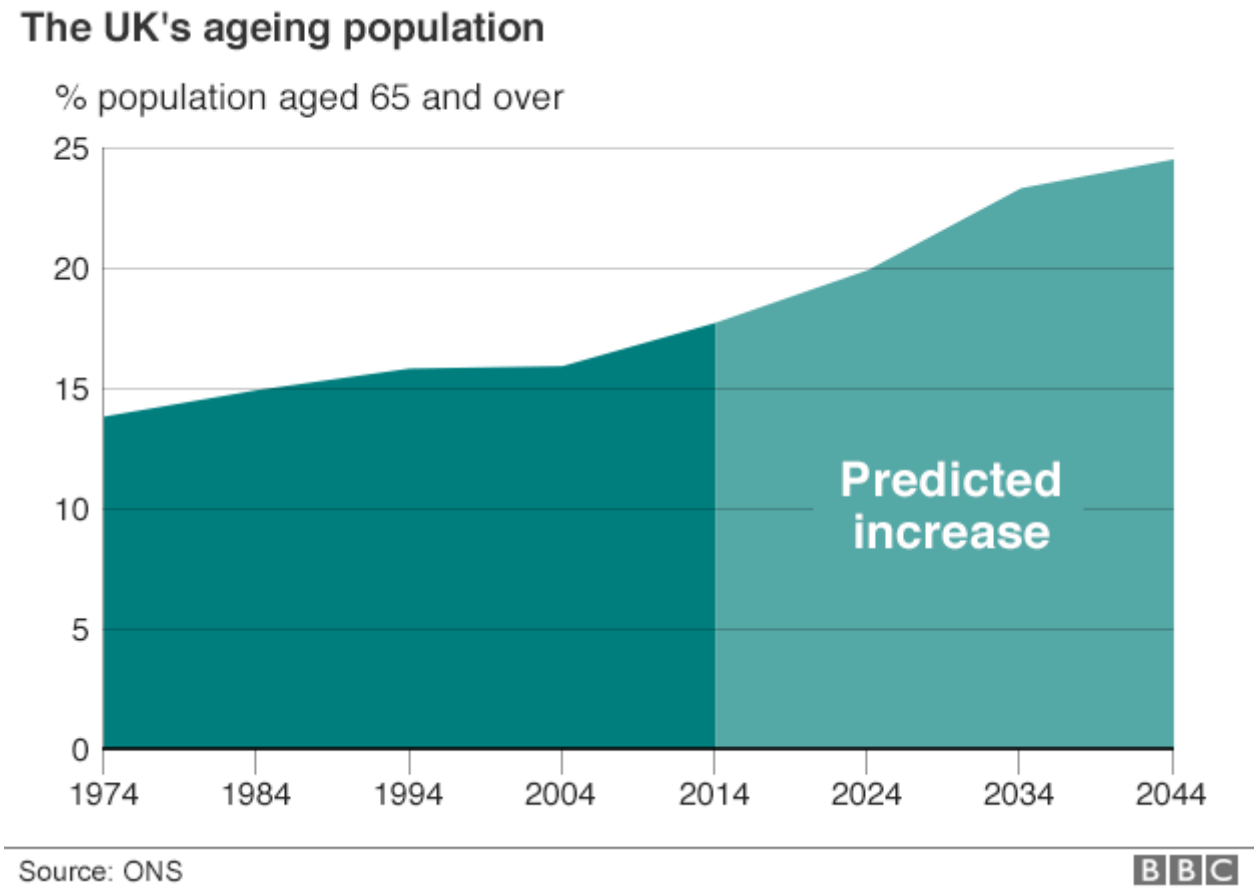


Figure for December 2016 (including a few days of data for January 2017) is based on data leaked to the BBC

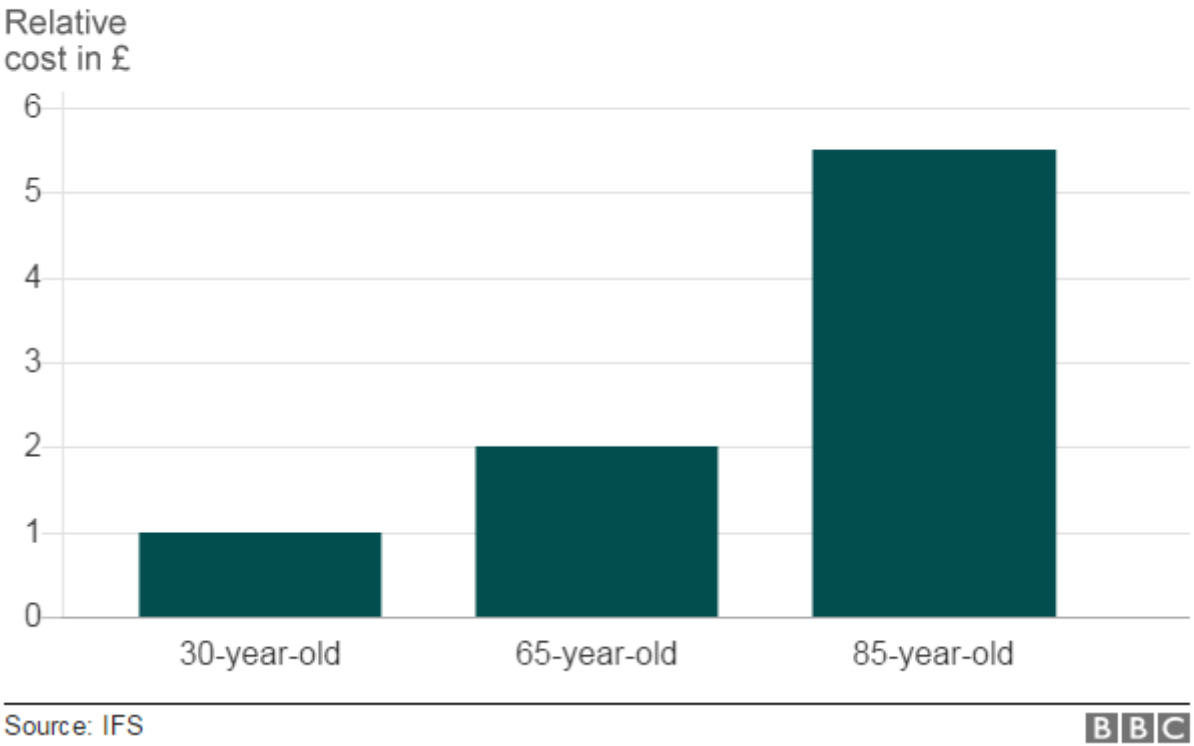
Source: NHS England

BBC


The UK's ageing population
% population aged 65 and over
25
20
15
10
5
0
1974
1984
1994
2004
2014
2024
2034
2044
Predicted increase
Source: ONS
BBC

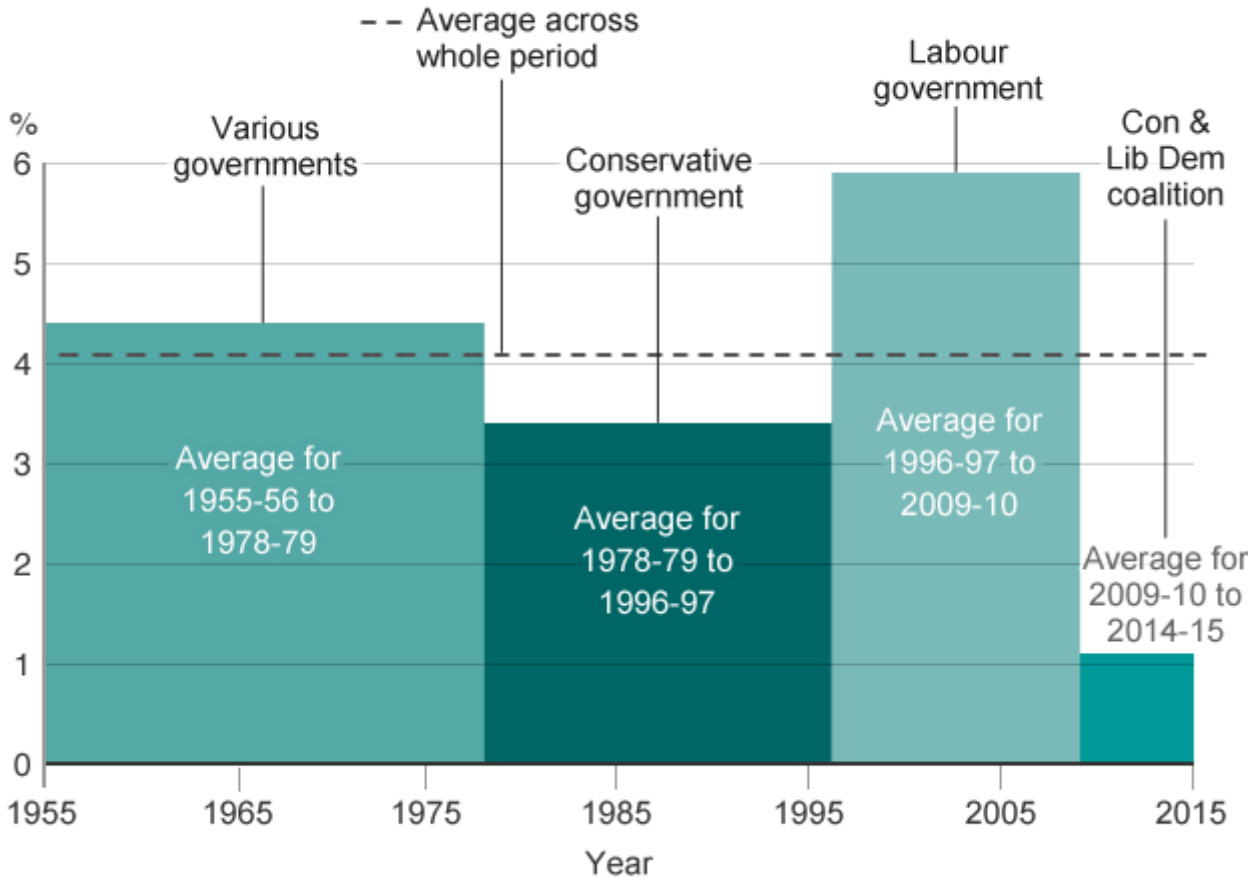
Comparing NHS spending on people by age

Spending for patients increases as they get older



How spending on health has slowed down

Average annual increase in government spending on health

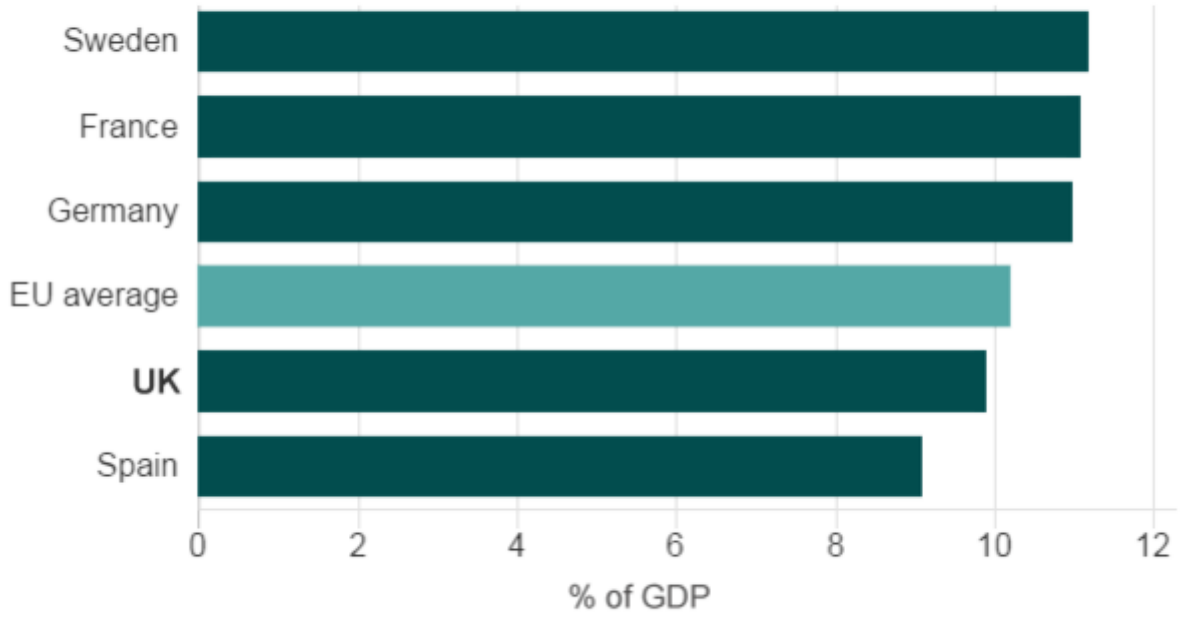


Source: IFS

BBC

How the UK compares

Comparison of spending on public and private health and care as a percentage of GDP in 2014

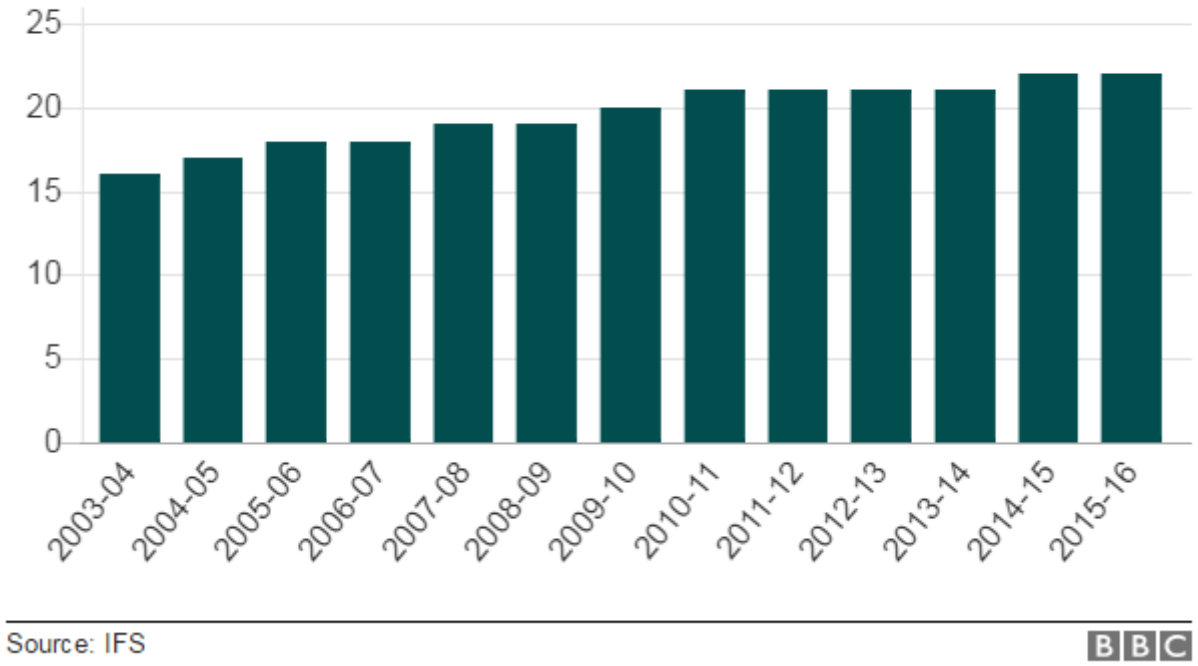


Source: Nuffield Trust / Health Foundation

BBC

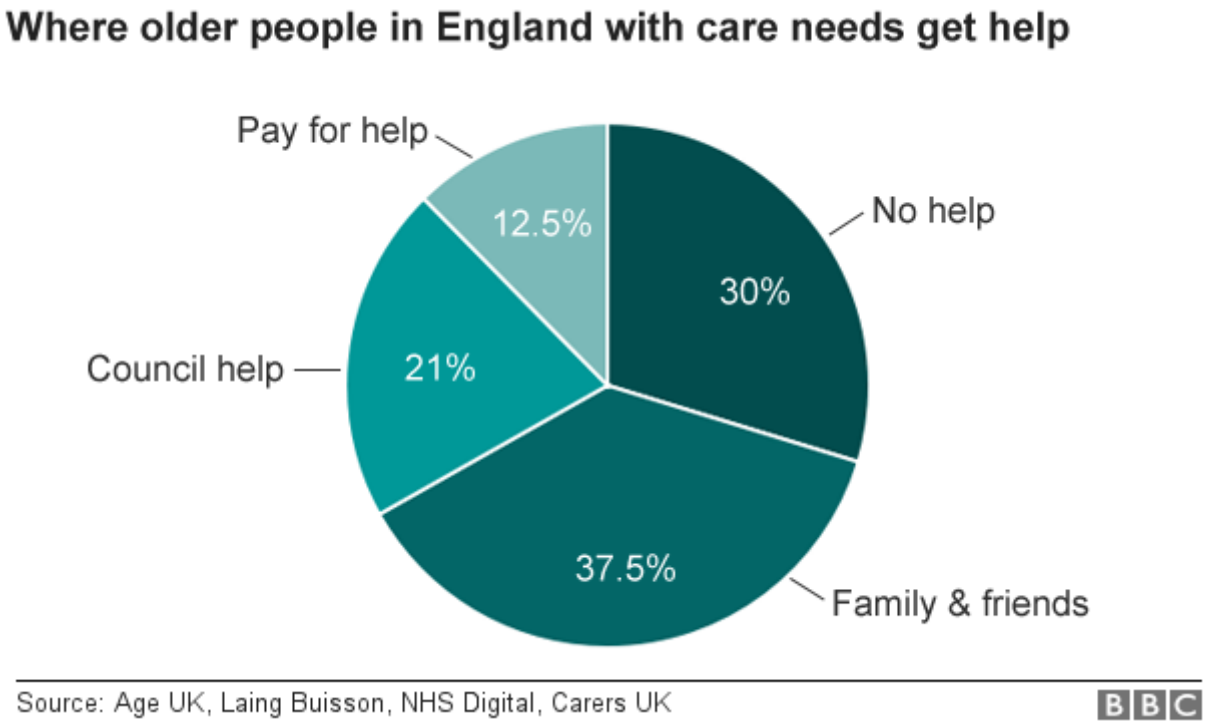
Increasing demand for urgent treatment

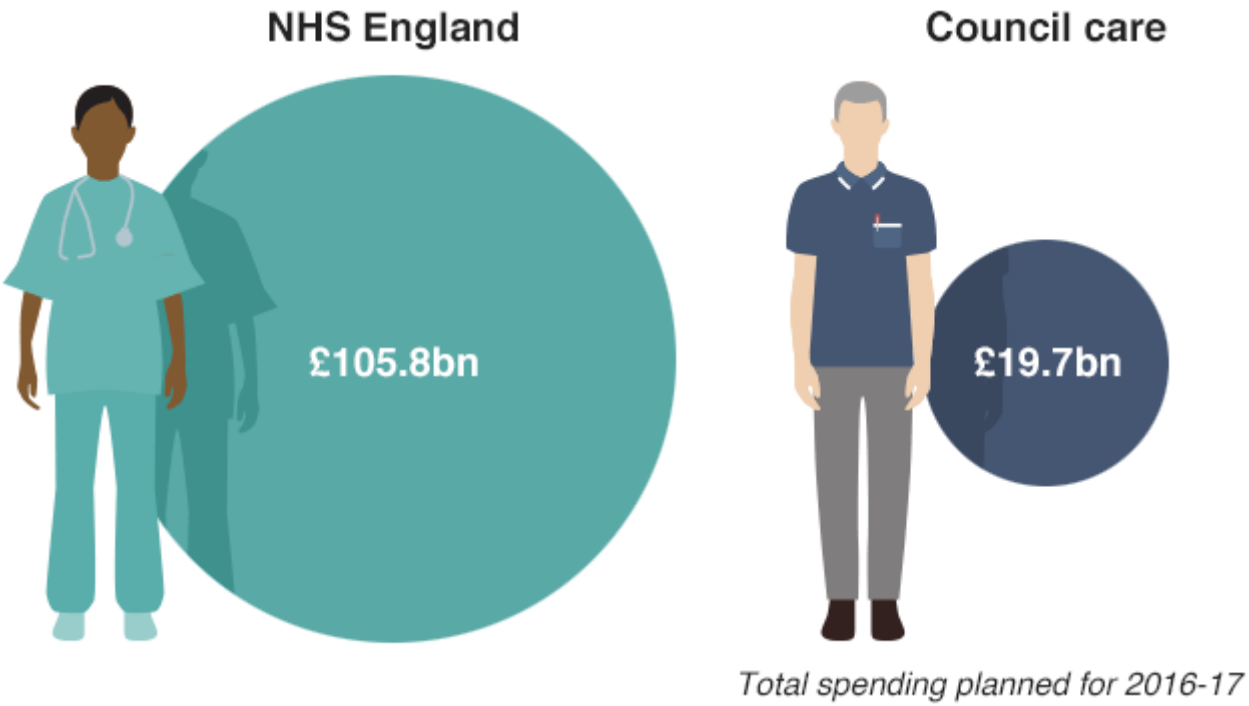
Visits to A&E in England (in millions)



Source: IFS

BBC


Where older people in England with care needs get help
Pay for help
12.5%
No help
30%
Council help
21%
37.5%
Family & friends
Source: Age UK, Laing Buisson, NHS Digital, Carers UK
BBC


NHS England
£105.8bn
Council care
£19.7bn
Total spending planned for 2016-17

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 2nd March 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: High Level Risk Register - Presentation of the significant risks facing the Trust as at February 2017.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Risk and Compliance Group reviewed the high level risk register on 14 February 2017	
Governance Requirements: Keeping The Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

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

Background/Overview:

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

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

The Issue:

The attached paper includes:

i. A summary of the Trust risk profile as at February 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

Two new risks have been added to the high level risk register during February, these are

- Risk 6878 scored at 15 relating to malware affecting IT systems
- Risk 6924 relating to the risk of mis-placed nasogastric tubes for feeding scored at 15

Discussion continues regarding the collective estates risks affecting the Intensive Care Unit at Huddersfield Royal Infirmary and this will be further discussed at the meeting on 14 March 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:

Risk Register Report - 170217.pdf

HIGH LEVEL RISK REGISTER REPORT

Risks as at 17 February 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 February 2017.
RISKS WITH REDUCED SCORE
The risk relating to divisional governance structures, risk 6694 has been reduced in score to 12 from 15 and is being managed within the quality directorate's risk register.
NEW RISKS
There are two new risks that have been added to the high level risk register during February 2017 which are: • Risk 6878 scored at 15 relating to malware affecting IT systems • Risk 6924 relating to the risk of mis-placed nasogastric tubes for feeding scored at 15
CLOSED RISKS
None

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

Risk ref	Strategic Objective	Risk	Executive Lead	O	N	T	H		
		Strategic Risks		**Sept 16**	**Oct 16**	**Nov 16**	**Dec 16**	**Jan 17**	**Feb 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	↓15	↑ 20	=20	=20
6886	Transforming & Improving Patient Care	Non compliance with 7 day services standards	Medical Director (DB)	-	-	!15	=15	**=15**	**=15**
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	↓16	=16	=16	=16	=16	=16
2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
6822	Keeping the Base Safe	Not meeting sepsis CQUIN	Medical Director (DB)	-	!16	=16	=16	=16	=16
5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	-	!16	=16	=16	=16	=16
6829	Keeping the Base Safe	Aspetic Pharmacy Unit production	Director of Nursing	-	!15	=15	=15	=15	=15
6841	Keeping the Base Safe	Not being able to go live with the Electronic Patient Record – operational readiness	Chief Operating Officer (HB)	!15	=15	=15	=15	=15	=15
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=16	↑20	=20	=20	=20	=20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD	=16	=16	=16	=16	=16	=16
6924	**Keeping the base safe**	**Mis-placed naso gastric tube for feeding**	**Director of Nursing (BB)**	**-**	**-**	**-**	**-**	**-**	**!15**

6878	**Keeping the base safe**	**Risk of malware to IT systems**	**Director of Nursing (BB)**	**-**	**-**	**-**	**-**	**-**	**!15**
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
6753	Keeping the base safe	Inappropriate access to person identifiable information	Director of THIS (MG)	=16	=16	=16	=16	=16	=16
Risk Ref	**Strategic Objective**	**Risk**	**Executive Lead (s)**	**Sept 16**	**Oct 16**	**Nov 16**	**Dec16**	**Jan 17**	**Jan 17**
		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)	↓15	15 =	=15	=15	=15	=15
		Performance and Regulation Risks							
6658	Keeping the base safe	Inefficient patient flow	Chief Operating Officer (HB)	↓16	16=	=16	=16	=16	=16
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Director of Workforce (IW)	=15	=15	=15	=15	=15	=15
		People Risks							
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce (IW)	=20	=20	=20	=20	=20	=20

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 17/02/2017

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 ! 6924 Mis-place naso gastric tube ! 6878 malware risk to IT systems
Unlikely (2)					
Rare (1)					

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HIGH LEVEL RISK REGISTER

Risk No	Div	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6131	Corporate	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.	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	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	10 5 x 2	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. **February 2017** Update after 23 February 2017 meeting with Overview and Scrutiny Committee.	Mar-2017	Mar-2017	WEB	Anna Basford	Catherine Riley
2827	Medical	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	December 2016: No changes, the Trust continues to advertise vacancies for specialty doctors and ED consultants. January 2017: 1 Substantive Consultant has resigned (PEM lead) - post advertised. BC for CESR posts to cover gaps in MG rota **February 2017**: Consultant interviews on March 3rd 2017 (2 candidates) CESR job description completed, rotational training posts arranged and aim to go out to advert in March 2017	Mar-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Caroline Smith

6345	Trustwide	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	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 4 x 4	20 4 x 5	9 3 x 3	January 17 Previous actions continue Nurse Staffing • Targeted recruitment for substantive Registered Nursing and Midwifery workforce ongoing. Focusing on local recruitment from graduate programmes and overseas recruitment • Liaise with staff who have recently left the Trust to ascertain reasons for leaving, and encourage return to the Trust • Specific recruitment to bank, night and weekend posts • Focus on retention of existing staff underway • Branded recruitment process under development, promoting CHFT as an exemplar employer • Development programmes for Ward Managers in progress • Standard Operating procedure for use and authorisation of temporary nursing staff launched • Workforce review of ward nursing establishments undertaken by Chief Nurse office January 2017 **February 2017:** Further work to recruit to Registered Nurse, Medical and AHP vacancies continues. A further Registered Nurse recruitment fair is scheduled for the 25th February. Plans to recruit from the Philippines are also underway, and recruitment to the peripatetic (Enhanced Care Team for 1-1 care) has started. The Trust is also introducing Nurse Associate training roles as part of the national roll out of this programme.	Mar-2017	Jan-2018	WLG	David Birkenhead, Brendan Brown, Ian Warren	Lindsay Rudge, Jason Eddleston & Claire Wilson

5806	Estates & Facilities	Keeping the base safe	There is a realised risk of the current HRI Estate failing to meet the required minimum condition due the age and condition of the building resulting in a failure of the Trust achieving full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will mean the stopping of patient care, suspension of vital services, with delays and stoppage of treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. The main risks being: • Flooring: in ICU at HRI, Ward 19, CCU CRH- a lips and trips hazard • Windows: Ward 6 at HRI and all elevations of the hospital, A& E Resus, creating potential of closure to services from water affecting core services • Theatres / Environment ; HRI Main, DSU and Theatre 6 and CRH Theatres & creating potential for inability to treat patients so missing national targets and affecting patient care • HRI road surfaces, pipework, second water main, aseptic unit improvements with potential to close the entire hospital • Staff Residences Saville Court and Dryclough Close Properties (fire and utilities compliance) • Trust wide roofs which need repairs and edge protection. Without this there is a danger of falling from heights, water closing wards and services, and eclectic failures. • 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 • Structural as we cannot drill any more large holes into HRI floors without a risk of creating	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	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. Jan 17 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. **February 2017** 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.	Mar-2017	Mar-2018	RC	Lesley Hill	Paul Gilling / Chris Davies

6503	Corporate	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	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. **Jan/Feb 17 update**: 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. All divisional	Mar-2017	Sep-2017	RC	Mandy Griffin	Mandy Griffin
6721	Corporate	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	**February update:** At Month 10, the year end forecast position is to deliver the planned £16.15m deficit Control Total. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding. Hoever, there remains some uncertainty in the forecast. 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. The increase in Agency expenditure seen in Month 10 is also a concern. The Trust must drive the necessary reductions in agency expenditure whilst maintaining 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, £0.25m of schemes remain as high	Feb-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer

6722	Corporate	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	**February 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. The Trust has now transferred it's Working Capital Facility into a Revenue Support loan at a lower interest rate, but this does now mean that we have no agreed Working Capital Facility to drawn down on should our forecast cash requirements change.	Feb-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer
6753	Corporate	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. **Jan / Feb 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.	Mar-2017	Apr-2017	RC	Mandy Griffin	Rob Birkett

6822	Medical	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	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 update Work continues across all areas but data not showing improvements as yet. Focus to continue on delivering the actions identifies above. **February 2017 Update** Sustained position for emergency admissions Improvement seen in in patient screening CQUIN target still unlikely to be met for Q4 2016/17	Feb-2017	Mar-2017	PSQB	David Birkenhead	Juliette Cosgrove
5862	Medical	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	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 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. **February 2017 Update** New chair of Falls Collaborative appointed New falls prevention plan to be presented at the February meeting of the falls collaborative Falls update presented to Serious Incident Review Group. More detailed analysis of falls data has taken place.	Mar-2017	Mar-2017	PSQB	Brendan Brown	Maggie Shepley

4783	Corporate	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	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 (CAIP). Mortality Review Protocol updated to include consultant led review process and escalation process for new national avoidability scores. 14 Consultants trained to perform initial mortality screening. Joint CHFT and Bradford training for national mortality case record review programme delivered by NHS Improvement Academy took place on 16 January. **February 2017 Update** CAIP Plan updated monthly and on track and reports to Clinical Outcomes Group. Positive feedback from telephone interview with NHSI in late December with recognition of the ongoing work to reduce mortality in the trust. Mortality Surveillance Group meets monthly and receives reports from outlier conditions and learning from mortality reviews	Mar-2017	Mar-2017	COB	David Birkenhead	Juliette Cosgrove

6596	Corporate	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	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. **February 2017** Capacity of investigators remains an issue impacting on timeliness of report completion. Exploring how to increase investigator capacity by using more corporate staff. Serious Incident Review Group on 6.2.17. received proposal on framework for learning from adverse events.	Mar-2017	Mar-2017	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove

6658	Medical	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	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 are 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 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. **February 2017** No update	Feb-2017	Mar-2017	BOD	COO Helen Barker	Bev Walker

6300	Trustwide	Keeping the base safe	As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services.	-CQC Response Group monitors improvements and progress with actions System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being held to monitor progress with the action plans chaired by the Chief 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	December 2016 Update Work continues on delivery of actions, "go see" visits and reportting on progress with actions to the CQC response group . January 2017 Update 29 actions now rated green and completed. 14 actions moving from amber to green, 1 action moved green to blue (embedded). Remaining actions on track. 4 actions received approval for an extended deadline. **February 2017** 24 of the 33 CQC actions are now rated as green (completed) and a further 7 rated blue (delivered and embedded). The remaining 2 actions are rated amber (on track to deliver). Extensions to deadlines have been approved for 2 actions: MD8: Medicines - Embedded date extended from 31.12.16 to 31.3.17 to enable further embedding of the actions to achieve a sustained impact SD8: 7 day working (radiology) – Action deadline extended from 31.12.16 to 31.1.17 to enable further updating of the radiology 7 day service plan A series of mock inspections have commenced of the core services that received a rating of 'requires improvement' – maternity, children and young people and critical care.	Mar-2017	Mar-2017	WEB	Brendan Brown	Juliette Cosgrove
6598	Corporate	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	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. 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. **February 2017** Work underway to set up the 11 maternity specific essential skills with 4 of these now completed. Requests for other training to be added to the list have been received, these have been referred to Brendan Brown for a decision.	Mar-2017	Jul-2017	NA	Jason Eddleston	Pamela Wood

6723	Corporate	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	**February update:** The forecast capital expenditure is £26.13m against the planned £28.2m. 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 will need be added to the assessment of 2017/18 borrowing. 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	Feb-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer
6829	Family & Specialist Services	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. 25.Jan.17 update - draft plan for feasibility study agreed with Engie - to incorporate engineering costs. Costs for business case will then be available. Next EL Audit of unit to take place on 5th April 2017 **February 2017** Feedback expected at end of Feb/early Mar on electrical and mechanical plans along with costings from quantity surveyor	Mar-2017	Dec-2018	DB	Brendan Brown	Mike Culshaw

6841	Corporate	Keeping the base safe	Risk of: Not being able to go live with the Electronic Patient Record Due to: Pre Go-live Lack of operational readiness: unable to extend clinics, inability to maintain safe patient flow 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. Worsening staffing levels (see risk 6345), vacancies, sickness and staff leaving to work in Trusts with non EPR systems Lack of colleague ownership and engagement for the EPR at all levels of the organisation. The potential un-availability of suitable IT equipment in all areas of the Hospitals that need access to EPR. CUT OVER Lack of clear processes that are documented, communicated and resourced in order to carry out paper monitoring of patients through the go-live period. Productivity and efficiency may reduce as colleagues defer to paper systems. POST GO LIVE Inability to use the system effectively once the extended support mechanisms start to reduce following Early Live Support.	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	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. Jan 17 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. **February 2017 Update** As above plus; Divisional operational readiness plans are positive and progressing well, these are monitored every 2 weeks at the Ops board. EPR Friends training underway. Initial response to End User Training (EUT) is also positive with circa 3000 people booked onto various courses. Training rooms have all been identified (on CRH/HRI sites) and surveyed in readiness for set up (starting 20th Feb) and Training (Starting 6th March). Change resource has been bolstered during Feb but further work needs to be done to drive progress - to be monitored. Likelihood score remains the same until training starts and DNA rates can be monitored at least.	Mar-2017	Sep-2017	RC	Helen Barker	Mandy Griffin

6715	Corporate	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 Awaiting the ward accreditation review in order to recommence audit (which will not collect comparable information)	20	4 x 5	15	3 x 5	6	3 x 2	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 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. **February 2017** The Trust now has a cutover and go live date for 1st and 2nd May. Following this a process and reporting mechanism wil	Mar-2017	May-2017	QC	Brendan Brown	Jackie Murphy
6693	Corporate	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 Workforce Modernisation 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	15	3 x 5	20	4 x 5	15	3 x 5	**February 2017** FWD tasked to prep new system Allocate (Bank Staff) to replace current VMS and data capture system by 01/03/17. Procurement to evaluate benefits from moving to PSL to Managed Service Provider (MSP) by 01/03/17. Awaiting ratification of Agency Control Panel from WEB/WWLC Awaiting approval from WEB/WWLC to set agency cap levels to +5% of national cap and set policy for Trustwide adherence to cap Regional Working Group of MD's to co-ordinate regional approach to determine regional bank solution Business case to be completed by 01/03/17 to implement Trust wide e-rostering to automate booking processes and embed rostering efficiencies NHS-I to provide peer review of Trust status against gency spend toolkit recommendations and to assist in further action identified where appropriate.	Mar-2017	Mar-2017	WLG	Ian Warren,	Mark Borrington, Programme Manager

6886	Corporate	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	High level action plans are being reviewed with the aim of developing more detailed plans to review what can be achieved within current resources and current configuration of acute services. This will include details of workforce and skill mix, financial implications and full benefits such LOS and patient experience. This will need to take into account what can realistic be achieved with the scope of the 5-year plan. 7DS reports via the Safer Programme.	The main reasons for not achieving compliance include: • Lack of dedicated funding to recruit additional consultants to meet compliance • Existing difficulties in retaining and recruiting to consultant posts within certain specialties especially in Medicine and Radiology • Split-site configuration of hospital services. Whilst the completion of a more detailed action plan will help identify possible solutions towards achieving compliance it is doubtful that within current resources and current configuration of acute services that full compliance will be achieved. Note the national	15 3 x 5	15 3 x 5	9 3 x 3	Impact and in particular response to non-compliance from NHSI will require further monitoring. December 2016: No changes or updates as yet. 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. **February 2017 Update** Additional expectation nationally that stroke and vascular services will be compliant by November 2017with the same 4 standards. Progress towards the standards will require reconfiguration of services and increased investment.	Feb-2017	Mar-2017	BOD	David Birkenhead	Sal Uka
6924	Corporate	Keeping the base safe	Risk of mis-placed nasogastric tube for feeding due to lack of of knowledge and training in insertion and ongoing care and management of NG feeding tubes from nursing and medical staff resulting in patients fed into the respiratory tract or pleura and possible death or severe harm	Risk overseen by Nutritional Steering Group Task and finish group established by director of nursing to address elements of NPSA alert 22.7.16 on nasogastric tube misplacement Training package available Nursing staff have been encouraged to undertake self assessment and declaration of competency Check X rays are performed where aspirate is not obtained, or greater than pH5.5 Radiology team flag when sighted if tube is in the lung following xray Training and competency package in place for nursing staff identified from high use areas	Initial X Rays are reviewed by medical staff - currently have no record of training or competency assessment for medical staff working at CHFT Daily process for checking is dependent on individuals competency to be performed accurately Training data base is only available through medical device data base and is not monitored for compliance No assurance that all medical and nursing staff who are inserting and managing NG tubes have the competency required to do this No policy in place at CHFT to support guidelines	15 5 x 3	15 5 x 3	8 4 x 2	NPSA self -assessment has been completed and action plan is in development High use areas identified and training plan in place to ensure all nursing staff are trained and assessed as competent by 1st April 2017 Training figures monitored weekly for compliance from these areas Task and finish group – next steps will be a focus on training of medical staff Draft nutrition policy has been developed – plan to sign off through task and finish group. Currently with medical staff for comments.	May-2017	Apr-2017	QC	Brendan Brown,	Jo Middleton
6878	Corporate	Keeping the base	RIsk Of: Ransomware / malware disabling IT Systems affecting patient care. Due to: National increase in Ransomware attacks targeting Health Organisations Resulting in: Total/partial loss of IT Systems, network drives, or network systems affecting patient care	Current control measures are: Firewalls - to protect from direct internet attacks End-Point Anti-virus - to protect from KNOWN malware Quarantine / Sandpit environments Relationship with CareCert (NHS Digital) to understand national threats IT Security audited regularly (IASME/ISO etc)	- No current visibility/detection of new threats, - Behavioural monitoring, - Intrusion detection, - Network anomaly tracking.	15 5 x 3	15 5 x 3	5 5 x 1	Funding is required to introduce multi-level security and provide a 360 view of all IT systems and their connection to external partners/services, and also provide protect for non-standard computer/network based clinical equipment.	Mar-2017	May-2017	BOD	Mandy Griffin	Jason Cresswell

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

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

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:
- Membership Council Elections
- Performance Management Framework - Update on work from Sub Committee Workplans

Main Body

Purpose:

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Background/Overview:

Membership Council Elections
Each year, elections are held for a range of seats on the Membership Council. This year there are 10 seats spread across both public and staff constituencies which are eligible for election. Membership Councillors in some of these constituencies are eligible to stand for re-election.
In accordance with the Trust's constitution, and for the purposes of fairness and transparency, an independent specialist organisation conducts these elections on behalf of the Trust. We have recently re-tendered the election service. Our previous provider, Electoral Reform Services (ERS), was successful in the tender. The process involves briefing prospective candidates; verification of membership; creating and distributing ballot papers; counting and notifying the Trust. In order for this to process to be conducted in an efficient and democratic manner, ERS issues a timetable for these activities on the attached.

Performance Management Framework
At a previous meeting, the Board of Directors asked for assurance that the performance management arrangements were working through the sub-committees in the same way as the risk management arrangements. A review of the work plans and minutes of each of the sub-committees has concluded that each sub-committee reviews the relevant part of the performance report and highlights the main areas of action or issues to the Board. There is a clear line of scrutiny and assurance from the divisional performance management review meetings through to the relevant sub-committee. Each sub-committee is also currently doing its own self-assessment. Any issues identified through this process will be brought to the Board.

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Membership Election timetable.

Appendix

Attachment:

DRAFT ELECTION TIMETABLE 2017.pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

PROPOSED ANNUAL ELECTION TIMETABLE – 2017

DAY	DATE	ACTION
Thursday	20 July 2017	Trust & Members Annual General Meeting – Formal Election Announcement
Friday	7 July 2017	Issue of Results to Trust
Thursday	6 July 2017	Close of Ballot
Tuesday	13 June 2017	Voting packs despatched by ERS to members
Monday	12 June 2017	Notice of Poll Published by ERS provided to Trust
Tuesday	30 May 2017	Electoral data to be provided by Trust. Uncontested report provided to Trust
Wednesday	24 May 2017	Final date for Candidate withdrawal
Monday	22 May 2017	ERS & CHFT publish summary of nominated candidates upon validation
Friday	19 May 2017	Deadline for receipt of nominations
Thursday	20 April 2017	ERS/CHFT issue the Notice of Election. Nomination forms to be made available to CHFT
Thursday	13 April 2017	Briefing Sessions for prospective Council Members – Boardroom, Sub Basement, Huddersfield Royal Infirmary
Monday	3 April 2017	Briefing Sessions for prospective Council Members – Large Training Room, Learning Centre, Calderdale Royal Hospital

DRAFT

BRIEFING SESSIONS FOR PROSPECTIVE CANDIDATES		
Thursday	**13 April 2017**	**Discussion Room 2, Learning Centre, Huddersfield Royal Infirmary**
Monday	**3 April 2017**	**Large Training Room, Learning Centre, Calderdale Royal Hospital**

VACANT POSITIONS AND CANDIDATES ELIGIBLE FOR RE-ELECTION*	
NAME	**CONSTITUTENCY**
PUBLIC	
Peter Middleton	3 - Almondbury, Dalton, Denby Dale, Kirkburton
Grenville Horsfall	4 - Batley East, Batley West, Birstall & Birkenshaw, Cleckheaton, Dewsbury East, Dewsbury West, Heckmondwike, Mirfield, Spenborough, Thornhill
George Richardson	5 - Brighouse, Elland, Greetland, Stainland, Rastrick, Skircoat
Brian Richardson*	6 - Bingley Rural, Clayton, Great Horton, Hipperholme, Lightcliffe, Northowram, Shelf, Odsal, Queensbury, Thornton, Tong, Wibsey, Wyke
Kate Wileman (2 posts) Lynn Moore*	7 - Mixenden, Illingworth*, Ovenden, St John's, Sowerby Bridge, Town, Warley
STAFF	
Dr Mary Kiely	9 – Doctors/Dentists
Eileen Hamer - resigned	11 – Management/Admin/Clerical
Vacant post	12 – Ancilliary
Vacant post	13 – Nurses/Midwives

* = Eligible for Re-election

/KB/MC-ELECTION2017

DRAFT

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Senior Nurse Clinical Governance
Date: Thursday, 2nd March 2017	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient (CAIP) Programme Report - This report provides an update of the progress of the CAIP Programme	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Reporting is provided monthly to the Clinical Outcomes Group and Quarterly to the Quality Committee	
Governance Requirements: Transforming and improving patient care	
Sustainability Implications: None	

Executive Summary

Summary:

The Care of the Acutely Ill Patient (CAIP) programme has an overall aim to reduce mortality and is divided into six themes:

1) Investigating causes of mortality and learning from findings
2) Reliability in clinical care
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Caring for frail patients
6) Clinical coding

Main Body

Purpose:

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

Background/Overview:

As per the Executive Summary

The Issue:

Although HSMR is currrently 103.76 and remains a concern there is evidence that the improvement work has contributed to the reduction of HSMR over the last year.

Next Steps:

Continue monthly monitoring of the CAIP themes to the COG

Recommendations:

To note the content of the report

Appendix

Attachment:

CAIP programme summary for BoD Feb 2017 LF.pdf

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors February 2017

The Care of the Acutely Ill Patient (CAIP) programme has an overall aim to reduce mortality and is divided into six themes:

1) Investigating causes of mortality and learning from findings
2) Reliability in clinical care
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Caring for frail patients
6) Clinical coding

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

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	**SHMI** Data has been released in January for SHMI incorporating performance data up to **June 2016** Looking at the rolling 12 month SHMI (July 15 – June 16), the score is **112.02**. This is an improving position from 113.80 (from the previous rolling 12 month period of (January 15 –December 15) **HSMR** Data has been released in **January** for HSMR incorporating performance data up to **October 2016.** Looking at the rolling 12 month HSMR (November 15 –October 16), the score is **103.74** and a slightly worse position from **102.94** (from the previous rolling 12 month period of October 15 – September 16) **Mortality Reviews**	The SHMI is currently expected to stay at a steady level of 112 when the next quarter is released. This is based on the comparable period of time when the HSMR also started to reduce slightly and level out. HSMR performance continues to be monitored

	Around 45% of all deaths receive an initial screening mortality review. Consultants have been invited to join the mortality review process ahead of the job planning next year; 23 consultants have joined the team of reviewers. A training day was held for the National Mortality review programme (Structured Judgement Review) on 16th January and attended by 11 staff. This was a train the trainer approach delivered by the Improvement Academy. Learning themes from mortality reviews are included in the CAIP Plan **Alerting Conditions** There is a CUSUM alert for Urinary tract Infections (September 16) and SHMI alert for Deficiency and other anaemia cases (August 2015-July 2016).	Clinical Directors to be requested to confirm when consultants have mortality reviews agreed within their job plans Further consultants to be trained for the National Programme SJR using the train the trainer approach. Summary reports prepared for both alerts and to be presented to Mortality Surveillance Group to agree level of further investigation.
2) Reliability in clinical care	There are five conditions where evidence-based care bundles have been developed to improve patient outcomes. These are; • Asthma • Acute Kidney Injury (AKI) • Sepsis • Chronic Obstructive Pulmonary Disease (COPD) • Community Acquired Pneumonia (CAP) There remains variation in completion of the bundles. Bundle leads have been invited to present progress updates to COG bi-monthly	Sepsis bundle continues to be prioritised for improvement work. Matrons providing a check on all patients with a NEW >5 A behavioural change focus group is being arranged with the Improvement Academy to understand the barriers to enable effective interventions. This methodology can be used for other improvement work Liaison with the EPR team to seek assurance on reliable care built into the EPR
3) Early recognition and treatment of	An action plan was submitted to NHSI by 31st January 2017 Hospital out of hours (HOOP) team	Further work looking patients for one month who have a NEWS score of 5 being referred to outreach team to understand impact and benefit

deterioratin g patients.	established at CRH (5pm to 8am weekdays and all weekend) and has commenced at HRI at the beginning of February 'Code purple' implemented on 10 wards helping to recognise patients who staff suspect may deteriorate but are not triggering on NEWS	A paediatric deteriorating patient action plan has been developed to include introduction of safety huddles
4) End of life care	EOLC Steering group is now active and reports to Quality Board. Trust Strategy for End of Life Care ratified by Executive Board 2 new Band 7 Advanced Nurse Practitioners and Nurse Prescribers have been appointed to work in MAU/A&E as a 2 year pilot funded by Macmillan and will enable the Specialist Palliative Care Team to work 7 days a week from May.	Quality Indicators still to be set and will be measured and will report to the COG quarterly and also the Patient Experience Group. End of Life Care Engagement Event has been postponed until March/April
5) Caring for frail patients	A frailty strategy has been developed with a work plan and led by a multi-disciplinary team and community partners with a focus on falls, UTI and assessment on frailty by district nurses. Working with Patient Safety Collaborative and care homes regarding falls assessments and providing training.	Implementation of the frailty strategy work plan. Continued work to increase knowledge and understanding of services available to avoid admissions Identify quality measures and add to the CAIP dashboard
6) Clinical coding	Improvement works shows that for 2nd month in a row the UQ has been achieved for average diagnosis and for average Charlson score at a Trust level we are 0.01 away from UQ but acknowledge specialities differences	Clinical engagement work needs to continue to provide consistency in documentation. Local targets to be re-based to ensure consistency with National improvements. Close working with the EPR team to mitigate or reduce risk following 'go live'

CAIP Dashboard

: ACUTELY ILL PATIENT (CAIP) PROGRAMME

15/16		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	YTD	Target
Theme 1: Investigating Mortality and Learning from findings																			
Number of In Hospital Deaths		123	132	140	148	142	148	139	155	135	118	123	95	136	119	156	194	1370	
Deaths within 30 days of Discharge		78	63	79	77	71	72	60	58	77	71	72	59	40	60	51	In arrears	578	
Total Number of deaths (In hospital + Within 30 days of discharge		201	195	219	225	213	220	199	213	212	189	195	154	176	181	207	In arrears	1756	
% of Deaths Occurring In Hospital vs within 30 days of discharge		61.19%	67.69%	63.93%	65.78%	66.67%	67.27%	69.85%	72.77%	63.68%	62.43%	63.08%	61.69%	77.27%	65.75%	75.36%	In arrears	78.0%	
% Mortality Reviews (Month behind)		60.20%	62.60%	56.60%	46.20%	43.90%	46.20%	50.37%	46.98%	37.59%	34.21%	32.50%	36.17%	25.74%	36.97%	In arrears	In arrears	38.02%	95%
In hospital Crude Mortality Rate (all Admissions)		1.21%	1.33%	1.41%	1.53%	1.46%	1.49%	1.43%	1.60%	1.32%	1.17%	1.22%	0.94%	1.69%	1.17%	1.57%	1.89%	1.36%	
Local SHMI - Relative Risk (12 months Rolling Data)		113.80	113.80	113.80	113.34	113.34	113.34	111.17	112.28	112.02	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	112.02	100
Hospital Standardised Mortality Rate (12 months Rolling Data)		116.22	116.06	116.49	116.30	114.04	111.62	111.62	109.38	108.67	106.12	105.00	102.94	103.49	101.97	In arrears	In arrears	101.97	100
Hospital Standardised WEEKEND Mortality Rate (12 months Rolling Data)		124.54	122.49	121.45	117.86	116.71	114.04	113.06	112.71	112.17	111.87	108.03	104.61	107.69	105.34	In arrears	In arrears	105.34	100
Hospital Standardised WEEKDAY Mortality Rate (12 months Rolling Data)		114.43	113.55	114.44	115.19	112.25	110.07	108.84	108.22	107.36	104.34	104.08	102.43	102.21	100.93	In arrears	In arrears	100.93	100
SHMI - COPD		132.80	132.80	132.80	122.76	122.76	118.68	119.77	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	122.76	100
HSMR - COPD		131.92	133.22	131.12	120.11	130.47	130.31	135.65	130.65	125.76	122.71	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	122.71	100
SHMI - Pneumonia		113.70	113.70	113.70	134.82	134.82	105.43	104.52	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	134.82	100
HSMR - Pneumonia		121.46	120.54	122.52	123.65	116.96	115.24	118.86	111.12	110.98	108.87	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	108.87	100
SHMI - Sepsis																			100
HSMR - Sepsis		125.25	126.70	136.20	133.14	127.63	121.67	123.12	117.71	106.34	102.82	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	102.82	100
SHMI - AKI																			100
HSMR - AKI		109.18	108.68	108.01	109.80	111.40	112.39	117.75	117.60	118.01	111.94	In arrears	In arrears	In arrears	In arrears	In arrears	In arrears	111.94	100
Theme 2: Reliability																			
AKI - Bundle Started		53.00%	n/a	n/a	33.00%	71.00%	91.00%	58.00%	62.00%	79.00%	67.00%	82.00%	45.00%	100.00%	96.00%	96.00%	100.00%	80.00%	95.00%
AKI - Bundle Completed		70.00%	n/a	n/a	0.00%	67.00%	40.00%	39.00%	38.00%	48.00%	19.00%	44.00%	33.00%	15.00%	50.00%	28.00%	46.00%	38.00%	95.00%
Sepsis - Bundle Started		58.00%	n/a	n/a	89.00%	70.00%	63.00%	88.00%	91.00%	86.00%	77.00%	70.00%	93.00%	90.00%	90.00%	79.00%	100.00%	86.00%	95.00%
Sepsis - Bundle Completed		58.00%	n/a	n/a	50.00%	71.00%	60.00%	41.00%	45.00%	39.00%	22.00%	47.00%	43.00%	37.00%	37.00%	26.00%	30.00%	37.00%	95.00%
COPD - Bundle Started		47.00%	n/a	n/a	47.00%	48.00%	78.00%	43.00%	65.00%	77.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	89.00%	95.00%
COPD - Bundle Completed		60.00%	n/a	n/a	60.00%	62.00%	57.00%	85.00%	33.00%	48.00%	50.00%	30.00%	11.00%	10.00%	46.00%	27.00%	27.00%	34.00%	95.00%
Pneumonia - Bundle Started		50.00%	n/a	n/a	0.00%	38.00%	50.00%	40.00%	23.00%	43.00%	30.00%	27.00%	40.00%	40.00%	47.00%	100.00%	100.00%	51.00%	95.00%
Pneumonia - Bundle Completed		100.00%	n/a	n/a	0.00%	100.00%	33.00%	66.60%	20.00%	77.00%	67.00%	50.00%	83.00%	67.00%	64.00%	16.00%	17.00%	44.00%	95.00%
Theme 3: Early recognition and treatment of deteriorating patients																			
NEW MEASURES																			
NEW MEASURES																			
NEW MEASURES																			
Theme 4: End of Life Care																			
DNACPR % Discussion completion		92.30%	93.67%	89.70%	90.30%	96.20%	96.00%	89.20%	87.60%	91.00%	93.50%	94.20%	90.20%	90.40%	94.17%	87.39%	82.10%	91%	95.00%
DNACPR Review date completion %		84.60%	77.22%	78.20%	68.80%	76.90%	90.70%	79.50%	76.40%	80.90%	79.50%	82.70%	78.40%	74.00%	79.61%	79.28%	83.00%	79%	95.00%
% of patients on the ICDDD		46.61%	40.46%	35.29%	45.52%	42.45%	42.07%	46.67%	40.27%	37.59%	35.96%	42.50%	50.00%	37.78%	38.66%	46.45%	54.74%	44%	Monitoring
Theme 5: Frailty																			
NEW MEASURES																			
NEW MEASURES																			
Theme 6: Coding																			
Average Diagnosis		4.42	4.53	4.73	4.72	4.84	4.89	4.90	5.05	5.10	5.05	5.14	5.11	5.06	5.24	5.31	5.37	5.11	5.27
Average Charlson Score		3.86	3.92	4.18	4.03	4.30	4.25	3.78	4.17	3.96	3.93	4.08	3.92	3.92	4.10	4.23	4.39	4.01	4.43
Co-morbidity capture		30%	47%	41%	44%	44%	41%	45%	51%	61%	64%	63%	42%	53%	57%	52%	43.00%	56.00%	90.0%
% Sign and Symptom		10.10%	9.90%	9.60%	9.10%	9.10%	9.40%	9.10%	8.70%	9.58%	9.40%	8.20%	8.10%	8.90%	8.30%	8.50%	9.10%	8.60%	9.4%
% Coded with Specialist Pall Care		0.70%	0.70%	0.60%	1.00%	1.00%	0.90%	0.80%	0.90%	0.90%	0.80%	1.00%	0.90%	0.90%	1.00%	0.80%	1.00%	1.00%	NA

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 2nd March 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: REVIEW OF PROGRESS AGAINST STRATEGY - The Board is asked to receive and approve the review of progress against the strategy	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan for 2016/17.

Main Body

Purpose:

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan for 2016/17.

Background/Overview:

In June 2016, the Board of Directors agreed the updated 1 year plan and quality priorities for 2016/17.
The plan describes the objectives to be achieved against the four goals of the Trust:
- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

The Issue:

This report describes the progress made against each of the 16 objectives and identifies where the Board should expect to receive more detailed assurance of how the work is progressing.

Next Steps:

A further update will be brought to the Board in April 2017.

Recommendations:

The Board is asked to receive and approve the review of progress against the strategy.

Appendix

Attachment:

Progress against strategy Board report February 2017.pdf

Calderdale and Huddersfield NHS Foundation Trust
1 Year Plan - Progress Report March 2017

Introduction

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

In May 2016, the Board of Directors agreed the refreshed 1 year plan and quality priorities for 2016/17. The plan describes the four goals of the Trust:

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

These goals are underpinned by the four behaviours:

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

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

Year Ending 2017				
Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Subject to consultation, develop DoH approved implementation plans for the 5 Year Strategic Plan. Deliver on YE 2017 including strengthening community services for 2017	Undertake a Well Led Governance Peer Review and implement any actions to support the findings and ensure ongoing compliance with NHS Improvement & CQC	Develop and implement a 5 year workforce and organisational development plan	Deliver a robust financial plan including CIP for YE 2017
	Refocus the Care of the Acutely Ill Patient action plan and implement the SAFER (patient flow) and hospital@night programmes to improve quality of care	Implement the actions resulting from the findings from the CQC inspection	Implement the colleague produced action plan in response to Investor in People accreditation; the staff survey; Friends and Family Test and Workforce Race Equality Scheme	Working with partners, including across WY, develop and implement a sustainability and transformation plan including Carter compliance
	To work as an early adopter toward the implementation of selected 7 day NHS England standards (2,5,6 and 8)	Implement year 2 of the health and safety action plan and via the estates strategy, deliver against level B quality standards	Design and deliver a leadership and succession planning development programme	Develop a full CIP programme for YE 2021
	Together with our partners deliver and implement a robust EPR system	Implement the local quality priorities (see separate page)	Delivery of the integration of finance and workforce information systems ensuring consistency of provision and integrity of data	Develop a 5 year commercial strategy for THIS and consolidate the existing PMU strategy

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan 2016/17.

Structure of Report

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

1. On track – delivered (green)
2. On track - not yet delivered (amber / green)
3. Off track – with plan (amber / red)
4. Off track – no plan in place (red)

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

Summary

This report highlights that of the 16 deliverables:

- None are rated red i.e. off track with no plan in place.
- 2 are rated amber / red i.e. off track with a plan in place.
- 13 are rated amber / green i.e. on track but not yet delivered.
- 1 has been fully delivered or rated green.

Recommendation

Trust Board Members are requested to:

- Note the assessment of progress against the 2016/17 goals.
- Discuss and agree the future action and assurance that may be required

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Subject to consultation, develop DH approved implementation plans for the 5 Year Strategic Plan. Deliver on YE2017 including strengthening community services for 2017.	**On track - not yet delivered (amber / green)**	The Trust is progressing the development of the Full Business Case with a deadline of June 2017. This is being supported by NHS Improvement.	**Lead: AB** Hospital Services Programme Board Weekly Executive Board Quarterly Review Meeting
Refocus the Care of the Acutely Ill Patient action plan and implement the SAFER (patient flow) and hospital@night programmes to improve quality of care.	**On track but not yet delivered (amber/green)**	SAFER programme in place and seeing some impact on key indicators. Ambulatory Care and Community Place are running and having an impact with a Frailty Service commenced at HRI and plans to expand The Trust and wider system has enrolled on both the National Ambulatory and Frailty collaboratives. Hospital@night has rolled out at HRI. Progress continues to be made with the management of sepsis including building greater awareness of the BUFALO terminology.	**Lead: DB / HB** Reported to Weekly Executive Board and Quality Committee.
To work as an early adopter towards the implementation of selected 7 day NHS England standards (2,5,6 and 8)	**On track but not yet delivered (amber/green)**	Compliance with 7-day services now included as an indicator in the Single Oversight Framework for Trusts. Most recent	**Lead: DB** Quality Committee Weekly Executive Board
Together with our partners deliver and implement a robust EPR system	**On track but not yet delivered (amber/green)**	Cut-over and go-live agreed for 28 April 2017. Training plans in place to begin 6 March 2017 with over 3000 (as at 16.02.17) booked on the training. Operational Readiness meeting fortnightly to review progress against 90 / 60 and 30 day plans in each Division. Full operational checklist developed and overall programme focus moved to CHFT until early live support completed.	**Lead: MG / HB** Monthly to Board and Finance and Performance Committee Sponsoring Group Executive Board

<table>
<tr><th colspan="4">Goal: Keeping the base safe</th></tr>
<tr><th>Deliverable</th><th>Progress rating</th><th>Progress summary</th><th>Assurance route</th></tr>
<tr><td>Undertake a Well Led Governance Peer Review and implement any actions to support the findings and ensure ongoing compliance with NHS Improvement and CQC</td><td>On track – delivered (green)</td><td>Well Led Governance Review action plan signed off by the Board November 2016.</td><td>Lead: VP
Progress Review Meeting feedback to Board
Audit and Risk Committee</td></tr>
<tr><td>Implement the actions resulting from the findings from the CQC inspection</td><td>On track but not yet delivered (amber/green)</td><td>Following publication of CQC report on 15 August an action plan was approved at September Board meeting. This is being closely monitored through fortnightly Response Group. As at 16 February the progress against the Blue / Red / Amber / Green rating was:
<table><tr><th>Rating</th><th>Must do</th><th>Should do</th><th>Total</th></tr><tr><td>Delivered and sustained</td><td>7</td><td>5</td><td>12</td></tr><tr><td>Action complete</td><td>12</td><td>8</td><td>20</td></tr><tr><td>On track to deliver</td><td>1</td><td>0</td><td>1</td></tr><tr><td>No progress / Not progressing to plan</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Total</td><td>20</td><td>13</td><td>33</td></tr></table>Please note actions Must do 7 (safeguarding) and Should do 6 (children cared for outside Paediatric services) have both been split into 2 elements, therefore the total number of individual actions being monitored via internal processes are 20 must dos and 13 should dos. External reporting will remain at 19 and 12 respectively.</td><td>Lead: BB
Monitored through Quality Committee, Weekly Executive Board and Board of Directors</td></tr>
<tr><td>Implement year 2 of the health and safety action plan and, via the estates strategy, deliver against level B quality standards</td><td>On track but not yet delivered (amber/green)</td><td>Progress has been made on delivery of year two of the health and safety action plan and update was presented to the Board in February. Actions are still planned for completion by the end of March 2017.</td><td>Lead: LH
Monitored through Health and Safety Committee to Quality Committee and reported six-monthly to the Board.</td></tr>
</table>

Implement the local quality priorities	**On track but not yet delivered (amber/green)**	Progress is on track with the key Quality Priorities which includes the reduction of falls through the implementation of safety huddles; implementing the Hospital Out of Hours Programme; and improving patient experience in the Community. There have been good outcomes demonstrated through the implementation of the Hospital Out of Hours programme at the CRH site. The programme was implemented at the HRI site in January 2017 and outcomes will be measured. The Safety Huddles have been implemented across all the agreed wards and are having a demonstrable impact. Further information on this will come to the Board through the Quality Report. Further work is required on the community friends and family test.	**Lead: BB** Quality Committee

Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Develop and implement a 5 year workforce and organisational development plan	**On track but not yet delivered (amber/green)**	Workforce Strategy and implementation plan approved by the Board in January 2017. Workforce Modernisation Group in place to manage delivery of the plan.	**Lead: IW** To be signed off by the Board and then monitored through Workforce Committee
Implement the colleague produced action plan in response to Investor in People accreditation; the staff survey; Friends and Family Test and Workforce Race Equality Scheme.	**On track but not yet delivered (amber/green)**	Significant progress made against all actions described in the plan. Will be reviewed in light of the latest Staff Survey results. Last update to Workforce Committee in January.	**Lead: OW** Well Led Workforce Committee.
Design and deliver a leadership and succession planning development programme.	**Off track with plan in place (amber/red)**	Meeting held to discuss the organisational development plan for the Trust. This is articulated at a high level in the Workforce Strategy and supporting action plan. A paper on the National Improvement and Leadership Development Board's framework, Developing People – Improving Care was presented to WEB in February and further work will be done to look at how this fits with the Trust's leadership development arrangements.	**Lead: IW** To be monitored through Workforce Committee

Delivery of the integration of finance and workforce information systems ensuring the consistency of provision and integrity of data.	**Off track with plan in place (amber/red)**	A paper was presented to the Well Led Workforce Committee in January. A modernisation programme board is being established to oversee all of the workforce –related IT systems including ESR / e-rostering, e-rostering for medics and job planning.	**Lead: IW** To be monitored through Workforce Committee

Goal: Financial sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver a robust financial plan including CIP for YE 2017	**On track but not yet delivered (amber/green)**	Trust is on track to meet forecast financial position showing a small positive variance against plan at Month 10.	**Lead: GB** Weekly progress monitored through Turnaround Executive. Reported to Finance & Performance Committee
Working with partners including across WY, develop and implement a sustainability and transformation plan including Carter compliance.	**On track but not yet delivered (amber/green)**	The Trust is an active member of the West Yorkshire Association of Acute Providers and is proactively participating in the development of plans that will inform and contribute to the West Yorkshire STP. The West Yorkshire STP was finalised and submitted in October. Within the Trust all Divisions are undertaking work to explore and where possible realise the Carter efficiency recommendations and opportunities. Terms of reference and a Memorandum of Understanding for the WYAAT committee in common have been agreed. Programmes of work are in development around estates and facilities, HR and IT.	**Lead: AB** Updates on this work are regularly provided to the Trust's Finance and Performance Committee. STP presented to Board.
Develop a full CIP programme for YE 2021.	**On track - not yet delivered (amber / green)**	An outline report was submitted to Finance and Performance Committee setting out proposals for the five years. A full CIP day was held with divisional and corporate representatives on 15 February to develop further ideas and plans for 2017/18.	**Lead: AB** Finance & Performance Committee
Develop the 5 year commercial plan for THIS and consolidate the existing PMU strategy.	**On track - not yet delivered (amber / green)**	THIS 5 Year Strategy presented to Board in February. Links with the WYAAT work.	**Lead: MG / GB** Board approval of Business Plan.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 2nd March 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: CQC ACTION PLAN - The Board of Directors is asked to receive and approve the updated CQC Inspection Action Plan as at February 2017.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee CQC Response Group Weekly Executive Board Risk and Compliance Group	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board of Directors is asked to receive and approve the updated CQC Inspection Action Plan as at 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 receive and approve the updated CQC Inspection Action Plan as at February 2017.

Appendix

Attachment:

Combined CQC Action Plan update.pdf

CALDERDALE & HUDDERSFIELD NHS FOUNDATION TRUST CQC INSPECTION ACTION PLAN (Must and should actions)

Issues identified at the CQC Inspection in March 2016			Must do actions	Should do actions
Delivered and sustained			7	5
Action complete			12	8
On track to deliver			1	0
No progress / not progressing to plan			0	0
			20	**13**

Calderdale and Huddersfield NHS Foundation Trust

CQC Domain	Core Service Area	Governance Oversight	Action reference MD (must do) SD (should do)	Recommendation	Examples of issues reported	Associated regulation		Trust Response: Action taken to date	Trust Response: Further action (if required)	Measurable outcome expected following implementation of recommendation	Expected Date of Completion of Actions	Date of Sustained Improvement of Outcome (Embedded)	Exec Director Responsible	Implementing Officer	BRAG Status
Safe	Critical Care Emergency Department + All Services to review	Workforce (Well-led) committee	**CQC MD1**	The trust must continue to ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.	• Nurse and medical staffing was good at the time of inspection on the **critical care unit** however we found areas of noncompliance with intensive care standards for all staff groups. Recruitment and retention of nursing staff had been challenging for the unit, however recruitment of nursing staff had been successful in 2015/16. • The College of **Emergency Medicine** (CEM) (2015) states that every emergency department should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend. There were 9.84 whole time equivalent (WTE) A&E consultants employed by the trust who worked across both sites the trust was advertising current vacancies. There was Consultant presence on site from 8am-10pm Monday to Friday. There was additional ad hoc locum weekend on site cover by ED consultants and locum staff. Outside these hours a single consultant was on-call for both sites with a contractual 30 minute response time. • **Medical Care:** Some nurse shifts remained unfilled leaving wards below establishment. The division did not meet British Thoracic Standard guidelines for safe staffing ratios on the respiratory unit when caring for patients who required non-invasive ventilation. **C&YP HRI:** • There was no paediatric medical cover out of hours, even though the unit provided 24 hour care for surgical patients. • Advanced paediatric nurse practitioner staffing levels were not always adequate to provide a safe service on the paediatric observation and emergency surgery unit • **Community adults:** We found there had been some staff shortages but the service had managed this well. • Actual staffing levels on the **gynaecology** ward were often below the planned.	**Regulation 18: Staffing** Nurse staffing levels in some clinical areas were regularly below the planned number. This included accident and emergency for nursing and medical staffing, medical care, children's services and adult community services. At least 50% of nursing staff should have post registration training in critical care nursing; this had been completed by 39% of nursing staff.	See also core service plans: ComAd16; M&G6; C&YP15; MC1; U&ES1; Sur7; CC1; CC2; CC3	Trust wide	A range of approaches have been taken to maximise our recruitment opportunities and monitor current workforce levels: • Trust wide review led by Chief Nurse of nurse staffing levels • Safer staffing internal audit report • Hard truths report • Promotional videos (CEO & DoN) re recruitment • Recruitment fair • Business plan approved for oversees recruitment - 75 nurses • Targeted recruitment continues with increased focus of recruitment from graduating nurses & midwives from local HEI's • Continued EU recruitment programme • Specific job advert now continually running advertising the Trusts commitment to flexible working contracts & shift patterns • Focused recruitment event in October 2016 to attract potential staff, showcase the organisation & promote current vacancies • Standard operating procedure now in place for use & authorisation of temporary nursing staff. • Specific recruitment continues with the flexible workforce • Branded recruitment and advertising process under development – promoting CHFT as an exemplar place to work • Pilot site submission for Associate Nurse HEE programme completed	• Peripatetic enhanced care team business case in development to support 1.1 care provision • Rotational programme across nursing specialities completed •Procurement of new e roster management tool to include safe care module • Establish Trust medical staffing bank	• Increase in registered nurses WTE, reduction in turnover • Monthly monitoring of WTE registered nurses • Ensure established pipeline for HCSW posts is robust to allow rapid fill of vacancies with HCSW posts filled at time post is vacant • Monthly monitoring turnover of registered and unregistered nurses • 90 % compliance with roster management KPIs	31.12.16	31.3.17	- Medical Director - Director of Nursing - Chief Operating Officer	- Divisional Directors of Operations - Divisional Associate Directors of Nursing	Green
Well Led	All Divisions	Quality Committee	**CQC MD2**	The trust must continue to embed and strengthen governance processes within the clinical divisions and at ward level.	• There was a governance framework in place however there was a need to embed and strengthen governance processes within the clinical divisions and at ward level. • The trust had a PWC well-led governance review in October 2015 which identified areas of strength and areas for improvement. As a result the trust had developed an action plan for improvement and progress was monitored against actions. • The trust had also secured additional external support into the organisation to embed and strengthen governance arrangements at divisional and ward level. The trust aimed to build capability and capacity to write risk registers with workshops to support staff to make risk registers more meaningful and a tool to support staff with the management of risk.	**Regulation 17: Good Governance** There was a governance framework in place however there was a need to embed and strengthen governance processes within the clinical divisions and at ward level.			• Review of existing arrangements held with the clinical divisions to agree what actions and support are needed to meet requirements of good governance • Implementation of ward managers development programme	• Assistant Director of Quality to become an interim member of each PSQB to provide support to the Chairs and share learning across the Divisions • Director of Nursing to make recommendations regarding the minimum standard of Clinical Governance support to each Division • Testing of quality of directorate risk registers and recommendations for improvement to be made • Governance standards for ward and departments to be developed and implemented • A framework for learning from complaints and incidents to be developed and implemented at ward and department levels • Delivery of ward managers development programme to include quality, risk and governance • Delivery of 'ward to board' assurance programme	• Standardised reports from the PSQBs to the Quality Committee • Directorate risk registers developed and tested as evidence of good risk management	31.12.16	31.3.17	Director of Nursing	Assistant Director for Quality	Green
Effective	All Divisions	Workforce (Well-led) committee	**CQC MD3**	The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.	• There were variable rates of appraisals across the divisions within the trust. In some services there was inconsistency in the way staff received clinical supervision and this required standardising and strengthening. • Data provided by the trust was not always accurate with different information provided for the same time period. Mandatory training and appraisals data was unreliable with trust and divisional data differing from ward level records. • **ED:** Staff shortages to both nursing and medical staff meant there was high usage of agency and locum staff. This had also affected training rates and mandatory training rates did not meet trust targets. • **Mat:** Mandatory training figures were variable and figures were generally lower for medical staff and safeguarding training. Training was not provided on the mental capacity act and deprivation of liberty safeguards which left a gap in knowledge for staff.	**Regulation 17: Good Governance** Data provided by the trust was not always accurate with different information provided for the same time period. Mandatory training and appraisals data was unreliable with trust and divisional data differing from ward level records. **Regulation 18: Staffing** Staff appraisals were below trust target in some areas. There were variable rates of appraisals across the divisions within the trust. In some services there was inconsistency in the way staff received clinical supervision and this required standardising and strengthening. Mandatory training compliance did not meet the trust's target in several areas including accident and emergency, medical care, critical care, maternity services, children's services and community adult services.		Trust wide	• Mandatory training and appraisal process reviewed and updated by the Executive Director of Workforce and Organisational Development. • Trajectories established for all areas - monitored on a monthly basis through PRM. • Essential skills under review by Director of Nursing and Director of Workforce and OD	• Monitoring and escalation of perfomrance and achievement through monthly PRM meetings - inlcudinding Exec Director of Workforce	• Achievement of monthly trajectory • 100% appraisal in last 12 months and at year end	Monthly / Cumulatively / Year End (100%) 31..3.17	31.3.17	Director of WF&OD	Divisional Directors of Operations	Amber
Effective	All Divisions	Safeguarding Group	**CQC MD4**	The trust must continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards	• Across the services we found a variable understanding from staff regarding consent and mental capacity. In addition there was variable completion of MCA/DoLS documentation and some patients with transient symptoms suggestive of cognitive impairment did not have capacity assessments undertaken.	**Regulation 18: Staffing** There was variable understanding of the mental capacity act and deprivation of liberty safeguards.		• Two Trust-wide audits undertaken 2015 and bespoke training and masterclasses. Review of existing work undertaken • MCA DoLS is discussed in Safeguarding Adults level 2 and 3 training	• MCA DoLS to be part of essential skills training for staff which will include patients who lack capacity and consent • Trust wide MCA DoLS audit twice yearly, with results reviewed at safeguarding committee and disseminated to divisions • Ward and department MCA DoLS champions • Matrons alongside band 7 and 6 staff to develop knowledge and skills in completion of DoLS paperwork and processes • Develop a strategy to ensure all Matrons attend multi-agency MCA / DoLS training	• All staff who undertake MCA DoLS training will be recorded via ESR and included in training numbers • Further audit and action planning to safeguarding committee meeting in Q4 • Divisional PSQBs to monitor compliance with evidence in minutes of review and actions	31.10.16	31.3.17	Director of Nursing	Deputy Director of Nursing	Green

CQC Domain	Core Service Area	Governance Oversight	Action reference MD (must do) SD (should do)	Recommendation	Examples of issues reported	Associated regulation		Trust Response: Action taken to date	Trust Response: Further action (if required)	Measurable outcome expected following implementation of recommendation	Expected Date of Completion of Actions	Date of Sustained Improvement of Outcome (Embedded)	Exec Director Responsible	Implementing Officer	BRAG Status
Effective	Maternity and Gynaecology	Safeguarding Group	CQC MD5	The service must ensure staff have an understanding of Gillick competence.	• Staff involved in the care of children could not explain Gillick competence (mat & gynae). • Staff could not articulate what was meant by Gillick competence despite giving examples of children accessing services (mat & gynae).			• Consent Task and Finish Group established led by Associate Medical Director with an associated action plan and delivery • Gillick and Fraser competencies are covered in Safeguarding level 2 and 3 training • Detailed information shared with staff in maternity and gynaecology to support understanding • Additional training sessions offered to maternity staff	• A 10-key messages sheet being developed by the consent group to include information re Gillick Competence • Additional training sessions to taking place to the end of October (mat & gynae) • Review of compliance following these sessions to inform next steps	• Training figures regarding Gillick and Fraser competencies covered in adult and children safeguarding training, monitored monthly at the safeguarding committee meeting. • A selected sample of staff are able to articulate and demonstrate an understanding of Gillick competence (mat & gynae)	31.10.16	31.12.16	Director of Nursing	Deputy Director of Nursing	Blue
Effective	All Divisions	Mortality Surveillance Group	CQC MD6	The trust must continue to identify and learn from avoidable deaths and disseminate information throughout the divisions and trust.	• HSMR data as reported in as reported in the integrated performance report February 2016 was 116.34. The local Summary Hospital-level Mortality Indicator (SHMI) was also reported at 111. • There were no active mortality outliers identified by the Care Quality Commission at the time of inspection.			• Care of the Acutely Ill Patient action plan in place and overseen by the Clinical Outcomes Group • Mortality review process in place and learning from the reviews shared with divisions • Mortality Surveillance Group established and meeting monthly	• Implement changes to the mortality review process to align with national recommendations and also become consultant led • Implement action plans from Independent Service Reviews in Stroke, Elderly Medicine and Respiratory Medicine	• All mortality outlier alerts are considered for investigation and reports on the findings shared with relevant staff • Learning from mortality is included on PSQB and Directorate Clinical Audit agendas • Any avoidable death is investigated as a serious incident and lessons learnt shared across the organisation	30.11.16	31.1.17	Medical Director	Assistant Director for Quality	Blue
Safe	All Divisions	Workforce (Well-led) Committee	CQC MD7a	The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role.	• Staff within children's services had not undertaken safeguarding training at the appropriate levels for their role and the trust target of 100% had not been met. • Mat: Training compliance figures for adult and children's safeguarding were between 15.9% and 56.6% so we could not be assured all staff were up to date in this area.	**Regulation 18: Staffing** Level 2 and Level 3 children's safeguarding training compliance in children's and maternity services was below the trust target of 100%. Level 2 safeguarding adults training was also below the trust target in maternity services, surgical services and medical services.		• All staff have been reviewed in line with the intercollegiate document for safeguarding children and the draft intercollegiate document for adults • This resulted in more staff requiring level 3 childrens training • Additional sessions have been added this year. Level 3 adult safeguarding has not been recorded before and is a new target audience • Training and supervision information sent to Divisions for circulation relating to individual responsibilities in relation to supervision and training • Level 2 eLearning package was developed last year for adults and children to enable the team to provide additional level 3 sessions	• To ensure / liaise with training department so that all staff who require level 3 / 2 adults or children are assigned the separate training package and not the joint package. • PSQBs to monitor uptake of training within the Divisions and Departments • Provide standard information for safeguarding information boards within departments - scope content and location • To ask divisions and wards to sponsor a member of staff to become a safeguarding champion. This will include MCA/DoLS, adult and children safeguarding agendas. • To scope how junior medical staff receive safeguarding training • To liaise with named and designated Doctors regarding Paediatrician compliance with safeguarding training • Prevent training paper to safeguarding committee to consider e-learning and competencies framework and compliance	• Divisional training figures to show an increase in compliance at all levels of training including Prevent	31.12.16	31.3.17	Director of Nursing	Deputy Director of Nursing	Green
Safe	All Divisions	Safeguarding Group	CQC MD7b	The service must also ensure all relevant staff are aware of Female genital mutilation (FGM) and the reporting processes for this.	• Within maternity services not all relevant staff were aware of Female genital mutilation (FGM) and the reporting processes for this.	**Regulation 18: Staffing** Within maternity services there was variable knowledge and understanding of female genital mutilation.		• FGM guidelines in place with detailed process and statutory reporting process - data is collected monthly and discussed at the safeguarding committee • Detailed information shared with staff in maternity and gynaecology to support understanding • Additional training sessions offered to all maternity staff	• Paper to be shared at ELG proposing FGM training is mandatory for relevant staff within maternity, health visiting and ED • 4 training sessions to take place in September and October • Review of compliance following these sessions to inform next steps	• A selected sample of staff are able to articulate and demonstrate an understanding of FGM and reporting processes required	31.10.16	31.12.16	Director of Nursing	Deputy Director of Nursing	Blue
Safe	All Divisions	Patient Safety Group	CQC MD8	The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.	• **Surg:** Daily temperatures for the storage of medications were not all within the correct limits on all wards and were recorded outside the margins for the safe storage of medicines. No action had been taken to check whether records were accurate or whether there was a fault with equipment. • **Mat:** We were not assured medications within fridges were always stored at the appropriate temperatures. • **Med (CRH):** Medicines management needed to improve at ward level to ensure refrigerated medications remain stable and those past their expiry date are disposed of in a timely manner and in accordance with local policy.	**Regulation 12:** Safe care and treatment Medicines were not always managed appropriately. Within the medical, surgical and maternity divisions there was inconsistent monitoring of medicines requiring refrigeration. For example out of range fridge temperatures were not always acted upon. On one of the medical wards visited we identified that a controlled drug date expired but this had continued to be administered on a further five occasions over three days before a replacement supply was obtained Within maternity services controlled drug checks were not always checked in line with trust policy and recorded.		• Identified a calibrated thermometer that is simple to use and can be mounted externally to the fridge and will be used Trust wide to monitor the temperature in the fridge. The temperature probe is within a liquid and measures the temperature of product rather than air temperature within the fridge. This will reduce false positive temperature variations when the fridge door is opened. • Updated the monitoring sheet for cold storage to reflect what must be recorded and how, and the action to be taken when out of range. This was shared with all Ward/Departmental Managers for implementation. Copies are available for clinical areas on the nurse repository • Frontline Ownership audit (FLOW) updated to include checks on cold storage including fridge locked, daily check of temperature undertaken and out of range temperatures actioned • Ward/Departmental Managers CD checklist agreed at Nursing and Midwifery Practice Group August 2016 for monthly use to identify any issues with CDs in the area including expired medicines. • Prepared a bulletin to raise awareness of medicines with a shortened expiry and the action required when opening to use- awaiting printed labels • Established CD task and finish group to improve standard of record keeping for CDs within the Trust through learning from incidents and development of easier to use CD record books particularly for Patient's own CDs.	• Roll out the use of these calibrated thermometers with training to all clinical areas with a medicines fridge and checking that correct fridge monitoring sheet is in use. • Ensure all areas are continuing to use the correct record sheet, recording daily as per Trust guidelines and taking appropriate action when out of range temperatures recorded; using Pharmacy ATOs to check that documentation completed and action take with feedback to Ward Manager. Escalation to Matrons will be introduced via Senior Pharmacy Staff if action not taken. • Article of clinical importance of fridge temperature monitoring to be included in Trust weekly Newsletter • Liaise with Estates to agree a clear action to be taken and response times following a fridge failure • Two spare fridges to be purchased for interim use following a fridge failure • Role of Ward based Pharmacy ATO's to be developed to include removal of no longer required/expired medicines from wards. Invest to save business case to be prepared • Awareness training for Nursing staff in relation to expiry of oral liquids once opened • Ward/Departmental Managers with a CD cupboard are all using the CD checklist on a monthly basis • Regular Joint Pharmacy/Nursing leadership walkabouts to be undertaken by DoN and Dir of Pharmacy in order to reinforce the clinical and patient safety aspects of the above action plan. • Bulletin and extra labels will be shared and available for nursing staff.	• All Medicine Fridges have the same calibrated thermometer in use. (Database giving information) • All Fridges are monitored daily by ward staff as per Trust guidelines. Any out of range temperatures are managed according to Trust guidelines. (Flow Audits/ATO Record sheet/Ad-hoc audits of medicine storage) • Each Ward/Department with a CD cupboard has a completed monthly CD checklist from 1 September 2016. • Pharmacy CD checklists in clinical areas shows use of the Ward/Departmental CD checklist every month. (Every six months for each area) • No reports on Datix of expired medicines being administered and a reduction in incidents related to CDs in clinical areas. • Medicines in clinical areas all in date (Ad-hoc audit of medicine storage)	31.10.16	31.3.17	Director of Nursing	Director of Pharmacy	Green

CQC Domain	Core Service Area	Governance Oversight	Action reference MD (must do) SD (should do)	Recommendation	Examples of issues reported	Associated regulation		Trust Response: Action taken to date	Trust Response: Further action (if required)	Measurable outcome expected following implementation of recommendation	Expected Date of Completion of Actions	Date of Sustained Improvement of Outcome (Embedded)	Exec Director Responsible	Implementing Officer	BRAG Status
Responsive	Community adults	Community division	**CQC MD9**	The trust must ensure that interpreting services are used appropriately and written information is available in other languages across all its community services.	• Staff were able to access a translation service which was provided by an external organisation who were a member of the NHS framework. There was a telephone service as well as interpreters being available to accompany staff if required. The top three languages used in 2014/2015 were Punjabi, Urdu and Polish. Staff reported that this service was less responsive than the previous provider and that they sometimes had concerns about the professionalism of the staff. • Staff in the continence advisory service told us they would ask family members to attend appointments if there were language or communication issues identified. • There was a lack of availability of leaflets in other languages than English. Staff told they could request leaflets to be produced in other languages as and when required. The English version of some leaflets we saw stated these could be reproduced in other languages. However some staff told us that this was not the case and gave an example of when it had not been possible.			• Information on interpreting services shared with staff in the community division • Escalation process in place with the interpreting service contract manager	• Trust to review access to interpreted information for both hospital and community services	• Appropriate use of interpreting service - and reduced issues with access to interpreters	30.11.16	31.1.17	Director of Nursing	Director of Operations - Community Division	Blue
Safe	All Divisions	Patient Safety Group	**CQC MD10**	The trust must ensure that appropriate risk assessments are carried out in relation to mobility and pressure risk and ensure that suitable equipment is available and utilised to mitigate these risks.	• **Med:** The completion of risk assessment documentation required improvement • In the public board meeting minutes of 17 December 2015 there was an exception report which related to pressure ulcers. It was noted that the trust continued to have more ulcers each month than the planned target, although recent months had begun to see a reduction in the monthly numbers from the peak. The root cause of the pressure ulcers were largely unchanged and related to underlying medical/ nursing complexity, care delivery problems around the assessment level of risk, skin, reposition and the provision of the necessary equipment. The exception report detailed actions to be taken to improve performance and timescales. • The trust held 2 full day harm summits in November 2015 with a focus on reducing patient harm; particularly in relation to falls, pressure ulcers and medication errors. The trust were also working with the Improvement academy and had introduced safety briefings and a Falls Collaborative.			• Falls lead appointed and now in place • Falls improvement action plan developed • Safety huddle action plan • Use of cohorting and in-bay nursing • Use of double sided socks trust wide for high risk patients • Monthly falls collaborative • Improved validation process and pressure ulcer review panel • Work led by matrons on basic care, nutrition, intentional rounding • New repose pressure relieving equipment • Increased seniority of Lead Tissue Viability Nurse and is now in post • Ward managers development programme specific session on patient safety • Review of national best practice	• Review of existing equipment for falls • Review Centralised Equipment Library to include falls equipment and mattresses • Ward assurance programme under review • Implementation of EPR	• Reduction in falls in Q1 17/18 • Improvement in falls bundle compliance • Improved performance in CRAS audit for compliance with risk assessments for falls and pressure ulcers • Equipment is available at point of care and has been reviewed	31.12.16	31.3.17	Director of Nursing	Deputy Director of Nursing	Green
Caring	Maternity	FSS Division	**CQC MD11 (M&G12)**	Within maternity services the service must focus on patient experience and ensure women feel supported and involved in their care.	• During both our announced and unannounced inspection in maternity services we received comments from women who felt they had not being involved in decision making about their care and felt unsupported. A period of time had passed since the birth for some of the women we spoke with and they still felt affected by the experience. • However within maternity services although positive comments were received and the overall friends and family test data responses were good, we were concerned about the number and content of the negative comments we received during the inspection.			• Develop new 1/4ly report of themes and trends of complaints - to be shared across the workforce • Each clinical area to develop patient experience action plan based on themes and trends • Deliver National Performance Advisory Group 'Putting the Patient First - Customer Care & Communication Skills in the NHS' Training to the MDT maternity team - 4 sessions delivered in August and September 2016 - 27 staff attended • Refreshed approach to increasing FFT feedback rates and quality of written feedback (Leads: Ward clerks and support workers) • Matrons attending every inpatient and clinic area every day to provide visible leadership to women and staff	• All clinical areas to develop a customer care pledge (by end October 2016) • Clinician allocated to each clinical area to assist with involvement of MDT in developing, implementing and evaluating impact of pledges • Work with Healthwatch to further assess patient experience feedback and ensure service developments are patient focused	• Reduction in the number of women who report (via formal and informal feedback, complaints and FFT) that they have not felt listened to	31.12.16	31.3.17	Divisional Director for FSS	Associate Director of Nursing for FSS	Green
Safe	Maternity	FSS Performance Meeting	**CQC MD12 (M&G2)**	The trust must review the provision of a second emergency obstetric theatre to ensure patients receive appropriate care.	• The RCOG guidelines recommended two obstetric operating theatres for a hospital with a birth rate of over 4000. There was a second theatre within the main operating department, but out of hours the team which staffed it were not on site and had to travel from home. We had concerns about the process of opening a second obstetric theatre out of hours and the potential impact this had for women requiring an emergency caesarean section. We found evidence of delays in women requiring category one caesarean sections getting to theatre within the recommended time scale of 30 minutes.	**Regulation 17: Good Governance** During the inspection there were a number of concerns raised within maternity services there was limited assurance that the systems in place for sharing information, monitoring and identifying risks were effective in addressing these concerns.		• Established group to review factual evidence relating to delays in accessing maternity theatre capacity • External review of maternity theatre arrangements by RCOG • Set local standards for measuring and monitoring delays in accessing maternity theatres • Commenced revised data collection to monitor delays • Reviewed and acted on weekly at maternity governance meeting Update Oct - see below Update Nov - See below	• Conclude theatre work and make final recommendations	• Reduced risk relating to delays in accessing maternity theatres: - specifically poor maternal or neonatal outcome - delay in repair of 3 and 4 degree tear - rates of PPH	31.10.16	31.12.16	Chief Operating Officer	Director of Operations for FSS	Blue
Safe	Maternity	FSS Division	**CQC MD13 (M&G7)**	The trust must continue work to reduce the numbers of third and fourth degree tears following an assisted birth and the incidence of PPH greater than 1500mls following delivery.	• During the inspection we raised concerns with the chief executive and executive team regarding a number of areas within maternity services. These included feedback from patients during the inspection, the numbers of large volume postpartum haemorrhages (PPH), third and fourth degree tears, the antenatal assessment of mums to ensure the delivered in the appropriate setting and the ability to open a second obstetric theatre. We were concerned that staff we spoke with did not highlight these issues as a risk. We were therefore not assured that the systems in place for sharing information, monitoring and identifying risks were effective. The culmination of all these concerns had not been identified or acted upon by the senior management team with maternity services.	**Regulation 17: Good Governance** During the inspection there were a number of concerns raised within maternity services there was limited assurance that the systems in place for sharing information, monitoring and identifying risks were effective in addressing these concerns.		• Maternity action plan developed and implemented. • Shared plan with CQC • External visit from RCOG who provided verbal assurance relating to service. • Written report received Update Oct - see below Update Nov - See below	• Continued refinement and implementation of action plan	• Rates of PPH and 3 and 4 degree tears to be within regional interquartile range	31.10.16	31.3.17	- Medical Director - Director of Nursing	- Divisional Director for FSS - Associate Director of Nursing for FSS	Green
Responsive	Critical Care	Surgical Division Performance Meeting	**CQC MD14 (CC8)**	The trust must review the admission of critical care patients to theatre recovery when critical care beds are not available to ensure staff suitably skilled, qualified and experienced to care for these patients.	• There was issue with delayed discharges across both critical care units. Sixty three percent of patients discharged to wards were delayed greater than four hours after the decision had been made to discharge. Out of hours discharges between 10pm and 7am were particularly high at CRH site at nineteen percent of all discharges. • **Crit care (HRI):** Between January and March 2016 the theatre recovery unit had been utilised every week by critical care for admission of patients. This was not a safe arrangement; activity was not being planned, monitored or managed by the critical care senior team.	**Regulation 12: Safe care and treatment** In critical care services there were delays in discharges and admissions which led to patients being cared for in the theatre recovery area. **Regulation 18: Staffing** There were occasions where critical care patients were cared for in recovery. Theatre nursing staff were not trained in critical care competencies and access to ITU staff for support and advice was limited.		• In circumstances when critical care beds are unavailable, theatre recovery continues to be used • Since April 16 usage has significantly reduced • Patients awaiting ICU beds in recovery are nursed appropriately in accordance with the local guidelines, to ensure they are looked are looked after safely • Patients are cared for by recovery staff with the appropriate competencies • An Anaesthetist is always present for level 3 patients with access to the ITU consultant of the day • Business case to nursing panel for 24/7 supernumerary Nurse Coordinator not supported for investment in 2016 • Proposal to increase the Outreach Team on the HRI site not supported by the Nursing Panel	• 6 month trial of flexible working roster in critical care to support peaks and troughs of activity • Business case for 24/7 supernumerary Nurse Coordinator to be re-submitted to the Nursing panel • Retrospective audit of critical care patients managed in recovery over the last 3 months to be undertaken and presented to October DMT to inform management of safety issues • Monthly audit to be undertaken to enable DMT to monitor safety and inform planning • Staff satisfaction survey to be undertaken in both critical care and recovery • Review outputs from audit and survey and agree further actions as required	• Report to DMT regarding 3 month retrospective audit of recovery and action plan • Audit data regarding use of recovery	31.10.16	31.3.17	Chief Operating Officer	Associate Director of Nursing for Surgery	Green
Responsive	Critical Care	Surgical Division Performance Meeting	**CQC MD15 (CC10)**	The trust must continue to review arrangements for capacity and demand in critical care.	• There was issue with delayed discharges across both critical care units. Sixty three percent of patients discharged to wards were delayed greater than four hours after the decision had been made to discharge. Out of hours discharges between 10pm and 7am were particularly high at CRH site at nineteen percent of all discharges. • **Crit Care:** 41% of all patient discharges were delayed more than four hours after the decision to discharge.			• Ongoing communication with ICU Consultants as to capacity of critical care beds • Patient flow team given increased priority to patients being discharged to wards • Patients awaiting ICU beds in recovery are nursed appropriately in accordance with the Clinical Guidelines • An Anaesthetist is always present for level 3 patients • Business case to nursing panel for 24/7 supernumerary Nurse Coordinator not supported for investment in 2016 • Proposal to increase the Outreach Team on the HRI site not supported by the Nursing Panel	• Further improve the escalation process when a patient is ready to step down to a ward and there is likely to be a delay greater than 4 hours after the decision has been made due to availability of ward beds • ICU staff to implement a more proactive process to ensure escalation to patient flow team (in line with Escalation guidance) • Embed the escalation guidance • To undertake a 'go see' of Site-Commander role	• Reduction in delay of transfer of patients to ward beds when declared fit to step down - available from ICNARC data	30.11.16	31.3.17	Chief Operating Officer	Director of Operations for Surgery	Green

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CQC Domain	Core Service Area	Governance Oversight	Action reference MD (must do) SD (should do)	Recommendation	Examples of issues reported	Associated regulation		Trust Response: Action taken to date	Trust Response: Further action (if required)	Measurable outcome expected following implementation of recommendation	Expected Date of Completion of Actions	Date of Sustained Improvement of Outcome (Embedded)	Exec Director Responsible	Implementing Officer	BRAG Status
Responsive	Emergency Department	Medical Division Performance Meeting	**CQC MD16 (U&ES 6)**	The trust must ensure that patients on clinical decision unit meet the specifications for patients to be nursed on the unit and standard operating procedures are followed.	• Patients were being admitted onto the clinical decisions unit (CDU) where there were no beds available on main wards. Staff on the unit were not always aware who was responsible for the care of these patients and did not always have the specialist skills to assess and treat these patients. • The clinical decision unit was often not available to ED patients as patients waiting for beds on other wards remained on the unit for long periods of time. The CDU was being used as a general ward. This was against the specification set out by the trust in June 2014. This was having an adverse effect on flow through the emergency department and was putting patients at risk as the unit did not have the facilities to care for patients who needed longer than 24 hours care. • At the inspection we found a number of patients on the clinical decision units in the accident and emergency departments who had an extended length of stay on the units whilst waiting for a general inpatient bed and staffing levels on CDU. We were concerned that when we raised this with the director of nursing and medical director they were not aware the CDU were used in this way and these areas had not been raised as a concern within the department or by senior managers. • During the inspection we had concerns around the use of the clinical decisions unit (CDU). Patients were being admitted for substantially longer than the 24-48 hours outlined in the trusts policy. There was confusion as to which medical teams were responsible for patients waiting for beds on inpatient wards were being treated on the CDU as well as ED patients.	**Regulation 17: Good Governance** At the inspection there were issues with flow and these had not been identified and therefore adequately addressed and patients were being admitted to the CDU for inappropriately long times.		**Staffing** • WFM put in place • Protocol to ensure only substantive staff work in CDU • Designated CDU rosta • CRAS audits improved • SIT Rep 2 hourly • Updated action plan with evidence completed **Documentation -** • SOP for transferring patients to specialty bed base and managing LOS • Still some inappropriate patients in CDU, all incidented on DATIX, matron escalation in place • Evidenced LOS reduction • Reference 2 week SITREP and DATIX check	• Evidence LOS needs to capture range as well as the average • Review risk assessment process for putting inappropriate patients in CDU - this is captured in the SOP, need to check this is embedded across all matrons trust wide and working in practice • Daily monitoring is now in place to ensure the SOP is being adhered to and audited on a regular basis. The audit results will be presented via the Directorates QI forum	• Reduction in LOS • Monthly CDU audit demonstrate compliance with SOP	30.11.16	31.12.16	Chief Operating Officer	Director of Operations for Medicine	Blue
								Go see undertaken by CQC inspector and CCG (26.10.16) identified **Positive:** CDU protocol followed Escalation in place to keep patients safe Appropriate use of current pathways Good care **Areas to Work on:** Appropriateness of current use of CDU pathways, particularly for frail patients on a social pathway	Carry out an audit of the use of the social pathway with particular reference to the age of patient, LOS and co-morbidities and compliance with current inclusion / exclusion criteria	Change to the pathway with specific inclusion / exclusion criteria SOP revised in line with other Directorate activity - ambulatory care and frailty reviews			Divisinal Director	Emergency Care: Clinical Director and General Manager	
Responsive	All Divisions	Divisional Performance Meetings	**CQC MD17**	The trust must ensure there are improvements to the timeliness of complaint responses.	• The trust performance for responding to complaints within the relevant timescale was 48% against a target of 100%. • **Surg:** Trust data showed only 45% of complaints were closed within target in the surgical division. • For April 2015 to March 2016 the trust's year to date performance for the three day acknowledgement letter was 93.31% against a target of 100%. In the same time period the year to date response rate to complaints within the time frame was 48.45% against a target of 100%.Regular weekly monitoring of overdue complaints was provided to divisions and weekly	**Regulation 17:** Good Governance There was a backlog across the trust in responding to complaints and this failed to meet the trust timescales.		• The Trust has a policy which describes the standards required to meet the PHSO standards • Weekly reports are sent to the divisions showing compliance with the standards • The Complaints Manager meets with each division regularly to review progress and offer support • Performance monitoring is through the Divisional Performance Meetings	• Assistant Director for Quality to meet with each division to establish the causes for delay and agree a recovery and sustainability plan • Complaints Department to agree escalation process for when it is failing to meet its own targets and an early warning sign in the case of a division starting to fail to meet targets	• Complaint responses meet targets as reported in the Trust Integrated Performance Report	30.11.16	28.2.17	Director of Nursing	Assistant Director for Quality (working with the ADNs)	Green
Responsive	Medicine	Medical Division	**CQC MD18**	The trust must ensure there is formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant	• **Surg:** There was no rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant. This had not been resolved at the time of our inspection and staff identified this as a risk to the safety of patients.	**Regulation 12: Safe care and treatment** There was no formal rota for the management of patients with gastrointestinal bleeds by an endoscopy consultant.		• New SOP/Pathway in place Bleeds AUGIB protocol (V4 final) • Expect to be signed off as sustained improvement that is embedded by the end of October 2016	• Audit to ensure patients are going to HRI (June data; GI bleed Patients Admitted to MAU HRI) • Rota to ensure no gaps (Monthly Rota)	• Audit evidence to demonstrate patients are going to HRI as planned. • Formal GI bleed rota in place with no gaps.	30.09.16	31.1.17	Divisional Director for Medicine	Director of Operations for Medicine	Blue
Responsive	Children & Young People	FSS Divisional Performance Meeting	**CQC MD19 (C&YP16)**	The trust must review the model of care for the services provided on the paediatric assessment unit at Huddersfield Royal Infirmary.	• At HRI there was no paediatric medical cover on site even though the paediatric observation and emergency surgery unit provided 24 hour care for surgical patients. Advanced paediatric nurse practitioner staffing levels were not always adequate to provide a safe service on the paediatric observation and emergency surgery unit. • It was difficult to determine how the service had planned services to meet the needs of local children and young people. There was no clear rationale or model of care for the services provided on the paediatric observation and emergency surgery unit. The trust was undertaking emergency surgical procedures on children and young people over the age of four months. This meant on occasions children and young people stayed overnight in the unit with the support of advanced nurse practitioners. No paediatricians were on site if a child or young person deteriorated suddenly; however, there were anaesthetists on site with competencies in paediatric care.			**Staffing(also covered within MD1)** • Undertaken consultation with surgical, ED, Paeds and medical colleagues to develop a planned short term model to manage gaps in the APNP rota • Escalation process in place for unplanned gaps in the APNP rota to ensure risk is mitigated and key stakeholders are aware of any staffing shortfalls • Four newly qualified APNPs who are undertaking a period of consolidation to ensure they have the appropriate skills to work on ward 18 • SOP in place and has been updated in response to service modifications	• Monitor the impact of the gap in the rota by : - DATIX reporting to have a good understanding of the impact of the gap in rota - Monitor and analyse ED breaches on a monthly basis - complaints related to ward 18 - FFT performance and comments • Audit the current compliance of the expected Paediatric consultant input	• Safe workforce model (numbers and competencies) in place to meet the needs of the service	31.12.16	31.3.17	Chief Operating Officer	Director of Operations for FSS	Green
								Model of care **Revised staffing arrangements:** - The unit's nursing staff and support staff is managed on a day to day basis by a ward sister with an Advanced Paediatric Nurse Practitioner being based on the unit 24 hours a day with open access to the Paediatric Consultant as required. - From Monday to Friday 9.00 am to 5.00 pm there is a nominated Consultant for Children's Unit HRI The Consultant attends for a morning ward round on a daily basis and is then be available for advice by phone and for emergencies is housed on the ward every week day afternoon to deliver safeguarding medical provision. - On a Friday, when a dedicated day of paediatric day case activity takes place at HRI, the paediatric consultant offers senior paediatric clinical advice to the day-case unit and anaesthetic and surgical colleagues. Those patients who require an unplanned inpatient stay following surgery will continue to be transferred back to CRH. At a weekend the Consultant on call for general paediatrics will conduct a joint handover/board round meeting from CRH at 9am on Saturday and Sunday. • SOP in place and has been updated in response to service modifications Sudden deterioration of a child: any child who is sick post-surgery is discussed between the Surgical, Anaesthetic and Paediatric Consultants to agree the most appropriate care management. However, a child requiring HDU level of care would either be transferred to CRH or to the PICU if condition indicated.	• Work with the Surgical Division to prepare a detailed briefing paper describing activity on ward 18 to include: - chronology of changes and why - current model including workforce - any weaknesses in the model • Carry out a desktop exercise with Paediatric, Surgical and ED colleagues to test the options presented in briefing paper • Review the SOP in response	• Agreed model going forward which articulates the organisational and clinical risks and outlines any mitigating arrangements					

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Safe	Community adults	Community Division Estates & Facilities Division	**CQC SD1 (ComAd 1)**	The trust should ensure that the equipment inventory is updated in community adult services and that all equipment in use is properly maintained and checked.	• There was a lack of control and assurance regarding equipment and medical devices. This meant that staff were not aware of what equipment was available or if it was safe to use. • We were provided with a list of community portable equipment which consisted of 1,956 items. The list was not up to date in terms of when the items were last checked or serviced. For example 183 of the 1,956 items listed had been seen in the last 12 months. There were items listed such as a Doppler Pulse Detector that had not been checked since it was installed in May 1999. Another example was an electronic ear syringe which had not been checked since December 2005. Nursing staff did not know when equipment had last been calibrated as there were no records available to them. • The trust was aware of equipment maintenance assurance problems in January 2015 and had identified there were gaps in planned preventative maintenance of equipment and medical devices. The trust's in-house medical engineering department and third party companies were identified as being responsible for the servicing and maintenance of equipment and medical devices.				• Community register of medical devices in place • All staff requested to review equipment and to action any outstanding calibration requirements • Divisional representation on the medical devices and procurement group • Continued update of the asset register	• Work with the Medical Engineering team to implement a robust process for identifying an up to date position with equipment / devices and ensuring staff are clear about their responsibilities	• Up-to-date asset register	31.12.16	31.3.17	Director of Estates & Facilities	Director of Operations for Community	Green
Caring	Critical Care	Surgical Division	**CQC SD2 (CC12)**	The trust should review the availability or referral processes for formal patient psychological and emotional support following a critical illness.	• There were no examples of formal access to psychological support at the time of inspection. We spoke with a senior nurse who told us that this service did exist previously and staff were hoping to reinstate this emotional support at discharge clinics in the future.			• Monthly Nurse led discharge clinics commencing October 2016 • Reviewing, formalising and standardising the process for psychological support for critical care patients • Consultation in progress with IAPT (Improving Access to Psychological Therapies) for Calderdale and Kirklees to confirm in-reach service to follow up clinic to assess patients - agreed in principle	•To meet with IAPT to arrange their attendance for assessment of psychological needs	• Monthly clinics taking place • Formal patient psychological and emotional support available via the clinics	30.11.16	31.1.17	Director of Nursing	Associate Director of Nursing for Surgery	Blue
Responsive	Critical Care	Surgical Division	**CQC SD3 (CC13)**	The trust should review the handover arrangements from the hospital at night team to the critical care team to ensure continuity of patient care across the hospital.	• There was an established seven day service for the critical care outreach team who were available from 7:30 to 20:00 hrs. The team were well regarded by colleagues we spoke with across the Trust. Outside of these hours the hospital at night team provided cover. At night time, there was a face-to face handover between outreach team and the Hospital at Night team, and in the morning, there was a written handover document available for the outreach staff when they arrived on shift. However we spoke to a registrar and CCOR staff who told us that handover was written on paper and left in the office for the next shift on duty.			• CRH : Face to face handover between Outreach and Out of hours team both morning and evening commenced 14th September, following a change in hours of Out of Hours team (OHT) • HRI: Face to face handover continues in the evening	• Morning face to face handover at HRI to commence in November when new OHT hours start	• Face to face handover in place twice daily to improve continuity of care	30.11.16	31.12.16	Medical Director	Associate Director of Nursing for Surgery	Blue
Safe	All Divisions	Patient Safety Group	**CQC SD4**	The trust should ensure that relevant staff have received training in root cause analysis to enable them to provide comprehensive investigations into incidents.	• **Med:** We found the divisional management of patient safety incidents to require improvement, in particular, around incident grading and investigation. The division were consistently below their target for harm free care.			• We have an RCA training programme • .Some staff are trained in RCA techniques and our investigation tools support the use of RCA investigation approaches • Ward and department managers in the Medicine Division are having 1-1 sessions with the risk management team on the grading of incidents	• Ensure all serious incident investigations are undertaken by a colleague with RCA training • Continue to deliver the RCA training programme • Risk management team to support staff to develop competence in the use of RCA techniques and tools	• All serious incident investigations are conducted by an RCA trained colleague • Monitor the %age of incidents that the Risk Management Team are regrading the severity	31.10.16	30.11.16	Director of Nursing	Assistant Director for Quality	Blue
Well Led	EoLC	Patient experience & Caring Group	**CQC SD5 (EoLC 4)**	The trust should provide consultation opportunities and team collaboration in the development and completion of its business strategy and vision for end of life care.	• **EoLC:** The end of Life Strategy / Vision was in draft form. It did not contain business objectives for the team and lacked robust definition of what the vision and outcomes would be for the team in the future.			• End of Life Care strategy has been developed and shared at WEB • End of Life Care scoping facilitator in post with a focus on delivering the strategy	• Review the End of Life Care strategy taking into account recent audit findings, current work streams and new CQC report findings • Internal verification of draft strategy with key members of staff • Acute Trust Steering Group to develop an implementation plan to enable the End of life Care Strategy to be delivered • Hold a breakthrough event to engage with external stakeholders and Commissioners in End of life care to look at a health economy wide plan	• Strategy developed and shared across the organisation • Team objectives in place to support delivery of the plan	31.12.16	31.3.17	Director of Nursing	Deputy Director of Nursing	Green
Responsive	Children & Young People	FSS Performance Meeting	**CQC SD6 (C&YP 17 and ED7)**	The trust should ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.	• **OPD:** • Several clinics, including ophthalmology and ENT, saw children in adult clinics. We found none of the nursing staff working in OP clinics were trained to safeguarding level 3. Nurses working with children who could potentially contribute to assessing, planning intervening and evaluating the needs of child where there are safeguarding/ child protection concerns should be trained to safeguarding children level 3. • Children were seen in adult outpatient areas. Not all staff in these areas had level 2 safeguarding training and no staff had training or skills in paediatric life support. **ED:** The accident and emergency departments' provision for paediatric patients was limited with only one paediatric qualified staff member on duty during our inspection across both sites and limited facilities available for children and young people. • Provision for paediatric patients was limited. Other than the paediatric waiting room and cubicle there was no dedicated paediatric area within the department. The Department only had one qualified paediatric nurse. Paediatric staff from Ward 18 / Ward 3 within the hospital could provide support and would attend the department to manage the care of critically unwell patients.		SD6a: OPD	• Checked with Safeguarding Team in CHFT who advised that for adult nurses working with children level 2 training is in line with our training strategy and the intercollegiate document. However as good practice it is agreed that all Band 6 & 7 adult nurses would complete level 3 training. OPD Matron has allocated band 6 & 7 adult OPD staff to attend Level 3 training in the forthcoming months • All Paediatric OPD outpatient staff complete level 3 training • OPD nursing staff have completed Level 2 training • OPD Band 6 staff and above have completed safeguarding study day training run by safeguarding team in May16 • Mapped requirements and training opportunities for Paediatric Life Support	• Further staff scheduled to attend safeguarding training in October 2016 • Establish delivery plan for any staff who still require safeguarding training • Clear plan for delivery of Paediatric Life Support training	• Training schedule delivered against plan • Trust target achieved	30.11.16	31.3.17	Director of Nursing	Associate Director of Nursing for FSS	Green
							SD6b: ED	• The Consultation on acute services is directly linked to this issue - without a separate Paeds ED there is pressure on recruitment of childrens nurses and limited clinical space. It would be difficult to establish audio/visual separation of children without significant structural work • Band 6 Paediatric lead is out to advert • Dates are identified for Paediatric sepsis training • Discussions have started about streaming children in ED	• Establish a business case for the Paediatric Vision including workforce modelling in response to consultation on reconfiguration of services • Recruitment of band 6 children's nurse to lead development of care delivery to children • Establish a plan for service development over the next 12 - 18 months that covers: - creation of a separate children's stream at CRH - implementation of an education strategy, to include provision of a series of masterclasses in the care of children: - band 5 rotational post(s) between Paediatrics and ED - engagement with the local community re the design of improvements in the environment - increasing feedback from children / carers	• Plan in place which provides clear direction and timescales for staff and service development	31.12.16	31.3.17	Director of Nursing	Associate Director of Nursing for Medicine	Green

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								Action taken to date	Further action (if required)						
Responsive	OPD & diagnostics	Estates &Facilities Division	**CQC SD7**	The trust should ensure signage throughout the HRI main building and Acre Mills reflect the current configuration of clinics and services.	• Patient-led assessment of the care environment (PLACE) audits had been carried out in April 2015; the team inspected the Acre Mills site. The overall opinion was positive and cleanliness overall was good. It was noted some extra signage was required to help with wayfinding; this had been actioned at the time of this inspection. • Signage to OP clinics was clear in the HRI main building and Acre Mills. However, we noted signs in the main building directing patients to the 'Eye Clinic.' We confirmed with senior staff that there were no ophthalmology services located in the HRI main building. The OP manager in Acre Mills told us the trust was currently reviewing the signage. • Staff pointed out signage with black writing on yellow background in large fonts; this was the best colour combination for visually impaired people. However, not all signs in Acre Mills were in this colour. This meant visually impaired patients could only see the signage for their own clinic. Other signs, such as the location of the toilets, were not in these colours.	EFM Standards Wayfinding (Former HTM 65)		• New signage at Broad Street is now complete • HRI and Acre Mill – A signage consultant has conducted a survey with a view to accounting for the comments / actions detailed in the CQC action plan. Their recommendations have been received and E&F have put together a project plan for the resulting works including the estimated completion date.	• Complete the actions resulting from the signage survey	• PLACE assessment and visitor feedback	31.12.16	28.2.17	Director of Estates & Facilities	Associate Director of Estates & Facilities	Green
Responsive	OPD & diagnostics	FSS Divisional Performance Meeting	**CQC SD8**	The trust should ensure there is access to seven-day week working for radiology services.	• The radiography services were available seven days a week with a combination of regular opening times and on-call services. • The diagnostic imaging department had a local development plan in place to improve services and the environment. The plan gave a comprehensive review of the demand and capacity on the department to deliver a sustainable and high quality clinical service, taking account of seven-day working plans. • We looked at the development plan for radiology for 2016/17. This included looking at developments to meet the impact of seven day working and new cancer targets.			• Radiology improvement plan in place, which incorporates how to meet demand including 7-day working	• Progress the associated actions • Timescales for sustained improvement to be reviewed in line with annual planning process (subject to change)	• Increased access to 7 day service	31.1.17	30.4.17	Chief Operating Officer	Director of Operations for FSS	Green
Well Led	Community children	Community Division	**CQC SD9 (ComCh 1)**	The trust should continue to escalate, take an action plan forward and meet with stakeholders about therapy service provision.	• There had been problems of recruitment in children's therapy services. The risks had been mitigated by temporary actions. • The service had identified a shortfall of therapists working with children. This risk had been included on the services risk register. There had been a series of meetings and an action plan in progress. Actions included addressing recruitment and retention problems. Therapy services had a number of temporary contracts to fill vacancies. Sickness rates across therapy service were 2.7% which was lower than the trust average of 4.5%. • There were difficulties in the provision of children's therapy services reflecting national and local recruitment problems. The trust were sourcing an independent person to undertake a workforce review.			• Robust recruitment process in place - review of SLAs across services • Staffing position much improved - all vacancies within children's therapy are now filled and maternity leaves are filled with temporary posts • Currently have 3 staff members on long term sick with no cover	• Workforce model to be developed	• Actual v planned staffing will balance , against acuity	31.12.16	31.3.17	Chief Operating Officer	Director of Operations for Community	Green
Effective	Community children	Community Division	**CQC SD10 (ComCh 2)**	The trust should audit the effectiveness of the pathway between midwifery and the health visiting service.	• 7 of the incidents related to health visitors not being informed of new ante natal cases relying on paper forms as midwifery services did not use System 1. • Staff told us that sometimes there were communication difficulties with midwifery staff. This had been mitigated by monthly meetings being arranged between health visiting and midwifery staff to share information. • We saw a clear pathway between health visiting services and midwifery. There had been occasions when this had been problematic as community midwives did not use System 1. The current system was using a paper form. Staff told us that this had much improved over the last two months and helped by co-location in some areas.			• Matrons for Childrens community and Maternity services have developed an action plan to enable more efficient transfer of information between the 2 services • Audit of current practice completed	• Delivery of the detailed action plan to include: - Feasibility of electronic transfer - Crib sheet for staff to increase awareness - Audits of current practice	• Timely communication systems in place	31.12.16	17.3.17	Director of Nursing	Associate Director of Nursing for Community (working with Associate Director of Nursing for FSS)	Green
Well Led	Community children	Community Division	**CQC SD11 (ComCh 3)**	The trust should ensure that staff are informed about new tendering arrangements as they develop.	• Staff we spoke to had an understanding of the changing NHS, commissioning and the current uncertainties around tendering for services. Managers were aware of the worries staff had around this.			• When tenders / end of contract are announced staff are invited into meetings • Lessons learned from other procurements used to help with processes and communication	• Meetings arranged as required to formulate bid plans	• Staff report being informed of procurement processes	31.10.16	31.12.16	Chief Operating Officer	Director of Operations for Community	Blue
Responsive	Community adults	Community Division	**CQC SD12 (ComAd 8)**	The trust should ensure there are systems to measure effectiveness and responsiveness of the services within community adult services.	• There was a lack of comprehensive performance data within the community services. This was impacting on their ability to properly measure effectiveness and responsiveness of the services within the division.	**Regulation 17: Good Governance** There was a lack of comprehensive data for community adult services which impacted on the ability of the service to measure its effectiveness and responsiveness.		• The division has developed a community dashboard that is populated monthly, is reviewed through the performance review meetings with Executive Directors and included within the Trust Integrated Performance Report • The dashboard captures the core quality elements of responsiveness, safe, caring, effectiveness, well led	• Further develop a performance framework within the directorates – Community nursing, Specialist nursing, Intermediate care, Children's therapy, Community therapy, and Children's public health • Complete the development of live dashboards that will provide community nursing with access to patient level information regarding patients on caseloads who have attended the acute hospital emergency department or have been admitted	• Performance data utilised at Divisional and Directorate level meetings	31.1.17	28.2.17	Chief Operating Officer	Director of Operations for Community	Blue

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 2nd March 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report - The Board is asked to receive and approve the Integrated Board Report for January 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board, Quality Committee, Finance and Performance Committee	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

January's Performance Score is 64% for the Trust, with SAFE maintaining a Green rating. CARING and RESPONSIVE domains are just short of a Green rating, whereas WORKFORCE has slipped to a Red rating due to a drop in Mandatory Training for Infection Control.

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

Appendix

Attachment:

Integrated Performance Report - January 2017 (short version).pdf

Board Report

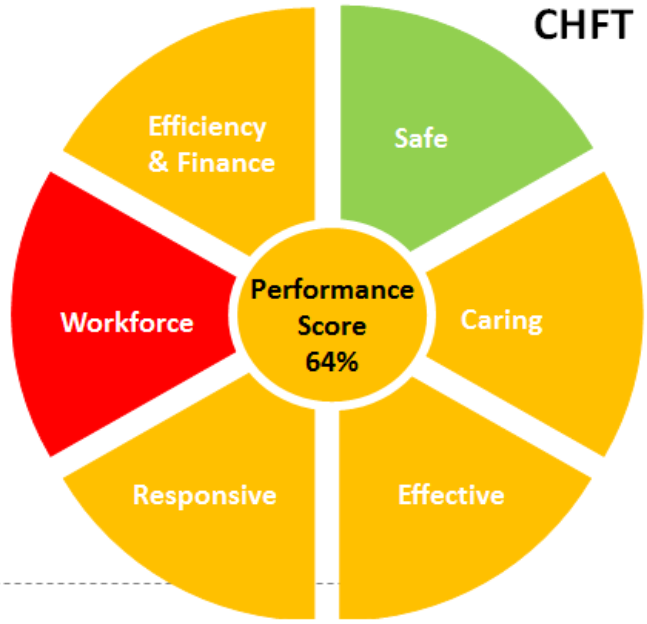
January 2017

Performance Summary

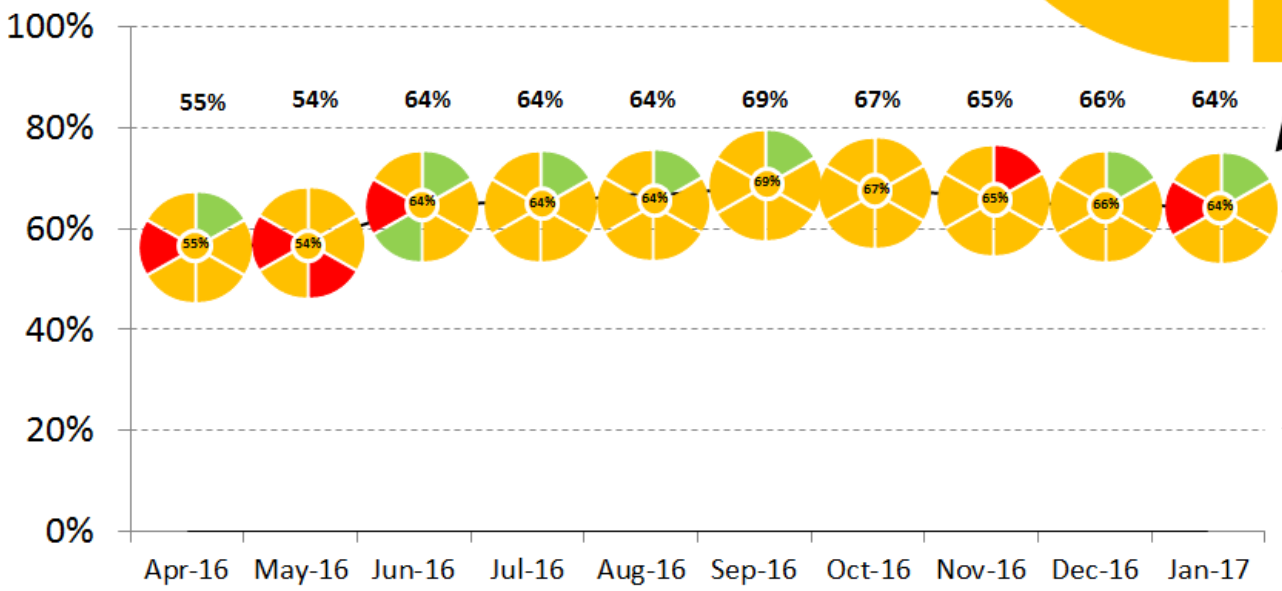
January

RAG Movement

January's Performance Score is 64% for the Trust with SAFE maintaining a Green rating. CARING and RESPONSIVE domains are just short of a Green rating whereas WORKFORCE has slipped to a Red rating due to a drop in Mandatory Training for Infection Control.



Total performance score



January Score by Domain	
Safe	82%
Caring	70%
Effective	63%
Responsive	72%
Workforce	41%
Efficiency & Finance	60%
Performance Score	64%

SINGLE OVERSIGHT FRAMEWORK

SAFE	Emergency C-Section Rate
VTE Assessments	Never Events
CARING	
FFT Community FFT OP	FFT Inpatients FFT Maternity FFT A&E
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
CDiff Cases	Avoidable Cdiff
MRSA	SHMI
HSMR	HSMR - Weekend
Emergency Readmissions GHCCG	Emergency Readmissions CCCG

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

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.7%	97.7%	⇔	0%
	Inpatient Complaints per 1000 bed days	1.6	2.1	↑	TBC
EFFECTIVE	Average Length of Stay - Overall	5.3	5.2	↓	5.17
	Delayed Transfers of Care	1.35%	1.36%	↑	5%
	Green Cross Patients (Snapshot at month end)	153	109	↓	40
	Hospital Standardised Mortality Rate (12 months Rolling Data)	101.97	103.74	↑	100
	Theatre Utilisation (TT) - Trust	83.6%	83.4%	↑	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.49%	0.49%	⇔	0.6%
	Emergency Care Standard 4 hours	92.19%	92.49%	↓	95%
	% Incomplete Pathways <18 Weeks	95.58%	95.64%	↓	92%
	62 Day GP Referral to Treatment	89.5%	92.6%	↓	85%
SAFE	% Harm Free Care	93.99%	95.17%	↓	95.0%
	Number of Outliers (Bed Days)	1153	779	↓	495
	Number of Serious Incidents	5	8	↑	0
	Never Events	0	0	⇔	0

MOST IMPROVED

Improved: Average Diagnosis per Coded Episode and Average co-morbidity score have both improved again to best position over last year. CHFT targets have been re-based using National data from HED.

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: % Harm Free Care. Performance dropped in January to 93.99% from 95.17% in December. The YTD figure was 94.31%.

Deteriorated: 62 Day GP Referral to Treatment. 92.6% to 89.5% in month.

Deteriorated: Green Cross Patients (Snapshot at month end). Increased from 109 to 153 in month.

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: The data collection process is under review and a deep dive regarding performance is being undertaken. Improvement work continues on reducing the number of Falls and Pressure Ulcers.

Action: Pathways with regular breach volume under review via Divisional PRMs with focus on early first appointment, MDT discussions and referral to tertiary by D38. In addition work required to close pathways for patients referred in on a cancer pathway but subsequently diagnosed as not cancer.

Action: Focus of activity through system Transfer of Care list, additional capacity found in Calderdale and looking at options in Kirklees. Focus continues on internal delays which remain minimal.

Arrow direction count ⇔ 3 ↑ 8 ↓ 8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.5	7.7	↓	
Sickness Absence Rate	4.60%	4.61%	↑	4.0%
Turnover rate (%) (Rolling 12m)	11.62%	12.25%	↑	12.3%
Vacancy	299.59	355.20	↑	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)	£4.43	£4.01	🟢
Expenditure vs Plan var (£m)	-£4.93	-£4.45	🟡
Liquidity (Days)	-17.24	-15.85	🔴
Variance from Plan (£m)	-£0.21	-£0.22	🔴
CIP var (£m)	£1.66	£2.00	🟡
UOR	3	3	🔴
Temporary Staffing as a % of Trust Pay Bill	15.46%	15.53%	🟢

Executive Summary

The report covers the period from January 2016 to allow comparison with historic performance. However the key messages and targets relate to January 2017 for the financial year 2016/17.

Area	Domain
Safe	• **% Harm Free Care** - Performance dropped in January to 93.99% from 95.17% in December. The YTD figure was 94.31%. The data collection process is under review and a deep dive regarding performance is being undertaken. Improvement work continues on reducing the number of Falls and Pressure Ulcers. • **Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed) -** 2 reports sent to CCG in January - 2 within agreed extension date. In both cases the additional time was needed to complete the investigation.
Caring	• **Complaints closed within timeframe** - 46 complaints were closed in January, 41% of these were closed within target timeframe. The number of overdue complaints has risen slightly to 15 at the end of January. The Trust expects to see the number of overdue complaints fall and performance improvement to be maintained to ensure no complaints are overdue. • **Friends and Family Test Outpatients Survey** - % would recommend the Service - 90.9% of patients would recommend OP Services against a target of 95% which is a slight reduction in month. YTD is also 90.9%. Both of these results are on track to achieve the internal Q4 target of > 90%. The Outpatient teams continue to review associated comments to identify themes. As previously reported there is an improvement focus on car parking (Acre Mill) and reducing waiting times neither of which will have an immediate impact on the FFT score. • **Friends and Family Test Community Survey** - FFT reports 3% of people would not recommend services. Support to change the way FFT responses are collected has been agreed and expect that this will provide more robust information. This will be implemented from April 2017.
Effective	• **Number of E.Coli - Post 48 Hours – Trust assigned** - There were 7 E-coli infections in January, 2 in Surgical division and 5 in Medicine. Hand hygiene discussed at PSQB - Matrons continue to enforce during daily walk rounds. teams are challenging poor practice. Recurrent issues will be escalated to CDs. • **Hospital Standardised Mortality Rate** (12 months Rolling Data December 15 - November 16) - has improved to 102 with the month of November at 92. The weekday/weekend split shows a 4 point difference in 12 month performance. • **Mortality Reviews** - The completion rate for Level 1 reviews stands at 41.9% (YTD). 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 from December's figure fits into a seasonal pattern. The timing and extent of the winter rise in crude mortality has varied year to year. However, the ratio of inpatient deaths to deaths within 30 days after discharge in January was unusual and is under closer scrutiny to ensure that there are no underlying concerns. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours**. 24 of the 45 (53.3%) Fragility Hip Fracture patients discharged in January were operated on within 36 hours of admission via A&E. There were a lot of admissions over the Christmas and New Year period when the Trauma theatre provision was reduced so a number of patients were delayed and this had a significant impact on performance. A presentation at WEB 23rd February following the 'Go-See' to Pilgrim Hospital in Boston demonstrated positive plans moving forward with opportunities for improvement based on the good practice that was recognised.

Background Context

Early January saw a significant increase in AED attendances, non-elective admissions and overall acuity. This caused significant bed pressures as discharges coming out of the festive period failed to meet admission numbers on most days.

The Trust ran internal command and control through the first 2 weeks in January and on several occasions called external partners into Silver Command where responses from partners supported flow. There remains a variance in the level of risk partners take at times of pressure leaving the Trust with escalation beds above original plan and an increased use of agency staff to ensure these were safely staffed.

The Accelerator schemes started to embed in January, increasing both out of hours and ED medical cover and supporting an increased frailty team. Ambulatory services at HRI moved into dedicated facilities. In addition Calderdale Council purchased a significant number of additional hours of Packages of Care through to quarter 1 2017/18.

Non-elective activity overall is 0.4% above the month 10 plan, an increase in activity against plan compared to month 9. The in-month over-performance is mainly due to General Medicine with emergency long stay and short stay above plan. This is offset by underperformance within Obstetrics and Midwifery.

Planned day case (DC) and elective activity (EL) has continued to be above plan in month 10 by 4.5%. This is however a reduction from the overperformance seen in month 9. The month 10 position is driven by an overperformance in DC offset by a further reduction within the EL activity.

Executive Summary

The report covers the period from January 2016 to allow comparison with historic performance. However the key messages and targets relate to January 2017 for the financial year 2016/17.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours -** January's position was 92.2% which is above the STF trajectory and sees the Trust delivering some of the strongest performance seen nationally. Accelerator Zone funding is supporting increased medical cover into AAU and admission avoidance OOHs and the HOOP team is gearing up for a February launch at HRI. • **Stroke -** All targets improved in month with % scanned within 1 hour performance at its highest level since February 2016. An action plan commenced after the ISR visit incorporated the actions needed to sustain an A grade on SSNAP which include the relocation of the HASU and ASU, 7 day SALT services and increased capacity in the Dietetic services. • **RTT pathways over 26 weeks** - numbers increased to 130 in month, highest since August. Fluctuations in > 26 week open pathways is as a result of capacity constraints and improved ASI position in some specialities. • **38 Day Referral to Tertiary** - at 50% is the best performance since May 2016. • **Appointment Slot Issues on Choose & Book** - As at 13th February there were 792 referrals awaiting appointment of which 400 were e-referrals. This was a reduction of 1,032 referrals from 22nd July 2015 position of 1,824. Ophthalmology has reduced the number of ASI's in the last month from 465 to 277.
Workforce	• **Sickness Absence rate** - Sickness rates remain stable at 4.6% however within this there has been a further increase in both Medicine and Surgery. All staff involved are being managed within Trust policy. • **Return to work Interviews** have peaked again at 79% but still short of the 100% target. 1 in 5 still not being completed. • **Mandatory Training and Appraisals** are still below target. The Workforce Business Intelligence Team provide employee level compliance lists to HR Business Partners on a weekly basis which are used in discussions with Divisions to ensure non-compliant employees are targeted for appraisal and mandatory training.
Efficiency/ Finance	• **Finance:** Year to date: The financial position is a deficit of £14.64m as reported on a Control Total basis , a favourable variance of £0.07m from the planned £14.71m. The underlying deficit position is £14.88m, an unfavourable variance of £0.21m mainly reflecting a Loss on Disposal of £0.23m that is excluded from the Control Total. Overall this is positive news as the Trust is continuing to maintain both the financial position and operational performance linked to Sustainability Transformation Funding, despite significant operational pressures over the last few weeks, with additional capacity open and high levels of emergency 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 £1.95m; £0.40m higher than the previous month and closer to peak levels seen in the year to August where expenditure reached £2.1m per month. The year to date agency expenditure remains beneath the revised trajectory submitted to NHSI, but the margin by which the Trust is forecast to achieve this trajectory is much reduced. It should be noted that within the agency spend £0.1m relates to spend against the Accelerator Zone funding which has been agreed as excluded from the trajectory. The impact of this operational position is as follows at headline level: • EBITDA of £6.17m, an adverse variance of £0.51m from the plan. • A deficit (on Control Total basis which excludes exceptional costs relating to property disposals) of £14.64m, a £0.07m favourable variance from plan. • Delivery of CIP of £12.40m against the planned level of £10.74m. • Contingency reserves of £1.36m have been released against pressures. • Capital expenditure of £13.15m, this is below the planned level of £23.07m. • A cash balance of £5.29m, 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 at CRH. On day cancellations due to bed availability and patient illness has impacted on CRH theatre performance.
Activity	• **Activity** in month is above planned levels in all of the main points of delivery apart from Elective inpatients and A&E attendances. Cumulatively elective inpatients and daycase combined are above plan whilst non-elective activity is below plan however waiting lists are still high reflecting ongoing demand.

Background Context

January has been another challenging month for Community staff as they continue to manage increased demand with community nursing teams delivering over 21,000 contacts and intermediate care teams delivering over 4,000 contacts. At times of surge the Division enacted a changed admission profile for intermediate care to support increased hospital discharges.

Surgery reduced elective admissions in early January as required by NHSI however maintained capacity for cancer and urgent patients.
Concerns remain on the Division's ability to ensure sufficient subcontracted capacity for Plastic Surgery and Max-Fax with ongoing conversations with partners regarding capacity for these services.

EPR has increased its profile with EPR friends' training requiring some release from normal activity and the developemnt of 90/60/30 day plans ongoing.

Direct access and unbundled outpatient imaging has continued to perform above plan but has seen a reduction in month 10 to 2% from 19.7% above plan last month. Diagnostic testing has seen a further worsening performance in month 10 and is 0.3% below plan compared to month 9 which was 0.8% above plan. This reduction is driven by a change in Anti-Coagulation from 79% below plan in month 9 to 91% below plan in month 10.

Outpatient activity overall has continued to overperform and has seen a further increase of 7.3% above the month 10 plan. This is across both first and follow-ups, but to a larger extent within follow-ups reflecting the validation of all follow-up outpatient waiting lists. More significantly overperformances within firsts are in ENT, Paediatrics, Gynaecology and Respiratory. General Surgery and Breast Surgery have underperformed in-month. Overperformances within follow-ups have continued within T&O, Gastroenterology, Dermatology, Haematology (Clinical) and Gynaecology with increases also in Urology, Ophthalmology, ENT and Rheumatology. Cumulatively Outpatient activity is now 4.6% 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

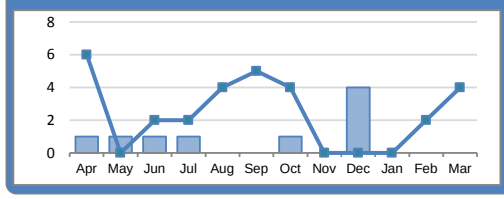
Area	Reality	Response	Result
Safe	**Grade 3 pressure ulcers:** Year to date the division has had 9 grade 3 community acquired pressure ulcers; 4 of these occurring in December. 2 were attributed to other providers however communication between services could have been improved.	**Grade 3 pressure ulcers:** Where appropriate route cause analysis has been carried out. A focus on communication between partners in relation to pressure ulcer identification and management has been discussed with community nursing teams. The review process by senior colleagues of caseloads is also an area of focus to ensure adequate supervision and support for community nursing colleagues.	**Grade 3 pressure ulcers:** To return to consistently good performance for the community nursing teams. By when March 2017 Accountable: ADN
Effective	**Leg ulcer healing rate:** 3 ulcers in total (2 patients) being treated by the DN team had not healed within 12 weeks. Both patients healed within 15 weeks.	**Leg ulcer healing rate:** The TVN is supporting community nursing with best practice methodology around leg ulcer management. There is specific work underway looking at reducing pressure ulcer healing rate as the division prepares for 2017/18. CQUIN focussing on reducing time to heal rate in community settings.	**Leg ulcer healing rate:** To achieve compliance with 2017/18 CQUIN target. Plan in place by end March 2017. Accountable: ADN
Caring	**End of life patients preferred place of death:** 6 patients were recorded as not dying in their preferred place of death in January - the reasons for these have been explored by the teams involved with care to support any learning - change in circumstances is the common cause for the preferred place changing.	**End of life preferred place of death:** Preferred place of death to continually be reviewed by the specialist teams. To liaise with key partners as appropriate.	**End of life preferred place of death:** To ensure those patients at end of life are in the most appropriate setting to meet their needs. To strive to achieve that all patients die in their preferred place of death by the end of April 2017. **By when: April 2017** **Accountable: ADN**
Responsiveness	**MSK responsiveness** The typing turnaround performance has worsened again in January after an improvement in December. There has been some sickness in the admin team - bank staff have been brought in to support the typing. Signing of letters continues to be an issue and the manager of the service continues to work with the team on improving this position.	**MSK responsiveness - Typing turnaround*:*** A recovery plan has been requested by the individual practitioner who has the most backlog of letters to sign. The Head of Therapies is reviewing the other commitments of this individual to provide opportunity to catch up and to maintain a safe level of performance.	**MSK responsiveness - Typing turnaround:** There were 239 letters that required sign-off from clinics at the end of January 2017. Most of these related to one practitioner. A recovery plan has been requested by the individual practitioner to be on track before the end of March 2017. **By when: End March 2017.** **Accountable: Head of Therapies**

Dashboard - Community

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

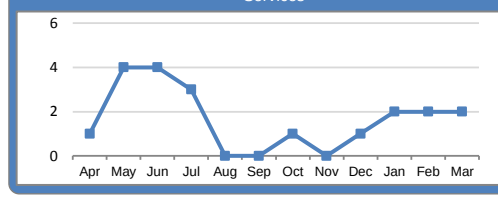
Safe

Community acquired grade 3 or 4 pressure ulcers



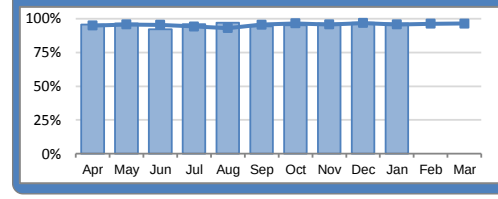
One month in arrears

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

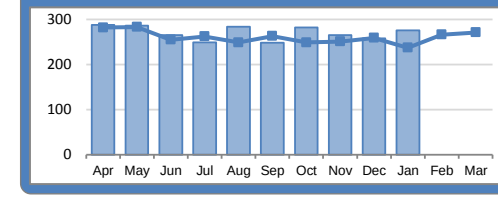


One month in arrears

Incidents Harm free care

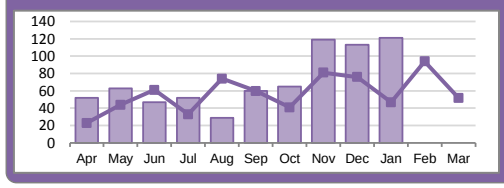


Urinary Catheter Management

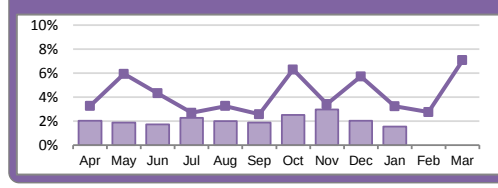


Effective

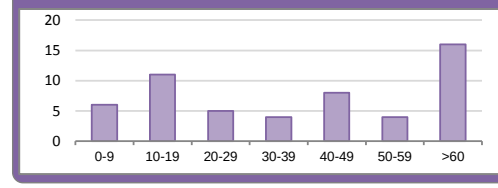
Number of Hospital admissions avoided by Community Nursing services



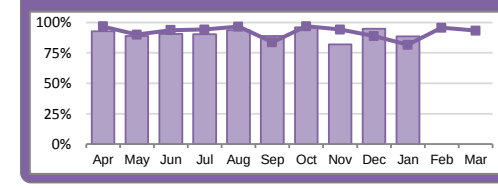
Patients who attended A&E while on a Community Matron Caseload, who readmitted within 30 days



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

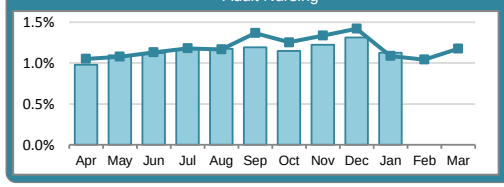


House Bound leg ulcers healed within 12 weeks

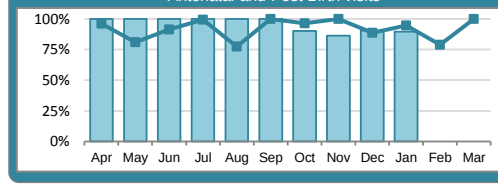


Caring

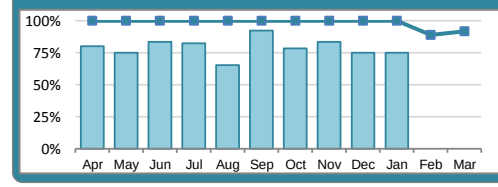
Community No Access Visits Adult Nursing



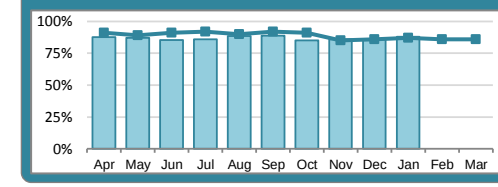
Health Visitor achieved Targeted visits Antenatal and Post Birth visits



End of life patient died in preferred place of death

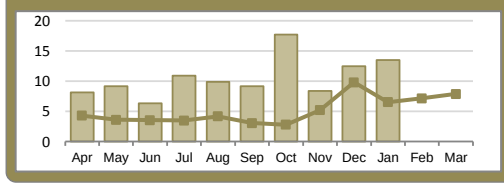


Friends and Family Test- Likely to recommend

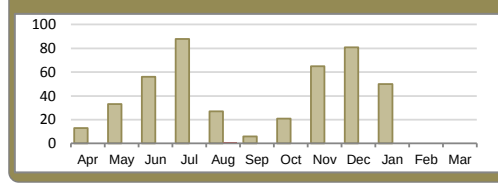


Responsive

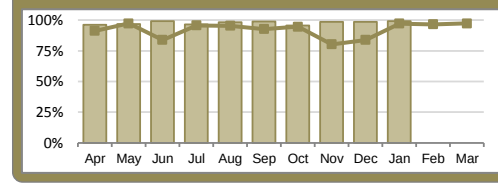
Average time to start of reablement (days)



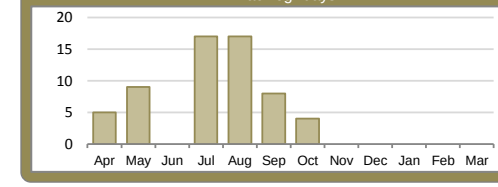
Appointment Slot Issues for MSK & Podiatry



Waiting Times - 18 week RTT

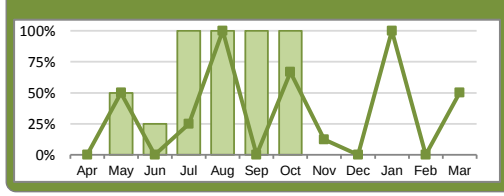


MSK Responsiveness Backlog -days

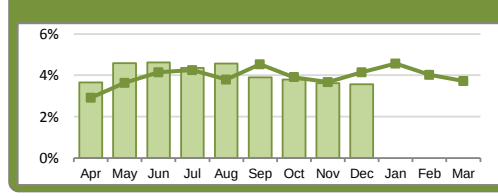


Well Led

% Complaints closed within target timeframe

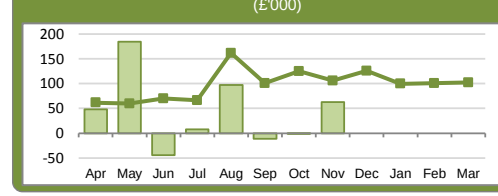


Staff sickness rate

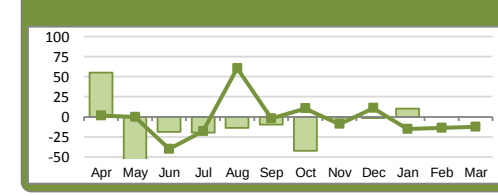


One month in arrears

Finance - Planned variance against actual (£'000)



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



Hard Truths: Safe Staffing

Fill Rates

Average fill rates reported to Unify for Registered Nurses (RN) on day shifts decreased slightly on both sites in comparison to December 2016. Table 1 indicates fill rates of less than 90%.

Average fill rates for care staff on both sides remain above 100%.

Table 1: Average Fill Rates Registered Nurses and Care Staff (Overall Summary)

Average Fill Rates:	Registered Nurses		Care Staff	
	Day	Night	Day	Night
January 2017 HRI	85.30%	89.50%	103.80%	132.00%
January 2017 CRH	85.00%	92.60%	102.90%	119.20%
December 2016 HRI	87.45%	91.07%	106.58%	128.25%
December 2016 CRH	85.06%	91.61%	103.93%	119.18%
November 2016 HRI	86.10%	92.10%	104.66%	125.00%
November 2016 CRH	84.73%	92.17%	106.50%	123.11%

Table 2: Wards with fill rates 75% or below

	Nov-16		Dec-16		Jan-17	
	Ward	% Rate	Ward	% Rate	Ward	% Rate
Wards below 75%	-	-	-	-	2a/b	0.74
	5a/d	64.80%	5a/d	64.40%	5a/d	63.00%
	5b	65.80%	5b	69.40%	-	-
	8a/b	70.60%	8a/b day	64.00%	-	-
	-	-	8a/b night	73.30%	-	-
	Ward 17	68.97%	Ward 17	68.80%	Ward 17	72%day
	-	-	-	-	Ward 17	50.5% night
	-	-	CCU	71.84%	CCU	74.80%
	15	67.80%	15	67.60%	-	-
	-	-	9crh	74.20%	-	-
	8	60.70%	8	67.70%	Ward 8	67.00%
	-	-	-	-	Ward 19	0.731

The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. In January six wards reported fill rates of less than 75%. This is managed and monitored within the divisions by the matron and senior nursing team to ensure safe staffing against patient acuity and dependency is achieved. The low fill rates reported in January are attributed to a level of vacancy and the teams not being able to achieve their WFM.

Average fill rates for HCA's on night of <75% have been recorded within the FSS division during January. This is due to long term sickness. The shortfall is being managed on a daily basis balanced against the acuity of the workload. The post has been recruited to and fill rates are expected to improve.

Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; realisation of supervisory time for band 7 registered nurses and for care staff supporting reduced fill rate of registered nurse hours.

Hard Truths: Safe Staffing (2)

Table 3: Overall ward breakdown for January 2017 including CHPPD.

Ward	Main Two Specialties on Each Ward		DAY (Day shifts are all the periods not included in night shift)				NIGHT (Night is defined as the shift period within which midnight falls)				DAY		NIGHT		Cumulative count over the month of patients at 23:59 each day	Care Hours Per Patient Day					
			Registered Nurses/Midwives		Care Staff		Registered Nurses/Midwives		Care Staff		Average Fill Rate - Registed Nurses/ Midwives (%)	Average Fill Rate - Care Staff (%)	Average Fill Rate - Registed Nurses/ Midwives (%)	Average Fill Rate - Care Staff (%)		Registered midwives/ nurses		Care Staff		Overall	
	Specialty 1 (Select from drop down list)	Specialty 2 (Select from drop down list)	Total Daily **PLANNED** Staff Hours	Total Daily **ACTUAL** Staff Hours	Total Daily **PLANNED** Staff Hours	Total Daily **ACTUAL** Staff Hours	Total Daily **PLANNED** Staff Hours	Total Daily **ACTUAL** Staff Hours	Total Daily **PLANNED** Staff Hours	Total Daily **ACTUAL** Staff Hours						Total **PLANNED** CHPPD	Total **ACTUAL** CHPPD	Total **PLANNED** CHPPD	Total **ACTUAL** CHPPD	Total **PLANNED** CHPPD	Total **ACTUAL** CHPPD
CRH MAU	GENERAL MEDICINE		2511	2039.5	1302	1198.9	1705	1408	682	858	81.2%	92.1%	82.6%	125.8%	651	6.5	5.3	3.0	3.5	9.5	8.5
HRI MAU	GENERAL MEDICINE		2511	2205.5	1302	1768.5	1705	1714	682	1551	87.8%	135.8%	100.5%	227.4%	841	5.0	4.7	2.4	3.9	7.4	8.6
WARD 2AB	GENERAL MEDICINE		2139	1583	1302	1535	1364	1374	682	722	74.0%	117.9%	100.7%	105.9%	893	3.9	3.3	2.2	2.3	6.1	5.8
HRI Ward 5 (previously ward 4)	GERIATRIC MEDICINE		1813.5	1508.5	1209	1190.5	1023	1023	1023	1063.5	83.2%	98.5%	100.0%	104.0%	769	3.7	3.3	2.9	2.7	6.6	6.2
HRI Ward 11 (previously Ward 5)	CARDIOLOGY	RESPIRATORY MEDICINE	2076	1901.5	1006.5	1021.5	1364	1342	682	671	91.6%	101.5%	98.4%	98.4%	789	4.4	4.1	2.1	2.6	6.5	6.3
WARD 5AD	GERIATRIC MEDICINE	GENERAL MEDICINE	2371.5	1497.5	1209	2120.5	1364	1364	1023	1309	63.1%	175.4%	100.0%	128.0%	951	3.9	3.0	2.3	2.8	6.3	6.6
WARD 5C	GENERAL MEDICINE	RESPIRATORY MEDICINE	1069.5	1071.5	837	674.5	682	682	341	341	100.2%	80.6%	100.0%	100.0%	481	3.6	3.6	2.4	2.1	6.1	5.8
WARD 6	GENERAL MEDICINE		2046	1702.5	744	973	1023	1023	682	682	83.2%	130.8%	100.0%	100.0%	672	4.6	4.1	2.1	2.5	6.7	6.5
WARD 6BC	GENERAL MEDICINE	CARDIOLOGY	2139	1711.5	837	1021.5	1364	1380	682	756	80.0%	122.0%	101.2%	110.9%	957	3.7	3.2	1.6	2.2	5.2	5.1
WARD 5B	GENERAL MEDICINE		1209	996	744	1116	682	704	341	759	82.4%	150.0%	103.2%	222.6%	495	3.8	3.4	2.2	3.0	6.0	7.2
WARD 6A	GENERAL MEDICINE		930	817.5	465	744.5	682	704	341	408	87.9%	160.1%	103.2%	119.6%	459	3.5	3.3	1.8	2.4	5.3	5.8
WARD 8C	GENERAL MEDICINE		976.5	774	713	1141	713	703	356.5	657.5	79.3%	160.0%	98.6%	184.4%	489	3.5	3.0	2.2	2.8	5.6	6.7
WARD CCU	GENERAL MEDICINE	CARDIOLOGY	1767	1415	372	317.5	1364	1020.5	0	12	80.1%	85.3%	74.8%	-	319	9.8	7.6	1.2	3.2	11.0	8.7
WARD 6D	GENERAL MEDICINE		1674	1286	837	806.5	1023	957	682	671	76.8%	96.4%	93.5%	98.4%	369	7.3	6.1	4.1	4.4	11.4	10.1
WARD 7AD	GENERAL MEDICINE	REHABILITATION	1674	1415.9	1534.5	1527	1364	1056	682	990	84.6%	99.5%	77.4%	145.2%	769	4.0	3.2	2.9	2.7	6.8	6.5
WARD 7BC	GENERAL MEDICINE	REHABILITATION	1674	1563.5	1534.5	1548.5	1364	1034	682	1001	93.4%	100.9%	75.8%	146.8%	805	3.8	3.2	2.8	2.5	6.5	6.4
WARD 8	GERIATRIC MEDICINE		1534.5	1228.5	1209	1736	1023	695	1023	1434	80.1%	143.6%	67.9%	140.2%	676	3.8	2.8	3.3	3.1	7.1	7.5
WARD 12	MEDICAL ONCOLOGY	CLINICAL HAEMATOLOGY	1674	1478.5	837	519	1023	891	341	564	88.3%	62.0%	87.1%	165.4%	629	4.3	3.8	1.9	2.3	6.2	5.5
WARD 17	GASTROENTEROLOGY		2046	1475	1209	853.5	1364	686	341	730	72.1%	70.6%	50.3%	214.1%	758	4.5	2.9	2.0	1.9	6.5	4.9
WARD 21	REHABILITATION		1209	927	976.5	1028.5	682	682	341	488.5	76.7%	105.3%	100.0%	143.3%	560	3.4	2.9	2.4	2.1	5.7	5.6
ICU	CRITICAL CARE		4030	3494.5	821.5	581.75	3921.5	3428.2	0	37.5	86.7%	70.8%	87.4%	-	206	38.6	33.6	4.0	16.8	42.6	36.6
WARD 3	GENERAL SURGERY		1054	1013.5	589	820.5	713	713	356.5	678.5	96.2%	139.3%	100.0%	190.3%	442	4.0	3.9	2.1	3.1	6.1	7.3
WARD 8AB	TRAUMA & ORTHOPAEDICS	GENERAL SURGERY	1290	1154	961	786.5	966	869.5	483	601.5	89.5%	81.8%	90.0%	124.5%	478	4.7	4.2	3.0	3.1	7.7	7.1
WARD 8D	ENT	OPHTHALMOLOGY	821.5	794.5	821.5	724.5	713	667	0	57.5	96.7%	88.2%	93.5%	-	337	4.6	4.3	2.4	2.1	7.0	6.7
WARD 10	GENERAL SURGERY		1302	1309	589	626.5	690	699.5	690	701.5	100.5%	106.4%	101.4%	101.7%	593	3.4	3.4	2.2	2.4	5.5	5.6
WARD 15	GENERAL SURGERY		1562.5	1458.5	1083.5	991.5	1069.5	724.5	356.5	747.5	93.3%	91.5%	67.7%	209.7%	809	3.3	2.7	1.8	1.8	5.0	4.8
WARD 19	TRAUMA & ORTHOPAEDICS		1751.5	1280	1286.5	1302.5	1069.5	1000.5	1069.5	1055	73.1%	101.2%	93.5%	98.6%	650	4.3	3.5	3.6	3.2	8.0	7.1
WARD 20	TRAUMA & ORTHOPAEDICS		1999.5	1514	1410.5	1610.5	1069.5	1023.5	1069.5	1334	75.7%	114.2%	95.7%	124.7%	862	3.6	2.9	2.9	2.7	6.4	6.4
WARD 22	UROLOGY		1178	1129.5	1178	1074	713	713	713	713	95.9%	91.2%	100.0%	100.0%	568	3.3	3.2	3.3	2.5	6.7	6.4
SAU HRI	GENERAL SURGERY		1891	1664	966	912.5	1426	1414.5	356.5	391	88.0%	94.5%	99.2%	109.7%	554	6.0	5.6	2.4	3.3	8.4	7.9
WARD LDRP	OBSTETRICS	MIDWIFE EPISODE	4278	3756	945.5	789	4278	3964	713	609.5	87.8%	83.4%	92.7%	85.5%	294	29.1	26.3	5.6	15.6	34.7	31.0
WARD NICU	PAEDIATRICS		2247.5	2031.5	930	470.5	2139	1947	713	632.5	90.4%	50.6%	91.0%	88.7%	515	8.5	7.7	3.2	5.0	11.7	9.9
WARD 1D	OBSTETRICS		1234.5	1063.5	356.5	246.5	713	701.5	356.5	264.5	86.1%	69.1%	98.4%	74.2%	278	7.0	6.3	2.6	3.5	9.6	8.2
WARD 3ABCD	PAEDIATRICS		2945.5	2871	1208	774.5	2495.5	2492.5	356.5	366.5	97.5%	64.1%	99.9%	102.8%	451	12.1	11.9	3.5	6.3	15.5	14.4
WARD 4C	GYNAECOLOGY	GENERAL SURGERY	758	738	465	416.5	713	701.5	356.5	356.5	97.4%	89.6%	98.4%	100.0%	324	4.5	4.4	2.5	3.3	7.1	6.8
WARD 9	OBSTETRICS		1069.5	984.5	356.5	283.5	713	713	356.5	345	92.1%	79.5%	100.0%	96.8%	301	5.9	5.6	2.4	3.5	8.3	7.7
WARD 18	PAEDIATRICS		790	714	0	30	713	667	0	0	90.4%	-	93.5%	-	71	21.2	19.5	0.0	9.4	21.2	19.9
WARD 4	GENERAL MEDICINE		930	819	930	765.3	682	671	341	352	88.1%	82.3%	98.4%	103.2%	451	3.6	3.3	1.8	2.3	5.1	4.9
OVERALL STAFFING TOTAL			**66177.5**	**56386.9**	**35078**	**36048.45**	**47675.5**	**43553.2**	**19897**	**24912**	**85.21%**	**102.77%**	**91.35%**	**125.20%**	**21516**	**5.3**	**4.6**	**0.1**	**3.2**	**7.8**	**7.5**
HUDDERSFIELD ROYAL INFIRMARY (Not including ICU)			28438	24313	16882	17507.3	18065.5	16395.5	10424	13501.5	85.49%	103.70%	90.76%	129.52%	10995.00	4.23	3.70	2.48	2.72	6.71	6.52
CALDERDALE ROYAL HOSPITAL (Not including ICU)			33709.5	28579.4	17374.5	17959.4	25688.5	23729.5	9473	11373	84.78%	103.37%	92.37%	120.06%	10315.00	5.76	5.07	2.60	3.40	8.36	7.91

Care Hours Per Patient Day

A review of January CHPPD data indicates that the combined (RN and Care staff) metric resulted in 28 clinical areas of the 37 reviewed having CHPPD less than planned. 1 area reported CHPPD as planned. 8 areas reported CHPPD slightly in excess of those planned.

Areas with CHPPD more than planned were due to additional 1-1's requested throughout the month due to patient acuity in the departments.

Internal Red Flag Events

X3 Red Flagged events were recorded in January: Ward 4C CRH reported Unsafe staffing levels 10th January due to short term sickness. The shift was supported by GAU staff and the night sister.

6B reported a red flagged incident 21st January as a staff member had to leave the ward unexpectedly. The shift was supported from staff across the floor and the site co-ordinator. 6B also reported an incident 29th January due to staff movement. The shortfall was again managed across the floor and supported by the site co-ordinator. No harm was reported to patients.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 2nd March 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: Financial Commentary for Monthly NHS Improvement Submission - Copy of the Month 10 Financial Commentary that was submitted to NHS Improvement on 15th Feb 17 alongside the Monthly Monitoring submission.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance & Performance Committee	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

See attached commentary

Main Body

Purpose:

For Information. See attached commentary

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To Note

Appendix

Attachment:

NHSI Financial Commentary Month 10 1617 BOD.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 10 JANUARY 2017, NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

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

The report is structured into three sections to describe:

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

1. Key Messages

The year to date financial position stands at a deficit of £13.94m, a favourable variance of £0.73m from the planned £14.67m of which £0.94m is purely a timing difference on the accrual of Sustainability & Transformation Funding (STF) versus the planned quarterly profile. The underlying variance from Control Total is £0.07m favourable compared to the 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 due to high levels of clinical activity, staff vacancies and Delayed Transfers of Care.

Operational performance linked to the STF has also been maintained in the year despite the challenge stepping up considerably in January, 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. Despite operational actions that have been put in place to curb the use of agency, total agency spend in month was £1.95m, an increase of £0.4m compared to Month 9, reflecting the challenges the Trust continues to face in securing safe staffing levels. However, this remains an improvement compared to the average for the first six month of the year which was in excess of £2.0m a month and agency expenditure remains beneath the revised trajectory submitted to NHSI. It is worth noting that within the agency spend £0.10m relates to the Accelerator Zone funding which has been agreed as excluded from the Trajectory.

Month 10, January Position (Year to Date)

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	307.97	313.34	5.37
Expenditure	(301.29)	(306.22)	(4.93)
EBITDA	**6.68**	**7.11**	**0.44**
Non-Operating items	(21.35)	(21.06)	0.29
Surplus / (Deficit)	**(14.67)**	**(13.94)**	**0.73**
Less: Items excluded from Control Total	(0.04)	0.24	0.28
Surplus / (Deficit) Control Total basis	**(14.71)**	**(13.70)**	**1.01**

- EBITDA of £7.11m, a favourable variance of £0.44m from the plan.
- A bottom line deficit of £13.94, a £0.73m favourable variance from plan;

- Items excluded from Control Total includes £0.23m for Loss on Disposal of properties
- Delivery of CIP of £12.40m against the planned level of £10.74m.
- Contingency reserves of £1.36m have been released against pressures.
- Capital expenditure of £13.15m, this is below the planned level of £23.07m.
- Cash balance of £5.29m; this is above the planned level of £1.94m.
- 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 £1.66m 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	£5.37m favourable variance
Operating expenditure	(£4.93m) adverse variance
EBITDA	**£0.44m favourable variance**
Non-Operating items	£0.43m favourable variance
Restructuring costs	(£0.14m) adverse variance
Total	**£0.73m favourable variance**

Operating Income

There is a £5.37m favourable variance from the year to date plan within operating income. Of this operating performance £0.94m is driven by a timing difference on the accrual of Sustainability and Transformation Funding (STF) versus the planned quarterly profile. Total STF funding included in the year to date position is £9.42m, 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 £5.37m favourable income variance, NHS Clinical income shows a favourable variance of £2.44m. 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:

In month activity is above planned levels in all of the main points of delivery apart from Elective & A&E. Cumulatively elective and daycase combined are now above plan by 969 spells whilst non elective activity is below plan by 331 spells.

- Planned day case and elective inpatient performance is 4.5% (172 spells) above the month 10 plan which is a reduction from the over-performance seen in month 9. Cumulatively, the aggregate performance across day case and electives is also above plan, driven by strong day case activity.

- Non-elective activity overall is 0.4% (16 spells) above the month 10 plan. In the year to date non elective activity is just slightly below planned levels by 0.8% with fluctuation in individual months.

- A&E activity has dropped compared to month 9. The month 10 activity is 0.8% (96 attendances) below plan, but cumulatively remains above plan by 3.0% (3,667 attendances).

- Outpatient activity overall has continued to over-perform with 7.3% (2,074 attendances) above the month 10 plan. The over-performance in month is across both first and follow-up attendances, including procedures. Cumulatively activity is 4.6% (12,891 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 12.9% (639 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's resources by year end. Provision has been made in forecast to reflect commissioner challenges to changes to counting and coding practices that have been driven through the Trust's CIP.

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 above plan by £0.25m in month 10 and £1.99m cumulatively. The year to date position is predominantly driven by the shift of Local Authority Health Visitor income previously reported within NHS Clinical income of £3.5m. This is offset in part by a number of smaller adverse variances including: the transfer of the West Yorkshire Audit Consortium to another provider which has reduced income by £0.72m cumulatively and the Trust's Pharmacy Manufacturing Unit (PMU) is driving income of £0.41m lower than planned levels.

Operating expenditure

There was a cumulative £4.93m adverse variance from plan within operating expenditure across the following areas:

Pay costs	(£2.94m) adverse variance
Drugs costs	£1.93m favourable variance
Clinical supply and other costs	(£3.92m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £2.94m 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.

Total Agency expenditure year to date is now £19.91m. The combined overspend against qualified nursing and support to nursing (Healthcare Assistants) is £3.90m in the year to date. Medical staffing expenditure is now slightly better than planned in the year to date, however, medical agency remains high, accounting for £11.90m, 60% of the overall year to date agency spend. The assessment of the risk of switching off this agency cover has been made on a case by case basis by Divisions and, as with nursing, the drive to recruit staff is ongoing including advertising new types of roles to aid recruitment potential. The work to drive down the contractual rates paid to Medical agencies and develop a tiered approach to bookings has had some 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 £1.95m; £0.40m higher than the previous month, but still lower than the peak levels seen in the year to August where expenditure reached £2.1m per month. The year to date agency expenditure remains comfortably beneath the revised trajectory submitted to NHSI, particularly once £0.1m Accelerator Zone agency expenditure is excluded as agreed.

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 pay overspend year to date is almost £5.0m. In overall terms, there has been a year to date benefit from releasing reserves of £1.36m to the bottom line, a provision has been made against the £0.64m 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 £1.93m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £1.95m below plan. Underlying drug budgets are therefore overspent by £0.02m.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £3.93m 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, ('pass through' costs), which are £0.41m 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 £0.64m 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 £0.29m 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.

These year to date benefits are offset in part by higher than planned interest payable of £0.32m due to higher than planned interest rates. The impact of this pressure has reduced in the forecast position compared to the Month 9 forecast due to the transfer of our Working Capital Facility at 3.5% interest into a Revenue Support Loan at 1.5% interest from the 31st Jan 17.

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, £12.40m of CIP has been delivered against a plan of £10.74m, an over performance of £1.66m. 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 has now started to be counterbalanced by under-delivery in the latter half of the year. The £1.66m 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. In month 10, these continuing pressures were offset by the release of contingency reserves and some other technical / non recurrent benefits. 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 is adding to a larger CIP target for 17/18.

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 January 2017 the Trust had a cash balance of £5.29m against a planned position of £1.94m, a favourable variance of £3.35m. In month the variance was higher than forecast due to: a number of large receipts including Accelerator Zone funding and contract overtrade invoices, the capital plan being lower than forecast, and the number of invoices received and paid being lower than forecast despite all invoices approved for payment being paid by the end of January.

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	0.73
	Non cash flows in operating deficit	(0.34)
	Other working capital movements	(6.19)
	Sub Total	**(5.80)**
Investing activities	Capital expenditure	10.02
	Movement in capital creditors	0.75
	Sub Total	**10.77**
Financing activities	Drawdown of external DoH cash support	(1.13)
	Other financing activities	(0.49)
	Sub Total	**(1.63)**
	Grand Total	**3.35**

Operating activities

Operating activities show an adverse £5.80m variance against the plan. The favourable cash impact of the I&E position of £0.36m (£0.73m favourable I&E variance and £0.34m non-cash flows in operating deficit) is coupled with to a £6.19m adverse working capital variance from plan. The working capital variance reflects the catch up of payments to suppliers, combined with the accrued STF for Months 7-10 of £3.77m. The performance against the Better Payment Practice Code remained above target with 96.13% of invoices paid within 30 days against the 95% target, as many of the older outstanding invoices have been flushed through in previous months and we are now paying recent invoices in the main.

Total aged debt based on invoices raised is £4.66m which is a reduction on last month as some material invoices have been settled, the remaining value include; 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 £13.15 m which is £9.92m below the planned level of £23.07m.

Against the Estates element of the total, year to date expenditure is £4.00m against a planned £9.38m. The main areas of spend in month were: Emergency lighting, Roofing work for both Kitchen and Laundry, Fire compartmentation, Boilers in Learning centre and Medical Air Plant.

IM&T investments total £5.67m against a plan of £6.70m. The main areas of spend in month were the continuation of the Electronic Patient Record (EPR). The main reason for the underspend against plan is the revised timescale for go live of EPR.

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

Financing activities

Financing activities show a £1.63m adverse variance from the original plan, of which £1.13m is due to cash support through borrowing being less than originally planned, plus £0.49m on other financing activities due to higher than planned interest and loan repayments.

Our borrowing requirements for this financial year have now been secured following the conversion of our Working Capital Facility (at 3.5%) to a Revenue Support Loan (at 1.5%) as at the 31st of Jan 2017. This has resulted in a forecast saving of £0.09m compared to our Month 9 forecast. However, this switch has occurred later in the year than had been assumed in our plan resulting in higher than planned interest payments in the year to date of £0.3m.

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 £16.15m Control Total.

The reported forecast year end deficit is £16.31m, including exceptional costs relating to the disposal of property of £0.22m. As Losses on Disposal are excluded from the deficit for Control Total purposes they therefore have no impact on our STF allocation or UOR metric. The Forecast Deficit on a Control Total basis is £16.08m, a £0.07m favourable variance, (excluding the matching of this variance through STF finance incentive fund payments).

This position assumes delivery of £15.05m 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 £16.15m 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 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 potential loss of £1.97m of System Resilience funding to the Trust, against which expenditure commitments cannot be released, Junior Doctor's strike action and loss of income due to commissioner challenges to counting and coding practices. 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 and the need to reduce agency staff usage whilst maintaining safe staffing levels.

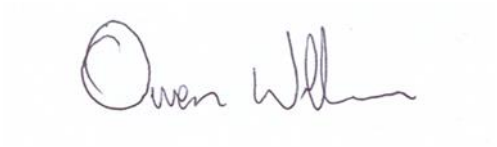
The Trust has made good progress in implementing recovery plans to mitigate these risks. These include a range of divisional plans, rigorous budgetary control and innovative solutions. Under the latter heading the Trust has sought to negotiate with the soft FM provider on the PFI site to secure a favourable 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.

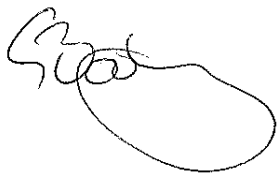
Forecast – Capital and cash

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 and on this basis is reviewing the possibility of reducing Capital Expenditure by a further £3m in this financial year. Any reduction in 16/17 Capital Expenditure would be as a result of deferring schemes into next year and in order to do so, the Trust is seeking assurance from NHS Improvement that capital funding will be available early in 17/18 to support this.





Owen Williams
Chief Executive

Gary Boothby
Executive Director of Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 2nd March 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from each of the sub-committees	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from each of the sub-committees:-
- Quality Committee - minutes of 30.1.17 and verbal update from 27.2.17
- Finance and Performance Committee - minutes of 31.1.17 and verbal update from 28.2.17
- Workforce Well-Led Committee - minutes of 19.1.17
- Updated Health & Safety Policy

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive the updates and minutes from each of the sub-committees:-
- Quality Committee - minutes of 30.1.17 and verbal update from 27.2.17
- Finance and Performance Committee - minutes of 31.1.17 and verbal update from 28.2.17
- Workforce Well-Led Committee - minutes of 19.1.17
- Updated Health & Safety Policy

Appendix

Attachment:

There is no PDF document attached to the paper.

QUALITY COMMITTEE

Monday, 30th January 2017
Board Room, Trust HQ, Calderdale Royal Hospital

PRESENT

Linda Patterson	Non-Executive Director **(Chair)**
Jan Wilson	Non-Executive Director
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
Dr Tim Jackson	Consultant Anaesthetist and Lead for ????
Kathy Kershaw	Clinical Governance Midwife
Andrea McCourt	Head of Governance and Risk
Julie O'Riordan	Divisional Director, Surgical Division
Lindsay Rudge	Associate Director of Nursing
Peter Middleton	Membership Councillor
Michelle Augustine	Governance Administrator **(Minutes)**

ITEM NO	
019/17	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
020/17	**APOLOGIES** Dr David Anderson — Non-Executive Director Rob Aitchison — Director of Operations, FSS Division Asif Ameen — Director of Operations, Medical Division Helen Barker — Chief Operating Officer Karen Barnett — Assistant Divisional Director, Community Division Gary Boothby — Deputy Director of Finance Diane Catlow — Associate Nurse Director, Community Division Dr Mark Davies — Clinical Director for Emergency Medicine Martin DeBono — Divisional Director, FSS Division and Associate Medical Director 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 Vicky Pickles — Company Secretary George Richardson — Membership Councillor 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
021/17	**DECLARATIONS OF INTEREST** There were no declarations of interest to note
022/17	**MINUTES OF THE LAST MEETING** The minutes of the last meeting held on Tuesday, 3rd January 2017 were approved as a correct record.

DRAFT

023/17	**ACTION LOG AND MATTERS ARISING** ▪ Terms of Reference ▪ NICE Compliance Report MDB has asked for the paper to be deferred for when he can attend the meeting – March meeting (Wednesday, 3rd May 2017) ▪ Stroke Services Update Report See item 032/17 ▪ Invited Service Reviews HB has asked for this to be deferred to the next meeting. ▪ Care of the Acutely Ill Patient Programme (CAIP) See item 033/17 ▪ Care Quality Commission (CQC) Report See item 035/17
024/17	**QUALITY AND PERFORMANCE REPORT** Brendan Brown (Chief Operating Officer) reported on the circulated paper (Appendix C1 and C2) and summarised that December's performance score is 65% for the Trust. Safe gone back into green. Need to be cognitive on what is being reported. Complaints – should not of had a backlog – work ongoing to cover that FFT – some work on compliance – CTY are looking at physio perspective Serious Incidents – need to do the same with this MRSA – failed to screen on admission – put decolonisation in for that patient CDiff – had 25 to date – 6 are unavoidable JW – glad we have caught up. BB - Work ongoing on how we manage tone on it. How diffuse complaints at ward level. Educate staff to diffuse in the right way. Significant delay from BB (word diff) and want to put something on entrance of wards on how to encourage people to raise issues. AMcC – dates for the year re. complaints. Refined tracker system now and know how many weeks' overdue it is PM – Areas for improvement – sometimes small things. Is data comparable? BB – yes. PM – no metric to say where we are against other trusts. QC liked the reporting style **OUTCOME**: The Quality Committee received and noted the content of the report.
025/17	**QUALITY QUARTERLY REPORTING** Juliette Cosgrove (title) ……. Paper Each month bring a service – Q1 – Patient flow, then learning disabilities, then maternity services. Proposed list and left one open as topical item

DRAFT

	Presentation for Q3 – experience – doing some work on children's voice and ISCOMAT study – hoping that study will be part of how we can learn and engage better with people with LTC and self-management. Well-led – achieved flu vaccine, DoC is still hard to get done in tome and seeing sustained improvement with this and staff now know it's important to do **BB** – get same data every month in IPR and looking back and forward now. Trying to promote good stories now and data is available on monthly basis. **LP** – the topics to Board will come to QC first. **JW** – people managing own medication – really good **LP** – ties into co-creating health work **LP** – this report will go to the Board – ensure that this follows at Board in the same week if there are not any changes. **PM** – debate in membership council in A&E – still not understanding sustainability. What is not clear is 317 pts had triage then waited 8 hours, had assessment and sat on trolley for 8 hours? **JC**- will have been seen and assessed and can be a mix of 2. They would have been admitted, had plans and simply waiting for a bed. Varying reasons. There shouldb't be anyone waiting 8 hours for treatment. **LP** – have we had increased admissions and attendance as they can vary. Having conversation at Board on Thursday. **JW** – would be interesting to see how this goes when YAS triage. **LR** – starting to come down and will be reported on from this month. Have put some things in place to support this. **DB** – some wards closed with flu and still have staff who are at risk of flu. Try and get message **ACTION: message from DB and BB on email re. seeing pts in hospital and community** **OUTCOME**: The Quality Committee received and noted the content of the report.
026/17	**BOARD ASSURANCE FRAMEWORK** QC noted the report. QC are aware of what the risks are and keeping on top of and driven by risk register. **OUTCOME**: The Quality Committee received and noted the content of the report.
027/17	**SERIOUS INCIDENT REPORT** Andrea McCourt (Head of Governance and Risk) reported on the circulated paper (Appendix F) which summarises ……. Paste from report AMcC seen some other reports - PU are the first and cancer pathway was the third **LP** – how are lessons learnt **AMcC** – here for DD for learning and to PSQBs. Also some framework on how learning will be taken to SIRG next week, and will come through to here as the reporting group. **LR** - Some sit in orange panels and not all sit in SI groups. **JOR** – had a number of cancer reviews through division that have been orange and pulled together 5 or 6 into a report on short summary on themes, some things that can be done in division, but there are more overarching issues on where they should sit. Is there a group for those, and not specifically that can be done in the division. **JC** – need to be joined up with clinical, quality, safety, etc…. **OUTCOME**: The Quality Committee received and noted the content of the report.
028/17	**RISK REGISTER (CORPORATE)**

DRAFT

	Andrea McCourt (Head of Governance and Risk) reported on the circulated papers (Appendix G) which gave a summary of changes in the risk register from …….. Paste from report No movement from report since December. Risk needs discussion at SIRG on ICU. **JC** - keep 3 months active and archive the rest at Board. A copy of the risk register was also available. **OUTCOME**: The Quality Committee received and noted the content of the report.
029/17	**SAFEGUARDING ADULTS AND CHILDREN'S COMMITTEE REPORT** Lindsay Rudge (title) reported on the Appendix H…….. Increase in application in Dols All action plans are through safeguarding cttee Training – mapping to intercollegiate document – not seen improvement. Divisions have info to track and move forward. Tracker – expect to chage MD5 to blue. Challenge to sustaining those actions. At time of inspecition took action with CASH and satisfied part of review to ensure had robust process. Made positive process and now resolved. A lot of activity in relation to inspection. LR manage in safeguarding committee in the same way. Have process in place both internally and externally to safeguarding board as well. LR meeting chairs of boards to update. Kirklees Ofsted inspection – CHFT are supporting this in their improvement journey. Will update cttee of any impacts of review. Taking impact assessment to next Cttee if there is any urgent response needed from CHFT. Joint targeted inspections – preparing for next one. Not yet been visitied Improvement plans for 2017/2018 – see list LR ask Cttee to approve reports and appendices and overview that cttee will continue to do so. **JW** - Have we triggered any reviews – LR – on e recent case, but no problems with progressing – end of Q3. **LP** – will Kirklees get better? **LR** – process in place from secretary of state – under conditions of that and being assessed if they can continue to provide and manage those services. Will report on this next FGM been positibve and done mock inspection in maternity services and some services to embed. BB – push to cty to improve stats in helath visiting **LP** – good progress **LP** – MCA – not just training but also how to use it **LR** – challenge is to simplify it and not complicate it. Will separate trg on MCA and that aspect of it. It is currently with safeguarding and put into essential skills framework. **PM** – if this could be brought to the membership council – LR agreed to do presentation. **OUTCOME**: The Quality Committee received and noted the content of the report.
030/17	**HEALTH AND SAFETY COMMITTEE REPORT** See report Policies – Still issues with manual handling – not enough facilitators

	Security – Wanted more lone worker trg and conflict resolution trg – now in place Incidents – one RIDDOR – staffing, slips and falls Escalation – staff trg attendance – medical devices trg is still low in some areas. Had coroners case where some eqt was not used properly and staff got reprimanded. Also issues with oxygen – when runs out, porters cannot turn on cylinders. Some work to do with xray and other areas to be able to turn oxygen on. – mindful of wording **OUTCOME**: The Quality Committee received and noted the content of the report.
031/17	**ORGAN DONATION REPORT** CHFT Level 2 80% consent rate by 2020 Mtg provided all data that will follow of trust similar case mix coming through ED and ICU dept Page 5 – number 6 on chart Level 2 neuro death testing rate – green line is national target and we are in bronze section – number 6 Page 8 – 100% on this Page 8 – SNOD – 100% on this and on top line Page 9 – DBD Page 10 – conversion rate – bronze Page 11 – DCD – number 6 and nearly in silver Page 12 – SNOD involvement – over 80% Page 13 – Page 14 – on group of pts that we have Page 15 – tabulated tables – this is what is seen on the graphs **TJ** – minimise time from death to retrieving of organs – shaved some time off as rooms are not far from **BB** – having the right conversations, but the conversion rates are not that good **JC** – why are we doing so well **TJ** – had good buy-in from consultant and nursing staff. Clinicians are open and positive with organ donation and have key clinicians who are OK with organ donation. Practice EoL care proactively at CHFT. **BB** – thank you and the team for the work done in getting CHFT to the position we are in. Would be good for CQC to have a conversation with Organ Donation team. If there is anything else needed from QC, please let tehm know. **TJ** – what does the Cttee want to see in future? Level 2 data will not be specified in future. The annual report will not be in so much depth once it is published. Will bring figures as and when available. **JC** – if we adapt the data would be helpful to hear stories from staff to show that it is working well. QC agreed that TJ would attend twice a year to this Cttee.- once for annual report and good about staff experience and have this report twice a year, and have as pt story to Board. **DB** – will there be a patient story at Board? TJ – agreed that this can be done – May or June **OUTCOME**: The Quality Committee received and noted the content of the report.
032/17	**STROKE SERVICES REPORT** JC reported on see report Had ISR since the last meeting – expecting report in Feb 2017. Already done some work on feeding and improvement on thrombolysis – still some work to do on best practice area, therapy triage, coding – medical colleague working with coding and why there was variance with mortality, leadership, pall care team, continued work with FSS re. CT scan within one hour. **LP** – any vacancies with stroke

DRAFT

	DB – seem to be well staffed with clinical service and have specialist staff delivering that. Are in quite a strong place. Still have challenges with dietetics and SALT and radiology. Trying to get to a 'B', but should aim for an 'A'. Convos across WYorks and how services should be configured. Should be doing minimum on 900 pts per year, CHFT or Bradford do not meet that at the moment. Maybe a proposal to reduce units from 5 to 3. **LP** – will it link in with clot out manually through a catheter. **DB** – this would be where you would go if had acute stroke. **JC** – ISR team feel that we should be able to keep acute element of it. **JC** – need to continue to understand what that is. Work with Pall Care team is important and should get some learning on that. **LP** – Are relatively adequately medically staffed **JC** – not sure if have correct supply of nurses as yet. Need to ensure getting feeding regimes right. **LP** – see what ISR says **DB** – generally positive review **OUTCOME**: The Quality Committee received and noted the content of the report.
033/17	**CLINICAL OUTCOMES GROUP REPORT** Dr David Birkenhead (Medical Director) reported on the circulated paper (Appendix l) and the key issues discussed at the last Clinical Outcomes Group meeting held on …… See report HSMR Consultants in reviews How NC will relate into package. Hoping to roll out HAN at HRI Sepsis Int for dep MD and Assoc MD will be able to put more management time into programme and positive report **JC** – conversation with Vince Connelly – regional Med Director for NHSI, interested in SHMI position as was outlier for 5 years. Assured on work doing, wants to visit and will facilitate that , sent him ISRs and happy with approach taking, and will bring that here for the next meeting. Not planning any further follow-up. Starting to see benefits on HOOP Should we lower from 5 to 3 DB will look at trackers for performance on reviews over the weekend, how many are reviewed over 12 hours, are they reviewed by consultant and can they be done if missed. May be possible in EPR. Doing work on 7-day services and will do on that. **OUTCOME**: The Quality Committee received and noted the content of the report.
034/17	**MORTALITY SURVEILLANCE GROUP REPORT** Dr David Birkenhead (Medical Director) reported on the circulated paper (Appendix M) and the key issues discussed at the last Mortality Surveillance Group meeting held on ….. National meeting cancelled – trying to re-organise Reviewing more deaths Staff who are doing level 2 reviews and more consultants coming in to be reviewers and having better quality of conversations re. themes picked up. **LP** – weekend reviews – can see difficulties, but are we happy with daily rounds during the week? **DB** – the 4 key metrics from Keogh 10, and may get better response from people during the day. SU looking at similar co-ordinated role during the day as well as at night. **LP** – next SHMI figures due in March 2017

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	DB – confident that it should fall. May get back to expected if not now, may be in the next release of figures. **OUTCOME**: The Quality Committee received and noted the content of the report.
035/17	**RESEARCH AND DEVELOPMENT REPORT** Dr David Birkenhead (Medical Director) reported on the circulated paper (Appendix N) and ….. The total funding received to support this work is £758,555. The July 2016 R&D report provided a breakdown of this allocation across the Trust, in the main the funding is used for research delivery staff, service support departments (such as Pharmacy) and research governance. Since our initial allocation a further amount for £3,870 was made to directly support ophthalmology/medical illustrations. Money not spent on consultants Strong focus on cancer research – trials are becoming difficult to recruit to Large number of recruits is down to one study. Generated large number of recruits – if did not do, would not make study Did some go sees – been to Doncaster – have strong strong commercial research arm RTT is a challenge – a lot of trials are cancer-related Priorities – need to prioritise **JW** – what happens to trials once taken place **JW** - Is 122 trials too much to take on? **DB** – narrows down the field and the recruitment you could do. **JW** – does the commercial research produce any more. **DB** – have contract and have to deliver to. Need to build up reputation to deliver and struggling with that at the moment. Need to dedicate consultant time if we were doing it properly. Bradford do it a lot. **LP** – any other professors – JK Joffe, Tiefi James as well. And felicity Astin. **DB** - LTerrett is a lead clinician and starting to build some in cardiology. **JW** – need a project champion to lead **DB** – very time consuming and need to have an interest in subject to do it. JC – measuring nursing teams productivity and should be anle to free up some more time to support research **PM** – get three quarter of a million – is it only a contribution or does it cover the cost? **DB** – covers the cost and would be good to deliver some consultant time **PM** – is there a national project to genome project? **DB** - Seeing trend to more specific therapies FA paper raises profile of CHFT. **OUTCOME**: The Quality Committee received and noted the content of the report.
036/17	**CARE QUALITY COMMISSION (CQC) REPORT** Brendan Brown (Executive Director of Nursing) reported on the circulated paper (Appendix O) which focuses on …….. Mock CQC in maternity services – report will come here Planned in Feb for paed services and arranging one for ITU. Had meeting and given time to do work. Provided evidence. Expect to move to blue 2 actions on amber are mandatory training and seven day working. Has this moved on or in traction. CQC Response group is convening again next week and tasked divisions and service lines

	to date. Split risk and compliance and alternate on a monthly basis. From April alternate risk and compliance. Changes to CQC Relationship team – lead inspector and still keen to keep relationship mtgs. Local inspector is looking at ambulance and cty services and will support with cty services. **OUTCOME**: The Quality Committee noted the content of the report and agreed the changes and recommendations made by the CQC Response Group.
037/17	**SELF ASSESSMENT CHECKLIST** Summarise in Quality Committee annual report. Send out individually and back in 2 weeks.
038/17	**ANY OTHER BUSINESS** None Presentation on accreditation – pilot in paeds, JAG, March meeting
039/17	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** ▪ Safeguarding report – detailed report and received. ▪ CQC – QC recommending recommendations ▪ R&D – volume of work take place and Prof Astin ▪ Quality Report – approved recommendations ▪ Further presentation with Organ donation and suggesting Patient story to board.
040/17	**QUALITY COMMITTEE WORK PLAN** A copy of the Quality Committee's work plan for 2017 was circulated (Appendix Q) for information. **OUTCOME**: The Quality Committee received and noted the content of the report

NEXT MEETING

Monday, 27th February 2017
3:00 – 5:30 pm
Board Room,
Huddersfield Royal Infirmary

Email - DDs need to be in attendance and then in attendance at further PSQB meetings. And also dates for next PSQB meetings.

PM apols

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APP A

Minutes of the Finance & Performance Committee held on Tuesday 31 January 2017 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnerships
Gary Boothby	Director of Finance
Lesley Hill	Director of Planning, performance and Esates & Facilities
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)
Ian Warren	Director of Workforce & Organisational Development
Owen Williams	Chief Executive
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance
Mandy Griffin	Director of Health Informatics
Andrew Haigh	Chair of the Trust
Brian Moore	Membership Councillor
Victoria Pickles	Company Secretary
Betty Sewell	PA (Minutes)

ITEM

018/17 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

019/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
David Birkenhead – Medical Director
Brendan Brown – Director of Nursing

020/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

021/17 MINUTES OF THE MEETING HELD 3 JANUARY 2016

The minutes of the last meeting were approved as an accurate record.

022/17 MATTERS ARISING AND ACTION LOG

029/16: SAFER Programme Update – The Chief Operating Officer confirmed that a paper would not be tabled today but would be covered under the Private section of the Board on Thursday.

156/16 – CIP 17/18 & Beyond – The Director of Transformation and Partnerships presented the overview of the progress against the plan to deliver £17m of efficiency savings in 17/18. It was noted that has part of the Portfolio approach each Division has a differential target. The current value of schemes at Gateway 1 is £10m leaving us with a significant gap. The challenge will be to progress all schemes to

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Gateway 2 by the end of March 2017. It was also noted that a Star Chamber has been held for the Surgery Division. Details of how the on-going process will be supported was discussed which included a second Annual Planning Day on the 15 February.

The Chief Executive commented that following the Star Chamber it was noticeable that a broader story is required to ensure the clinicians have a clearer picture with regard to how Divisional cost savings are connected to the regulator imposed Control Total and the contractual process. He called upon the Director of Finance, Chief Operating Officer and the Director of Transformation & Partnerships to look at how this could be done.

In depth discussions took place with regard to how realistic it is to expect the organisation to find the £7m gap before the year-end and how we then take out similar cost savings recurrently. It was agreed that the organisation will continue to work hard to close the gap but that there is a limit to the amount of money which can be taken out of the system and that there is a fundamental underfunding issue. Also discussed was the acknowledgment to appeal against the Control Total.

Discussions then took place with regard to the fixed services and what, under the Terms and Conditions, we are required to provide. It was agreed that a review of the Commissioner Requested Services would be undertaken at the next Committee meeting.

ACTION: To revisit the Commissioner Requested Services that we are mandated to provide, to be brought to the Committee to review any opportunities next month – **AB**

In summary, it was recognised by the Committee that the plan to deliver a £17m is a challenge, however, there is more confidence in the CIP process which was seen as more robust with regard to opportunities and the evaluation of schemes. It was accepted by the Committee that it is getting harder to find cost savings and the requirement to appeal against the Control Total.

The Committee noted the contents of the updated report.

172/16: Strategic and Annual Plan Review – The Associate Director of Finance presented a paper which provided the Committee with a comparison of the key financial headlines from the Trust's Outline Business Case (OBC) and the Annual Plan submitted to NHS I on 23 December 2017. The following points were highlighted:-

- The comparison of the deficit reconciliation and the key variances
- The income analysis
- Pay Expenditure

The report concluded that whilst the financial deficit of the Trust has changed since the development of the OBC, the underlying financial position of the Trust remains consistent. Explanation of key movements on the treatment of EPR costs, depreciation on backlog maintenance and STF funding, ensures the underlying

financial deficit remains consistent. However, the underlying income base from clinical activity and the staff costs associated with delivery are fundamentally different to the OBC assumptions and remain a challenge for the Trust. These changes will be modelled within the development of the Full Business Case for the reconfiguration.

ACTION: The Chief Executive requested to take discussions off-line with the Director of Finance with regard to the modelling of the income phasing to track national figures – **OW/GB**

The Committee noted the paper.

FINANCE AND PERFORMANCE

023/17 MONTH 9 FINANCE REPORT

The Deputy Director of Finance, took the Committee through the Finance Report for Month 9, year to date, the following headlines were noted:

- The I&E year to date position at Mth 9 is a deficit of £13.1m (excluding exceptional items) which is still in line with the plan.
- December was a positive month in terms of income generation with activity not falling in line with the historical December dip and the over-performance against plan in planned daycases, outpatients and also A&E. We also manged to contain beds numbers within the planned levels and therefore expenditure was contained. All these positives allowed us to absorbed the level of risks particularly around the SRG funding.
- The Cash balance still remains above plan at £4.98m mainly due to a capital underspend but also receiving £685k of Clinical contract income in December which was due in January and the number of invoices received and paid being lower than forecast despite all invoices approved for payment being paid by the end of December.
- In overall terms, year to date, borrowing remains lower than planned and will remain lower than planned through to the year-end. It was noted that since this report, confirmation has been received that we have been successful in switching our borrowing from a 3.5% to 1.5% interest rate.

Discussions took place following a question from the Chair of the Trust, with regard to the robustness of our forward forecasting, particularly with regard to the growth in diagnostic testing year on year. It was recognised that the FSS Division have been highlighting the need for capital investment; the challenge for the Trust has been the growth in year which has exceeded previous year's growth. Through the Divisional PRMs the FSS Division has been asked to explain clinical variations. In addition, re-charging will take place from the 1st April, to try in influence behaviours. The Chief Operating Officer reported that there had been an increase in GP 'fast-track' and with the new cancer standards we need to map what this increase will be.

ACTION: To discuss with Divisional colleagues the scoping of a report of the Diagnostic service which will be reviewed at a future F&P Committee – **HB**

In relation to the Finance Report, the Director of Finance reported that since the F&P papers were issued a request from NHS I had been received to defer some of our

capital into next year, our response to this request was that we could defer capital monies if we received something in writing which states that this would be added to our current plan for next year.

Underlying Reporting Position at Month 9 – An additional paper was included within the Finance Report which had been provided to the Committee to help with the understanding of the reported financial position. The paper described both the year to date and forecast financial performance split out to show the underlying reporting position separated from any material non-recurrent or technical adjustments that have been accounted for in this financial year.

The Committee noted the contents of this additional paper.

024/17 FINANCIAL FORECAST AND RECOVERY PLANS AT MONTH 9

The Director of Finance talked the paper which explained that over the past few months the need for a further £2m of recovery schemes had been identified for us to deliver the agreed £16.1m Control Total. Assumptions are still in place and are being implemented and monitored. With the in-month improvement the level of risk including the non-receipt of SRG and the Commissioner challenge regarding counting and coding that existed within the forecast has been reduced.

The Chief Operating Officer highlighted the risk with regard to the Sustainability & Transformation Funding (STF) for emergency care for January, it was also noted that we are likely to spend all the allocated Accelerator Zone funding.

An early indication for January was discussed with no additional issues to note that are not in the forecast.

The Committee noted the contents of the paper.

025/17 CASH FORECAST

The Deputy Director of Finance reported on the 13 week cash flow forecast and the breakdown of the aged debt. Of the overall aged debt of £4.71m, £1.34m relates to invoices raised in relation to the SRG funding, £432k relates to invoices for non-contract activity and £339k relates to invoices for PMU sales. In Month 9 an agreement of balances has taken place with other NHS organisations which may see some movement.

It was noted that at the last Cash Committee a review of the success of the Committee and how further progress can be refreshed was carried out. It was agreed at that meeting that it may be worthwhile to allocate a team to concentrate on chasing aged debt. It was also agreed that 'go-sees' with other NHS organisations would be beneficial. A further paper will come to the next meeting which will review the future role of the Cash Committee and the actions taken to reduce the aged debt position.

It was confirmed that all the recommendations have been implemented following the KPMG review of Cash within the Trust in 2016.

ACTION: A review of the role of the Cash Committee will take place and this will be shared with the Committee next month – **KA**

The Committee noted the paper.

026//17 RESOLUTION ON WORKING CAPITAL

The Committee received a request to recommend to the Board the approval of the resolution required to support the Interim Revenue Support Facility.

The Committee recommended the resolution to the Board.

027/17 FINANCIAL PLANNING UPDATE

The Director of Finance reminded the Committee that for 17/18 the plan was to accept the Control Total required a £17m CIP. Issues relating to the signing of the contract with Commissioners were also discussed and it was noted that Commissioners had improved their position enabling us to move forward without requiring arbitration, this requires a 'Heads of Terms' but we are working together with the Commissioners to get the contract signed by mid-February. However, negotiations have left the Trust with a further challenge of £1m plus an additional £2m relating to the QIPP recommendations and the Health Visitor bid.

In confirming to the regulators we did not require arbitration the decision was made to appeal our Control Total which would now require a £20m CIP, which is thought to be too greater challenge. A Performance Review has taken place with the regulators since our decision to appeal; however, we still await details of the appeal process.

It was noted that the Chair of the Trust had been involved in the decision to appeal the Control Total which also had the backing of the Chief Executive.

STRATEGIC ITEMS

028/17 CIP UPDATE

The Chief Executive confirmed there was nothing more to report to the Committee this month.

029/17 EPR

The Associate Director of Finance reported that this month's report is consistent with previous month's financial forecast which supports the go-live date of May 2017 for CHFT. The following key points were highlighted:-

- Capital overspend against the original business case now forecast at £4.3m;
- Risk remains within the project to achieve a go-live date of early May 2017;
- Operational plans are being revised to support the planned May 2017 go-live date;
- Financial pressure in month on pay and non-pay expenditure, an adverse variance against the original business case as the original business case had completed capital spend by this point;
- The cost of VAT has been included within the YTD costs and forecast reported due to a change in guidance from the Trusts VAT advisors. The Trusts remain in dialogue with HMRC;

- Capital plan re-prioritised for 2016/17 to support the additional cost pressures of the EPR; and
- Adverse cash and benefits implications YTD and forecast within the financial year. Financial pressure in month on pay and non-pay expenditure, an adverse variance against the original business case

It was noted that the Trust had received associated media interest and some coverage has taken place in Digital Health and that further coverage in the local media should be expected.

The Committee noted the paper.

The Director of Health Informatics reported that we are 88 days from the go-live date. There has been a shift to operational readiness and as a result the Chief Operating Officer will be Chairing the EPR Programme Board which will take place every 2 weeks over the next 6 months with an agenda with particular focus on the operational areas for CHFT but will also include technical readiness for BHFT. Real people are being introduced into communications and the count-down has begun. Divisions are due to sign off their 90 day planning stages which need to be green for operational readiness. Training sessions, which cover 31 job plans, are also being booked. We are also into the 4th gateway review which starts 18 February to ensure operational readiness.

030/17 ESTATES & FACILITIES ALTERNATIVE DELIVERY MODEL
See the Minute under the Private Section of this meeting.

GOVERNANCE

031/17 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported the following position for December:-

- In month there have been positive movements in performance.
- Safe is now GREEN following the 'Never Event' reported last month.
- The single oversight framework is now being reflected in the performance summary sheet.
- Financial risks around performance are minimal.
- We will be losing Best Practice Tariff for Stroke as units were closed due to the Norovirus.
- Emergency Care Standards in December were at 92.4%
- A higher agency usage was factored in at the beginning of Q4 to respond to safety risks.
- With regard to the Contract, we are looking to get a better equity proxy to share with the contract group.
- Elective work was reduced as requested by NHS I pre/post the Christmas period, it was noted that the period between Christmas and the New Year was particularly challenging. The first part of January was spent in command and control.
- Activity is above plan and some of the position for cancelled operations was better on the IPR in January, against the national trend.
- The following risks going forward were called out:

    - 38 Day Cancer – shadow monitoring data centre
    - 62 Day at risk
    - CQUINS – Sepsis and Antimicrobial
- There is a positive bed position with just 3 beds open above plan (100 less than last year) which is a significant achievement
- Length of Stay is in a much better position, lowest excess bed number since October 2015 which reflects the package of care.
- Community Place is working well with 12 'guests' at the moment. A positive experience is being reported and examples of guest experience will be discussed at Board.

ACTION: It was requested that a composite benchmarking exercise with regard to performance should be reviewed by this Committee periodically with the first review in 6 months' time - **HB**

032/17 REVIEW FINANCE & PERFORMANCE TERMS OF REFERENCE

The Company Secretary asked the Committee to approve the revised Terms of Reference, the updates included the membership, terminology and reference to the role of the sub-committees. It was noted that more reference should be made to operational performance as well as finance performance and subject to that amend.

The Committee approved the Terms of Reference which will now go to Board.

033/17 BOARD ASSURANCE FRAMEWORK

The Company Secretary highlighted the Committee to the BAF risks monitored by the Finance and Performance Committee. It was noted that Risk 10 had an increased score from 16 to 20, this is due to the fact that we are at risk of not receiving STF funding due to the Trust not achieving the required performance for Q4. It was also noted that the 'Lead' for Risk 19 would be amended accordingly.

The Committee noted and approved the Board Assurance Framework.

034/17 MONTH 9 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 December 2016 which has been submitted to NHS I.

The Committee noted the contents.

035/17 DRAFT MINUTES OF THE CAPITAL PLANANING GROUP HELD 12/1/17

The Committee received the Minutes and noted the contents.

036/17 WORK PLAN

The Work Plan was received and noted by the Committee.

037/17 MATTERS FOR THE BOARD AND OTHER COMMITTEES

The Chair of the Committee summarised the following items which had been discussed during the meeting:-

- CIP 17/18 risks to plan

- Appeal to the Control Total
- Commissioning requested services
- Reconciliation of Annual Plan and the OBC
- FBC discussions
- Diagnostic capacity to review again at future meetings
- NHS I Capital noted
- Forecast year end in line with CT – soft FM risks noted
- Clinical coding
- Cash/Aged Debt/Role of Cash Committee
- Discussions with Commissioners to close gap through QIPP
- Approval of change to borrowing
- Financial Performance – stronger
- January indication good
- Operational Performance – activity above plan, challenges in A&E
- 100 beds below last year – significant achievement
- Terms of Reference approved
- Committee support progression on E&F

038/17 ANY OTHER BUSINESS

There were no further items for discussion.

DATE AND TIME OF NEXT MEETING

Tuesday 28 February 2017, 9.00am – 12.00noon,

Note change of venue : Discussion Room 1, Learning Centre, HRI

DRAFT

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

030/17 ESTATES & FACILITIES ALTERNATIVE DELIVERY MODEL

The Director of Planning, Performance and Estates & Facilities presented a paper outlining the opportunity to develop our Estates & Facilities services and collaborate across the WYATT footprint.

The Committee received and noted the contents of the paper, the Committee supported the progression of this work and recommended the paper to Board.

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CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 19 January 2017, 2.00pm – 4.00pm in Room 3, 3rd Floor, Acre Mill Outpatients, Huddersfield.

PRESENT:	
Brendan Brown	Executive Director of Nursing
Karen Heaton	Non-Executive Director (Chair)
Ian Warren	Director of Workforce and Organisational Development
Jan Wilson	Non-Executive Director
Rosemary Hedges	Membership Councillor
IN ATTENDANCE:	
Kirsty Archer	Deputy Director of Finance
Mark Borrington	Programme Manager – Safer Staffing Workforce Utilisation and Efficiency
Chris Burton	Staff Side Chair
Azizen Khan	Assistant Director of HR
Vicky Pickles	Company Secretary
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development
Nicola Sheehan	Head of Therapies
Claire Wilson	Assistant Director of Human Resources
Gail Wright	Head of Midwifery

01/17	**WELCOME AND INTRODUCTIONS:** The Chair welcomed members to the meeting.
02/17	**APOLOGIES FOR ABSENCE:** David Birkenhead, Medical Director Jason Eddleston, Deputy Director of Workforce and Organisational Development Anne-Marie Henshaw, Associate Director of Nursing, Families and Specialist Services Kristina Rutherford, Director of Operations, Surgery and Anaesthetics Ashwin Verma, Divisional Director, Medical
03/17	**DECLARATION OF INTERESTS:** No declarations of interest were received.
04/17	**MINUTES OF MEETING HELD ON 8 DECEMBER 2016:** The minutes of the meeting held on 8 December 2016 were approved as a true record.
05/17	**ACTION LOG (items due this month)** <u>Draft Workforce Strategy</u> **ACTION:** IW to submit Workforce Strategy to January 2017 Board of Directors <u>Terms of Reference and Structure</u> **ACTION:** IW/VP Amend Terms of Reference <u>Workforce Monthly Trust Report</u>

	See item 06/17 and 15/17 **ACTION:** IW to progress required amendments. <u>Safer Staffing, Workforce Utilisation and Efficiency Programme Update</u> <u>See item 95/16</u> **ACTION**: IW/MB to incorporate numbers into RAG rating system. TR to add as a standing agenda item. <u>Recruitment Plan</u> **ACTION:** TR to invite Recruitment Manager to June 2017 meeting. Discussed at today's Committee meeting, to invite the Recruitment Manager to the April 2017 Committee meeting as well. TR to share consultant advertisement with the Committee CW to provide job role and pay scale information. <u>Workforce Performance Report</u> **ACTION**: All to identify specific areas for deep dive <u>2015 WRES/Staff Survey Action Plan</u> **ACTION:** JE to identify separately BME actions
	MAIN AGENDA ITEMS
	FOR DECISION
06/17	**WORKFORCE PERFORMANCE REPORT – STRUCTURE AND FORMAT** CW outlined the further refinements of the report:- • Structure aligns more closely to the Carter report. • Performance from current month to last month easily identified. • KPIs and trajectories identified, report includes more comparable data and identifies where on track we are. CW advised work is being undertaken with HR business partners to include more narrative, for example we have the data but what are we doing about it? The Committee had queried previously the heading 'Employee Relations'. CW confirmed this is an ESR category but an explanation is given in the glossary. CW advised that medical and dental appraisals should be undertaken in the birth month of the individual. The planned position is calculated on this basis. Work is being undertaken within Medical Education in terms of how appraisals are being recorded. The Committee requested the following revisions to the report:- • Turnover, identify the number of starters and leavers over the 12 month period. • Agency spend – planned position to be identified.

	KH confirmed this was good progress in terms of the format of the report and its further alignment to the Workforce Strategy. **ACTION: CW to progress required amendments.** **OUTCOME:** The Committee **RECEIVED** and **APPROVED** the
	FOR ASSURANCE
07/17	**SAFER STAFFING, WORKFORCE UTILISATION & EFFICIENCY PROGRAMME** MB attended the Committee meeting to provide an update on progress of the Programme. The Trust's December 2016 agency spend was £1.55m. This is £0.34m below trajectory. IW highlighted that the Divisions need to understand their forward plan. A clear trajectory throughout the Trust is required - how workforce plans are driven in line with the annual plan. Divisions need to revisit their control mechanism and have a grip on their forward plan. It was noted in December 2016 the Medical Division had the top agency spend of £1m. The Committee agreed the Medical Division should formally be requested to attend the next Committee meeting to discuss the workforce elements of Medicine, specifically in relation to the governance and assurance processes within the division, in support of the implementation of the Workforce Strategy, and the associated action plans. The Committee will focus on the need for assurance in respect of delivering the Agency trajectory, and how Medicine will embed the workforce plans and programme, along with the core elements of the Workforce Strategy. The Committee agreed the recommendations put forward in the report are decisions which should be made by the Executive Directors. **ACTION: IW to request Medical Division attend February 2017 Committee meeting.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
08/17	**BOARD ASSURANCE FRAMEWORK** The Board Assurance Framework is shared with the Board of Directors on a quarterly basis. Each sub-committee is asked to consider the risks that relate to its responsibility. VP highlighted to the Committee Risk 14, 'Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites'. VP reported the position may change upon the results of the 2016 Staff Survey. The 2016 Staff Survey will be an agenda item at the February 2017 Committee meeting. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.
09/17	**CORPORATE RISK REGISTER**

	The Corporate Risk Register is to be considered by the Committee on a quarterly basis. VP highlighted the two risks which relate to staffing:- • Over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E • Broad staffing risk A further two risks were noted:- • Not being able to provide essential skills training data • Failure to comply with NHS Improvement cap rules (creating a finance risk as opposed to agency cap) VP advised the Workforce (Well Led) Committee should be aware the risks had been raised at the recent Risk and Compliance Committee. IW suggested he and VP meet to discuss both the risks identified in the Board Assurance Framework and the Corporate Risk Register. **Action: VP/IW to discuss identified risks.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
10/17	**WORKFORCE STRATEGY IMPLEMENTATION PLAN** AK reported work is progressing with regard to the identified actions within the Workforce Strategy Implementation Plan. The plan will be reviewed and action dates updated by HR colleagues w/c 23 January 2017. The RAG ratings will be incorporated into the document at this stage. The Committee requested key themes from the Implementation Plan which align to the staff survey are selected and then linked to identify progress. **ACTION: IW to progress selection of key themes from the Implementation Plan.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.
11/17	**LEARNING MANAGEMENT SYSTEM** IW reported the CQC concerns in reporting on appraisal, mandatory training and essential skill compliance. The current Learning Management System, OLM, lacks functionality resulting in difficulty in compliance reporting. The Oracle Learning Management (OLM) module of ESR is being developed and with planned added functionality this should reach 80% of the Trust's needs. It is estimated a commercial system could potentially deliver 95% of the requirements. The recommendation is to put on hold the procurement process for a new Learning Management System until September 2017 to assess if the enhancements made to OLM meet the Trust's requirements. It is thought the cost of an alternative learning management system to be in the range of £0.25m - £0.5m.

	VP confirmed the risk implications of inadequate reporting. VP advised a Leeds Trust are a pilot site for the ESR/LMS appraisal system. GW had previously used this system and fully supported its ease of use. The Committee supported the recommendations outlined in the report and requested a further update to the Committee in March 2017. **OUTCOME:** The Committee **RECEIVED** and **APPROVED** the recommendation.
12/17	**REVIEW OF EPR TRAINING SCHEDULE** IW gave a brief verbal update on the EPR training schedule. The 'go live' date is 2 May 2017. IW advised a weekly update is provided to Executive Board. Executive Directors are to be trained as 'EPR friends'. The Committee agreed to invite Jackie Murphy to the February 2017 Committee meeting. **ACTION: TR to invite Jackie Murphy to February 2017 Committee.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.
13/17	**REVIEW OF E-ROSTERING PROGRAMME** BB gave a verbal update of the E-rostering system. BB confirmed the system is being upgraded - Allocate is the provider. The system is being rolled out initially to nursing colleagues and the feedback has been very positive. Ward managers are engaged and staff are liking the new system. GW advised she had used the Allocate system previously and fully supports it. Further roll out to medics and other staff will follow. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.
14/17	**REVIEW OF ESR PROGRAMME** Dave Armitage updated the Committee regarding the current position of ESR Manager Self Service Project. At the February 2017 meeting of the ESR Self Service Project Board the position of the project was reviewed. It was agreed to halt further roll out of the Self Service facility in order to assess the requirements of the Trust. In addition ESR applications are due to have a major upgrade in March 2017. IW advised a new Trust Programme Board will have responsibility for overseeing the development of ESR Self Service and its effective roll out across the Trust. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	PERFORMANCE
15/17	**WORKFORCE PERFORMANCE REPORT (DECEMBER 2016** The Committee noted:-

	Turnover has reduced significantly over the last 12 months. The Committee discussed the importance of taking action to retain staff and not rely on Exit surveys. Opportunity for colleagues to move/progress within the Trust should be given. Appraisal compliance has increased and is on track to reach the planned position. Quality of appraisals should also be given serious consideration. Sickness absence has increased. IW reported this is a seasonal increase and is still improved from last year's position. Trend in agency spend has reduced but still overspending. Current sickness absence target is 4%. The Committee considered and agreed a target of 3.5% should be implemented across the Trust. BB suggested this should be communicated to the Trust in terms of headcount and cost. **ACTION: IW to take 3.5% sickness target to EB.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report
	INFORMATION
16/17	**2015 WORKFORCE RACE EQUALITY STANDARD (WRES)/STAFF SURVEY ACTION PLAN** The updated Action Plan was shared with the Committee. IW suggested presentations to be developed for both the WRES and the Staff Survey action plans which align to the 2016 staff survey results. **ACTION: IW to undertake Staff Survey presentation.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the action plan
17/17	**WORKFORCE RACE EQUALITY STANDARD (WRES)ACTION PLAN PROGRESS REPORT** AK presented the WRES Action Plan. The WRES actions were now identified separately from the combined WRES/Staff Survey Action Plan. The BME Network group had met in September and December 2016. The Network agreed going forward that Errol Brown, Buyer in the Procurement Team, would Chair the Network meetings supported by the Chief Executive and AK. With regard to mentoring and development programmes, AK confirmed she had met with the Leadership Academy who have offered one day's in house training to 15-20 staff members. Training date to be confirmed. The Learning Academy has launched a development programme aimed at Agenda for Change bands 5, 6 and 7, individuals are to apply directly to the Learning Academy. Bradford Trust has also offered CHFT places on their development programme along with mentoring training. AK reported the Embracing Diversity and ELearning module is being reviewed by the E&D Network. Lesley Hill is the Executive Lead for the in house review of Embracing Diversity. Specific training is being revised to include for example unconscious bias.

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	On 31 January 2017 a website was developed to sign post BME staff to additional information. BME champions identified on website. JW queried if E&D training is offered to Non-Executive Directors and Membership Councillors. VP confirmed Membership Councillors receive training separately but would check the position with regard to Non-Executive Directors as this is carried out via an e-learning module. KH acknowledged the good progress in maintaining engagement with BME staff. IW suggested presentations to be developed for both the WRES and the Staff Survey action plans which align to the 2016 staff survey results. **ACTION: VP/AK to check position re Non-Executive Director E&D training module.** **AK to undertake WRES presentation.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the action plan
18/17	**HEALTH AND WELLBEING CQUIN QUARTERLY REPORT** The report was shared with the Committee. The Committee agreed this item should be brought back to the February 2017 Committee meeting and invite Christine Bouckley, Head of Workforce Wellbeing to talk to the paper. **ACTION: TR to invite CB to February 2017 committee meeting.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the action plan
19/17	**WORKFORCE (WELL LED) COMMITTEE TERMS OF REFERENCE** The revised Terms of Reference were shared with the Committee for information. VP confirmed the Terms of Reference were approved at the January 2017 Board of Directors. The sub-group structure is to be finalised and brought to the April 2017 Committee meeting. **ACTION: VP/IW/JE to meet to discuss the sub-group structure**
	ITEMS TO RECEIVE AND NOTE
20/17	**ANY OTHER BUSINESS:** JW suggested the outcome of the Trust's Clinical Excellence Awards is shared with the Committee. The 2015/2016 awards panel is scheduled to take place on 25 April 2017. The Committee agreed to this and the report will be submitted to the May 2017 Committee. **ACTION: TR to add to May 2017 agenda**
21/17	**MATTERS FOR ESCALATION:** There were no matters identified for escalation to the Board of Directors
DATE AND TIME OF NEXT MEETING: Thursday, 16 February 2017, 2.00pm – 4.00pm, Room 4, 3rd Floor, Acre Mill Outpatients,	

Huddersfield.

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CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 16 February 2017, 2.00pm – 4.00pm in Room 4, 3rd Floor, Acre Mill Outpatients, Huddersfield.

PRESENT:	
David Birkenhead	Medical Director
Brendan Brown	Executive Director of Nursing
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Karen Heaton	Non-Executive Director (Chair)
Ian Warren	Executive Director of Workforce and Organisational Development
Anne-Marie Henshaw	Associate Director of Nursing, Families and Specialist Services
IN ATTENDANCE:	
Kirsty Archer	Deputy Director of Finance
Mark Borrington	Programme Manager – Safer Staffing Workforce Utilisation and Efficiency
Chris Burton	Staff Side Chair
Juliette Cosgrove	Associate Director of Nursing and Quality
Azizen Khan	Assistant Director of HR
Ruth Mason	Associate Director of Inclusion and Engagement
Richard Metcalf	Human Resources Manager
Barry Mortimer	Senior HR Adviser
Jackie Murphy	Deputy Director of Nursing - Modernisation
Vicky Pickles	Company Secretary
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development
Claire Wilson	Assistant Director of Human Resources
Asif Ameen	Director of Operations

22/17	**WELCOME AND INTRODUCTIONS:** The Chair welcomed members to the meeting.
23/17	**APOLOGIES FOR ABSENCE:** Rosemary Hedges, Membership Councillor Kristina Rutherford, Director of Operations, Surgery and Anaesthetics Jan Wilson, Non-Executive Director
24/17	**DECLARATION OF INTERESTS:** No declarations of interest were received.
25/17	**MINUTES OF MEETING HELD ON 19 JANUARY 2017:** The minutes of the meeting held on 19 January 2017 were approved as a true record.

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26/17	**ACTION LOG (items due this month)** Workforce (Well Led) Committee Sub Groups and Terms of Reference **ACTION:** Progress establishment of sub groups and develop terms of reference Liaise with existing group Chairs regarding review of terms of reference Workforce Performance Report **ACTION:** Identify dates and specific areas to undertake deep dive Take recommendation of 3.5% sickness target to EB Safer Staffing, Workforce Utilisation & Efficiency programme **ACTION**: Request Medical Division attend February 2017 Committee meeting Corporate Risk Register **ACTION:** Discuss identified risks Review of EPR Training Schedule **ACTION**: Invite Jackie Murphy to February Committee meeting 2016 Staff Survey Action Plan **ACTION:** Produce PowerPoint presentation Workforce Race Equality Standard (WRES) Action Plan **ACTION:** Check position re Non-Executive E&D training module Health and Wellbeing CQUIN Quarterly Report **ACTION:** Invite Christine Bouckley to February Committee meeting Clinical Excellence Awards **ACTION:** Add outcome briefing paper to May 2017 Committee agenda and Workplan
	MAIN AGENDA ITEMS
	For Assurance
27/17	**SAFER STAFFING, WORKFORCE UTILISATION & EFFICIENCY PROGRAMME** MB attended the Committee to provide a progress update. The Executive Board have approved a Programme Board, the 'Workforce Modernisation Programme' which is derived from a combination of the Trust's 5-Year Workforce Strategy and outstanding agency spend objectives of the Safer Staffing, Workforce Utilisation & Efficiency Programme. The Programme Board will report to EB. It will allow for the escalation and discussion of project performance, progress against plan and associated risks and issues. MB advised the Trust's January 2017 agency spend was £1.95m, which is £90k

	above trajectory. The Trust's agency spend has not substantially reduced over the last 6 months. MB advised there are some quick wins to reduce agency spend, specifically:- • Use alternative staffing solutions rather than agency, build up internal nursing, medical, AHP bank • Replace systems with Allocate Executive support is being sought through the Workforce Modernisation Programme Board to embed specific controls:- • Embed tighter control of agency use and spend, especially high cost agencies • The programme board will consider the approval and formation of a Workforce and Agency Control Panel ('break glass' approach) to facilitate operational workforce flexibility over agency use • The programme board will consider the agreement of a common approach with neighbouring Trusts to collectively tackle agency spend MB put emphasis on the need for effective workforce planning. JE advised the NHSI have a self-assessment tool and have offered to undertake a peer review. JE agreed to circulate the tool along with the original self-assessment submitted to Executive Board. JC confirmed the Trust has a Standing Operating Procedure in place and this needs to embed across the Trust. DB reported that decisions are based on patient safety. It was noted 48 extra beds were opened in November 2016. The Committee asked if there was an associated increase in agency spend. This is currently being assessed. The Committee agreed the Surgery and Anaesthetic Division should be formally requested to attend the March 2017 Committee meeting in relation to governance and assurance processes within the Division in respect of delivering the agency trajectory, and how it will embed the workforce plans and programme, along with the core elements of the Workforce Strategy. **ACTION: JE to circulate the self-assessment tool along with the Trust's original self-assessment submission to EB.** **IW to formally request Surgery and Anaesthetic Division attendance at March 2017 Committee meeting.** **MB to identify any additional agency cost associated to opening of additional beds.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
28/17	**MEDICAL DIVISION – ASSURING THE WORKFORCE PLANS AND STRATEGY** AA, JC and RM attended the Committee meeting to provide assurance in relation to the Medical Division's priorities in order to deliver the agency trajectory and its response in support of delivering the Workforce Strategy. Reality in the Division:- • Recruitment, retention and vacancy challenges (160 vacancies) • Shortage of professionals in key areas eg Consultants (19 vacancies) and

nursing staff
- Stretched time to recruit
- Over reliance on agency locums
- Impact on quality and patient care
- Staff engagement

Divisional priorities:-

- Governance structure in place through Workforce and Finance Sub Committee
- Divisional Workforce Strategy in final stages
- 'Ward to Board' - improve the ability of colleagues to have a voice (listening events)
- Greater connection and communication with line managers
- Confirm and challenge meetings
- 100% appraisal completion (quality appraisals)
- Team and individual recognition
- Understand colleagues' career aspirations/ Create and nurture future leaders
- Reduce and sustain sickness absence (currently sickness absence rate of 5.35%). Strict adherence to Attendance Management policy- more focus on return to work interviews

Medical Workforce specific activity:-

- 19 consultant vacancies currently
- BMJ Consultant recruitment campaign December 2016
- 4 Consultants appointed at AACs held in February 2017
- Further 2 AACs scheduled to take place over the next 3 weeks
- Further BMJ campaign planned for April 2017
- Successful MTI (Medical Training Initiative) programme and planned expansion
- Development of CESR (Certificate of Eligibility for Specialist Registration) programme
- Exploring different roles eg Physician Associates
- 15 March 2017 - Careers Fair, Leeds Medical School
- Rota reviews: General medicine registrar rota to change from 1:12 to 1:15 from April 2017 following review to increase medical cover out of hours

Nursing Workforce specific activity:-

- Divisional nursing workforce strategy
- Practice Development Nurses - support and retain new nurses
- International recruitment campaign (trip to the Philippines departs March 2017)

IW asked what the Committee could do to support the Division.

AA clarified that much of the pressure was due to increased demand for services, and was clear that the pressure on Agency spend, in particular, was due to increased number of beds and patient numbers. The division were clear that spend could only be reduced by reduction in bed numbers, although an increased focus on reducing bureaucracy was necessary.

AA advised that in terms of bed numbers, decisions based on patient care often mean a patient needs to remain in hospital because there isn't a package of care (largely due to funding) from primary to secondary care. If care can't be provided in the community the alternative is to open additional CHFT beds.

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	AMH reported that ED Paediatric professionals often transfer between ward working and ED. The Committee discussed a deep dive of fill rates across the Division and agreed that as wards and departments are all different it would be a matter of looking at a workforce model in each clinical area. The Committee agreed HR and nursing work together to formulate a plan to undertake a deep dive on one ward. AA advised that intelligence/data from the Workforce and OD Directorate is critical in supporting the Division's plans along with support from an OD point of view in terms of training and appraisal. IW confirmed full support will be available from the WOD Directorate. IW confirmed he had been invited to attend a Divisional meeting ('Go See') on 7 March 2017. **ACTION: IW/BB to progress plan for a deep dive of one Medical ward.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the position.
29/17	**WORKFORCE STRATEGY IMPLEMENTATION PLAN – PROGRESS REVIEW** The implementation plan had been circulated to Committee members. IW confirmed that work is progressing on schedule in terms of the identified actions. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.
30/17	**ANNUAL MEDICAL REVALIDATION REPORT** The report had been circulated with papers to the Committee meeting. DB confirmed the report covers the period 1 April 2015 to date. The first revalidation cycle started in January 2013 and all non-training grade have completed their first revalidation cycle by 31 March 2017. During this period all doctors to whom the Trust is the designated body will have a recommendation made about their fitness to practise by the Trust's Responsible Officer (the Medical Director). Summary of key points: • As at 31 March 2016, 309 doctors had a prescribed connection to CHFT. This has subsequently increased to 329 (February 2017). • In the 2015/16 revalidation year (1 April 2015 – 31 March 2016) 94 non training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC). For the 2016/17 year the figure was 25. • Based on headcount, 93.5% of non-training grade appraisals were completed and submitted in the appraisal year. 5.5% of non-training grade medical staff were not required to complete an appraisal (for example due to recently joining the Trust, maternity leave or sabbatical). DB reported that there were 7 doctors for whom a positive recommendation could not be made at the time the Revalidation Panel met due to insufficient evidence being presented. However, they were able to provide, prior to their revalidation date, the missing information. This met the panel's requirements so a positive recommendation could be made. It was also noted that revalidation of any doctor under a GMC investigation is put on hold.

	From April 2017 the Trust will be rolling out the Premier IT (PReP) revalidation and appraisal e-portfolio. In order to drive through quality the allocation of appraisers to appraisees is being reduced from 70 to 50, ie 5 appraisals per year. DB confirmed that the Trust is performing well compared to its peers. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
31/17	**ANNUAL NURSING REVALIDATION REPORT** The report had been circulated with papers to the Committee meeting. BB reported that from April 2016, Nurses and Midwives in the UK are legally expected to undertake a process of revalidation every 3 years in order to remain on the nursing register. The Trust actively supports colleagues to achieve revalidation through engagement and training events, providing appropriate documentation, utilising ESR, and ongoing performance management. All Nurses and Midwives will have ownership of, and will be held accountable for their own revalidation process. A process is in place for managing those individuals who have not revalidated. A monthly trajectory of actual number of colleagues due to revalidate has been developed and is illustrated within the report along with the trajectory % over time. The Associate Directors of Nursing have divisional data providing detailed information of registrants' revalidation dates. BB advised that there is a system in place for the revalidation of colleagues without patient care. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
32/17	**REVIEW OF EPR TRAINING SCHEDULE** The training plan report had been circulated to the Committee ahead of the meeting. JM outlined the training plan and activity that has been undertaken in order to deliver training to all end users of EPR. It further describes the work that continues to develop ELearning to support EPR as the Trust enters into Business as Usual. It highlights the work required to be enable the clinically safe and effective deployment of EPR, it is essential that all users are supported to attend the relevant training to ensure they are effectively trained. The report details the resources, training design, development, delivery, evaluation and assessment required to support this training. JM confirmed the training team is in place in readiness for the commencement of the training programme for the 600+ colleagues over an 8 week period. Training commences on 6 March 2017 with 300 bookings confirmed to date. As part of the engagement and support network, EPR Friends have been identified and are being trained to give additional support to colleagues in their areas of work. EPR friends/floor walkers will be available for 2 – 6 weeks following the go live date

	of 1 May 2017 Any agency staff who have worked more than 75 hours in the previous 3 months will have end user training but be available for shifts over the go live period. The Committee acknowledged and commended the detailed planning work in respect of the implementation of the programme. In terms of change in working practices JM confirmed that a Work Together Get Results methodology had been used with 4 additional colleagues recruited to look at change. JM confirmed that there would be engagement with HR regarding any job role changes. The Committee asked for a summary paper covering progress against the training plan to be provided at its next meeting in March 2017 along with an update in respect of the process regarding change in roles. **ACTION: JM to provide for 16 March 2017 Committee meeting a summary paper and an update in respect of the process regarding change in roles.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
33/17	**STAFF STORY – 'ROLE AS GUARDIAN OF SAFE WORKING HOURS'** DB provided a verbal update to the Committee. Tamsyn Grey, Consultant in General and Colorectal Surgery commenced the Guardian role on 1 October 2016. The Guardian role is a requirement of the junior doctor contract and is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service for doctors and dentists in training. The Guardian will ensure that any issues of compliance are addressed as they arise. A quarterly report is submitted to the Executive Board which summarises all exception reports and work schedule reviews and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programmes. A Junior Doctor Forum has been established comprising of the Guardian, Director of Medical Education and representatives from the Local Negotiating Committee and other elected junior doctor members to provide quality assurance of safe working practice, and scrutinise the distribution of fines. To date the Trust has received no fines in terms of breaching its duties. DB confirmed there are currently 80 doctors on the new Junior Doctor contract. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.
34/17	**WHISTLEBLOWING ANNUAL REPORT** The Whistleblowing annual report was shared with the Committee ahead of the meeting. BM provided an update to the Committee. The Whistleblowing Annual Report was submitted to Board of Directors on 2

	February 2017. The report set out the activity undertaken over the last 2 years in light of the France Report. The Board requested a greater awareness of the raising concerns/whistleblowing process was required with actions to be reported back to the Board in May 2007. In 2014 the Trust engaged the leading charity Public Concern at Work (PCaW) to help revise the Trust's policy. In 2016 the Raising Concerns (Including Whistleblowing) Policy replaced the Trust's Freedom of Speech Policy and a public campaign was launched to introduce the policy. All Trusts were required to appoint a Freedom to Speak Up Guardian by 1 October 2016. David Anderson, Non-Executive Director was appointed to the role. Specific activities delivered over the last 2 years are identified in Section 3 of the Annual report. Going forward a workplan has been developed and key initiatives include: • Assess the 2016 staff survey local questions to identify any trends from the 2014/2015 results • Introduce a more comprehensive reporting tool • Look at ways of improving training of line managers – utilising HEE e-learning programmes • Relaunch efforts to establish a network of raising concerns champions • Review local questions included in the Staff Survey In terms of managing the risk to the Trust a comprehensive approach to whistleblowing has been developed with a well-established incident reporting procedure. Staff appear to be confident in raising issues and having them dealt with. The policy is a 'backstop' should anything not be resolved at an earlier stage. This approach was given 'significant assurance' in a recent audit. JE raised a point to note that Trusts are being encouraged to appoint a substantive Guardian who has direct contact with the CE rather than a Non-Executive Director. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
35/17	**HEALTH AND WELLBEING CQUIN QUARTERLY REPORT** The quarterly report had been circulated to the Committee ahead of the meeting. AK reported on the progress of the NHS Staff Health and Wellbeing CQUIN 2016/2017 against the three parts of the Wellbeing CQUIN. The whole CQUIN holds a value to the Trust of £1.95m during the 2016/2017 year. The three component parts, each representing a value of £650,000, are:- Part 1a - Introduction of Health and Wellbeing initiatives There were 2 options to consider. The Trust chose option b which was to develop a peer review action plan in relation to the three given areas. The action plan was well received by the CCG. The action plan incorporated:- <u>Physical Activity</u> – examples of initiatives include discounted gym membership (on-site gym being explored), pedometer challenges, sports events, fitness classes and cycle to work schemes.

	Access to physiotherapy – 304 referrals were made over the 12 months. As there is limited physiotherapy resource alternative initiatives are in place – triage with the inclusion of signposting to self-help materials. Self-help resources are in development and planned to be published as an electronic resource for staff by 1 April 2017. Mental health initiatives – include the mindfulness programme, revision of stress training, retreat days led by the chaplaincy, working with South West Yorkshire Partnership NHS FT to increase availability of mental health first aid training, increasing the Wellbeing Champion Network and the publication of a wellbeing booklet. Part 1b - Healthy food for NHS staff, visitors and patients This section of the CQUIN relates to the provision of healthy food options, in particular focusing on the reduction of sugar. This CQUIN is led by the Estates and Facilities Division. Initiatives include the change of vending machine contents and the development of edible food forests Part 1c - Improving the uptake of flu vaccinations for frontline staff The CQUIN was to increase the uptake of flu vaccination for frontline staff. Full payment of the CQUIN would be received if a target of 75% was reached. The Trust uptake was 75.99% at 31 December 2016. The CQUIN for 2017/18 and 2018/19 will measure against the same 3 indicators with some differences for example:- 1a: 5% improvement in two or the three NHS annual staff survey questions on health and wellbeing, MSK and stress. 1b: 70% of drinks lines stocked must be sugar free. Provision of lower calorie confectionery, sweets and pre-packed sandwiches/meals. 1c: flu vaccination target lowered and over a longer campaign period. AK confirmed the Trust is on track to deliver the full value of the CQUIN value for this year. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	PERFORMANCE
36/17	**WORKFORCE PERFORMANCE REPORT** The Committee noted the content of the report. CW highlighted in particular the number of staff leaving the organisation in a short period of time (12 months). Analysis identifies that voluntary resignation is the main reason given. The staff group with the highest number of leavers over the last 12 month period is Registered nurses and midwives. A sickness absence benchmarking exercise for the period November 2015 to October 2016 identified that CHFT was mid-range for that period. IW suggested that a deep dive into sickness analysis trend to provide a trajectory over a 13 month period is undertaken for discussion at the next Committee meeting.

	ACTION: CW to undertake sickness analysis deep dive and build a trajectory for March 2016 Committee meeting. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	INFORMATION
37/17	**2015 STAFF SURVEY ACTION PLAN PROGRESS REPORT** The updated Action Plan was shared with the Committee. JE confirmed that the action plan had been updated as at February 2016 with any delivery dates been revised where appropriate. The action plan identifies the live actions which are all on-track along with completed actions. The 2015 action plan will be superseded by 2016 Staff Survey results and its associated action plan. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the action plan.
38/17	**2016 STAFF SURVEY RESULTS** The survey results had been described in a presentation which had been circulated to the Committee ahead of the meeting. Trust undertook the 2016 NHS National Staff Survey between October and December 2016. 209 staff completed a paper survey and 344 completed an online survey. The survey results described in the attached presentation are those of the Survey Co-ordination Centre (Picker Institute). The national survey results for 2016 (NHSE) will be available on 20 February, embargoed until 7 March 2017. The Trust response rate was 44.7% (an increase of 4% from 2015). The average response rate based on all Trusts using Picker was 39.9%. The presentation identifies those scores which are better and worse than Picker. The Trust scores very much mirror last year's results. The Trust is average nationally. Of the 88 questions used in both the 2015 and 2016 surveys there were 5 questions which scored significantly better than the 2015 survey • 80% of staff were enthusiastic about their job (74% in 2015) • 83% of staff knew who the senior managers were (77% in 2015) • 38% (in the last 3 months) of staff have not come to work when not feeling well enough to perform duties (29% in 2015) • 69% of staff feel the organisation takes action to ensure errors are not repeated (62% in 2015) • 65% of staff receive regular updates on patients/service user feedback in their directorate/department (56% in 2015) And one question which scored significantly worse than the 2015 survey: • 78% of staff said time passed quickly when working (84% in 2015) Next steps will be include:- Design action plan

	Compare the survey to other surveys Analysis of free text comments NHS England survey results to go to Board of Directors in March Results shared with staff side groups in March/April 2016 and the Colleague Engagement Network in March 2016 The survey results will also link into the Health and Wellbeing CQUIN. The full report will be shared at the March Committee meeting along with details for the action plan. IW confirmed that a 'Go See' visit to Wrightington, Wigan and Leigh NHS Trust regarding engagement is planned to take place on 10 March 2017. **ACTION: JE to share the full Staff Survey report along with details for the action plan** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the action plan.
39/17	**ANNUAL PLAN UPDATE** The Committee had received ahead of its meeting a presentation outlining the Trust's financial plans for 2017/18 and 2018/19. KA gave an overview of the key points of the presentation. The Trust submitted to NHSI a draft plan in November 2016 and a final plan in December 2016. At the point of final submission commissioner contracts were not agreed. The final control total for 2017/18 is set at £15.9m deficit. If the Trust cannot commit to delivering this Sustainability Transformation Funding (STF) is lost and borrowing becomes more restricted. This year the STF is worth £10.1m in 2017/18 and £10.1m in 2018/19. After considering the income the Trust is likely to receive and its expected costs, we are left with a £20m challenge which becomes the Cost Improvement Programme (CIP) target. This represents a 5.3% challenge. The Board of Directors has 'appealed' the £20m challenge feeling a more realistic CIP target would be £17m or 4%. The Trust is awaiting the NHSI response to the appeal. The Investment and Expenditure bridge for 2016/17 – 2017/18 showed a planned deficit of £16,064m. The residual deficit is £15.9m. The pay uplift is a significant factor. Developments and positive investments total approximately £700,000. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
40/17	**DEVELOPING PEOPLE – IMPROVING CARE** RM advised this report had also been presented to Executive Board on 16 February 2017 requesting approval. The paper introduces The National Improvement and Leadership Development Board's framework, Developing People – Improving Care and describes the impact the framework will have on the organisation.

	The framework applies to everyone in NHS-funded roles in all professions and has been created because the evidence and experience from high performing health and care systems shows that having these capabilities enables teams to continuously improve population health, patient care, and value for money. Developing these capabilities and giving people the time and support required to see them bear fruit is a reliable strategy for closing the three gaps identified in the NHS Five Year Forward View. The framework identifies 4 critical capabilities it aims to deliver; systems leadership skills, improvement skills, compassionate, inclusive leadership skills and talent management with five associated conditions which are described in the report. The Trust's Workforce Strategy connects and addresses the requirements of Developing People – Improving Care through its focus on organisational development and leadership. It is important to note there is no national funding to support the framework. A paper called Standards for Managers was supported at Executive Board on 3 November 2016, however it was unsuccessful in securing funding. Through a new collaborative partnership with colleagues in the NHS Leadership Academy and the Director of Workforce and OD this work will be progressed in the coming year. Monitoring will take place through the Workforce Modernisation programme Board and Workforce (Well Led) Committee. The Committee fully support the framework and request progress is reported at the May 2017 Committee meeting. **ACTION: RM report progress to May 2017 Committee meeting.** **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	ITEMS TO RECEIVE AND NOTE
41/17	**ANY OTHER BUSINESS:** KH requested a list of Trust acronyms is attached to the agenda and papers for each meeting. **ACTION: TR to action.** KH advised that David Anderson will replace Phil Oldfield as a Non-Executive member of the Committee with effect from March 2016.
42/17	**MATTERS FOR ESCALATION:** There were no matters identified for escalation to the Board of Directors
DATE AND TIME OF NEXT MEETING: Thursday, 16 March 2017, 2.00pm – 4.00pm, Discussion Room 1, Learning & Development Centre, Huddersfield. **NOTE CHANGE OF VENUE**	

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UNIQUE IDENTIFIER NO: G-10-2002
EQUIP-2017-009
Review Date: December 2018
Review Lead: Director of Planning, Performance, Estates & Facilities

Calderdale and Huddersfield
NHS Foundation Trust

Health & Safety Policy

Part 1 – Statement of Policy
Part 2 – Organisation & Responsibilities
Part 3 – General Arrangements

Version 6

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UNIQUE IDENTIFIER NO: G-10-2002
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Review Date: December 2018
Review Lead: Director of Planning, Performance, Estates & Facilities

Document Summary Table		
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Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Health & Safety Committee	Director of Planning, Performance, Estates & Facilities	21 December 2016
Other Stakeholders Consulted		
Sinclair Associates (Legal Health & Safety Advisor)		6 November 2013

Does this document map to other Regulator requirements?	
Health and Safety at Work Act 1974 Management of Health & Safety at Work Regulations 1999. Health & Social Care Act – 2008 "Essential Standards of Quality & Care" Outcome 10 & 11	The Act and Regulations set the standards that must be met to ensure the health and safety of all employees and others who may be affected by any work activity. Safety and Suitability of Premises (10) Safety, Availability and Suitability of Equipment (11)

Document Version Control	
Version 6	Removal of list of principles in INDG 417 from part 2 as these are already detailed in the health and safety statement, already contained in this policy. Removal of reference to the 'strategic health and safety committee' as this no longer meets. Changes to information provided about individual responsibilities including: • General duties for Directors, other than for those with specific health and safety duties. • Reduction of duplication in duties to one category 'All Managers". Reduction in detail about specific hazards. Reference is instead made to hazard specific Trust policies that already exist.

Version 5	This policy has been updated to reflect the health and safety roles and responsibilities and incorporate general arrangements. Risk scoring matrices have been up dated in line with risk management policy.
Version 4	The Policy is a statement of intent which identifies strong and active leadership from Trust Board. The policy is part 1 of Trusts health and safety management system. Part 2 “Organisation and Responsibilities” and Part 3 “General Arrangements for Health and Safety” provides the detailed framework.

Contents

PART 1 – STATEMENT OF HEALTH AND SAFETY POLICY

Calderdale and Huddersfield NHS Foundation Trust (the **"Trust"**) is committed to achieving and maintaining high standards of health, safety and welfare throughout the Trust. The Trust will ensure, so far as is reasonably practicable, the health, safety and wellbeing of its employees, patients and others who may be affected by its activities. In order to achieve this and to ensure continual improvement the Trust will utilise the following health and safety principles:

1. **Strong and active leadership by the Trust Board**
   - Showing active commitment to health and safety.
   - Establishing effective 'downward' communication systems and management structures.
   - Integration of good health and safety management into business decisions.

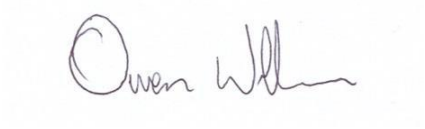
2. **Staff and contractor involvement**
   - Engaging staff and contractors in the promotion and achievement of safe practices.
   - Establishing and maintaining effective 'upward' communication.
   - Providing health and safety training for staff.

3. **Assessment and review**
   - Identifying and managing health and safety risks.
   - Providing access to and following competent health and safety advice.
   - The Board and managers monitoring, reviewing and reporting on health and safety performance.

This policy applies to all Trust premises and activities and is part of the Trust's health and safety management system that has been adopted by the Board.

The Trust's health and safety system is set out in:

- **Part 2 - Organisation and Responsibilities**
- **Part 3 - General Arrangements for Health and Safety**



January 2017

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Owen Williams Dated
Chief Executive for & on behalf of the Trust Board

PART 2 – ORGANISATION & RESPONSIBILITIES

Purpose of policy

The purpose of this policy is to provide staff with information about the Trust's arrangements and individual responsibilities for ensuring the health and safety of staff, patients and visitors.

2.1. Membership Council

The Membership Council is responsible for holding the Board of Directors to account in respect of any failure by the Trust to comply with its statutory and contractual obligations. These duties include, but are not limited to, holding non-executive directors to account for the performance of the board. A full list of duties for the Membership Council is contained within the Trust's Membership Councillors' Charter.

2.2. Board of Directors

The Board of Directors is responsible for ensuring there is effective health and safety leadership. Failure to include health and safety as a key business risk in board decisions can have catastrophic results.

The Board and individual directors will apply the essential principles identified in INDG 417 "Leading Health & Safety at Work" which are detailed the Trust's health and safety policy statement on **page 4**. Adopting these principles will allow the Trust to lead and promote health and safety and therefore meet its legal obligations.

2.3. Non-Executive Director / Health and Safety Champion

The Trust has appointed a Non-Executive Director as its health and safety champion and non-executive scrutineer. They are responsible for, so far as it is within their control:

- Raising the profile of health and safety at Board level by ensuring that health and safety is considered during corporate debate and the decision making process
- Raising matters pertaining to health and safety at board level that have been escalated or from other sources

2.4. Trust Directors

All Directors are responsible for ensuring that:

- There are suitable health and safety systems in place to ensure that hazards (both clinical and non-clinical) are identified, risk assessments are carried out and adequate controls are put in place to control the risks in their area of responsibility
- Sufficient resources are made available for anything that is deemed necessary and appropriate under legislation to reduce the level of risk in their area
- Trust health and safety policies and procedures are implemented in their Directorate and that staff in their area of control are aware of these and the requirement to comply
- There is a safe working environment and safe systems of work

- Staff within their area are aware of the health and safety policies and procedures they are required to comply with
- Staff within their area are aware of the need to report incidents and near misses in line with the learning from experience policy
- Health and safety information is effectively communicated to all staff and they are consulted with about any proposed changes that might affect their health and safety
- Staff with delegated health and safety responsibilities are competent to carry out their role

2.5. Director of Planning, Performance, Estates and Facilities

The Director of Planning, Performance, Estates and Facilities is the executive lead for health and safety and will promote and escalate health and safety issues to the Board of Directors. They will:

- Chair the Trust's Health and Safety Committee
- Ensure that the necessary risk assessments are in place within their Division
- Ensure that competent health and safety advice is available from within their Division
- Ensure that agreed health and safety systems have been implemented
- Promote and support health and safety
- Ensure that professional health and safety advice is available and that the content of health and safety training is suitable, through the use of professional advice

2.6. Director of Workforce and Organisational Development

The Director of Workforce and Organisational Development has the same responsibilities as all other Trust Directors (see page 5). In addition they are responsible for:

- Providing an occupational health service for all staff
- Facilitating health and safety induction training through the staff online portal that is managed by Workforce and Organisational Development. (The content of the training is developed by health and safety professionals)

2.7. Associate Director of Estates and Facilities

The Associate Director of Estates and Facilities is responsible for ensuring that systems and resources are in place for the provision of a safe, clean and secure working environment and the provision of health and safety advice within the Trust. Other responsibilities are:

- Ensuring that there is a planned preventative maintenance (PPM) program in place for equipment, both medical and non-medical. This will identify and rectify faulty equipment and service equipment to reduce the likelihood of equipment failure
- To provide the Trust with emergency planning systems and controls as set out in the Fire Safety Strategy, Emergency Management Arrangements and Preparing for Emergencies Policies
- To monitor Calderdale Hospital Special Purpose Company (CHSPC) contract in relation to health and safety contractual obligations

2.8. Assistant Divisional Directors / General Managers

Managers are responsible for, so far as it is within their control to do so:

- Ensuring that the number of incidents and near misses in their area are monitored on a regular basis. Any trends will be addressed in order to reduce the number of incidents. Any incidents will be investigated in proportion to the level of seriousness
- Monitoring training attendance in their area of control and ensuring staff are compliant
- Ensuring that staff within their area are aware of the health and safety policies, procedures and that there is a communication process in place to make sure information is accessible and available to all staff
- Ensuring that systems are in place to make safety equipment, including PPE, and relevant training in its use available to relevant staff

2.9. General Manager Estates & Facilities

In addition to the general duties on **page 6 (Assistant Divisional Directors / General Managers)** the General Manager of Estates and Facilities will ensure that:

- Systems are in place to provide health and safety support, guidance and advice to all staff
- Systems are in place for the review of the Trust's health and safety policies and for the effective communication of these policies
- Health and safety training is developed based on the training needs of the Trust and to ensure competence and legal compliance
- Regular updates are provided to the Board of Directors on changes in health and safety legislation and developments that may affect the Trust
- An annual Health and Safety Report is provided to the Board of Directors

2.10. General Manager Risk Management

In addition to the general role requirements on **page 6 (Assistant Divisional Directors / General Managers)**, the role holder is responsible for ensuring that systems are in place to:

- Manage insurance claims and complaints in a manner that highlights any shortfalls on the part of the Trust and makes recommendations to address these in order to reduce the likelihood of reoccurrences
- Record and monitor accidents, near miss incidents and incidences of ill health to ensure compliance with the Trust's statutory and contractual obligations and as required by the Reporting of Injuries Diseases and Dangerous Occurrence Regulations
- Ensure moving and handling advice and training is available
- Oversee the Trust's risk register system ensuring key stakeholders have access to manage Divisional and Departmental risks in their areas of control

2.11. All Managers

Managers must consider health and safety as part of a holistic management system, rather than in isolation from other management arrangements or processes such as patient safety, personnel or finance.

Managers are responsible for, so far as it is within their control to do so:

- Making sure that hazards are identified, assessed and risks are adequately controlled. These should be fed into the Trust's risk register
- Ensuring that incidents and near misses which occur in their area are reported using the Trust's reporting system and investigated at a level that is appropriate to the seriousness of the incident
- Ensuring that staff are competent to carry out their job role and attend relevant training to ensure that they remain competent. This includes the use of work equipment, which should not be used until suitable training has been carried and competence is established
- Providing and maintaining suitable personal protective equipment (PPE), where required, and making sure that staff are able to use it
- Ensuring that staff are aware of the health and safety policies and procedures they are required to comply with
- Ensuring effective means of communication are used to cascade health and safety related information to all staff
- Making sure that systems are in place to ensure staff are aware of how to report equipment defects
- Periodically carrying out workplace inspections to ensure that the workplace remains safe

2.12. General Manager Estates Technical Services

The Estates General Manager is responsible for compliance with engineering Health Technical Memoranda (HTM) and the maintenance of the Trust's properties (other than those covered by PFI) whether owned or leased to the Trust and there is a requirement to maintain the property. To achieve this they will:

- Appoint competent authorising engineers, authorised and competent persons as required under specific HTMs
- Ensure that systems are in place to manage contractors working within their area of control on behalf of the Trust

2.13. Trust Health and Safety Advisor

The Trust's Health and Safety Advisor is appointed to:

- Provide health and safety support, guidance and advice to all staff
- Analyse accident and work related ill health data to identify trends to implement necessary improvements
- Undertake formal accident investigations, on request, where there has been a work related incident, ill health or dangerous occurrence
- Carry out regular reviews of health and safety policies
- Provide health and safety training in line with the Trust's training needs analysis
- Compile an annual health and safety report
- Provide regular updates to the Health and Safety Committee

2.14. Trust Fire Officer

The Fire Officer is responsible for the provision of fire safety advice to the Trust.

2.15. Trust Resilience and Security Management Specialist

The Resilience and Security Management Specialist is appointed to provide advice on security issues and emergency planning arrangements. Full details of the role can be found within the Emergency Preparedness, Resilience and Response Policy and the Management of Violence and Aggression in the Workplace Policy.

2.16. Moving and Handling Advisor

The Moving and Handling Advisor is appointed to provide advice in relation to both patient handling and static load handling. Full details can be found in the Trust's **Moving and Handling Policy**.

2.17. Health and Safety Representatives

The Trust recognises a number of trade unions and involves them in collective bargaining and the consultation process with regard to health and safety matters as required under the Safety Representatives and Safety Committees Regulations 1977 (as amended). Trade Union staff are represented on the Trust's Health and Safety Committee.

Trade unions within the Trust represent those employees who are not trade union members on health and safety matters. Therefore the requirements of the Health and Safety (Consultation with Employees) Regulations 1996 (as amended) do not apply.

2.18. All Trust Employees

Employees must:

- Work in accordance with the Trust policies to take care of themselves and others who may be affected by his / her actions or lack of actions
- Co-operate with the Trust and its managers in the implementation of health and safety, by following related policies, procedures, protocols, safe systems of work and codes of practice
- Use personal protective equipment provided to them as determined by risk assessment
- Attend health and safety training
- Only use equipment they have been trained to use
- Report all incidents, accidents and near misses using the Trust's Incident Reporting System, and in the event of a serious incident, escalate through their line management to ensure that controls are put in place immediately to prevent a reoccurrence

2.19. Contractors

The Trust procures contractors to undertake work on its behalf. The Management of Contractors Policy sets out how contractors working on behalf of the Trust shall be managed to ensure contractors work in a safe manner.

2.20. Calderdale Hospital Special Purpose Company Ltd

CHSPC is responsible for the Calderdale Royal Hospital site, including the procurement of estates and facilities services. As part of this contract, CHSPC will provide assurance to the Trust that systems are in place to provide a safe work

environment in line with the terms of the contract and replicating the requirements of the assurances provided to the Director of Planning, Performance, Estates and Facilities.

PART 3 – GENERAL ARRANGEMENTS FOR HEALTH AND SAFETY

3. Health and Safety Arrangements

The Trust has a risk management strategy and supporting framework for identifying and managing risks throughout the whole organisation, including the management of health and safety risks.

The Health and Safety Committee will monitor performance and progress towards achievement of the objectives through quarterly reports to be produced by the objective leads.

An annual review will be carried out to determine the extent to which the objectives have been achieved. The review will be used to provide a report on progress and performance to Board of Directors and form part of the Annual Health and Safety Report.

3.1 Committee and Group Reporting Structure

As part of this framework, the Trust has a committee and group structure that monitors, analyses and implements targets against organisational objectives including the effective management of health and safety risks. The key reporting forums for health and safety are the Quality Committee and the Health and Safety Committee. The health and safety reporting structure is set out in **Appendix 1**.

3.2 Consultation with Employees (Health and Safety Committees)

Joint consultation with recognised staff side representatives is considered an essential part of the arrangements to maintain and improve health and safety performance. The Trust consults staff as required under the Safety Representatives and Safety Committees Regulations 1977 (as amended) to ensure that staff are effectively represented by health and safety representatives. The Health and Safety Committee is the forum for this joint consultation.

3.3 Health and Safety Committee

In accordance with section 2 (7) of the Health and Safety at Work Act 1974, the Trust has established a Health and Safety Committee. This Committee is the Trust's forum for the discussion of health and safety matters with managers, union representatives and divisional representatives.

The Committee will monitor the effectiveness of the management of health and safety within the organisation by examining the health and safety risks raised by:

- Divisional Representatives
- Considering reports from sub-committees and sub-groups
- Staff side and committee members
- Considering incident statistics / trends

The Committee will ensure that any lessons learned are communicated through the Divisions by management representatives on the Committee.

The Health and Safety Committee will escalate any significant risks to the Weekly Executive Board or Quality Committee. Where there are matters of significant concern the Chair will ensure they are addressed by the relevant directorates or services through relevant Group meetings.

3.4 Risk assessments

The Management of Health and Safety at Work Regulations 1999 require that employers undertake suitable and sufficient risk assessments, covering risks to employees and to others that could be affected by their undertaking. Managers are provided with the training and the tools to carry out risk assessments.

The Trust use the Health and Safety Executive's (HSE) model "5 steps to risk assessment" which is a simple 5 step process to ensure all risks are considered and that a systematic process is used. Risk assessment is a careful examination of the identified hazards to determine whether and how they could cause injury loss or damage to people or property, whether enough precautions are in place or whether more should be done.

Appendix 2 provides a step by step approach to risk assessment complete with the HSE template.

3.5 Risk Registers

Risk Registers provide details of the highest risks in each Division as calculated through risk assessment. They are maintained electronically and each Division manages its own risks. Risks with a score of 15 or more are escalated to the necessary Director within the Division and must be presented and approved at the Risk Compliance Committee. Once such risks are approved they will feature on the Corporate Risk Register which is shared with the Board of Directors.

Guidance and support on completion of risk registers is available from the Risk Management Department and on the Trust intranet.

3.6 Safe Systems of Work

The Trust is required by law to implement safe systems of work (SSOW). These are developed following a risk assessment process. The SSOW are by various names eg:

- Working procedures (WPs)
- Standard operating procedures (SOPs)
- Method statements

They are the detailed instructions given to employees to enable them to work safely. SSOW are designed to standardise working practice in order to

ensure that no-one gets hurt or injured. When these are developed they should be rigorously implemented.

3.7 Accident Reporting

Staff must report all accidents, incidents and near misses using the Trust's reporting system. The data is analysed on a frequent basis and discussed at the health and safety committee.

Further guidance is available in the Trust's **Incident Reporting, Management and Investigation Policy.**

3.8 Health and wellbeing

The Trust provides an Occupational Health Service whose overall function is to ensure the health and wellbeing of staff, with specific regard to the relationship between health and work. This is done through the provision of advice and support, including:

- The provision of health surveillance for staff who may be exposed to hazardous substances (for details see the Trust's Control of Substances Hazardous to Health
- Workplace adjustments for staff with long-term health conditions or disabilities
- Systems for ensuring that occupational diseases and ill health are reported to relevant bodies (e.g. HSE)
- Organising vaccination programs for staff where there is a risk of vaccine preventable infection (and the risk posed to staff, patients and / or the organisation has deemed by assessment as unacceptable)
- Support for managers in undertaking stress risk assessments, health surveillance or screening
- Assessing staff prior to returning to work following an accident or ill health where managers have identified there may be a risk to themselves, the individual's colleagues or patients due to the work the individual undertakes

3.9 Emergency Procedures

There are many emergency situations that need to be considered to ensure that the risk to staff and others is reduced as far as reasonably practicable. These will include (but are not limited to) fire situation, patients being admitted following a chemical spillage or release of a biological agent. Therefore, the Trust will ensure that plans and procedures are in place.

Further guidance is contained within the Trust's **Emergency Preparedness, Resilience and Response Policy**, **Fire Strategy** and associated plans.

3.10 Noise at Work

The Control of Noise at Work Regulations 2005 require the Trust to have policies and procedures in place for managing the risk from noise exposure at

work. The Trust must prevent or reduce risks from exposure to noise at work by:

- Assessing the risks to staff from noise at work
- Taking action to reduce the noise exposure
- Providing staff with hearing protection if the noise exposure cannot be reduced sufficiently by using other methods
- Providing mandatory warning signs of high risk noise area
- Ensuring the legal limits of noise exposure are not exceeded
- Providing staff with information, instruction and training
- Implementing a programme of health surveillance and audiometric testing for those staff identified as regularly exposed to high levels of noise

3.11 Work Equipment

All work equipment, which requires guards, will be fitted with such and operators will make full and proper use of them. All operating controls including emergency stop controls shall be clearly marked. Full and adequate information, instruction, training and supervision will be provided to staff before being required to work with new or unfamiliar equipment. Any defective equipment must not be used and arrangements made for its repair, replacement or disposal.

Further guidance is available from the Estates General Manager.

3.12 Electricity at Work

The Trust has safe working practices in place to ensure the competence of its staff, contractors, electrical systems and equipment. These include permit to work procedures, regular testing and examination of all electrical equipment used in the Trust.

Further guidance is available from the Estates General Manager.

3.13 Driving at Work (including workplace vehicles)

The Trust will take all reasonable steps to manage the risks associated with driving for work.

Employees who drive on Trust business will be:

- competent and trained to carry out their duties in a manner which is safe for themselves and others
- hold the required driving licence for their duties
- sufficiently fit and healthy to carry out their duties in a safe manner
- provided with adequate training and information to carry out their duties (eg: vehicle safety checks / correct driving posture)

Vehicles provided for or used for work purposes must be fit for the purpose for which they are used and maintained in a safe and suitable condition.

Further guidance is available from the Trust Transport Manager.

3.14 Young Persons at Work (over 16 but under the age of 18)

Where the Trust is employing or offering work experience to young persons under the age of 18 a risk assessment must be carried out by the Department offering the work to ensure the young person is not exposed to risk by the work they are undertaking.

The young person's risk assessment will take into account their lack of experience; lack of awareness of existing or potential risks and lack of maturity. This assessment will also consider the risks associated with the environment they will be working in.

3.15 Other workplace hazards

The Trust has policies and guidance relating to specific health and safety hazards in support of this policy. These can be found on the staff intranet site and are listed below:

- Asbestos Policy
- Control of Substances Hazardous to Health (COSHH) Policy
- Display Screen Equipment Policy
- Emergency Preparedness, Resilience and Response Policy
- Fire Safety Policy
- First Aid at Work Policy
- Food Hygiene Policy
- Ionising Radiation Protection Policy
- Maternity, Adoption, Paternity and Parental Leave Policy
- Medical Device Management Policy
- Mental Health Wellbeing and Stress Management Policy
- Moving and Handling Policy
- Optical Radiation Policy
- Smoking Policy
- Violence and Aggression Policy
- Waste Management Policy

4. TRAINING AND INFORMATION

The Trust will ensure that employees receive health and safety training to enable them to understand the hazards associated with their environment and the controls that are put in place to reduce the risks to an acceptable level.

New employees will receive health and safety training at induction and a departmental induction specific to their role and working environment.

Managers will receive health and safety training to enable them to effectively undertake their role.

The training needs analysis is detailed in **Appendix 3**.

5. MONITORING COMPLIANCE

5.1 Health and Safety Auditing

An internal audit team periodically carries out health and safety audits. Health and safety elements are also included in regular external inspections, including those carried out by the Care Quality Commission (CQC). Written reports and action plans are provided to the relevant areas with corrective action progress monitored.

5.2 Annual Health and Safety Report

An annual health and safety report is provided to the Board of Directors via the health and safety committee. The report details health and safety performance over the previous year and makes recommendations for proactive health and safety strategies for the forthcoming year.

6. TRUST EQUALITIES STATEMENT

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

7. ASSOCIATED DOCUMENTS / FURTHER READING

This policy should be read in association with the Trust policies, procedures and protocols detailed in section 3.15 and those detailed below:

- Management of Contractors' Policy
- Major Incident Plan
- IRMER Policy
- Mobile Telecommunications Policy
- Safe Handling and Disposal of Healthcare Waste Policy
- Incident Reporting, Management and Investigation Policy
- Waste Management Policy

8. REFERENCES

- Health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations 1999
- Managing for health and safety, HSG 65
- Control of Substances Hazardous to Health Regulations 2002
- Health and Safety (Display Screen Equipment) Regulations 1992
- Electricity at Work Regulations 1989
- Health Technical Memorandum 06 Electrical Services
- Health and Safety (First Aid) Regulations 1981, as amended 2013

- Manual Handling Operations Regulations 1992
- Provision and Use of Work Equipment Regulations 1998
- Control of Noise at Work Regulations 2005
- Personal Protective Equipment Regulations 2002 (as amended)
- Equality Act 2010
- Regulatory Reform (Fire Safety) Act 2005
- Health Technical Memorandum 05 Managing Healthcare Fire Safety
- Ionising Radiation Regulations 1999
- Smoke-free (Premises and Enforcement) Regulations 2006
- Control of Asbestos at Work Regulations 2012
- Misuse of Drugs Act 1971
- Food Safety Act 1990
- Environmental Protection Act 1990
- Controlled Waste (England and Wales) Regulations 2012
- Health Technical Memorandum 07-01 Safe Management of Healthcare Waste
- Health, Safety and Welfare Regulations 1992
- HSE Five Steps to Risk Assessment

APPENDIX 1

HEALTH AND SAFETY REPORTING FRAMEWORK

APPENDIX 2

RISK ASSESSMENT GUIDANCE

Step 1 - Identify the hazards

First you need to work out how people could be harmed. When you work in a place every day it is easy to overlook some hazards, so here are some tips to help you identify the ones that matter:

- *Walk around your workplace and look at what could reasonably be expected to cause harm*
- *Ask the staff working in the area what they think. They may have noticed things that are not immediately obvious to you*
- *Check manufacturers' instructions or data sheets for chemicals and equipment as they can be very helpful in spelling out the hazards and putting them in perspective*
- *Have a look back at your accident and ill-health records – these often help to identify the less obvious hazards*

Remember to think about long-term hazards to health (e.g. High levels of noise or exposure to harmful substances) as well as safety hazards.

Step 2 - Decide who might be harmed and how

For each hazard you need to be clear about who might be harmed; it will help you identify the best way of managing the risk. That doesn't mean listing everyone by name, but rather identifying groups of people (e.g. 'people working in the storeroom' or 'passers-by').

In each case, identify how they might be harmed, i.e. what type of injury or ill health might occur. For example, 'shelf stackers may suffer back injury from repeated lifting of boxes'.

Remember that some workers have particular requirements, e.g. New and young workers, new or expectant mothers and people with disabilities may be at particular risk. Extra thought will be needed for some hazards. Don't forget:

- *Cleaning services, catering, portering, visitors, contractors, maintenance workers etc, who may not be in the workplace all of the time*
- *Members of the public, if they could be hurt by your activities*
- *If you share your workplace, you will need to think about how your work affects others present, as well as how their work affects your staff – talk to them*
- Ask staff if they can think of anyone you may have missed

Step 3 - Evaluate the risks and decide on precautions

Having spotted the hazards you then have to decide what to do about them. The law requires you to do everything 'reasonably practicable' to protect people from harm. You can work this out for yourself, but the easiest way is to compare what you are doing with good practice.

So first, look at what you're already doing; think about what controls you have in place and how the work is organised. Then compare this with good practice and see if there's more you should be doing to bring yourself up to standard. In asking yourself this, consider:

- *Can I eliminate the hazard altogether?*
- *If not, how can I control the risks so that harm is unlikely?*

When controlling risks, apply the principles below, if possible in the following order:

- *Try a less risky option (e.g. Switch to using a less hazardous chemical)*
- *Prevent access to the hazard (e.g. By guarding)*
- *Organise work to reduce exposure to the hazard (e.g. Put barriers between pedestrians & traffic)*
- *Issue Personal Protective Equipment (e.g. Clothing, footwear, goggles etc.)*
- *Ensure that staff are trained to use equipment and PPE*
- *Provide welfare facilities (e.g. First aid and washing facilities for removal of contamination)*

Involve staff, so that you can be sure that what you propose to do will work in practice and won't introduce any new hazards.

Calculating the level of risk

The Trust uses a 5 x 5 matrix to calculate the level of risk (see *Table 1*). Each risk is measured by multiplying the severity of harm and the likelihood of that harm occurring, i.e. multiplying the consequence / severity score by the likelihood score (*Table 2*).

Risk scoring matrix

Table 1

SEVERITY INDEX		LIKELIHOOD INDEX		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Suspension of CQC Registration; Hospital closure; Total loss of public confidence.	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months.
4	Severe permanent harm or death caused by an event;£1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure.	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months.
3	Moderate harm – medical treatment required up to 1 year; £100k - £1m loss; Temporary disruption to one or more Divisions; Service closure.	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100k loss; or Temporary service restriction.	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0- £50k loss; or No disruption – service continues without impact.	1	Extremely Unlikely	Very good control ; or <1 in 1000 chance (or less) within 12 months.

Severity
Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood
Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

Differing Risk Scenarios
In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register**.

Table 2

SEVERITY		LIKELIHOOD				
		1	2	3	4	5
	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Risk grading
Having assessed and scored the risk using the 5x5 risk scoring matrix, use the table below to grade the risk as very low, low, moderate, high or significant.

Table 3

SCORE	Incident / Risk Grade (NPSA Cat.)	Level of Risk	Communicated to and overseen by	Investigation Level
15 - 25	Catastrophic	SIGNIFICANT	Alert Chief Nurse Reported to Board of Directors	SI Procedures RCA – 45 days (Board notification)
10-14	Major	HIGH	Alert Clinical Director Reported to Risk Management Committee	Divisional RCA – 28 days
8 - 9	Moderate	MEDIUM	Inform Divisional Manager Overseen at Divisional Level	Directorate Analysis – 28 days
4-6	Minor	LOW	Inform Ward/Departmental Manager Oversee at Ward/Departmental Level	Ward/Department Analysis – 10 Days
1-3	None	VERY LOW	Ward/Departmental Management	Ward/Department Analysis – 10 Days

Step 4 - Record your findings and implement them
Writing down the results of your risk assessment and sharing them with your staff will aid with the implementation of the controls. Putting the results of your risk assessment into practice will make a difference when looking after people, developing your service and providing evidence for assessments.

When writing down your results, keep it simple, suitable and sufficient ensuring:

- *A proper check was made*
- *You asked who might be affected*
- *You dealt with all the significant hazards, taking into account the number of people who could be involved*
- *The precautions are reasonable, and the remaining risk is low*
- *You involved your staff or their representatives in the process.*

It is important that arrangements are put into place for:

- Training employees about the main risks that remain and how they are to be controlled.
- Regular checks to be carried out to ensure the control measures stay in place
- Identifying clear responsibilities and timelines for action
- Prioritising actions and tackling the most important things first. As you complete each action, tick it off your plan.

Step 5 - Review your risk assessment and update if necessary
Few work areas stay the same. Sooner or later, you will bring in new equipment, substances and procedures that could lead to new hazards. It makes sense, therefore, to review what you are doing on an ongoing basis. Every year you should formally review where you are, to make sure you are still improving, or at least not sliding back.

Look at your risk assessment again. Have there been any changes? Are there improvements you still need to make? Have your workers spotted a problem? Have you learnt anything from accidents or near misses? Make sure your risk assessment stays up to date.

During the year, if there is a significant change, don't wait. Check your risk assessment and, where necessary, amend it. If possible, it is best to think about the risk assessment when you're planning your change – that way you leave yourself more flexibility.

What do I do with the risk assessment?
An action plan should be prepared after an assessment has been made. Studies have shown that training is a relatively ineffective method of control, and therefore should only be considered after other methods.

A general guide on the effectiveness of controls is in descending order of effectiveness:

- Eliminate the risk
- Substitute the risk activity with a less risky method
- Use physical barriers to prevent the escape of energy which would lead to injury loss or damage
- Use procedural methods to prevent the injury loss or damage
- Protect at source the person, property or data from loss
- Training in safe ways of working

If ward/departmental managers are unable to manage the risk, it should be placed on the Division's Risk Register.

Communication
At all stages of the assessment it is important that those who were first involved in assessing the risk are informed of decisions relating to the management. This should be through line management, team meetings and feedback from the respective committees.

Staff should have access to records of the assessment in a risk assessment folder where preliminary, focused and general risk assessments with agreed action plans are stored. These records should be shared with staff working in the department and brought to the attention of new staff, temporary and agency staff.

RISK ASSESSMENT PROFORMA

Date:	**Risk Assessment:**			**Risk Assessment Team:-**			**Dept:**	
DESCRIPTION OF RISK *"Failure to …… caused by …… will result in ……. "*	**WHO COULD BE HARMED?** *Patient, Staff, Visitor, Environment, Reputation?*	**MEASURES IN PLACE** *What are you doing to control or reduce the risk?*	**Risk Assessment Consequence x**	**FURTHER MEASURES NECESSARY** *What more needs to be done to reduce the risk further?*	**Post Risk Assessment Consequence x**	**Action By**	**Date**	**Complete**

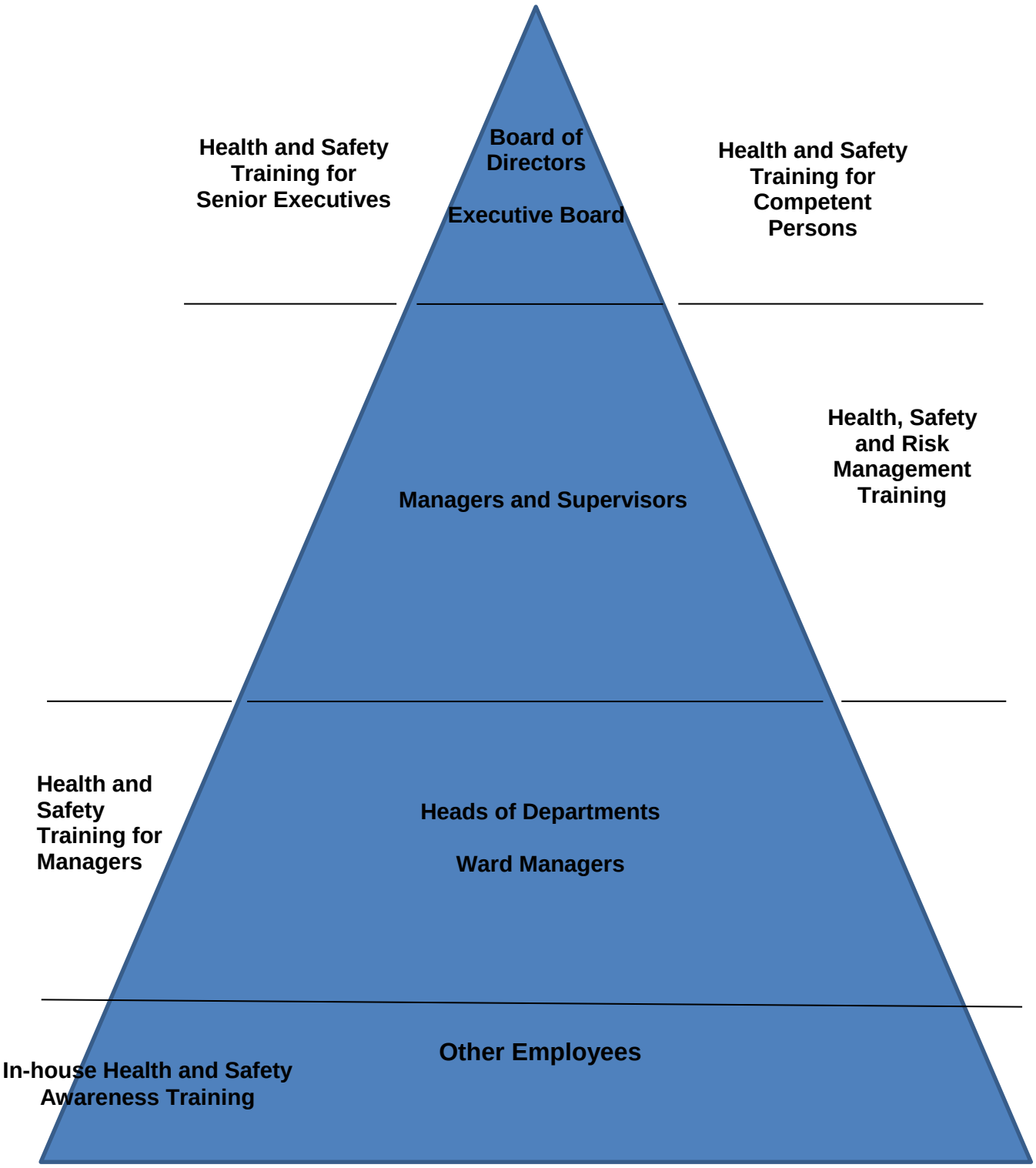
RISK RANKING - CONSEQUENCE

	1	2	3	4	5
DESCRIPTOR	**INSIGNIFICANT**	**MINOR**	**MODERATE**	**MAJOR**	**CATASTROPHIC**
OBJECTIVES/ PROJECTS	Insignificant project slippage. Barely noticeable reduction in scope or quality	Minor project slippage. Minor reduction in quality/scope	Serious overrun or project. Reduction in scope or quality.	Project in danger of not being delivered. Failure to meet secondary objectives	Unable to deliver project. Doesn't meet primary objectives
INJURY (STAFF/ PATIENTS/ VISITORS)	Minor injury not requiring first aid or no apparent injury	Minor injury or illness, first aid treatment needed	Some permanent harm up to a year.	Major injuries, or long term incapacity/ disability (loss of limb)	Death or major permanent incapacity
PATIENT EXPERIENCE/ OUTCOME/ COMPLAINT	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience - readily resolvable	Mismanagement of patient care, short term effects (less than a week)	Serious mismanagement of patient care, long term effects (more than a week)	Totally unsatisfactory patient outcome or experience
CLAIMS	Un-substantiated claim	Losses and comps claim	Small claim less than £25k	Medium claim £25000-£75000	Multiple claim or single major claim above £75k
SERVICE/ BUSINESS INTERRUPTION	Loss/ interruption up to 1 hour	Loss/ interruption 1-8 hours	Loss/ interruption 8 hours – 2 days	Loss/interruption 2 days to 1 week	More than 1 week/permanent loss of service or facility

	1	2	3	4	5
DESCRIPTOR	**INSIGNIFICANT**	**MINOR**	**MODERATE**	**MAJOR**	**CATASTROPHIC**
HR/ ORGANISATIONAL DEVELOPMENT **STAFFING AND COMPETENCE**	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective/ service due to lack of staff. Minor error due to ineffective training. Ongoing unsafe staffing level	Uncertain delivery of key objective/ service due to lack of staff. Serious error due to ineffective training	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. Critical error due to insufficient training
FINANCIAL	No obvious/ small loss	Less than £99k. Failure to meet national target 1st quarter.	£100k to £499k. Failure to meet national target 2nd quarter.	Over 750k. Extended failure to meet national target.	Over £1m.
INSPECTION/ AUDIT	Minor recommendations Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduced rating. Challenging recommend-ations. Non-compliance with core standards.	Enforcement Action. Low rating. Critical report. Major non-compliance with core standards.	Prosecution. Zero Rating. Severely critical report
ADVERSE PUBLICITY/ REPUTATION	Rumours	Local media - short term.	Local media - long term.	National adverse publicity.	MP concern (Questions in House). International publicity.

APPENDIX 3

Calderdale and Huddersfield NHS Foundation Trust
Health and Safety Training Requirements



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