Calderdale and Huddersfield NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 6 April 2017 from 8:30 am

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

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	Welcome and introductions: Mrs Lynn Moore, Publicly Elected MC Mr Brian Moore, Publicly Elected MC	Chair	**VERBAL**	Note
2	Apologies for absence: • Mrs Mandy Griffin, Director of THIS (Jackie Murphy, Deputy Director of Nursing - Modernisation to attend) • Victoria Pickles, Company Secretary	Chair	**VERBAL**	Note
3	Declaration of interests	All	**VERBAL**	Receive
4	Minutes of the previous meeting held on 2 March 2017	Chair	**APP A**	Approve
5	Action log and matters arising:	Chair	**APP B**	Review
6	Patient Story: To receive a patient story re 'Wound Care Transformation' From:- Jane Findlater, Clinical Lead - Podiatry Vijay Bangar, Consultant Physician Nicola Sheehan, Head of Therapy Professions	Executive Director of Nursing	**Presentation**	Note
7	Chairman's Report a. Feedback MC Meeting 5.4.17 b. Feedback from NHS Providers Chair/CE Meeting – 23.3.17	Chair	**VERBAL**	Note
8	Chief Executive's Report: a. 'Shifting the Balance of Care' Research Summary – Nuffield Trust b. NHS Mandate Update	Chief Executive	**APP C** **VERBAL**	Note

Keeping the base safe				
9	High Level Risks Register	Executive Director of Nursing	**APP D**	**Approve**
10	Governance report a. Attendance Register b. Constitutional Changes c. Nominations and Remuneration Committee (MC) Terms of Reference d. Board Workplan	Company Secretary	**APP E**	**Approve**
11	CQC Update on Action Plan	Executive Director of Nursing	**APP F**	**Approve**
12	Quarterly Quality Report – Quarter 3 presentation	Executive Director of Nursing/ Assistant Director for Quality	**APP G**	**Approve**
12	EPR Operational Readiness	Chief Operating Officer	**APP H**	**Approve**
13	Integrated Performance Report	Chief Operating Officer	**APP I**	**Approve**
Financial Sustainability				
14	Month 11 – 2016-2017 – Financial Narrative	Executive Director of Finance	**APP J**	**Approve**
Transforming and improving patient care – no items				
A workforce for the future – no items				
15	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 30.1.17, 27.2.17 and verbal update from meeting of 3.4.17 ▪ Finance and Performance Committee – minutes of 28.2.17 and verbal update from meeting 4.4.17 ▪ Workforce Well Led Committee - minutes 16.2.17 and 16.3.17 ▪ Draft Nomination and Remuneration Committee (MC) Minutes – 8.3.17		**APP K**	**Receive**

Date and time of next meeting
TO BE CONFIRMED ? Thursday 4 May 2017 commencing at 9:00 am

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).*

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 6th April 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 2.3.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3 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 minutes of the last Public Board of Directors Meeting held on Thursday 3 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 minutes of the last Public Board of Directors Meeting held on Thursday 3 March 2017.

Appendix

Attachment:

draft BOD MINS - PUBLIC - 2.3.17.pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 2 March 2017 in 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

Dawn Stephenson	Nominated Stakeholder Membership Councillor
Veronica Maher	Publicly Elected Membership Councillor
Karen Melling	Matron, Pain Service and Endoscopy Units
Michael Taylor	Observer

38/17 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

39/17 APOLOGIES FOR ABSENCE

Apologies were received from:
Michelle Rich, Publicly Elected Membership Councillor

40/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

41/17 MINUTES OF THE MEETING HELD ON 2 FEBRUARY 2017

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

42/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG

9/17 – International Staff – The Executive Director of Workforce and OD reported that work was still being undertaken nationally and once this was complete feedback would be brought to the Board.

ACTION: Feedback to be brought to a future BOD Meeting

168/16 - Well Led Governance Assessment – The Company Secretary advised that the consultation had now closed and guidance was awaited. It was agreed that this item would be closed on the Action Log.

ACTION: Closed Action Log

175/16 - Update From Sub-Committees – Declarations of Interests – The Company Secretary advised that guidance had been received but the final policy was still awaited. The guidance suggested that all band 8d and above employees should declare annually, even if it is a nil response. It was noted that currently there is no process in place for the increased declarations which would be made within the Trust. It was agreed that this item would be taken to the Audit and Risk Committee in April with a proposed solution.

ACTION: ARC Agenda – 19.4.17

33/17 – Mandatory Training – The Chief Operating Officer asked the Board to approve the proposal that, given the need to ensure all relevant staff are trained for the implementation of the new electronic patient record (EPR), Divisions be asked to concentrate on EPR Training and only four of the mandatory training modules. It was noted that phasing of Mandatory Training during 2017/18 was being scheduled. Discussion took place regarding the importance placed by the CQC on training compliance. It was recognised that EPR training is business critical. The Board supported the proposal and asked that Quality Committee discuss the 2017/18 Mandatory Training plan.

ACTION: Quality Committee Agenda – 3.4.17

43/17 **STAFF STORY – 'PATIENT STORY THROUGH A STAFF LENS'**

Karen Melling, Matron, Pain Service and Endoscopy Units attended the meeting to share with the Board her personal experiences of care within the Trust. It was noted that Karen had been employed in the Trust for approximately 28 years. Unfortunately she had recently encountered health issues which involved care through a number of Divisions and she wanted to document her experiences of the journey so that lessons could be learnt and improvements made.

Karen shared with the Board the failings in care within Diabetic, Gynaecological, Diagnostics and Urology departments which had mainly been associated with lack of communications between the various departments. The Board heard details of the areas working in silos, although the care given by individual staff had been very good. The experiences highlighted the impact of poor communication and the need to ensure that patients are supported and tracked through the system. It was noted that she had received good support throughout her care from internet support groups.

The Board thanked Karen for sharing her experiences and offered their apologies for the lack of compassionate care she had received and agreed it was important to continue to drive compassionate care throughout the Trust in the future.

The lessons learnt had given Karen the opportunity to be involved in producing a patient leaflet explaining the care and process for the removal of urological stents. The Chief Operating Officer asked that Karen work closely with her team to prioritise improvements in timings between referrals in departments and any other areas which could be improved upon.

ACTION: HB/KAREN MELLING

44/17 CHAIRMAN'S REPORT

National Audit Office Report – Health and Social Care Integration and Kings Fund Key Messages

The Chairman had circulated the two documents published by the National Audit Office and Kings Fund to highlight the complex environment of the health service, the need to integrate systems in the future and the lack of evidence of benefit from the Better Care Fund process.

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

45/17 CHIEF EXECUTIVE'S REPORT

a. Health Service Context

The Chief Executive had circulated a presentation from the BBC which supported the above documents. The presentation highlighted how the NHS budget had grown since its inception and testing had shown how spending on health has slowed down in recent years. The increase in demand and aging-population was noted and overall the presentation emphasised the need for a system leadership role to make a difference from the bottom up.

Discussion took place regarding the increasing responsibilities of Sustainability and Transformation Plans and recognised the input of different cultures in the country, particularly in respect of the level of care given by relatives and friends.

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

46/17 EPR OPERATIONAL READINESS

The Chief Operating Officer provided a presentation regarding the operational readiness for implementation of the Electronic Patient Record which covered the following areas:-

- Process – regular meetings taking place throughout the organisation and with stakeholders.
- Training – the number of places already booked and areas requiring greater focus were noted.
- Admin staff support – additional validation staff in place – new patient booking process team to address.
- Communication – a detailed communications plan was being delivered.
- Command and Control – operational plans in place to support staff.
- Cutover and Early Live Support – rostering of management staff in place. Review of outpatient clinics during the six week cutover to be reviewed.
- Command and Control – Systems in place and further work to be undertaken.
- Safe to Go – full dress rehearsal, operational checklist, technical checklist and CEO readiness to go live sign off

It was agreed that the presentation would be circulated to all Board members.

The Board noted that preparation was on going and the operational team was driving this with the technical team. The Director of THIS reported that the health informatics staff had given assurances that they will have staff available to support the other systems within the Trust as well as EPR implementation. It was noted that continuity plans were in place and would be revisited regularly during the pre EPR launch period.

ACTION: KB - Circulation of presentation to all Board members.

OUTCOME: The Board received the assurances and **APPROVED** the process for the readiness to go live sign off by the CEO.

47/17 **HIGH LEVEL RISKS REGISTER**

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

These were:-
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Staffing risk, nursing and medical
6131 (20) : Service reconfiguration
5806 (20): Urgent estates schemes not undertaken
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 scores
The risk relating to divisional governance structures, risk 6694 had been reduced in score to 12 from 15 and was being managed within the quality directorate's risk register.

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

Discussion took place regarding the nasogastric tube risk and it was agreed that a position statement would be brought to the Board in June.

ACTION: BOD Agenda item 1.6.17

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

48/17 **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. Membership Council Elections Timetable
It was noted that 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. The Board noted that this service had been re-tendered and the previous provider, Electoral Reform Services (ERS), was successful in the tender. In order for this process to be conducted in an efficient and democratic manner, ERS issues a timetable for these activities and these had been included. The Board noted the timetable for the elections.

b. Performance Management Framework – Update on work from sub-committees

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.

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

49/17 CARE OF THE ACUTELY ILL PATIENT REPORT

The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report and reminded the Board on the overall aim of the programme to reduce mortality. It was noted that this is divided into six themes:

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

The Executive Medical Director reported that HSMR is currently falling and is now 103.76, however it remains a concern. There is evidence that the improvement work has contributed to the reduction of HSMR over the last year and this would continue to be monitored.

Discussion took place regarding Sepsis and as discussed at the last meeting, the Executive Medical Director reported that work continued to be undertaken to ensure that all staff treated sepsis as a medical emergency. It was agreed that an update would be brought to the Board in May/June to assure the Board that attitudes and behaviours were being addressed in the Trust to ensure that the care of the Sepsis patient was made a priority.

ACTION: BOD Agenda May/June 2017

OUTCOME: The Board **APPROVED** the Care of the Acutely Ill Patient update report

50/17 REVIEW OF PROGRESS AGAINST STRATEGY

The Company Secretary reported that the purpose of the report was to provide a single update for Board members on the progress made against the four goals described in the Trust's 1 year plan for 2016/17.

The Board noted the contents of report which described the progress made against each of the 16 objectives and identified where the Board should expect to receive more detailed assurance of how the work is progressing. A further update would be brought to the Board in April 2017.

ACTION: BOD AGENDA – JUNE 2017

OUTCOME: The Board **APPROVED** the updated progress against strategy and agreed that an update would be brought to the Board in April 2017.

51/17 **CQC UPDATE ON ACTION PLAN**

The Executive Director of Nursing presented the updated CQC Action Plan and the Board noted the progress made which was on track. Apologies were given that the two evidence reports had not been circulated and it was agreed that these would be circulated to Board members after the meeting. It was requested that any comments are returned to either the Executive Director of Nursing or Company Secretary before the 8 March 2017. As the report had been discussed in detail at the Quality Committee and the Risk and Compliance Group, it would be assumed that the evidence is approved subject to any comments being received.

OUTCOME: The Board **APPROVED** the updated CQC Action Plan

52/17 **INTEGRATED PERFORMANCE REPORT**

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

Prof. Roberts questioned whether high level risks between the Risk Register and Integrated Performance Report were embedded or whether a deep dive was required. The Executive Director of Nursing and Company Secretary reported that this would be undertaken as part of the housekeeping exercise agreed at the last Board meeting and would be taken to the Audit and Risk Committee in May. It was agreed that Prof. Roberts would be invited to discuss workforce associated risks further with the Executive Director of Workforce and Chair of Workforce Well-led Committee.

ACTION: Meeting – PR/IW/KH

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

53/17 **MONTH 10 – 2016-2017 - 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 28 February 2017. The key messages and summary were noted:-

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 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. 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 NHS Improvement. 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.

Summary

- 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.

OUTCOME: The Board **APPROVED** the Month 10 financial narrative

54/17 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 27 February 2017 which had not been previously covered on the Board's agenda:

- Meeting to regularly receive divisional quality reports
- Good news stories – accreditation for microbiology and histopathology
- Response to complaints – improved time for responding to complaints and more responsive in terms of working with patients/relatives to diffuse issues before escalating to formal complaints.
- Sepsis – an area of focus
- Mortality Review – guidance awaited
- Fractured Neck of Femur – more work required – some improvements and some new issues. A go-see to Boston had been undertaken. Work continues to sustain position.

OUTCOME: The Board **RECEIVED** the verbal update and the minutes of the meeting held on 30.1.17.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 28 February 2017:-

- Focussed discussion around CIP and year-end position
- Good discussion around risks particularly 2017/18 level of CIP risks
- Paper on outpatient productivity received. Data showed fill rates in Outpatients being increased with challenges to sustain.
- Amendments to Terms of Reference for Cash Committee reviewed and approved – move from compliance to monitoring focus.

- Budget Book for 2017/18 circulated and agreed circulation to all Board members.
- Performance – discussion took place regarding Mandatory Training compliance.

OUTCOME: The Board **RECEIVED** the verbal update and the minutes of the meeting held on 31 January 2017.

c. Workforce Well-Led Committee

Karen Heaton, Chair of the Workforce Well-led Committee reported on the items discussed at the meeting held on 16 February 2017:-

- Presentation received from Medical Division on workforce plans and agency use
- Received update on training schedule for EPR
- Received feedback on CQC action plan
- Discussed agency spend – concerns continue
- Sickness and Absence – continued concerns. Analysis of data being undertaken.
- Nurse revalidation – report received – developing well.
- Guardian of Safe Working – report received – no breaches reported.

OUTCOME: The Board **RECEIVED** the verbal update from the meeting and the minutes of the meeting held on 19 January 2017.

d. Health and Safety Policy

The Board received and approved the Health and Safety Policy and noted the Directors responsibilities.

OUTCOME: The Board **RECEIVED** the **APPROVED** the Health and Safety Policy

55/17 DATE AND TIME OF NEXT MEETING

Thursday 6 April 2017 commencing at 8.30 am in Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary.

The Chair closed the public meeting at 10:30 am.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

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

Main Body

Purpose:

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

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
165/16 3.11.16	**BOARD ASSURANCE FRAMEWORK** It was agreed to bring the Board Assurance Framework to the Board in February and for the Company Secretary to review other organisations' BAFs to assess the types of risks included	VP	**1.12.16** It was agreed that the Company Secretary would undertake a deep dive of the top themes and bring back to the Board anything which would benefit changing on the BAF in February 2017. **2.2.17** Compliance with NHSI was discussed and the Board questioned whether this was still relevant. It was agreed that this would be further discussed through the Finance and Performance Committee. **2.3.17** Presented to the Finance & Performance Committee prior to Board in April.	6.4.17		
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** The Company Secretary advised that the consultation had now closed and guidance was awaited. It was agreed that this item would be			2.3.17

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 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
			closed on the Action Log.			
175/16 3.11.16	**UPDATE FROM SUB-COMMITTEES** **Audit and Risk Committee – Declarations of Interest** The Company Secretary explained that there would be a change to the declarations of interest policy as new guidance was due to be published in December. An update would be brought to a future Board meeting.	VP	**2.2.17** The Company Secretary advised that Guidance was still awaited. It was requested that this remain open on the Action Log for a report to come back in March 2017. **3.2.17** It was noted that this item would be taken to the Audit and Risk Committee in April with a proposed solution.	May/June 2017		
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/April 2017.	HB/BB/DB				6.4.17 via QC
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** **Completed by DB/IW/BB/OW/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 through the Workforce Well-led Committee and	IW		4.5.17		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	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 June 2017.	BB/VP/ARC	**2.3.17** Discussion took place regarding the nasogastric tube risk and it was agreed that a position statement would be brought to the Board in June.	1.6.17		
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** It was noted that this item had been referred to the Quality Committee for further discussion.			April 2017 Quality Committee
9/17 5.1.17	**INTERNATIONAL STAFF** The Acting Chief Executive reported that discussions had taken place regarding abuse towards international staff from patients or their families. The Board agreed that this would not be tolerated and the Executive Director of Workforce and OD agreed that a system would be put in place to safeguard against this via NHS Protect.		**2.3.17** The Executive Director of Workforce and OD reported that work was still being undertaken nationally and once this was complete feedback would be brought to the Board.	TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 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
2.3.17 49/17	**CARE OF THE ACUTELY ILL PATIENT – CULTURE** The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report and reminded the Board on the overall aim of the programme to reduce mortality. It was noted that this is divided into six themes: 1) Investigating causes of mortality and learning from findings 2) Reliability in clinical care 3) Early recognition and treatment of deteriorating patients. 4) End of life care 5) Caring for frail patients 6) Clinical coding The Executive Medical Director reported that HSMR is currently falling and is now 103.76 however it remains a concern. There is evidence that the improvement work has contributed to the reduction of HSMR over the last year and this would continue to be monitored. Discussion took place regarding Sepsis and as discussed at the last meeting, the Executive	DB		May/June 2017		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 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
	Medical Director reported that work continued to be undertaken regarding to ensure that all staff treated sepsis as a medical emergency. It was agreed that an update would be brought to the Board in May/June to assure the Board that attitudes and behaviours were being addressed in the Trust to ensure that the care of the Sepsis patient was made a priority.					

Research summary March 2017

Shifting the balance of care

Great expectations

Candace Imison, Natasha Curry, Holly Holder,
Sophie Castle-Clarke, Danielle Nimmons, John Appleby,
Ruth Thorlby and Silvia Lombardo

nuffieldtrust

About the report

This summary accompanies a report that forms part of our work programme on new models of care, and also contributes to our ongoing work on Sustainability and Transformation Plans (STPs). We have a long track record in analysing the evidence base surrounding out-of-hospital care and, with the need to move care from hospital into the community a core part of STP plans across the country, a review of the evidence is both timely and necessary.

This research draws on an extensive literature review to assess the realism of the narrative that moving care out of hospital will save money. It sets the context of this through analysis of hospital activity data over ten years. The literature review focuses on initiatives that were expected to impact on hospital care, as this is what STPs predominantly focus on. We explore these by looking at five key areas: elective care, urgent and emergency care, admission avoidance and easier discharge, at risk populations, and self-care.

The report aims to inform the development of STPs to ensure that they are drawing on the best available evidence. It also seeks to dispel some widely held myths about the 'magic bullet' of shifting care into the community.

Suggested citation

Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), *Shifting the balance of care: great expectations.* Research report. Nuffield Trust.

The full report can be accessed at:
www.nuffieldtrust.org.uk/research/shifting-the-balance-of-care

Acknowledgements

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We are appreciative of the time and advice given by colleagues in the Nuffield Trust for their help and support, including Nigel Edwards, Leonora Merry, Mark Dayan and Meilir Jones.

Key messages

- Demographic and other drivers create an imperative to shift the balance of care from hospital to community. The NHS plans to undertake this transition while demand rises and it experiences the longest period of funding constraint in its history.

- There is widespread hope – both within the NHS and amongst national policy-makers – that moving care out of hospital will deliver the 'triple aim' of improving population health and the quality of patient care, while reducing costs. This has long been a goal for health policy in England, and is a key element of many of the Sustainability and Transformation Plans (STPs) currently being developed across the country.

- Our analysis suggests that some STPs are targeting up to 30 per cent reductions in some areas of hospital activity, including outpatient care, A&E attendances and emergency inpatient care over the next four years. Yet this is being planned in the face of steady growth in all areas of hospital activity – for example a doubling of elective care over the last 30 years.

- The report provides insight from evidence on initiatives that plan to support this shift in care. Drawing on a review of the STPs and an in-depth literature review of 27 initiatives to move care out of hospital, we look at what their impact has been, particularly on cost, and what has contributed to their success or otherwise.

- Many of the initiatives outlined in the report have the potential to improve patient outcomes and experience. Some were able to demonstrate overall cost savings, but others deliver no net savings and some may increase overall costs.

- Where schemes have been most successful, they have: targeted particular patient populations (such as those in nursing homes or the end of life); improved access to specialist expertise in the community; provided active support to patients including continuity of care; appropriately supported and trained staff; and addressed a gap in services rather than duplicating existing work.

- Nonetheless, in the context of long-term trends of rising demand, our analysis suggests that the falls in hospital activity projected in many STPs will be extremely difficult to realise. A significant shift in care will require additional supporting facilities in the community, appropriate workforce and strong analytical capacity. These are frequently lacking and rely heavily on additional investment, which is not available.

- We argue that NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care. For example, they may use prices to calculate savings rather than actual costs and can therefore wrongly assume that overhead or fixed costs can be fully taken out. Similarly, many underestimate the potential that community-based schemes may have for revealing unmet need and fuelling underlying demand.

- The implementation challenges involved in shifting care out of hospital are considerable and even initiatives with great potential can fail. This is often because those responsible for planning and implementing them do not take into account the wide range of system, organisational and individual factors that impact upon their feasibility and effectiveness. Many schemes rely on models to identify 'at risk' groups that are often deficient and fail to adequately identify patients genuinely at risk of increased hospitalisation.

- Many initiatives we examine place additional responsibilities upon primary and community care, at a time when they are struggling with rising vacancies in both medical and nursing staff, and an increasing number of GP practices are closing. Addressing these issues is a necessary precursor to success.

- It is possible that many of the initiatives explored in the report have been too small and haven't been supported by wider system interventions and incentives, and have therefore failed to shift the balance of care and deliver net savings. A more radical approach to the design and scale of the models being used might be required, but this will take time and resources to support the transition.

- While out-of-hospital care may be better for patients, it is not likely to be cheaper for the NHS in the short to medium term – and certainly not within the tight timescales under which the STPs are expected to deliver change. The wider problem remains: more patient-centred, efficient and appropriate models of care require more investment than is likely to be possible given the current funding envelope.

Shifting the balance of care

The NHS is undertaking a journey of transformation while experiencing the longest period of funding constraint in its history. It needs to close a £22 billion gap in its finances by 2020/21. At the same time, the underpinning fabric of social care is being dismantled, and a range of demographic and other factors are fuelling demand for NHS services. It is a herculean, and some might say impossible, task – made all the more difficult by the small amounts of available transformation funding now being used to prop up a system that is going further into the red.

The goal of delivering health care closer to people's homes is not a new one and has been an aspiration of numerous policy initiatives within the NHS for many years. In its most recent incarnation, 44 STPs, published in October 2016, describe how local areas aim to bridge the gap in NHS finances while delivering the vision set out in the Five Year Forward View. The plans need to find credible ways of coping with rising demand with no equivalent rise in funding. Many areas hope that moving care out of hospital will deliver the 'triple aim' of improving population health and the quality of care for patients, while reducing costs.

The report provides insights from the available evidence to help inform these local strategies. It aims to help local planners ensure that their assumptions are credible – currently the STPs include widely differing assumptions about the net impact on activity and cost. It also aims to help areas identify the initiatives that may deliver the greatest benefits locally and the key contributors to successful implementation.

We have grouped the evidence on the initiatives into five areas (although these are not mutually exclusive):

1 Changes in the elective care pathway.

2 Changes in the urgent and emergency care pathway.

3 Time-limited initiatives aimed at avoiding admission or facilitating discharge from hospital.

4 Managing 'at risk' populations including end-of-life care and support for people in nursing homes.

5 Support for patients to care for themselves and access community resources.

We reviewed a large body of academic and grey literature, with a particular focus on robust evidence from randomised controlled trials (RCTs), Cochrane reviews and other systematic reviews, in order to draw on the most reliable evidence available. However, the quality of evidence on which we were able to call was mixed, and often reliant on poorly constructed evaluations.

We focused on initiatives that were expected to impact most on areas targeted by STPs and those most frequently measured in research papers. The list of initiatives is long, but not fully comprehensive. Initiatives were selected based on a review of STPs and our knowledge of what health care organisations are implementing across the country. We put the initiatives into four categories: those where there is robust evidence to suggest an initiative improved care and was cost effective; those where there is emerging positive evidence; those where there is contradictory evidence; and those that have poor evidence or where there is evidence of increased costs.

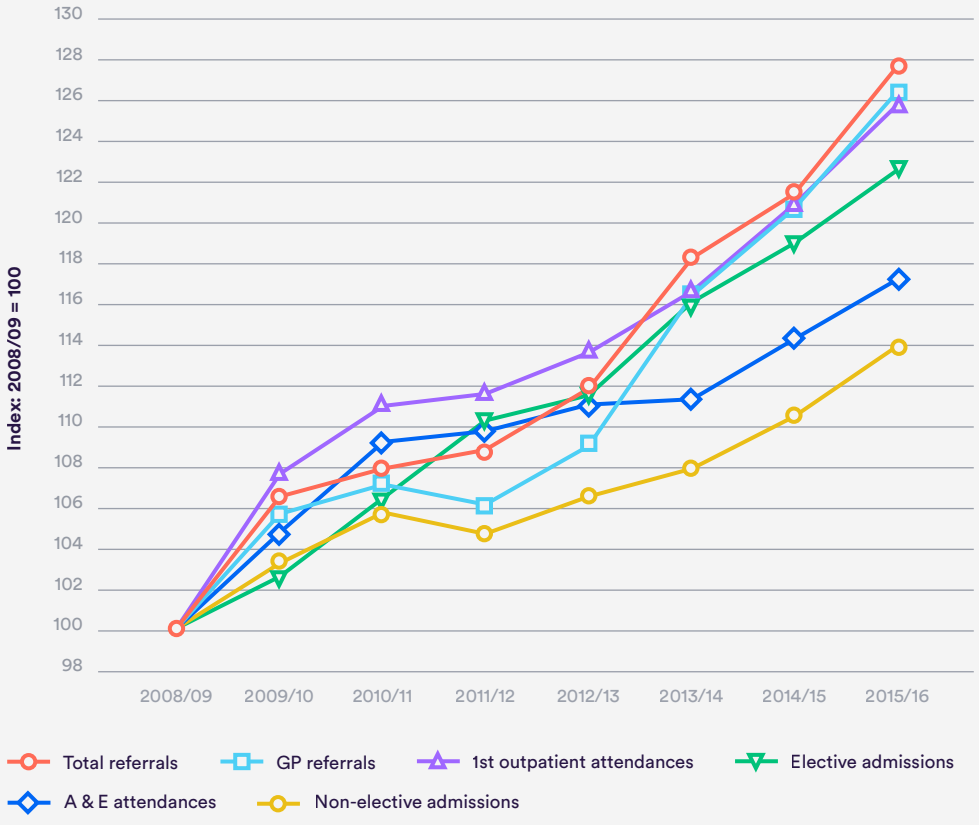
Context – underlying activity trends

Rising patterns of hospital activity

We lay the evidence on initiatives to shift care out of hospital alongside analysis of the underlying trends in hospital activity, as well as other factors that would influence the implementation and impact of these initiatives.

Seasonal fluctuations aside, the last eight years have seen steady growth in all areas of hospital activity (Figure 1). Emergency admissions have risen by 14 per cent since 2008/09. For planned care, growth has been even sharper: elective admissions are up 22 per cent, while both GP referrals and first outpatient appointments have risen 26 per cent. This continues a longer-term trend of growth stretching back to the creation of the NHS.

Figure 1: Summary of recent hospital activity trends, 2008–2016 (indexed at 2008)



Source: NHS England, 2017

These trends are likely to be magnified in future by demographic and epidemiological pressures. For example, the population of England is expected to grow by 4.4 million (7 per cent) and the number of people over the age of 85 by 0.5 million (33 per cent) between 2014 and 2024. Over a similar time period, the number of people living with dementia is expected to grow from 700,000 in 2014 to around 1.3 million in 2025.

STP assumptions on reducing hospital activity

Currently the STPs include widely differing assumptions about the impact that their local strategy will have on hospital activity and their underlying assumptions are often far from clear.

With this caveat, our interpretation of the material in the public domain is that in 2020/21 the STPs are predicting activity to be less than forecast (based on current trends) by the following amounts:

- 15.5 per cent fewer outpatient attendances (range 7–30 per cent)
- 9.6 per cent less elective inpatient activity (range 1.4–16 per cent)
- 17 per cent fewer A&E attendances (range 6–30 per cent)
- 15.6 per cent fewer non-elective inpatient admissions (range 3–30 per cent).

Only two thirds of STPs included an explicit risk assessment of these assumptions.

Summary of the evidence

Overview of initiatives

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Improved GP access to specialist expertise • Ambulance/paramedic triage to the community • Condition-specific rehabilitation • Additional clinical support to people in nursing and care homes • Improved end-of-life care in the community • Remote monitoring of people with certain long-term conditions • Support for self-care
Emerging positive evidence	• Patients experiencing GP continuity of care • Extensivist model of care for high risk patients • Social prescribing • Senior assessment in A&E • Rapid access clinics for urgent specialist assessment
Mixed evidence, particularly on overall cost reduction	• Peer review and audit of GP referrals • Shared decision-making to support treatment choices • Shared care models for the management of chronic disease • Direct access to diagnostics for GPs • Intermediate care: rapid response services • Intermediate care: bed-based services • Hospital at Home • Case management and care coordination • Virtual ward
Evidence of potential to increase overall costs	• Extending GP opening hours • NHS 111 • Urgent care centres including minor injury units (not co-located with A&E) • Consultant clinics in the community • Specialist support from a GP with a special interest • Referral management centres

Redesigning elective care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Improved GP access to specialist expertise
Mixed evidence, particularly on overall cost reduction	• Peer review and audit of GP referrals • Shared decision-making to support treatment choices • Shared care models for the management of chronic disease • Direct access to diagnostics for GPs
Evidence of potential to increase overall costs	• Consultant clinics in the community • Specialist support from a GP with a special interest • Referral management centres

There are a number of initiatives that aim to better manage elective care, the most promising of which is enabling GPs to access specialist opinion to help them manage patients in the community and avoid unnecessary referrals to outpatient services.

Peer review and audit of GPs' referral patterns can improve the quality of referrals and may reduce the overall number of referrals to outpatient services. Shared decision-making, shared care models and direct access to diagnostics for GPs have well-evidenced benefits for patients and professionals, but less conclusive findings on their capacity to reduce hospital activity and deliver savings. There are also initiatives where the evidence suggests that they may *increase* overall costs. These include consultants working in the community, referral to a GP with a special interest and the use of referral management centres.

Any strategy to redesign elective care does so in the context of sharply rising outpatient attendances, sharply rising day case activity and slowly falling elective inpatient activity (as care shifts from inpatient care to day case and outpatient procedures). In addition, many of the initiatives that have shown promise to date bring new expectations of GPs; nearly all require GP training or support. However, we believe there is significant scope in the

medium to long term to redesign the elective pathway and deliver a more integrated model of elective care, with much more outpatient care delivered in primary care. A much more radical redesign of elective care underpinned by technology, including clinical decision support, and adoption of shared decision-making could yield savings.

Redesigning urgent and emergency care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Ambulance/paramedic triage to the community
Emerging positive evidence	• Patients experiencing GP continuity of care
Evidence of potential to increase overall costs	• Extending GP opening hours • NHS 111 • Urgent care centres including minor injury units (not co-located with A&E)

A range of initiatives aim to reduce attendance at accident and emergency (A&E) departments, with some also helping to avoid subsequent hospital admission. Our review of the evidence suggests that, of the approaches reviewed, ambulance/paramedic triage to the community has the strongest evidence to support it.

The effective implementation of schemes designed to reduce emergency hospital care is dependent on capacity in primary care and improved data-sharing between sectors. The schemes that require staff working in different ways will need to ensure that individuals are sufficiently trained and working within their sphere of competency, particularly where decisions about referrals are made. However, other initiatives have the complex task of trying to influence patients' behaviour prior to their contact with urgent or emergency services, or to prevent further use of services (i.e. extending GP opening hours, NHS 111 and urgent care centres which are not co-located). Successfully changing patterns of service use requires access to appropriate and timely primary care, as well as high levels of trust in these alternative services.

Trends in use of A&E, and the significant increase in attendances in 2003 following the introduction of minor injury and specialist services, highlight an important consequence of the initiatives described in this section: supply-induced demand. Many of the initiatives we looked at increased contacts with the NHS without equivalent reductions in the use of A&E. In some cases, this has increased overall costs.

Avoiding hospital admission and accelerating discharge

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Condition-specific rehabilitation
Emerging positive evidence	• Senior assessment in A&E • Rapid access clinics for urgent specialist assessment
Mixed evidence, particularly on overall cost reduction	• Intermediate care: rapid response services • Intermediate care: bed-based services • Hospital at Home

Over the last 30 years the number of hospital beds has more than halved. At the same time, hospital admissions have been rising, particularly for older people. Bed reductions have been possible because of a reduction in length of stay and a shift from inpatient care to day case and outpatient care. Despite these bed reductions, some estimates suggest that up to 50 per cent of beds are occupied by people who could be cared for in community settings.

Of the evidence reviewed, the initiatives with the most positive outcomes are those for condition-specific rehabilitation. Pulmonary and cardiac rehabilitation improve quality of life and reduce hospital admissions, and have been shown to be cost effective. There is emerging positive evidence for rapid access clinics and senior decision-makers in A&E, but further research is needed, particularly around their economic impact.

Evaluation of rapid response teams and the use of intermediate care beds shows much more mixed results, suggesting that local implementation and context play a large part in their success. Clear referral criteria and good integrated working across health and social care appear to be important.

Hospital at Home schemes successfully provide a safe alternative to hospital, but there is little evidence that they deliver net savings.

Absence of evidence is not necessarily a sign that a particular initiative would not work if introduced in an appropriate context. What is clear is that to avoid hospital admissions and accelerate discharges, there must be sufficient capacity and funding of alternative forms of care in the community. Without this investment, analysis suggests that the NHS will need to expand, not contract, its bed capacity.

Managing 'at risk' populations

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Additional clinical support to people in nursing and care homes • Improved end-of-life care in the community • Remote monitoring of people with certain long-term conditions
Emerging positive evidence	• Extensivist model of care for high risk patients
Mixed evidence, particularly on overall cost reduction	• Case management and care coordination • Virtual ward

A large number of diverse initiatives over the last two decades have aimed to better manage 'at risk' populations, but while services are highly valued by patients, very few have successfully reduced hospital activity. The strongest evidence relates to those initiatives that target well-defined groups; that is, those in nursing and residential homes, and those at the end of life. There is growing evidence for initiatives that monitor people at home, particularly for some conditions such as heart failure. The extensivist model, which provides holistic care for those at greatest risk, has promising evidence from its use in the US, but its benefits have yet to be formally demonstrated in England. The initiatives which have the greatest challenge in demonstrating impact on hospital activity, but have other positive benefits for patients and their experience, are more general attempts to case manage those deemed to be at highest risk of admission, including the use of virtual wards.

There are several reasons for this lack of impact or cost savings. First, efforts to coordinate care involve initiatives to correct underuse and ensure timely access to care. In isolation, these efforts tend to increase the use of care, at least partially negating any reductions in preventable or unnecessary care resulting from coordination. Second, for every costly complication prevented, a care coordination programme must manage multiple patients at risk of such a complication, even if it selectively targets high-risk patients. And third, care coordination is costly. The cost of staff and other resources can offset the savings from the hospital care avoided.

Maximising impact on hospital use requires accurately targeting initiatives at the groups most likely to benefit, and where a reduction in admission will have most impact on resource use. Risk stratification tools still struggle to identify 'at risk' individuals at the point before they deteriorate.

Trends in life expectancy and the number of people with multi-morbidities suggest that the number of 'at risk' people will continue to rise, making it an even greater imperative to manage this group better. The lesson from the evidence is that significant attention needs to be paid to the accurate targeting of initiatives, while moderating expectations of their capacity to reduce overall cost.

Support for patients to care for themselves and access community resources

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Support for self-care
Emerging positive evidence	• Social prescribing

There are 15 million people living with long-term conditions and over two million with multiple long-term conditions. Together they account for 55 per cent of GP appointments and 77 per cent of inpatient bed days. Receiving support to help them manage their conditions may result in reduced crisis points and less costly care. However, despite the positive evidence for self-care, there remains a lack of clarity about which elements are most effective. Assessing the impact of social prescribing presents significant challenges as it encompasses highly diverse initiatives for a wide range of needs, and its benefits go beyond reduced resource use. But the growing evidence base is positive.

Both support for self-care and access to community resources require behaviour change on the part of patients and professionals; moving from a model in which the patient is a passive recipient in the traditional medical model, to a treatment programme that is based around engagement and active participation. Self-care requires significant infrastructure and professional support to improve health and digital literacy, as well as encourage engagement. Programmes that are well-supported, funded and given sufficient time to develop are most likely to demonstrate benefits. Given the many millions of people managing one or more long-term condition, the scale of what is required to realise the full potential in this area is considerable.

Implementation and other challenges

The challenges in implementing the sorts of initiatives we have analysed are considerable and even those with great potential can fail. This is often because the wide range of system, organisational and individual factors that impact feasibility and effectiveness are not taken into account. The proposed shift in care cannot be achieved without significantly increasing capacity and capability in primary and community care, and solving some of the prevailing social care problems.

A major challenge is workforce. The NHS is trying to grow services where clinical workforce numbers have fallen and disinvest in services where clinical workforce numbers have grown. For example, between 2006 and 2013, the number of consultants in hospital and community services grew by 27 per cent, while the total GP workforce rose by only 4 per cent and the number of GPs per capita fell. Between 2010 and 2015, the number of district nurses fell by 35 per cent.

There are large and growing gaps in the clinical workforce, particularly in the services facing some of the most acute demand pressures. A third of GP practices have a vacancy for at least one GP partner. There are vacancy levels of over 21 per cent for district nurses. It is questionable whether there is the workforce – in terms of numbers, skills and behaviour – needed to deliver these initiatives.

Many of the models being used within the NHS to identify 'at risk' groups (such as people who are frequently admitted to hospital) are frequently deficient and those using them are often too optimistic in their assumptions about the impact of targeting high-risk groups.

The NHS as a whole also has a tendency to view problems through the lens of a single condition (e.g. diabetes). The complexity that stems from multi-morbidity is frequently not well understood or addressed. This lack of understanding of a person's entire health and social care needs, and service use, leads to unrealistic assumptions being made about the potential impact of an initiative.

There are particular challenges in delivering economic benefits. A number of factors inhibit the delivery of system-wide savings. The use of prices to calculate savings rather than actual costs and a tendency in modelling the costs of services to assume all the overhead or fixed costs can be fully taken out, can mean that real-world savings are significantly over-estimated. There is also the risk of supply-induced demand; any strategy that aims to reduce over-use is also likely to identify under-use and unmet need.

The challenge of demonstrating economic benefits is part of the broader issue of the way in which success is measured. While initiatives may not deliver savings, they may increase 'value' by addressing unmet need, or encouraging need to be met in ways that deliver better outcomes for people. Bundles of initiatives and multifaceted programmes targeting high-risk populations are likely to be more effective than those involving single approaches, yet single initiatives are most often implemented and measured.

Also, initiatives are not given long enough to take effect. A key feature of so-called 'transformational' change is the length of time it takes. Yet policy-makers frequently want instant results. The STP process is a case in point here – one of the biggest shifts in how the NHS delivers care for a generation is expected to be completed within five years.

A further complicating factor is that in-hospital and out-of-hospital care are not on an equal footing when it comes to investment in staffing, infrastructure and the elusive but important issue of prestige. And despite the considerable pressures they are facing, hospitals have the infrastructure and payment systems to enable continued investment, while the same cannot be said for care out of hospital. This makes the goal of transferring care out of hospital all the more challenging.

Finally, a vital facilitator of all of the above is strong analytics and shared data. This is essential if the problems are to be correctly diagnosed, the solutions appropriately targeted and their impact evaluated.

Conclusion

Our research has shown that despite the potential of initiatives aimed at shifting the balance of care, it seems unlikely that falls in hospital activity will be realised unless significant additional investment is made in out-of-hospital alternatives.

Where schemes have been most successful, they have: targeted particular patient populations (such as those in nursing homes or the end of life); improved access to specialist expertise in the community; provided active support to patients including continuity of care; appropriately supported and trained staff; addressed a gap in services rather than duplicating existing work.

Implementation and contextual factors cannot be underestimated, and there needs to be realistic expectations, especially around the economic benefit of new care models. If STPs continue to work towards undeliverable expectations, there is a significant risk to staff morale, schemes may be stopped before they have had a chance to demonstrate success, and gains in other outcome measures such as patient experience may be lost.

There are a number of areas where STPs can learn from previous initiatives:

- Measures should be taken to really understand patient needs and what adds value, rather than using activity as a proxy for demand.
- More effective risk stratification and linked data should be used to identify genuinely high-risk patients and avoid 'regression to the mean' (whereby patients identified as high risk at a point in time do not meet this characteristic when analysed over a longer time period).
- Robust data and analytics to support change are essential.
- Staff need improvement methods that they can use, and support in implementing changes. Support from frontline managers, as well as leadership from the top, is vital.
- A workforce strategy is needed to ensure that staff are equipped with the competences required by the new models.

- A whole-system perspective needs to be taken when assessing the cost effectiveness of initiatives, including a realistic assessment of the capacity to disinvest in hospital and other services.

None of the above detracts from a significant challenge that this work poses to local and national planning assumptions. Shifting the balance of care from the hospital to the community has many advantages for patients, but is unlikely to be cheaper, certainly in the short to medium term. These findings echo the National Audit Office's recent conclusion that current attempts at integrating services provide no evidence that integration will save money and reduce hospital activity.

Any shift will also require appropriate analytical capacity, workforce and supporting facilities in the community. Currently these are lacking. And the wider problem remains: more patient-centred, efficient and appropriate models of care require more investment than is likely to be possible given the current funding envelope.

References

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Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 6th April 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 March 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 March 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 March 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

One new risk has been added to the high level risk register during March, risk 6903 scored at 16 relating to the intensive care unit at Huddersfield Royal Infirmary and environmental and estates risks.

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 combined March 17 HLRR.pdf

HIGH LEVEL RISK REGISTER REPORT

Risks as at 27 March 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 March 2017.
RISKS WITH REDUCED SCORE
There are no risks that have been reduced in score on the high level risk register during March.
NEW RISKS
There is new risk that has been added to the high level risk register during March 2017 which is risk 6903 accepted at a rating of 16. This relates to the collective environmental and estates issues within ICU at HRI.
CLOSED RISKS
None

		Strategic Risks		Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme - transformation	Director of THIS (MG)	=20	=20	=20	=20	=20	=20	=20	=20
		Safety and Quality Risks									
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	=20	=20	=20	↓15	↑ 20	=20	=20	=20
6886	Transforming & Improving Patient Care	Non compliance with 7 day services standards	Medical Director (DB)	-	-	-	!15	=15	=15	=15	**=15**
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=20	↓16	=16	=16	=16	=16	=16	=16
2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20	=20	=20
6822	Keeping the Base Safe	Not meeting sepsis CQUIN	Medical Director (DB)	-	-	!16	=16	=16	=16	=16	=16
5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	-	-	!16	=16	=16	=16	=16	=16
6829	Keeping the Base Safe	Aspetic Pharmacy Unit production	Director of Nursing	-	-	!15	=15	=15	=15	=15	=15
6841	Keeping the Base Safe	Not being able to go live with the Electronic Patient Record – operational readiness	Chief Operating Officer (HB)	-	!15	=15	=15	=15	=15	=15	=15
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=16	=16	↑20	=20	=20	=20	=20	=20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD	=16	=16	=16	=16	=16	=16	=16	=16
6694	Keeping the base safe	Divisional Governance arrangements	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15	=15	=15

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	Aug 16	Sept 16	Oct 16	Nov 16	Dec16	Jan 17	Feb 17	Mar 17
6903	**Keeping the base safe**	**HRI ICU collective environmental and estates issues**	**Director of Planning, Estates and Facilities (LH)**	-	-	-	-	-	-	-	!16
6753	Keeping the base safe	Inappropriate access to person identifiable information	Director of Director of THIS (MG)	16!	=16	=16	=16	=16	=16	=16	=16
6924	Keeping the base safe	Mis-placed NG tube	Director of Nursing (BB)	-	-	-	-	-	-	! 15	= 15
6878	Keeping the base safe	Ransom-ware/ Malware	Director of THIS (MG)	-	-	-	-	-	-	! 15	= 15
		Financial Risks									
6721	Financial sustainability	Non delivery of 2016/17 financial plan	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20
6722	Financial sustainability	Cash flow risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20
6723	Financial sustainability	Capital programme	Director of Finance (GB)	=20	↓15	15 =	=15	=15	=15	=15	=15
		Performance and Regulation Risks									
6658	Keeping the base safe	Inefficient patient flow	Chief Operating Officer (HB)	=20	↓16	16=	=16	=16	=16	=16	=16
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Director of Workforce (IW)	=15	=15	=15	=15	=15	=15	=15	=15
		People Risks									
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce (IW)		=20	=20	=20	=20	=20	=20	=20

KEY: = Same score as last period ↓ decreased score since last period

! New risk since last report to Board ↑ increased score since last period

Trust Risk Profile as at 27/03/2017

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 ! 6903 Collectice ICU/Estates	= 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 completed = 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 NG Tube risk = 6878 Ransomware
Unlikely (2)					
Rare (1)					

High Level Risk Register
Board meeting 6 April 2017

The Health Informatics Service
Informing Healthcare

Risks scoring 15 +

Mar-17

Risk No	Div	Dir	Dep	Opened	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	10 5 x 2	**March 2017 update** JOSC met in February and agreed to meet in July and make a decision on referral to SoS once the full business case is completed	Apr-2017	Aug-2017	WEB	Anna Basford	Catherine Riley
2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	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	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 **March 2017:** Awaiting above changes. Notification from School of EM that CHFT have been allocated a further 2 Higher Trainees from September 2017. Awaiting notification if posts have been filled.	Mar-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Caroline Smith

6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	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 Feb 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. **March 2017** Investment to modernise the medical workforce approved and recruitment into posts ongoing. Attendace at PA recruitment fair planned this month. BMJ recruitment campaign for Doctors has resulted in a number of appointments including 2 Con	Apr-2017	Jan-2018	WLG	David Birkenhead, Brendan Brown, Ian Warren	Lindsay Rudge, Jason Eddleston & Claire Wilson

5806	Estates & Facilities	Estates, Planning & Contracting	Capital Team	May-2015	Risk of HRI Estate failing to meet required standards, due to age and condition of the building resulting in a failure of the Trust to achieve compliance of statutory duties. This could result in the closure of areas causing impact on patient care, loss of services, treatment delays, closure of buildings, services and wards and harm to patients and staff. The main works required: Flooring: in a number of areas. Windows: All elevations of the hospital. Theatres: HRI and CRH environments. HRI road surfaces, pipe-work, 2nd water main, aseptic unit Staff Residences: Fire and utilities compliance. Trust wide roofs which need repairs and edge protection. Air Handling Units: High risk of closing theatres , A&E and ICU Medical Gas Plant: To prevent all gas and air from becoming unavailable. Structural: Cannot drill large holes into HRI floors without risk of collapse. Electrics: Upgrade of local distribution boards which could fail imminently. Plant room refurbishment: To meet HSE requirements. Facet Survey into how the Trust meets minimum requirements for patient care. Ward upgrade programme: To ensure all care provided in adequate facilities. ICU nurse call and fixed life support equipment: Could result in fatalities in ICU if it fails. Pathology Laboratory and Mortuary water supply at HRI to prevent the closure of these departments. Asbestos: Migration of asbestos dust in service ducts will affect all maintenance. Electrical 3rd substation: Both power feeds to	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	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. Feb 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. **March 2017 Update** The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. Various projects have recommenced after a significant delay in the capital programme due to environmental cleaning.O15	Apr-2017	Mar-2018	RC	Lesley Hill	Paul Gilling / Chris Davies

6503	Corporate	THIS	THIS Modernisation	Dec-2015	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	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 **March 17 Update:** - 3 weeks of Full Dress Rehearsal (FDR) is underway (1-17th of March). This will prove the Cut-over process. - End User Training (EUT) started on the 6th Mar, early signs are positive, engagement is being measured daily. - Technical readiness is still on plan for the cut-over being the 29th of April. - The successful completion of the above would mitigate the risk but not enough to lower the score at this point.	Apr-2017	Sep-2017	RC	Mandy Griffin	Mandy Griffin
6721	Corporate	Finance	Trustwide	May-2016	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	**March 2017 update:** At Month 11, 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. There remains some uncertainty in the forecast, although this has diminished following finalisation of a year end agreement with our two main Commissioners that incorporates our forecast activity and commissioner coding challenges. 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. CQUIN performance and seasonal operational challenges may bring further unplanned pressure. Continuing high levels of Agency expenditure are 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, £14.96m delivery is forecast and the risk profile of this has been reviewed, £0.12m of schemes remain as high risk.	Mar-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer

6722	Corporate	Finance	Trustwide	May-2016	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 * Revenue support loan in place (at 1.5% interest rate)	The level of outstanding debt held by the Trust is being closely monitored but is not entirely within the Trust's ability to control. The majority of this is owed by other NHS organisations, this has increased the borrowing requirement in the year to date.	15 5 x 3	20 5 x 4	15 5 x 3	**March 2017 update:** 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; uncertainly regarding the timing of Department of Health payments for Sustainability & Transformation Funding (STF+O15); and the fine balance required in managing working capital. The Trust has now transferred its 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.	Mar-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer
6903	Estates & Facilities	Estates	Estates	Dec-2016	Collective ICU Risk - There is a risk to ICU from all of the below individual risks due to inadequate access granted to Estates Maintenance and Capital to carry out ward upgrades / Life Cycling resulting in unplanned failure/ Injuries to patients & staff. - Air Handling Unit (AHU) - imminent failure due to end of useful life resulting in inadequate ventilation - Flooring - trips/falls, harbouring bacteria due to ageing end of life vinyl/screed resulting in inadequate access - Electrical Infrastructure - failure due to end of useful life resulting in unplanned disruptions - Plumbing infrastructure - failure due to end of useful life resulting in unplanned disruptions and the spread of infections - Life Support Beams/Pendant - imminent failure of the medical gas hoses due to end of useful life resulting in unplanned disruptions to the medical gases - Building Fabric - infections & failure due to moisture ingress within the plaster/concrete within ICU resulting in poor environmental conditions. - Nurse Call System - Current system now failed, operating on a temporary mobile system	Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.	Building, Mechanical and Electrical Systems require life cycling / replacing / upgrading to continue the safe use of ICU, currently this is not achievable due to inadequate access and budget constraints.	20 5 x 4	16 4 x 4	0 0 x 0	January/February Update - In order to carry out the work ICU needs to decant, The work effectively is a ward upgrade. Options are decant to ward 9 infrastructure already in place but reduction in beds. Refurbish another area to decant to which will be creating a temporary ICU or Refurbish another area for a permanent move. Discussion to take place in March by divisions to discuss the options. **March Update** Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.	Apr-2017	Sep-17	RC	Lesley Hilll / David McGarrigan	Chris Davies

6753	Corporate	THIS	THIS -Operational	Jun-2016	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	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. **March 2017 Update:** Progress is being made with SSO, completion due mid April, no further update.	Apr-2017	Apr-2017	RC	Mandy Griffin	Rob Birkett
6822	Medical	All Directorates Medical	All Departments/Wards Medical	Aug-2016	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	January update Work continues across all areas but data not showing improvements as yet. Focus to continue on delivering the actions identifies above. February update Sustained position for emergency admissions Improvement seen in in patient screening CQUIN target still unlikely to be met for Q4 2016/17 **March 2017 update** Continue to focus on actions that are having an impact Preparation for 2017/18 CQUIN underway CQUIN target for 2016/17 not likely to be met	Apr-17	Mar-2017	PSQB	David Birkenhead	Juliette Cosgrove

5862	Medical	All Directorates Medical	All Departments/Wards Medical	Aug-2013	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	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. **March 2017 update** Acute Directorate are developing falls prevention action plan with a focus on areas identified from incidents Review of NICE guidance+O18 Planning for national falls audit	Apr-2017	Jun-2017	PSQB	Brendan Brown	Juliette Cosgrove
4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	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	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 **March 2017 update** Latest SHMI (Oct 15 to Sept 16) has fallen to 108 Consultants are joining the initial screening reviews. Mortality Surveillance Group recieves monthly mortality review reports and alert/outlier mortality review reports. CAIP plan on track	Mar-2017	Sep-2017	COB	David Birkenhead	Juliette Cosgrove

6596	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Jan-2016	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	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. **March 2017** Capacity continues to be an issue. Further training course scheduled for April 2017.	Apr-2017	Jul-2017	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove

6658	Medical	Emergency Network	Accident & Emergency	Mar-2016	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	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. **Feb/ March 2017 Update** Variability noted with delays in February, increasing number of patients with a 50 day LOS- fortnightly LOS meetings arranged with senior managers from partner organisations to expedite discharge. Accelerator Zone funding provided to support delivery of the 95% ECS and improve flow out of the departments now in place. Impact is being monitored closely. Buddy managers supporting the OOH's period.	Apr-17	Apr-2017	BOD	COO Helen Barker	Bev Walker

6300	Trustwide	All Divisions	All Departments/Wards	May-2015	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	16	8	4 x 4	4 x 4	2	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. **March 2017** Further progress made with the must do (MD) and should do (SD) recommendation on the CQC plan, 20 actions green – complete, 12 actions blue – complete and embedded. One action amber (on track to deliver) Extension to deadlines agreed for 2 embedded dates MD14: critical care – use of theatre recovery (31.12.16 to 31.3.17) to scope the possibility of providing a supernumerary co-ordinator post out of hours to support the care of critical care patients admitted to theatre recovery if required. SD 10: midwifery / health visitor pathway (31.1.17 to 17.3.17) to gather midwifery feedback on the monthly meetings that are now in place Future oversight of the plan (April 2017 onwards) will be via the risk and compliance group.	Mar-2017	May-2017	WEB	Brendan Brown	Juliette Cosgrove

6598	Corporate	Workforce & Organisational Development	Workforce Development	Jan-2016	There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation. Further essential skills subjects are been identified and added to the list with increasing frequency. This obviously not only extends the period of time the roll out project will take but also leads to a re-prioritisation exercise around establishing which are the key priority essential skills to focus on first.	There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject - the project timeline extends until February 2017, however the risk will remain after this date as changes to the way essential skills are recorded and reported are presently under discussion and review. Compliance measurement will be enabled as each target audience (TA) is set although this is a lengthy process within the confines of the current Learning Management System. The business plan to commission an alternate learning management system has been approved therefore the tendering process is underway, however expected updates to the current system are likely to address many of these issues so interim measures are being established to with a view to keeping the current system if it delivers the planned updates.	1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. A manual system to facilitate the actions above will be require1/ Essential skills training data held is inconsistent and patchy. 4/ There are issues with PC settings which leads to completed e-learning not been recorded as complete. 5/ Planned updates to system not due until April 2017 so limitations as above will remain until this time.	16 4 x 4	16 4 x 4	12 4 x 3	January 2017 Update List reduced to 29 plus 11 specific to maternity areas. FGM now complete, work in progress to complete the priority essential skills and to address the 11 specific to maternity as these require only a small target audience. 14 of the 29 are complete and 9 are in progress. The remaining 6 require increased functionality that will be delivered either by the updates within OLM due in April OR a new LMS. 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. **March 2017** MCA/DoLS work in progress awaiting correspondence from safeguarding team to progress this. Awaiting response re 2 positions from maternity in order to complete the last 2 of the new maternity essential skills. The lead person for OLM target audience setting has now gone on maternity leave. A replacement starts later in the month but there may be a short period where delays are experienced.	Apr-2017	Jul-2017	NA	Jason Eddleston	Pamela Wood
6723	Corporate	Finance	Trustwide	May-2016	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	**March 2017 update:** The forecast capital expenditure is £24.12m against the planned £28.2m. A level of capital expenditure on EPR has now been pushed back to month 12 and a high 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.	Mar-2017	Mar-2017	FPC	Gary Boothby	Kirsty Archer

6829	Family & Specialist Services	Pharmacy	Pharmacy	Aug-2016	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 7.Feb.17 - Feedback expected at end of Feb/early Mar on electrical and mechanical plans along with costings from quantity surveyor **March 2017** Chased up feasibility costs with Engie. Expected within 14 days. HRI unit to be inspected by external auditors on 5 April 2017	Apr-2017	Dec-2018	DB	Brendan Brown	Mike Culshaw

6841	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Sep-2016	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	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. Feb 17 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. **March 17 Update:** - GE Assurance/Gateway report is positive and lists 3 critical issues (listed, plus 8 high & 7 evaluates) that were already highlighted and being dealt with: a/ SRO's to review the FDR gateway exit milestone and approve the work off plan b/ Both Trusts to track the completion, testing and awareness of the SOP's c/ Contingency planning for resource requirements during the intra go-live period. - 3 weeks of Full Dress Rehearsal (FDR) is underway (1-17th of March). This will prove the Cut-over process. - End User Training (EUT) started on the 6th Mar, early signs are positive, engagement is being measured daily. Training figures as at COP 15/03/17: 1300 people trained 3875 (67.88%) staff booked on training 10% DNA rate - The successful completion of the above would mitigate the risk but not enough to lower the score at this point. - Technical readiness is still on plan for the cut-over being the 29th of April.	Apr-2017	Sep-2017	RC	Helen Barker	Mandy Griffin

6715	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Apr-2016	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	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 The Trust now has a cutover and go live date for 1st and 2nd May. Following this a process and reporting mechanism wil **March 2017 Update** EPR training has commenced.	Mar-2017	May-2017	QC	Brendan Brown	Jackie Murphy

6693	Corporate	Workforce & Organisational Development	HR Business Partners	Mar-2016	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 bank cover for short-term demand/pressures Agencies not on PSL being engaged to meet short-term demand/pressures High cost agency workers being engaged to meet short-term demand/pressures No robust action plan yet to replace medium/long-term agency use Evidence of High Cost Medical Locums being engaged to cover annual leave in A&E Trust has not yet embedded internal agency cap levels recommended by Workforce Programme.	15 3 x 5	15 3 x 5	15 3 x 5	**March 2017 Update** FWD tasked to prep new system Allocate (Bank Staff) to replace current VMS and data capture system by 31/03/17. 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 Regional Working Group of MD's to co-ordinate regional approach to determine regional bank solution Business case to be completed by 31/03/17 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.	Apr-2017	Apr-2017	WLG	Ian Warren,	Lisa Cooper, Flexible Workforce Manager

6886	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Nov-2016	The seven day service compliance is a part of one of the five categories that the Single Oversight Framework is judged on. As the trust is an early adopter of the four priority standards (2, 4, 5 and 8) it is expected that full compliance will not be achieved by March 2017. At present the impact of not meeting this is not clear as NHS Improvement have not stated what (if) penalties are in place for un met targets. The panel discussed the likely outcomes of not meeting this deadline (financial? Monitoring? Greater oversight?). It was also mentioned that nationally the target is September 2020, and whether we would expect to be able to meet the standards by this date also. This is due to split site acute services, no additional investment for the extra consultants needed, consultant workforce vacancies and difficulties in recruiting. This will result in inconsistent service delivery over the 7-days and especially at weekends. In turn this may impact on clinical outcomes, patient flow and patient experience. Currently there is no contractual obligation or penalty in not achieving compliance with the four priority standards by March 2017. This may also impact on local and national reputational loss and be focus of future enquiry.	High level action plans are being reviewed with the aim of developing more detailed plans to review what can be achieved within current resources and current configuration of acute services. This will include details of workforce and skill mix, financial implications and full benefits such LOS and patient experience. This will need to take into account what can realistic be achieved with the scope of the 5-year plan. 7DS reports via the Safer Programme.	The main reasons for not achieving compliance include: • Lack of dedicated funding to recruit additional consultants to meet compliance • Existing difficulties in retaining and recruiting to consultant posts within certain specialties especially in Medicine and Radiology • Split-site configuration of hospital services. Whilst the completion of a more detailed action plan will help identify possible solutions towards achieving compliance it is doubtful that within current resources and current configuration of acute services that full compliance will be achieved. Note the national timeline for all trusts to achieve full compliance with the priority standards is 2020 which is before the likely 5-year timeline to reconfiguration of acute services. Also at present whilst there is no financial penalty in achieving compliance this may change in the future.	15	15	9	3 x 5	3 x 5	3 x 3	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. **March 2017 Update** The benchmark for standard 2 has changed from 'time of arrival' to 'time of admission'. Our current compliance with this standard is approximately 80% and so this change should enable near compliance with this specific standard. The next 7DS national survey will be from patients admitted over a seven day period in March with results likely to be available in April 2017. Depending on these results this risk may improve. ANHSI has committed further resource to the Trust to better understand what changes to services could be made to greater achieve compliance, although the timeline to complete this work is still being negotiated.	Mar-2017	Mar-2017	BOD	David Birkenhead	Sal Uka

6924	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Feb-2017	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	THIS	THIS -Operational	Nov-2016	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. **March 17 Update** **T**ender and procurement process for a revised IT security product (Trend to replace Sophos) complete. Risk will be updated and score amended in line with Mitigation as implementation starts in April/May.	Apr-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, 6th April 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - APRIL 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: The Constitution and the Nominations and Remuneration Committee (MC) terms of reference will be considered at the Membership Council meeting on Wednesday 5 April 2017.	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:-
- Board of Directors' Attendance Register
- Nominations and Remuneration Committee (Membership Council) Terms of Reference
- Board work plan

The Trust Constitution is also being considered by the Membership Council on Wednesday 5 April and the Chairman will provide a verbal update on the outcome of that discussion.

Main Body

Purpose:

This report brings together a number of items that evidence or strengthens the corporate governance arrangements and systems of internal control within the Trust.

1. Board of Directors attendance register
The Trust's Standing Orders state that 'the names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors.' The attendance register from April 2016 to March 2017 is
attached at appendix 1.

The Board is asked to NOTE the attendance register.

2. The Nominations and Remuneration Committee (Membership Council) terms of reference were reviewed at the last meeting in March. These are being presented to the Membership Council for approval on Wednesday 5 April.

Subject to that approval the Board is asked to RATIFY the terms of reference at appendix 2.

3. Board work plan
The Board work plan has been updated and is presented to the Board for review at appendix 3.

4. At its meeting on Wednesday 5 April, the Membership Council will consider an amended Constitution for approval. One of the items for discussion is the name of the Council and consideration being given as to whether to change the name to Council of Governors in line with the majority of other Trusts nationally. An update on this discussion will provided to the Board at the meeting and the full Constitution will be presented at the next public Board of Directors meeting.

Background/Overview:

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The Issue:

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Next Steps:

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Recommendations:

The Board is asked to:
1. NOTE the attendance register
2. RATIFY the Nominations and Remuneration Committee (MC) terms of reference.

3. REVIEW the work plan.
4. NOTE the outcome of the Membership Council discussion on the Constitution.

Appendix

Attachment:

COMBINED GOVERNANCE REPORT (2).pdf

Attendance	✓	Apologies	×	Not BOD members	-

ATTENDANCE REGISTER – BOARD OF DIRECTORS
1 APRIL 2016 – 31 MARCH 2017

DIRECTOR	28.4.16	26.5.16	30.6.16	28.7.16	25.8.16 (provision) NO MEETING	15.9.16 JOINT BOD/ MC AGM	29.9.16	27.10.16 MEETING RE-ARRANGED TO 3.11.16	3.11.16	1.12.16	5.1.17	2.2.17	2.3.16	TOTAL
A Haigh (Chair)	√	√	√	√	N/A	√	√	N/A	√	√	x	√	√	10/11
D Anderson	√	x	√	√	N/A	√	x	N/A	√	√	√	√	√	09/11
Helen Barker	√	√	√	√	-	√	√	-	√	√	√	√	√	11/11
D Birkenhead	√	√	x	√	-	√	√	-	√	x	√	√	√	09/11
G Boothby (Interim DoF from 1.11.16)	-	-	-	-	-	-	√	-	√	√	√	√	√	06/06
B Brown (from 13.6.16)	-	-	√	√	-	x	√	-	√	√	√	√	√	08/09
K Griffiths (resigned 28.10.16)	√	√	√	√	-	√	x	-	-	-	-	-	-	05/11
K Heaton	√	√	√	√	-	x	√	-	√	x	√	√	√	09/11
L Hill	√	√	x	√	-	x	√	-	√	√	√	√	√	09/11
R Hopkin	√	√	√	√	-	x	√	-	√	√	√	√	√	10/11
P Oldfield	√	√	x	√	-	x	x	-	√	√	√	√	√	08/11
L Patterson (Sabbatical leave 1.1.16 to Sept 2016)	-	-	-	-	-	√	√	-	√	√	√	√	√	07/07
P Roberts	√	√	√	√	-	x	√	-	√	√	√	√	√	10/11
I Warren (from 1.8.16)	-	-	-	-	-	√	√	-	√	√	√	√	√	07/07
O Williams	√	√	√	√	-	√	√	-	√	√	x	√	√	10/11
J Wilson	√	√	√	√	-	√	√	-	√	√	√ (Acting Chair)	√	√	11/11
Vicky Pickles	√	√	√	√	-	√	√	-	√	√	√	√	√	11/11
J Green (Interim Dir W & OD from April 2015 – 30.6.16)	√	√	x	-	-	-	-	-	-	-	-	-	-	
A Basford	√	√	√	√	-	√	√	√	√	√	√	√	√	
Mandy Griffin	√ (private)	√	√	√	-	√	√	-	√	√	√	√	√	
Lindsay Rudge (Acting DoN)	√	√	-	-	-	√	-	-	-	-	-	-	-	

~~APP C~~

NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)

TERMS OF REFERENCE

Version:	1.1 First draft circulated for review to Chair – 13.10.15 1.2 Draft submitted to Membership Council for approval – 4.11.15 1.3 Draft submitted to Board for approval – 26.11.15 1.4 Reviewed by Noms and Rems Committee 8 March 2017
Approved by:	Board of Directors & Membership Council
Date approved:	~~4.11.15 and 26.11.15~~ 5.4.17 (MC) & 6.4.17 (BOD)
Date issued:	
Review date:	March 2018

NOMINATION AND REMUNERATION COMMITTEE TERMS OF REFERENCE (MEMBERSHIP COUNCIL)

1. Constitution

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

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

2. Authority

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

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

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

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

3. Conflicts of Interest

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

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

4. Nominations role

The Committee will:

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

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

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

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

expertise needed on the Board of Directors in the future.

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

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

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

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

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

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

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

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

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

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

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

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

5. Remuneration role

The Committee will:

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

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

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

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

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

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

5.4.2 reflect the time commitment and responsibilities of the roles;

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

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

5.5 Oversee other related arrangements for Non-Executive Directors.

6. Membership and attendance

6.1 The membership of the committee shall consist of at least six Membership Councillors appointed by the Membership Council, four of whom must be public Membership Councillors.

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

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

7. Secretary

7.1 The Board Secretary shall be the secretary to the Committee

8. Attendance

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

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

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

9. Frequency of Meetings

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

10. Minutes and Reporting

10.1 Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to all members of the Membership Council unless a

conflict of interest, or matter of confidentiality exists.

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

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

11. Performance Evaluation

11.1 The Committee shall review annually its collective performance.

12. Review

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

DRAFT BOARD WORK PLAN 2017-2018 - WORKING DOCUMENT - SUBMITTED TO BOARD 6 APRIL 2017 – UPDATED 22.3.17 (v1)

Date of meeting	6 April 2017	4 May 2017	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
Date of agenda setting/Paper Review of drafts	28.3.17	24.4.17	22.5.17	26.6.17	24.7.17	28.8.17	25.9.17	23.10.17	27.11.17			
Date final reports required	29.3.17	26.4.17	24.5.17	28.6.17	26.7.17	30.8.17	27.9.17	25.10.17	29.11.17			
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework (Quarterly)	-	✓	-	-	✓	-	-	✓	-	-	✓	-
DIPC report	-	✓	-	Annual Report	✓	-	-	✓	-	-	✓	-
Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance report: to include such items as:												
- Standing Orders/SFIs/SOD review								✓				
- Non-Executive appointments (+ Nov - SINED & Deputy)								✓				
- Board workplan			✓			✓			✓			✓
- Board skills / competency									✓			
- Code of Governance	✓											

Date of meeting	6 April 2017	4 May 2017	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
- Board meeting dates						✓						
- Committee review and annual report												✓
- Annual review of NED roles								✓				
- Use of Trust Seal			✓			✓			✓			✓
- Quarterly Feedback from NHSI			✓			✓			✓			✓
- Declaration of Interests (annually)												✓
- Declaration of Interests Policy (Jan 2018)			TBC									
- Declaration of Interest – outcome from Consultation			TBC									
- Attendance Register (Apr+Oct 2017)	✓					✓						
- BOD TOR + Sub Committees												✓
- Constitutional changes (+as required)											✓	
- Compliance with Licence Conditions (April 2018)												
- Board to Ward Visits Feedback			✓			✓			✓			✓
Care of the acutely ill patient report	✓			✓		✓		✓		✓		✓
CQC Assessment Update on Action Plan										✓		
Patient Survey				✓								✓
Quarterly Quality Report (+ QA in Annual Report)	✓	Quality A/cs	✓			✓			✓			✓
Colleague Engagement /Staff Survey (NB - Gold Standard by 2018 and Platinum Standard by 2020 agreed at 25.2.16 BOD)	✓					✓						✓
Nursing and Midwifery Staffing – Hard Truths Requirement		✓						✓				
Safeguarding update – Adults & Children		✓ Annual report						✓				

Date of meeting	6 April 2017	4 May 2017	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
Review of progress against strategy (Qly)			✓					✓				
Plan on a Page Strategy Update			✓									
Quality Committee update & mins	✓	✓	✓	✓	✓			✓		✓	✓	
Audit and Risk Committee update & mins	✓	✓		✓	✓			✓		✓	✓	
F&P Committee update & mins	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Well Led Workforce Committee update & mins	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
Performance Management Framework – update on work from sub-committee workplans		✓										
ANNUAL ITEMS												
Annual Plan												✓
Annual Plan feedback from Monitor						✓						
Annual report and accounts (private)		✓ EO										
Annual Quality Accounts		✓ EO										
Annual Governance Statement		✓ EO										
Appointment of Deputy Chair / SINED						✓						
Board Development Plan											✓	
Emergency Planning annual report						✓						
HPS Annual Report		✓										
HPS Business Plan											✓	
Health and Safety annual report			✓					✓ (update)				
Capital Programme												✓
Equality & Inclusion				✓ (update)						✓ (AR)		
DIPC annual report			✓									
Fire Safety annual report			✓									

Date of meeting	6 April 2017	4 May 2017	1 June 2017	6 July 2017	3 Aug 2017	7 Sept 2017	5 Oct 2017	2 Nov 2017	7 Dec 2017	Jan 2018	Feb 2018	March 2018
Medical revalidation & appraisal				✓								
Whistleblowing Annual Report											✓	
Review of Board Sub Committee TOR								✓				
Risk Appetite Statement from Board (Nov 2017)								✓				
Winter Plan									✓			
ONE-OFF ITEMS												
Membership Council Elections				✓								✓
Single Oversight Framework (VP/GB)						✓						
Hospital Pharmacy Transformation Plan (AB/Mike Culshaw)												
Risk Management Strategy										✓		
Workforce Strategy											✓	

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 6th April 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: CQC Update on Action Plan - This paper provides an update on the delivery of the Trust's response to the CQC report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: WEB and Quality Committee	
Governance Requirements: Keeping the Base Safe.	
Sustainability Implications: None	

Executive Summary

Summary:

This paper provides an update on the delivery of the Trust's response to the CQC report.
The plan is based on the 19 must do and 12 should do actions detailed in the CQC report which was published on 15th August 2016.

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

The next update report for May 2017 will include a year-end position against all of the actions in the plan.

The Board of Directors are asked to approve the movements in the plan as recommended by the CQC Response Group and approved by the Trust Quality Committee.

Main Body

Purpose:

Please see attached paper.

Background/Overview:

Please see attached paper.

The Issue:

Please see attached paper.

Next Steps:

Please see attached paper.

Recommendations:

The Board of Directors are requested to:

1. Approve the movements in the plan (detailed in section 2) from March 2017 as recommended by CQC Response Group.

2. Note the one outstanding amber action.

3. Note that a year-end position against all of the actions in the plan will be included in the May 2017 update.

Appendix

Attachment:

Combined CQC Action Plan Update.pdf

BOARD OF DIRECTORS

CHFT Care Quality Commission (CQC) update March 2017

1. Context / Background

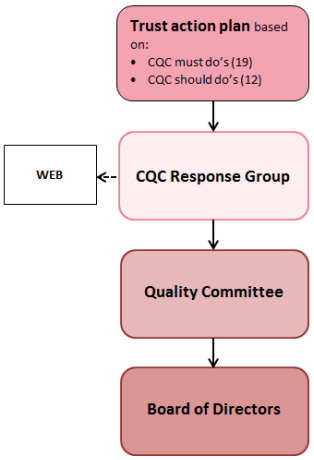
Following the publication of the Trust CQC action plan on 15th August 2016, a detailed plan was developed for all of the must and should do actions and governance arrangements were agreed.

This paper presents the current position with the plan, which is made up of 19 must do and 12 should do actions and details the movement against the target dates using BRAG rating.

Rating	*Must do*	*Should do*	*Total*
Delivered and sustained	*12*	*10*	***22***
Action complete	*7*	*3*	***10***
On track to deliver	*1*	*0*	***1***
No progress / Not progressing to plan	*0*	*0*	***0***
Total	***20***	***13***	***33***

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.*

Governance arrangements



2. Action Plan – movements

The plan was considered and challenged at the CQC Response Group on 6th and 20th March 2017 and the Group agreed to recommend the following BRAG rating movements in the plan:

MD1	Staffing	BRAG rating from **Green** to **Blue**
MD2	Governance Processes	BRAG rating from **Green** to **Blue**
MD11	Maternity Patient Experience	BRAG rating from **Green** to **Blue**
MD13	Third and Fourth degree tears and PPH	BRAG rating from **Green** to **Blue**
MD17	Complaints	BRAG rating from **Green** to **Blue**
SD1	Medical Devices (Cty)	BRAG rating from **Green** to **Blue**
SD5	End of life strategy and vision	BRAG rating from **Green** to **Blue**
SD6a	Paediatric provision adult OPD areas	BRAG rating from **Green** to **Blue**
SD7	Signage – HRI and Acre Mill*	BRAG rating from **Green** to **Blue**
SD10	Midwifery health visiting pathway	BRAG rating from **Green** to **Blue**

* This has been signed off as blue, with all arrangements in place for the new signage to be installed; however further testing will take place from a patient perspective once the installation programme is complete.

The update report for May 2017 will include a year-end position against all of the actions in the plan.

3. Amber actions

There is 1 remaining amber action on the plan:

- **MD3** *The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.* The deadline for the delivery of this action is the end of March 2017. Actions to validate current records and cleanse the data have been completed. Achievement of 100% compliance with appraisals by 31.3.17 is on track; however performance for the 4 elements of mandatory training is

below the 100% target:
Information Governance = 69.5%; Infection control = 71.5%; Moving and handling= 90.9%; Fire safety = 70.5% (at 28.3.27)
The revised Essential skills programme is on track to commence from April 2017.
The performance position in relation to mandatory training was escalated to Executive Board. It was recognised that the revised go-live date for the electronic patient record meant that EPR training was mandatory and would impact on the year end. A recommendation was made to the Board of Directors that Divisions be asked to concentrate on EPR Training and four of the mandatory training modules. This position remains challenging given the focus on EPR and is being managed through Divisional performance arrangements.

4. Actions currently not achieving / not on track to achieve the action delivery / embedded dates

MD3	Mandatory and Essential Skills Training and Appraisals	**Issue:** See section 3 above

5. Future management of the plan

The final meeting of the existing CQC response group will take place on 4th April 2017, following this oversight of the plan will transfer to the Risk and Compliance Group where the focus will be:

- Monitoring the impact of the actions delivered through the plan,
- Delivery of the CQC fundamental standards and associated regulations
- Responding to the revised inspection regimes.

The Board of Directors are requested to approve the recommendations made by the CQC Response Group and approved by the Trust Quality Committee: to move the BRAG ratings for the actions listed under section 2, note the one outstanding amber action and that a year-end position against all of the actions in the plan will be included in the May 2017 update

6. Monitoring arrangements

Monitoring of the plan follows the governance arrangements described below:

Governance arrangements

CQC Response Group:	Oversee the delivery of the plan, monitor progress, sign off actions, agree submission of sustained position to the Trust Quality Committee (must and should do actions)
Trust Quality Committee:	Provide assurance to the Board that the plan is achieving the expected impact and give final sign off for sustained actions.
WEB:	Receive a monthly report ahead of the Quality Committee, in order to be informed of any emerging concerns and agree any actions required by WEB.
Divisional PSQBs:	Oversee the delivery of the core service plans; escalate to Divisional performance meetings by exception any impacts on performance requiring Executive support, provide progress updates to the CQC Response Group.

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				12	10
Action complete				7	3
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	Blue
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	Blue
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 • ~~>90%~~ appraisal in last 12 months and at year end Agreed target is 100%	Monthly / Cumulatively / Year End-~~(90%)~~ 31..3.17 Agreed target is 100%	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

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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	~~31.12.16~~ 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	~~31.10.16~~ 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	~~31.12.16~~ 31.3.17	Director of Nursing	Director of Pharmacy	Green

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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	Blue
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	Blue
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	~~31.12.16~~ 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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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	~~31.10.16~~ 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)	Blue
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	~~31.10.16~~ 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					

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	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	Blue
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	Blue
Responsive	Children & Young People	FSS Performance Meeting	**CQC SD6 (C&YP 17 and ED?)**	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	~~31.10.16~~ 30.11.16	~~31.12.16~~ 31.3.17	Director of Nursing	Associate Director of Nursing for FSS	Blue
							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

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	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	~~31.1.17~~ ~~28.2.17~~ 17.3.17	Director of Estates & Facilities	Associate Director of Estates & Facilities	Blue
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	~~31.12.16~~ 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	~~31.1.17~~ 17.3.17	Director of Nursing	Associate Director of Nursing for Community (working with Associate Director of Nursing for FSS)	Blue
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
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Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 6th April 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Quarterly Quality Report – Quarter 3 Presentation - The Board is asked to approve the contents of the Quarterly Quality Report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee - 30 January 2017	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached.

Main Body

Purpose:

Please see attached paper.

Background/Overview:

Please see attached paper.

The Issue:

Please see attached paper.

Next Steps:

Please see attached paper.

Recommendations:

The Board of Directors is asked to approve the contents of the report.

Appendix

Attachment:

QQR_Q3.pdf

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Quarterly Quality Report
Q3 2016-17

Quality Committee 30 January 2017

Board of Directors 6 April 2017

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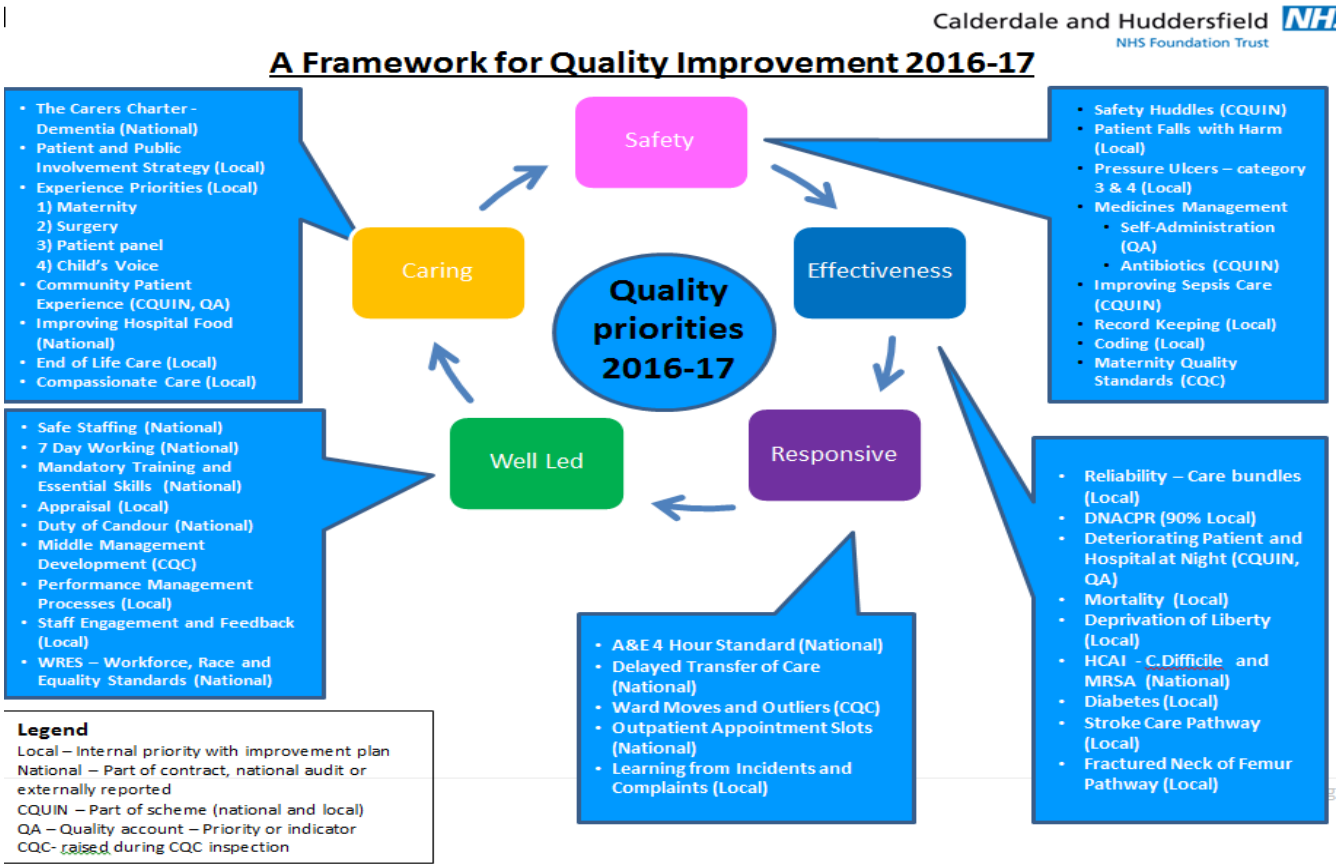
Quality Priorities



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Summary

Indicator	Target	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17
HSMR	100	104.14	105.06	113.94	106.12	103.74
SHMI	100	108.9	111.3	113.88	112.21	113.34
A&E within 4Hr Performance (Incl. CH)	95%	95.08%	90.07%	94.10%	94.40%	93.81%
% VTE Risk Assessments	95%	95.30%	95.20%	95.10%	95.10%	95.10%
MRSA	0	6	0	0	0	1
C. Difficile	6	7	8	6	11	6
Friends and Family Response Rate (Inpatient)	28%	31.60%	31.30%	32.80%	35.00%	33.50%
Friends and Family Response Rate (A&E)	14%	10.30%	9.50%	14.50%	12.40%	13.70%
Staff Sickness (YTD)	< 4.00% - Green 4.01 -4.5 Amber >4.5% Red	4.96%	4.69%	4.45%	4.19%	4.38%

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Quality Account and CQUIN

- **Quality Account –** on track with all 3 priorities
  - Falls reduction – introduction of safety huddles
  - Patient experience in the community
  - Introduction of Hospital Out of Hours Programme
- **CQUINS**
  - Local – all local CQUINS achieved
  - National – all on track except sepsis (awaiting data)

Safe

- **Falls prevention**
  - falls prevention plan reviewed
  - MAU improvement team identified
  - review of learning from avoidable falls incidents planned
- **Sepsis**– small improvement in sepsis indicators being seen. New group established chaired by Dr Ashwin Verma
- **Maternity** – PPH < 1500 mls at lowest level all year 1.3% in November
  Pressure Ulcers
  - reduction in category 3 / 4 pressure ulcers in community
  - static position for hospital acquired pressure ulcers

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Effective

- **Mortality** – HSMR continues to improve (102.9), 46% deaths (724) reviewed in 12 months from November 2015 , 98.8% not preventable
- **Safeguarding-** improvements in level 3 safeguarding children training rates
- **Reducing Hospital Acquired Infection** – 1 case MRSA bacteraemia in December in the Medical Division
- **Caring for frail patients –** community team strengthening services to prevent admissions
- **Clinical coding** – improved quality and depth of coding with better clinical engagement – 5.31 in Dec 16, up from 4.74 in Dec 15
- **Stroke –** Invited Service Review highlighted some areas of good practice, action plan being developed.

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Effective- HCAI

Indicator	Q3 performance	On Track?
Meeting the MRSA bacteraemia (Trust assigned)	1	Over Trajectory
Meeting the C-diff target (Post 48 hours)	6	Over Trajectory
MSSA Bacteraemias	5	On Track
E-coli rates	10	Over Trajectory

Responsive

- **Complaints**
  - – backlog of overdue complaints responses cleared in early December
  - 109 complaints closed in November 2016
  - measures in place to ensure sustainability of responsiveness
- **Learning from adverse events**
  - – staff survey on learning and barriers to learning completed
  - 4 focus groups held
  - findings and recommendations to Serious Incident Review Group (February 2017)
- **Incidents** – divisional orange incident panels working effectively resulting in improved learning
- **Emergency Care 4 hour standard** – 93.81%, 317 patients waited over 8 hours.
- **Medical outliers -** general improvement

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Well Led

- **Flu CQUIN achieved**
- **Safer community ward** – opening up of Community Place
- **Duty of candour** – sustained improvement with duty of candour in Q3
- **BME –** leadership course offered to staff
- **Sickness and absence** – increasing number of return to work interviews

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, 6th April 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: EPR Readiness Update - The Board is asked to accept the report as assurance that the necessary progress is being made for CHFT to undertake a successful go-live in early May 2017.	
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 EPR programme is progressing well and is now within the 30 day window for implementation. Reflecting the proximity the format, function and attendance at meetings has been reviewed with a more combined approach between operational and technical teams. A single master spreadsheet of key issues for Operations is in place and is being used as a checklist, but also repository for concerns and questions as they are raised by teams locally. In addition, a lessons learned document is also now being populated. Communications are activity involved in all elements of the programme to ensure clarity and consistency of message. The overall programme for CHFT is now rated 'yellow', i.e. all items will progress to schedule.

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 accept the report as assurance that the necessary progress is being made for CHFT to undertake a successful go-live in early May 2017.

Appendix

Attachment:

EPR Readiness Update - BOD - 06 04 17.pdf

EPR Readiness Update
Board of Directors April 2017

Presented by:	Helen Barker – Chief Operating Officer	Author:	Mandy Griffin, Director of the Health Informatics Service, Jackie Murphy, Deputy Director of Nursing and Helen Barker, Chief Operating Officer
Previously considered by:	N/A		

Key points	Purpose:
Operational and technical planning and monitoring is now combined	To inform
Training is progressing well with high volumes of staff booked and completing.	To Inform
Outpatients is high risk due to approach of Divisions in clinical scheduling and through the lack of a 724 solution	To discuss and note
FDR went very well, the outputs have been signed off by both CEOs	To discuss and note
Programme risks have significantly reduced and are, for many risks, close to target position.	To note and gain assurance

Executive Summary

The EPR programme is progressing well and is now within the 30day window for implementation. Reflecting the proximity the format, function and attendance at meetings has been reviewed with a more combined approach between operational and technical teams.

A single master spreadsheet of key issues for Operations is in place and is being used as a checklist but also repository for concerns and questions as they are raised by teams locally. In addition a lessons learned document is also now being populated.

Communications are activity involved in all elements of the programme to ensure clarity and consistency of message.

The overall programme for CHFT is now rated 'yellow' i.e. all items will progress to schedule

Recommendation
The Board is asked to accept the report as assurance that the necessary progress is being made for CHFT to undertake a successful go-live in early May 2017.

EPR Operational Readiness Update
Board of Directors April 2017

Purpose

This paper provides a high level current position in terms of readiness for the implementation of the Electronic Patient Record at Calderdale and Huddersfield Foundation Trust (CHFT) as of April 2017.

Background

The Trust in partnership with Bradford Teaching Hospitals NHS Trust (BTHFT) and Cerner commenced the work to build and implement an Electronic Patient Record (EPR) in May 2015. The Trust has agreed a cutover date of the 28th April 2017 with a proposed go-live date of May 2nd 2017. CHFT has made significant progress in the Programme since the last Board update in February 2017. The project status is currently rated as yellow; this is in line with the final GE Finnamore external gateway review carried out in February. Overall, the GE review team found evidence of good practice in the organisation and significant progress in preparing for a successful implementation. The overall delivery confidence assessment was amber /green, they state "this reflects the view that a successful go-live at CHFT is probable".

Operational Arrangements

The monthly Programme Boards have now been increased to fortnightly and are chaired by the CHFT Chief Operating Officer, in addition to the Divisional operational meetings that seeks assurance utilising the operational checklist. Assurance is sought against the project status, technical readiness, workstream activity, change, finance and risk. The Programme's key focus during February and March has been:

Data Migration

In order to test the quality of data migrated, a Full Dress Rehearsal (FDR) commenced on 27th February 2017. This activity was a critical step towards go-live, it ensured that the system is fit for purpose and allows the programme team to confirm timings for the cutover plan. A full list of issues was captured during this period and reviewed by the workstream leads. The issue is either; resolved, included in cutover plans or added to the FDR to Cutover "Work off Plan". This work off plan will be used in conjunction with the Master Copy of EPR Operational Checklist to focus the programme and operational teams on the required daily activities to be completed to drive towards a successful cutover and go-live. These combined activities will drive the programme, meetings and reporting for the remaining period between FDR and cutover. One of the more significant issues identified during FDR was in regard to the Trust Personnel Database and producing a single source of the truth so on go-live all colleagues are able to gain access to the system. Progress is being made with input from the divisional teams; the issue has been raised as high risk for go-live.

GE Finnamore recommended the work-off plan should be signed off by the Chief Executives from CHFT and BTHFT; this was completed 22nd March 2017. The Cerner view is that the FDR Exit report, work-off plan and operational checklist provided sufficient confidence to proceed to CHFT Cutover.

Reporting

Overall FDR testing went better than expected, considering only a 2 week window was allocated. The majority of the FDR checks were successfully carried out at a high level and the results were as we had expected. Further granular checks on PIEDW (Cerner data warehouse) tables will be carried out up until cutover.

RTT achieved a 67% success rate in terms of pathway migration and the impact of this on actual performance has yet to be confirmed. Work is continuing to secure a minimum of 90% migration and assurance on reported 'incomplete' performance.

Operational reports at cutover have been identified and work is ongoing to ensure these can be produced. A review of ongoing operational reporting is underway to identify where an automatic extract from Cerner can replace internally produced documents.

To ensure data quality the Trust has invested in 'Cymbio' which is an assurance system used across several Trusts who have implemented an EPR. This will ensure daily tracking of reporting from go-live and will be supported by a daily access meeting and a team of validators. A Task & Finish group is currently concluding implementation and ongoing governance arrangements.

Training

Training commenced on the 6th March 2017 and will continue to 28th April covering an 8 week period. Good progress is being made, figures up to and including the 27th March 2017 are shown below;

Booking Summary

Division	Total To Train	Total Booked	% Booked	Not Booked
372 CHFT Staff Bank L3	754	167	22.15%	
372 Community L3	683	511	74.82%	172
372 Corporate L3	358	126	35.20%	232
372 Estates & Facilities L3	96	35	36.46%	61
372 Families & Specialist Services L3	1609	1301	80.86%	308
372 Health Informatics L3	216	73	33.80%	143
372 Medical L3	1590	1534	96.48%	56
372 Pharmacy Manufacturing Unit L3	64	1	1.56%	63

372 Surgery & Anaesthetics L3	1262	1112	88.11%	150
CHFT Student	200	119	59.50%	
CHFT Temporary	250	187	74.80%	
Total	5878	4693	82.24%	1994.00

Bookings Cancelled by User	768
Bookings Rejected by Line Manager	424
EPR Friends 3 Bookings	548
Total EPR End User Training Bookings	5565

Attendance to up to 27/3/17

Total Attended To Date	2616
DNAs To Date	327
Assessments failed To Date	35

The detail behind these figures are passed to the Divisions each day, processes are in place that allows each Division to ensure their workforce colleagues attend training, re-book when necessary or organise additional support. The go-live “safe target” is 80%. Currently progress is indicating that CHFT should exceed this. Mitigation is provided in additional capacity being put in place as required.

Feedback is actively sought after all training sessions and, where appropriate, changes have been implemented quickly where concerns have been raised. Medical training has raised awareness of Consultants of the changes which is causing some nervousness about timings, these individuals and teams are being supported by Divisional teams and EPR colleagues and they all have access to the play domain.

Business Continuity

Our aim is to deploy a downtime solution that will enable the Trust to continue to safely care for patients should the EPR system fail for any reason. Our expectation is that the solution would provide a process for both inpatients and outpatients.

As part of the EPR deployment we procured the Cerner 724 Downtime Solution. This provides access to patient information and clinical documentation / e-prescribing should there be an unplanned downtime (network or power or main EPR system fail) or planned downtime (system upgrades). Currently there is some risk attached in delivering in line with.

The Trust's initial requirements. Work is on-going to resolve the risks and issues; it is likely that a satisfactory solution will be achieved for inpatients but as yet there is not a solution for outpatients which reflecting the high volume of pathways, is a risk. Options to mitigate risks are being explored and the current Outpatient Business Continuity plans are being refreshed.

The Trust have also secured the services of an experienced business continuity planner to support operational teams in the development of action cards for business continuity in additional to a single, clear electronic business continuity plan. This process will ensure adequate plans in place prior to cutover.

Device Management

An audit of all the wards and departments has now been completed. The areas previously considered out of scope have now been visited; as a result, the device requirement has risen. Following training and the increased understanding of the system, departments and teams are now requesting additional hardware. We have ensured that the base is kept safe with the level we are providing. After go-live, further analysis will be undertaken to assess appropriate deployment and distribution across all sites. Roll out has commenced and is on track to complete in readiness for go-live.

Standard Operating Procedures

There is good recognition of and engagement in the development of Standard Operating Procedures (SOPs) across the organisation however joint sign off has been slower than anticipated. The target date for completion is 31st March for all but three areas, Order Comms, Clinical Documents and NerveCentre were formally deferred to support FDR and are now scheduled to complete on 10th April. The position is detailed in the table below:

	CHFT	BTHFT
Total SOPS	327	317
Total signed off as now	227	231
Total still to be signed off	100	86
Total to sign off by end March	19	15
Total left to sign off by 10-Apr	81	71
Order comms	12	12
Clin docs	21	21
Nervecentre	10	0
Others	38	38
Total	81	71

The number of SOP's required was calculated during the future state analysis completed at the beginning of the programme.

Specific focus is being applied to areas where there is a fractured SOP i.e. where staff have to utilise 2 systems for a single pathway or patient. Testing of these is stringent with sign off by appropriate senior operational manager. No issues have been raised with this process.

Capacity / Activity / Outpatients

The original plan for all clinics was to increase length of clinic but retain the same number of patients; this would secure RTT maintenance. A 1:1 meeting took place with each Consultant and other staff who deliver clinics to agree templates. Through these meetings a significant number of clinicians were offered a choice of reduction in patient numbers or increased clinic time which was not the agreed position.

Divisions have worked with clinical staff to ensure that any lost activity is made up between 1st April and 31st May and clinic templates have been amended and locked. From this there is a small cohort of approximately 800 follow ups in Medical specialties that will be delivered post May and are being phased into plans.

Where concerns have been raised by individuals or teams post training bespoke support has been provided for example a Video Conference with a Consultant from West Suffolk.

Refreshments have been arranged for all clinics at go live reflecting the potential for increased waiting times, patients have been notified when invited for their appointment and the free time car parking has been extended on all meters.

EPR Friends

Three sessions of training are being delivered by the EPR Training Team to standard EPR Friends who will be End Users of the system. Session 1 is an overview, Session 2 is what to expect during go-live/ELS and how to support your colleagues and Session 3 is role-based training focusing on questions they are likely to be asked by colleagues using EPR in the way they do.

There are 550 standard EPR Friends within the organisation who will be further supported by Executive Friends, THIS Friends and Hospitality Friends, all of which undertake a role to support the smooth cutover and ELS. Additionally, regular update briefings are being held with all EPR Friends.

All clinical areas have identified the zones for EPR friends and these will be supernumerary at go live, this plan has been reviewed and agreed by the Cutover Manager who has then overlaid the EPR Floorwalkers. Some challenges remain to ensure all clinical shifts are staffed in addition to the EPR friends and this is being tightly monitored through nursing teams.

Types of EPR Friends:

The main group of EPR Friends – This largest group of EPR Friends will be End Users of the system and will provide the first line of support over the go-live and Early Live Support (ELS) period and into BaU. A joint letter from the Director of Informatics and the Chief Operating Officer is being sent personally to all EPR friends to thank them in advance and ensure clarity of roles and responsibilities which will include a requirement to work flexibly across all areas should the need arise.

The Executive Friends – Including Divisional Directors and other Senior Managers who are generally not going to be End Users of the EPR but will provide leadership support over the go-live and ELS period.

The Informatics EPR Friends – As another group that will not generally be End Users of the EPR it is proposed that this group will provide specific types of support over the cutover and go-live/ELS period.

The Go-Live Volunteers – As another group of staff that will not be EPR End Users e.g. staff from HR, Finance, Estates & Facilities and Trust Volunteers etc. Go-live volunteers will also be allocated specific areas of the hospitals to provide general support; signposting colleagues to the right place to get any issues resolved and explaining to patients about the new system and its benefits etc.

Floorwalkers

Floor walking teams are now in place (Ideal agency) and their management team has started engagement and are on site to plan the final allocation, preparation and mapping of floorwalkers to the relevant locations based on their skills. We are currently also looking at an additional 10 'desk walkers' to support the service desk during the cutover and early live support period.

Command and Control

During the cutover and ELS period the Trust will be running two, connected, Command and Control structures (one technical and one operational).

GOLD - Executive Directors level (meeting by exception),

SILVER x 2, 1 Operational & 1 Technical with a direct communication between the two. Key figures will be the Operational site lead, Divisional Leads and Programme Lead who will attend both sets of meetings to ensure consistency of message and identification of key interdependency

BRONZE x 2 teams Operational teams within each Division and the Trainers/EPR Leads for technical issues.

A full C&C plan and meetings structure has been shared with both operational and technical teams, amended following feedback and is shortly to be published along with a Roles and Responsibilities document.

Cutover and ELS

Following FDR, a detailed plan has been developed to ensure all activities are resourced appropriately across an agreed timeline. Decision points will form part of this timeline as the sequence of events is critical to success. All decision points need to achieve 100% in order to move to the next activity, all the way through to go-live. Briefings are underway with all colleagues through CHFT communication routes to ensure this is understood.

Operationally plans have been developed and reviewed for cutover at the Operational Readiness meetings to ensure safe and effective patient care and flow can continue through Cutover. This includes additional staff on key shifts, documentation packs, and communication devices cessation of all non-essential clinical activity.

A process for ensuring operational readiness for cutover and go live is in place and a leadership rota has been fully populated to support staff and patients. External stakeholders have been involved in planning and work is currently looking at how to secure a bed occupancy reduction at cutover. A request for support from BTHFT for both clinical and administrative shifts was made but as yet no formal response has been received. Early feedback suggests some administrative volunteers but clinical capacity is a challenge.

It should be noted that the Tour de Yorkshire takes place on the same weekend at cutover, this was considered by the EPR programme team and the Operational team, previous year's impact assessed and a decision taken to continue with implementation as planned. A table top exercise is scheduled prior to cutover to test plans should a major incident occur simultaneously with cutover and assurance of the outcome will be provided to NHSE

Specific attention has been placed around admin teams at cutover and ELS especially within the Booking/Outpatient services and whilst there is a request for internal staff to support the manual data migration we have excluded this group reflecting the need to ensure all other booking activity is robust and that the deferred referrals can be managed in a timely manner.

Backlogs

All elective activity has been reviewed and areas where backlogs have been identified have a clear trajectory to minimise prior to 28th April

E-Referrral

Work has been undertaken with GPs and Practice Managers to agree mitigations to the requirement to close to e-referrals for 1 week prior to go-live. Partners have been extremely supportive of the plan despite this impacting on their resources as all referrals deferred will have to be processed once the system is switched on.

Work is still ongoing with NHS Digital to enact this freeze.

Cancer fast track referrals will continue as per current route and a separate referral process has been agreed for non-cancer urgent referrals to ensure no delays for clinically urgent patients.

Manual Data Input

The capacity required to complete all manual data and information input has been calculated, volunteers are being requested for the data input from Trust and BTHFT staff and the EPR trainers are scheduled to complete the clinical information transcription from cutover. BTHFT & CHFT Directors of Pharmacy are working to populate the transcription teams and a Consultant has been identified as the supervising officer

Communications

The Communications team are heavily involved in all aspects of the programme, work has been completed through GP practices to listen to patients needs through the change, EPR communications boards are in place in all wards and departments, a patient leaflet has been developed for all attenders to the Trust as we implement and a 'get ready for EPR' campaign is live on all Trust screensavers.

Current Top Risks

The EPR and Operational teams are meeting together a minimum of twice weekly and a single master spreadsheet is in place, themed into key work areas with the relevant queries and issues. This is updated weekly and shared with wider Divisional colleagues. Many items have been closed although weekly more queries are added, this ensures there is a single clear list of items to be concluded as part of implementation and will form part of the operational final readiness checklist.

In addition the programme has a formal risk register that is reviewed in detail at a sub group of the Programme Board and discussed bot at the beginning and end of each Programme Board. There has been an accelerated reduction in risk scores as the programme moves closer to implementation. The key risks currently exercising the Programme are:

- Inaccurate Trust Personnel Database – Cerner require a list of all staff, their professional registration detail, smart card ID and Trust login by 3rd April. The initial collation of this, when validated, was not complete and is currently being worked through between EPR, HR and Divisions. Progress is being made on a daily basis with input from the divisional teams
- 724 Clinical Configuration – 724 has limitations particularly in the outpatient areas. Joint working is being undertaken to try to mitigate this.
- Financial Pressures caused by delayed go live – this has been on register for some time. The mitigation date is currently for CHFT go live but will move to BTHFT go live after May.
- Noncompliance with RTT reports/drop in RTT performance – This is a known risk factor from other go-lives. Testing continues and the deployment of Cymbio should mitigate the risk once we have secured a minimum 90% migration success rate.
- Staff awareness and anxiety – once staff have undertaken training there is a recognised risk that people will become anxious and seek reassurance. Operation and EPR teams are sharing information on areas of risk and are working together to ensure appropriate support is provided.

- Availability of additional staff at cutover and ELS both for clinical services and data entry – required staffing for all areas confirmed and currently populating rotas; this will be monitored weekly

Recommendation

The Board is asked to accept the report as assurance that the necessary progress is being made for CHFT to undertake a successful go-live in early May 2017.

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, 6th April 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 Performance Report for February 2017 and note the month's performance	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board (30/3/17), Quality Committee (3/4/17) and Finance and Performance Committee (4/4/17)	
Governance Requirements: Keeping the Base safe	
Sustainability Implications: None	

Executive Summary

Summary:

February's Performance Score is 60% for the Trust which is a 5 point drop since January. A number of the Trust's higher weighted targets have deteriorated in month:- FFT (A&E response rate and Maternity would recommend), MRSA, Emergency Readmissions, 62 day screening to treatment and Fire Safety training. These higher weighted target areas are differential across the services and do not indicate any systemic failure.

The SAFE domain has maintained its Green rating for the third month running. All other domains with the exception of Efficiency and Finance have seen a drop in performance in month reflecting some of the pressures in delivery of performance in quarter 4, the winter quarter.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the Integrated Performance Report for February 2017 and note the month's performance

Appendix

Attachment:

Short Version IPR - Feb 2017.pdf

Board Report

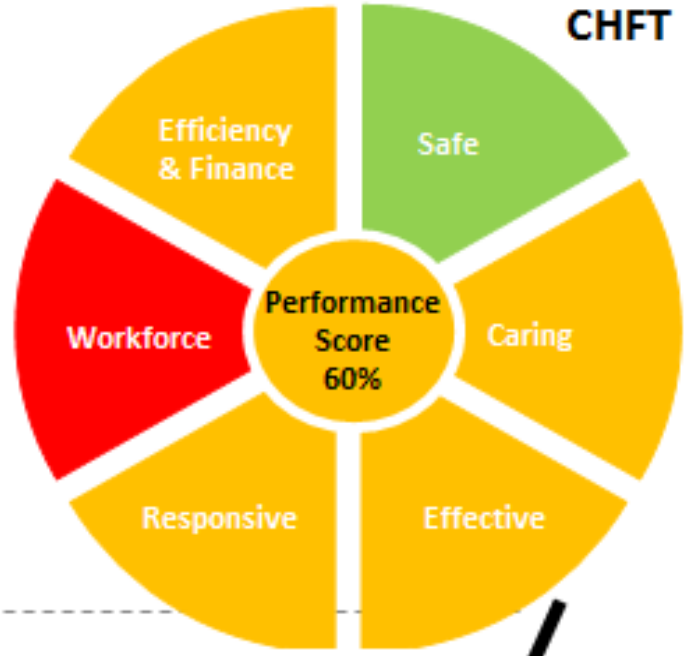
February 2017

Performance Summary

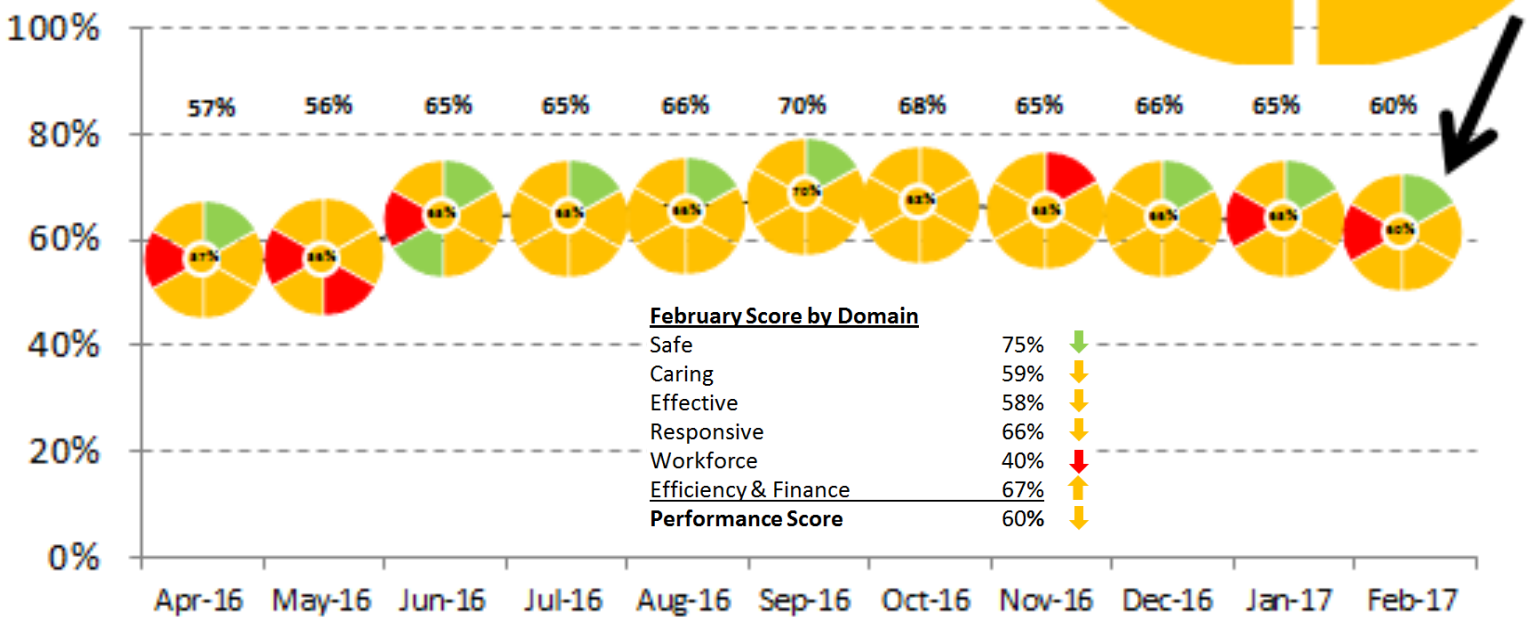
February

RAG Movement

February's Performance Score is 60% for the Trust which is a 5 point drop since January. A number of the Trust's higher weighted targets have deteriorated in month:- FFT (A&E response rate and Maternity would recommend), MRSA, Emergency Readmissions, 62 day screening to treatment and Fire Safety training. The SAFE domain has maintained its Green rating for the third month running. All other domains with the exception of Efficiency and Finance have seen a drop in performance in month.



Total performance score



February Score by Domain

Safe	75% ↓
Caring	59% ↓
Effective	58% ↓
Responsive	66% ↓
Workforce	40% ↓
Efficiency & Finance	67% ↑
Performance Score	60% ↓

SINGLE OVERSIGHT FRAMEWORK

SAFE	Emergency C-Section Rate
VTE Assessments	Never Events
CARING	FFT Maternity
FFT Community FFT OP	FFT Inpatients 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	97.6%	97.7%	↓	0%
	Inpatient Complaints per 1000 bed days	2.3	2.0	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	5.28	5.26	↓	5.17
	Delayed Transfers of Care	1.44%	1.35%	↓	5%
	Green Cross Patients (Snapshot at month end)	126	153	↑	40
	Hospital Standardised Mortality Rate (12 months Rolling Data)	101.55	101.97	↑	100
	Theatre Utilisation (TT) - Trust	86.3%	83.6%	↑	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.63%	0.49%	↓	0.6%
	Emergency Care Standard 4 hours	93.45%	92.19%	↑	95%
	% Incomplete Pathways <18 Weeks	95.33%	95.58%	↓	92%
	62 Day GP Referral to Treatment	86.7%	89.4%	↓	85%
SAFE	% Harm Free Care	94.06%	93.99%	↑	95.0%
	Number of Outliers (Bed Days)	579	1153	↑	495
	Number of Serious Incidents	4	5	↑	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: Summary Hospital-level Mortality Indicator (SHMI) - (October 2015 to September 2016). The Trust is no longer an outlying organisation with a score of 108 which is expected to reduce further to 106 at next release.
Hospital Standardised WEEKDAY Mortality Rate for calendar year 2016 was < 100.

Improved: % Stroke patients Thrombolysed within 1 hour. Performance at 100% equalled performance as at February 2016.

Improved: Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge. Second best performing month of the year.

MOST DETERIORATED

Deteriorated: Total Trust Pressure Ulcers plus Category 4. Highest numbers since March 2016.

Deteriorated: 62 Day Referral from Screening to Treatment. At 57% worst performance in most recent 12 months.

Deteriorated: Friends and Family Test A & E Survey - Response Rate. Worst position since March 2016.

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

ACTIONS

Action: A deep dive follow-up will be presented at Medicine's March PRM.

Action: Due to low number of patients a small number of breaches can have a significant effect on performance, key area of risk is for patients treated external to CHFT however reported in CHFT figures as host of the service. Patient details are now shared and monitored at Trust's weekly performance meeting.

Action: This is an unexpected drop and teams on both sites are reviewing the causes. The ED team have taken action to make improvements via safety huddles and team meetings.

Arrow direction count ↔ 1 ↑ 11 ↓ 7

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.6	7.5	↑	
Sickness Absence Rate	4.42%	4.58%	↑	4.0%
Turnover rate (%) (Rolling 12m)	11.61%	11.62%	↑	12.3%
Vacancy	292.53	299.59	↑	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)	£4.74	£4.43	●
Expenditure vs Plan var (£m)	-£5.30	-£4.93	●
Liquidity (Days)	-20.42	-17.24	●
I&E: Surplus / (Deficit) var - Control Total basis (£m)	£0.12	£0.07	●
CIP var (£m)	£1.26	£1.66	●
UOR	3	3	●
Temporary Staffing as a % of Trust Pay Bill	15.29%	15.46%	●

Executive Summary

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

Area	Domain
Safe	• **% PPH ≥ 1500ml - all deliveries** - 4.3% against a target of 3%. Ongoing audit - no concerns have been identifed. Additional review will take place should performance remain above target for a second month. • **Number of Category 4 Pressure Ulcers Acquired at CHFT -** There were 3 Category 4 ulcers in February. A deep dive follow-up will be presented at Medicine's March PRM.
Caring	• **Complaints closed within timeframe** - 54 complaints were closed in February, 54% of these were closed within target timeframe which is an improvement on the January position. • **Friends and Family Test Outpatients Survey** - % would recommend the Service remains at 90.9% against a target of 95%. YTD is also 90.9%. Both of these results are on track to achieve the internal Q4 target of > 90%. • **Friends and Family Test A & E Survey - Response Rate** - was 9.7% in month. This is an unexpected drop and teams on both sites are reviewing the causes. The ED team have taken action to make improvements via safety huddles and team meetings. • **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. Community division is reviewing the performance against web forms only in February as this is the methodology that will be implemented from April 2017. • **Number of Mixed Sex Accommodation Breaches** - There were 2 Mixed Sex Accommodation Breaches in February 2017.
Effective	• **Number of MRSA Bacteraemias – Trust assigned** - There was 1 case of MRSA Bacteraemia reported in month. RCA meeting has been concluded and it was likely to have been a contaminant. The patients was not screened on admission and the directorate is taking appropriate action. • **Perinatal Deaths (0-7 days)** - there was one perinatal death in month. • **Mortality Reviews** - The completion rate for Level 1 reviews reduced to 40.5% in January following increase in the previous 3 months. • Crude Mortality Rate has fallen to 1.61% following its peak in January. • **Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG** - Highest level since June 2016.

Background Context

A&E activity has fallen in month 11 to 5.6% below plan however cumulatively still 2.2% above plan.

For non-elective admissions it was a busy month with LOS increasing to over 6 days (average). Agreement was reached between Medicine and Surgery to reallocate Ward 14 to Medicine and whilst there was a good impact from increased Package of Care provision in January there still remains a high number of patients on the Transfer of Care list. Medical outliers reduced in February reflecting the Ward 14 change and the internal use of escalation beds within the Division protecting Surgical capacity.

Accelerator schemes continued in February but some changes eg. increased medical staffing were a March implementation, reflective of funding allocation, so further positive impact is to be expected.

Non-elective activity overall is 1.8% above the month 11 plan, an increase in activity against plan compared to month 10. The in-month over-performance is mainly due to General Medicine and Paediatric emergency short stay.

Planned day case (DC) and elective activity (EL) has continued to be above plan in month 11 by 0.29% which is a reduction from the overperformance seen in month 10. The month 11 position is driven by an overperformance in DC offset by a further reduction within DC Endoscopy and EL activity. This is mainly within Gastroenterology endoscopy and is due to the impact of the fire at CRH and the reduced decontamination capacity.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours -** February's position was 93.45% which was above the STF trajectory and the Trust continued to deliver some of the strongest performance nationally. • **Stroke -** All targets improved in month with the exception of % scanned within 1 hour performance which dropped from its peak in January. % Stroke patients Thrombolysed within 1 hour hit 100% for the first time in 6 months. The recent SSNAP results put the Trust at just below an A grade. • **RTT pathways over 26 weeks** - numbers dropped slightly to 126. 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 53% is the best performance since May 2016. • **62 Day Referral From Screening to Treatment** - at 57% is the worst position over the last 12 months. Due to low number of patients a small number of breaches can have a significant effect on performance. • **Appointment Slot Issues on Choose & Book** - As at 16th March 2017 there were 830 referrals awaiting appointment of which 461were e-referrals. This was a reduction of 996 referrals from 22nd July 2015 position of 1,824. Specialty action plans are in place to continue to reduce the ASIs over the forthcoming weeks.
Workforce	• **Sickness Absence rate** - Sickness rates have reduced to 4.4% with long term sickness back within target. All staff involved are being managed within Trust policy. • **Return to work Interviews** have fallen to 69% following last month's peak still short of the 100% target. 3 in 10 still not being completed. • **Mandatory Training and Appraisals**. Fire Safety training has fallen below target this month which means 3 out of the 5 areas monitored are now not achieving. Appraisals remain below target.
Efficiency/ Finance	• **Finance:** Year to date: The financial position is a deficit of £17.52m as reported on a Control Total basis , a favourable variance of £0.12m from the planned £17.65m. The underlying deficit position is £17.77m, an unfavourable variance of £0.17m 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. Divisional positions improved compared to forecast, allowing remaining contingency reserves to be retained for another month. 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 £1.68m; £0.27m lower than the previous month, but higher than the values recorded in November and December. The year to date agency expenditure remains beneath the revised trajectory submitted to NHSI, despite including £0.2m that 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 £5.34m, an adverse variance of £0.56m from the plan. • A deficit (on Control Total basis which excludes exceptional costs relating to property disposals and the I&E impact of donated assets) of £17.52m, a £0.12m favourable variance from plan. • Delivery of CIP of £13.67m against the planned level of £12.41m. • Contingency reserves of £1.36m have been released against pressures. • Capital expenditure of £14.58m, this is below the planned level of £25.96m. • A cash balance of £2.69m, 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.
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 day cases combined are above plan whilst non-elective activity is below plan however waiting lists are still high reflecting ongoing demand.

Background Context

All divisions have been busy in February developing CIP plans. Community have been working closely with partners in primary and social care and have become more involved at a West Yorkshire level with the STP primary and community group.

The Community Place bed base increased to 10 beds throughout February.

Surges in General Surgery and T&O acute activity continued in February having an impact on the Surgical elective programme.

Concerns remain on the Surgery Division's ability to ensure sufficient subcontracted capacity for Plastic Surgery and Max-fax with ongoing conversations with with partners regarding capacity for these services. The Division is also seeking support from neighbouring Trusts.

As a result of the Trust's RTT performance there is the opportunity to attract work from out of area CCG's and a number of proposals are being developed.

Work has also progressed on the cancer pathway between Surgery and FSS clinicians on how the length of the pathway can be reduced and practices standardised. Screening remains an area of concern and a number of new strategies are being explored to address this.

EPR training is progressing well as go-live approaches with the 90/60/30 day plans ongoing.

Direct access and unbundled outpatient imaging has continued to perform above plan in month 11 by 4.5%. Diagnostic testing has seen an overperformance in month 11 and is 6.7% above plan. The majority of this increase however is due to a correction within direct access anti-coagulation where activity has previously been missed when extracted from the COGNOS system.

Outpatient activity overall has continued to overperform and has seen a further increase of 1.2% above the month 11 plan mainly within follow-ups.
Cumulatively Outpatient activity is now 4.3% above plan however with demand continuing at high levels this is not resulting in a reduced waiting list size.

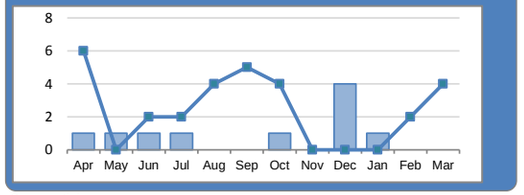
Safe, Effective, Caring, Responsive - Community Key messages

Area	Reality	Response	Result
Safe	Pressure ulcer management Much focus has been undertaken in community services around pressure ulcer care through 2016/17. There have been 10 grade 3 pressure ulcers reported within community services to date.	Pressure Ulcer management A new TVN joined the team and has supported the team in developing effective risk management tools and working with care homes on the "react to red" campaign. Each grade 3 pressure ulcer is reviewed at "orange panel" and investigated to determine root cause.	Pressure ulcer management Improved communication across agencies with regard to pressure ulcer care and care plans is expected. By when: March 2017 Accountable: ADN
Effective	Admission avoidance The team have focussed on recording accurately the patients that they have seen and subsequently avoided a hospital admission. Each hospital admission avoided is recorded on SystmOne.	Admission avoidance The Quest team have recorded only a small number of admissions avoided in February. The matron is meeting with the Quest team to understand the reasons behind this reduction and develop an action plan to improve this in future months.	Admission avoidance Increased numbers of admissions being avoided by community teams and supported in their own homes. By when : April 2017 Accountable: ADN
Caring	Health Visitor mandated contacts The HV mandated contacts are being delivered consistently and to the agreed specification. In Q1 of 2016/17 the HV capacity will be reduced due to staff turnover which could impact on performance levels through this time.	Health Visitor mandated contacts A proactive plan has been put in place to minimise the risk associated with the reduced staffing compliment. This will be monitored by the service lead to ensure that as many mandated contacts are undertaken as is practically possible.	Health visitor mandated contacts Proactive plan agreed by commissioners and systems in place to monitor adherence of mandated contacts. By when: April 17 Accountable: Matron children's services
Responsiveness	MSK responsiveness There continues to be challenges to meet clinical demand in the MSK service and the administrative tasks once a person has been seen (letter typing and signing).	MSK responsiveness Additional Saturday clinics continue through February and March. Additional staff have been recruited. Significant amount of redesign is being undertaken in the service in preparation for the implementation of the single point of access.	MSK responsiveness - Typing turnaround The service has committed to reduce the backlog of signing by 70% by the end of March 2017. By when: End March 2017 Accountable: Head of Therapies

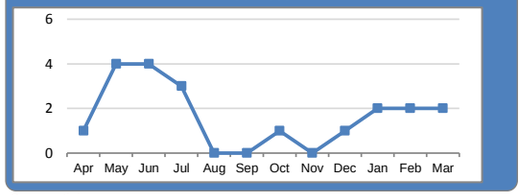
Dashboard - Community

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

Safe



One month in arrears



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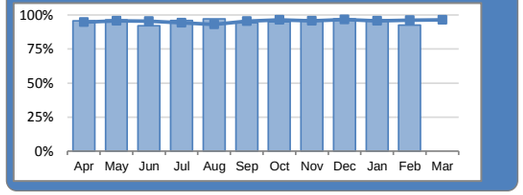

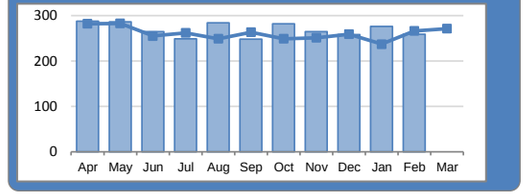

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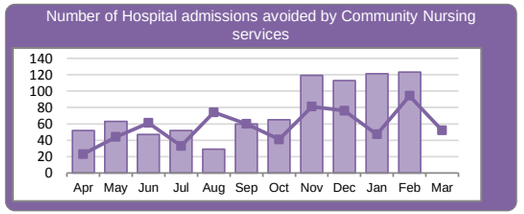

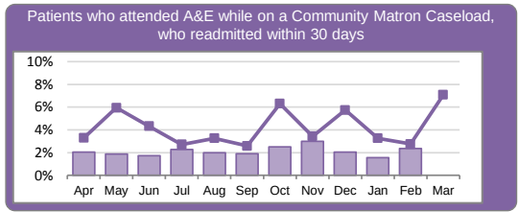

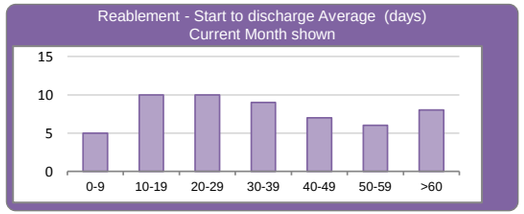

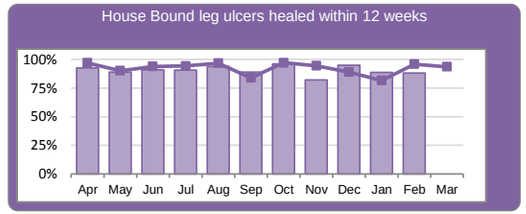

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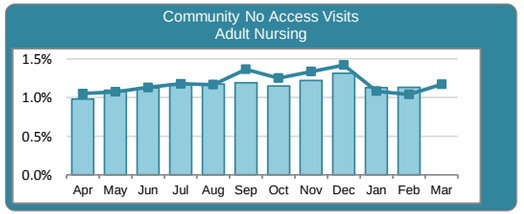
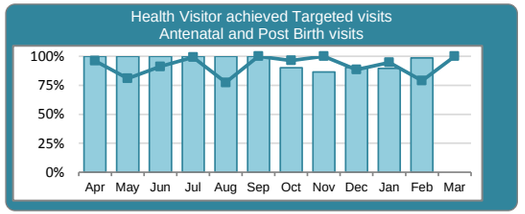
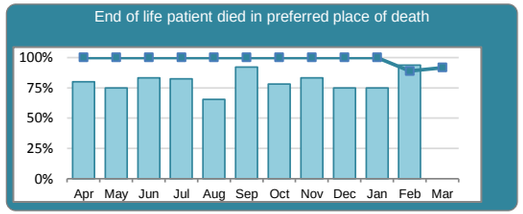
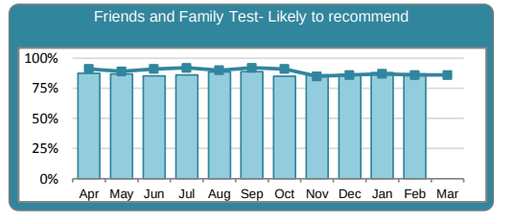
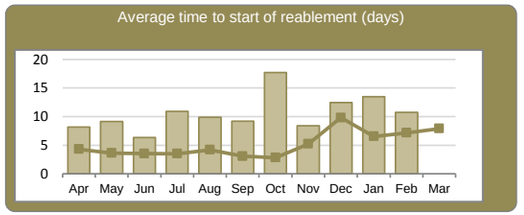


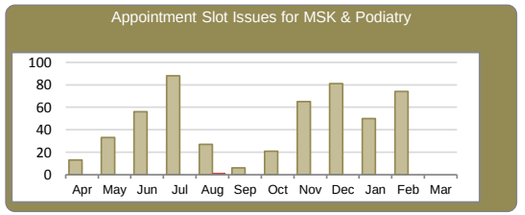


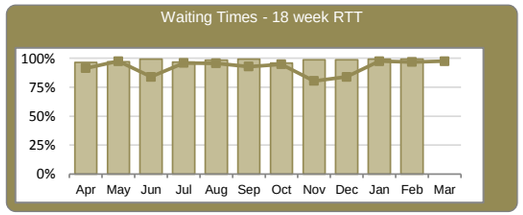


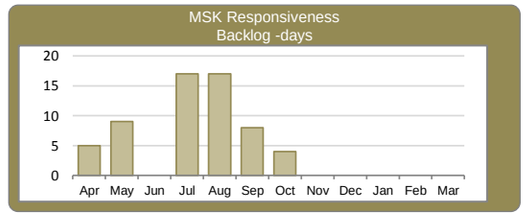


Responsive

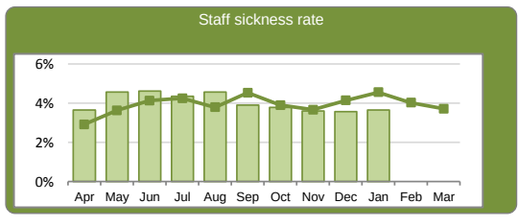




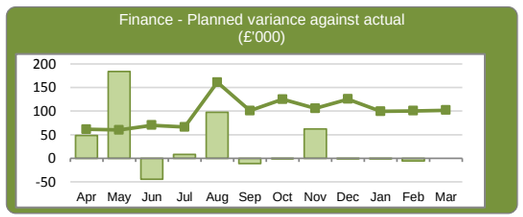


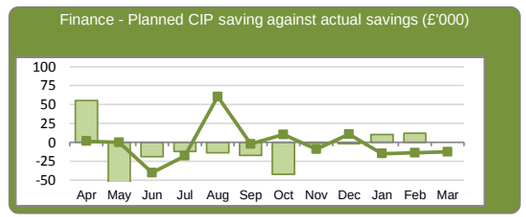


Well Led



One month in arrears





Hard Truths: Safe Staffing

Fill Rates

Average fill rates reported to Unify for Registered Nurse (RN) on day shifts remain largely the same on both sites as January 2017. 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
February 2017 HRI	85.13%	91.14%	107.49%	135.87%
February 2017 CRH	84.54%	91.69%	103.64%	127.50%
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%

Table 2: Wards with fill rates 75% or below

	Dec-16		Jan-17		Feb-17	
	Ward	% Rate	Ward	% Rate	Ward	% Rate
			2a/b	74.00%		
	5a/d	64.40%	5a/d	63.00%	5a/d	65.80%
	5b	69.40%				
					6d	73.40%
Wards below 75%	8a/b day	64.00%				
	8a/b night	73.30%				
	Ward 17	68.80%	Ward 17	72.00% day	Ward17	64.00%
				50.50% night		
	CCU	71.84%	CCU	74.80%		
	Ward 15	67.60%			Ward 15	68.30%
	9crh	74.20%				
	Ward 8	67.70%	Ward 8	67.00%	Ward 8	68.41%
			Ward 19	73.10%	Ward 19	73.70%

The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. In February 2017 six wards reported fill rates of less than 75% for registered nurses. 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 February 2017 are attributed to a level of vacancy and the teams not been able to achieve their WFM.

There are good RN fill rates at HRI on the MAU and ward 21 with HCA fill rates in excess of 190%. This has been attributed to extra bed capacity on the MAU and additional 1-1 usage on ward 21 due to patient acuity.

Average fill rates for HCA's on night of <75% have again been recorded within the FSS division during February 2017. This is due to long term sickness. The short fall 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 February 2017 including CHPPD.

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

	Total CHPPD (Qualified and Unqualified)						Fill Rates Day (Qualified and Unqualified)			Fill Rates Night (Qualified and Unqualified)		
	Dec-16		Jan-17		Feb-17							
	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	Dec-16	Jan-17	Feb-17	Dec-16	Jan-17	Feb-17
CRH MAU	10.0	8.6	9.5	8.5	10.3	9.0	81.6%	84.9%	84.9%	93.7%	94.9%	94.9%
HRI MAU	8.0	9.1	7.4	8.6	7.5	8.5	104.6%	104.2%	104.2%	126.7%	136.8%	136.8%
WARD 2AB	6.3	6.7	6.1	5.8	6.2	6.1	105.5%	90.6%	90.6%	106.8%	102.4%	102.4%
HRI Ward 5 (previously ward 4)	6.6	6.5	6.6	6.2	6.3	6.6	97.3%	89.3%	89.3%	101.6%	102.0%	102.0%
HRI Ward 11 (previously Ward 5)	6.6	6.5	6.5	6.3	7.0	6.8	98.7%	94.8%	94.8%	98.9%	98.4%	98.4%
WARD 5AD	6.6	7.0	6.3	6.6	6.3	6.7	102.0%	101.0%	101.0%	113.6%	112.0%	112.0%
WARD 5C	6.1	5.9	6.1	5.8	6.2	6.0	94.3%	91.6%	91.6%	100.0%	100.0%	100.0%
WARD 6	6.7	6.3	6.7	6.5	6.7	6.2	94.2%	95.9%	95.9%	91.6%	100.0%	100.0%
WARD 6BC	5.3	5.1	5.2	5.1	5.5	5.1	91.5%	91.8%	91.8%	101.6%	104.4%	104.4%
WARD 5B	6.1	6.8	6.0	7.2	6.1	6.9	97.3%	108.1%	108.1%	136.6%	143.0%	143.0%
WARD 6A	5.4	7.1	5.3	5.8	5.3	6.5	147.5%	112.0%	112.0%	106.4%	108.7%	108.7%
WARD 8C	6.1	7.0	5.6	6.7	5.7	6.8	111.5%	113.3%	113.3%	115.8%	127.2%	127.2%
WARD CCU	12.3	9.5	11.0	8.7	11.5	9.0	80.7%	81.0%	81.0%	72.6%	75.7%	75.7%
WARD 6D	11.3	9.4	11.4	10.1	12.5	10.8	75.2%	83.3%	83.3%	94.2%	95.5%	95.5%
WARD 7AD	6.9	6.8	6.8	6.5	6.7	6.3	91.4%	91.7%	91.7%	108.6%	100.0%	100.0%
WARD 7BC	6.9	7.0	6.5	6.4	6.6	6.5	98.6%	97.0%	97.0%	108.0%	99.5%	99.5%
WARD 8	7.4	8.7	7.1	7.5	5.8	6.5	114.0%	108.1%	108.1%	121.5%	104.1%	104.1%
WARD 12	6.5	5.7	6.2	5.5	6.0	5.8	81.3%	79.5%	79.5%	99.2%	106.7%	106.7%
WARD 17	6.1	5.3	5.6	4.9	6.9	5.2	81.1%	80.8%	80.8%	99.2%	103.8%	103.8%
WARD 21	5.8	5.5	5.7	5.6	5.2	5.6	89.1%	89.5%	89.5%	108.2%	114.4%	114.4%
ICU CRH / ICU HRI	29.0	24.8	42.6	36.6	31.7	26.9	85.0%	84.0%	84.0%	86.2%	88.4%	88.4%
WARD 3	6.1	6.6	6.1	7.3	6.1	7.5	101.9%	111.6%	111.6%	116.8%	130.1%	130.1%
WARD 8AB	10.9	7.9	7.7	7.1	6.7	6.7	70.4%	86.2%	86.2%	76.3%	101.5%	101.5%
WARD 8D	7.8	7.4	7.0	6.7	6.6	6.7	93.3%	92.5%	92.5%	100.0%	101.6%	101.6%
WARD 10	5.8	6.0	5.5	5.6	5.6	5.9	104.1%	102.4%	102.4%	100.7%	101.5%	101.5%
WARD 15	5.2	4.8	5.0	4.8	3.8	3.6	89.0%	92.6%	92.6%	100.7%	103.2%	103.2%
WARD 19	8.0	7.5	8.0	7.1	7.9	7.4	88.3%	85.0%	85.0%	99.5%	96.1%	96.1%
WARD 20	6.7	6.7	6.4	6.4	6.2	5.8	93.2%	91.6%	91.6%	113.4%	110.2%	110.2%
WARD 22	5.9	5.8	6.7	6.4	8.5	8.1	98.0%	93.5%	93.5%	99.2%	100.0%	100.0%
SAU HRI	9.7	9.4	8.4	7.9	9.0	8.5	95.3%	90.2%	90.2%	98.1%	101.3%	101.3%
WARD LDRP	32.3	29.3	34.7	31.0	28.9	25.9	90.5%	87.0%	87.0%	91.0%	91.6%	91.6%
WARD NICU	9.8	8.3	11.7	9.9	10.3	8.7	80.9%	78.7%	78.7%	89.0%	90.4%	90.4%
WARD 1D	10.0	9.1	9.6	8.2	8.9	7.9	87.4%	82.3%	82.3%	95.7%	90.3%	90.3%
WARD 3ABCD	12.4	11.5	15.5	14.4	15.8	14.2	86.3%	87.8%	87.8%	101.7%	100.2%	100.2%
WARD 4C	9.9	8.8	7.1	6.8	7.6	7.5	81.2%	94.4%	94.4%	100.0%	98.9%	98.9%
WARD 9	8.6	7.4	8.3	7.7	8.2	7.7	76.3%	88.9%	88.9%	98.9%	98.9%	98.9%
WARD 18	30.1	27.0	21.2	19.9	28.9	27.1	90.6%	94.2%	94.2%	88.6%	93.5%	93.5%
WARD 4	7.5	6.6	5.1	4.9	4.9	4.9	71.2%	85.2%	85.2%	90.3%	100.0%	100.0%
Trust	**8.1**	**7.7**	**7.8**	**7.5**	**7.8**	**7.5**	**92.1%**	**91.6%**	**91.7%**	**100.6%**	**101.8%**	**101.9%**

Care Hours Per Patient Day

A review of February 2017 CHPPD data indicates that the combined (RN and Care staff) metric resulted in 24 clinical areas of the 37 reviewed had CHPPD less than planned. 1 area reported CHPPD as planned. 12 areas reported CHPPD slightly in excess of those planned.

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

Internal Never Events

X2 Red Flagged events were recorded in Feb 2017: Ward 6A CRH reported Unsafe staffing levels on 10th February due to short term sickness. The shift was supported by night team and additional HCA support was provided.

8A reported a red flagged incident on 25th February due to full bed occupancy and reduced RN numbers. The short fall was again managed across the floor and supported by the site co-ordinator. No harm was reported to patients.

Conclusion

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 6th April 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: MONTH 11 FINANCE COMMENTARY ON THE NHS IMPROVEMENT MONTHLY RETURN - Financial Commentary for Monthly NHS Improvement Submission - Copy of the Month 11 Financial Commentary that was submitted to NHS Improvement on 15th Mar 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.

Main Body

Purpose:

For Information - See Attached

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To Note

Appendix

Attachment:

NHSI Financial Commentary Month 11 1617 final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 11 FEBRUARY 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 February 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 £15.89m, a favourable variance of £1.71m from the planned £17.60m of which £1.88m 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 £0.12m favourable compared to the year to date plan. This is positive news as the Trust is continuing to maintain the financial position in the final quarter 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 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 quarter so far despite a challenging January which saw 48 additional beds open and increased Delayed Transfers of Care due to higher demand and system wide challenges outside of our control. The pressure has abated slightly in February, but it continues to be the case that, in order to deliver activity and access standards across the Trust with high vacancy levels, there remains a reliance upon agency staffing to secure safe staffing levels. Total agency spend in month was £1.68m, a decrease of £0.27m compared to Month 10 and an improvement compared to the average for the first six month of the year which was in excess of £2.0m a month. Agency expenditure remains comfortably beneath the revised trajectory submitted to NHSI. It is also worth noting that within the agency spend £0.20m relates to the Accelerator Zone funding which has been agreed as excluded from the Trajectory.

Month 11, February Position (Year to Date)

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	337.01	343.64	6.63
Expenditure	(331.11)	(336.41)	(5.30)
EBITDA	**5.90**	**7.23**	**1.33**
Non-Operating items	(23.50)	(23.12)	0.38
Surplus / (Deficit)	**(17.60)**	**(15.89)**	**1.71**
Less: Items excluded from Control Total	(0.05)	0.25	0.30
Surplus / (Deficit) Control Total basis	**(17.65)**	**(15.64)**	**2.01**

- EBITDA of £7.23m, a favourable variance of £1.33m from the plan.
- A bottom line deficit of £15.89, a £1.71m favourable variance from plan.
- Items excluded from Control Total include £0.23m for Loss on Disposal of properties.
- Delivery of CIP of £13.67m against the planned level of £12.41m.

- Contingency reserves of £1.36m have been released against pressures.
- Capital expenditure of £14.58m, this is below the planned level of £25.96m.
- Cash balance of £2.69m; 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 £1.26m over and above that planned. The combined benefit has not flowed through in full to the bottom line but has rather absorbed the activity and performance related expenditure pressures, one off issues such as the Junior Doctors' strike action and the loss of System Resilience Funding.

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

Operating income	£6.63m favourable variance
Operating expenditure	(£5.30m) adverse variance
EBITDA	**£1.33m favourable variance**
Non-Operating items	£0.55m favourable variance
Restructuring costs	(£0.17m) adverse variance
Total	**£1.71m favourable variance**

Operating Income

There is a £6.63m favourable variance from the year to date plan within operating income. Of this operating performance £1.88m 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 £10.36m, 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 has become increasingly challenging for the Trust in the final quarter due to increases in A&E attendances and pressures on non elective capacity. This has been exacerbated by the volume of 'Green Cross' (medically fit for discharge) numbers and led to an additional 48 beds being open in January and a level of elective cancellations. This pressure has eased slightly in February with fewer beds open and A&E attendances below the planned level.

The Trust is 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.

NHS Clinical Income

Within the £6.63m favourable income variance, NHS Clinical income shows a favourable variance of £2.35m. In month activity is above planned levels in all of the main points of delivery apart from Elective & A&E. The breakdown by point of delivery is as follows:

- Planned day case and elective inpatient performance is 0.29% (10 spells) above the month 11 plan which is a reduction from the over-performance seen in month 10. The largest area of reduction is within Gastroenterology which has shifted from an over-performance of 32% (85 spells) in month 10 to an under-performance of 10% (-25 spells) in month 11. This is within endoscopy and is due to the impact of a fire in the department at Calderdale Royal Hospital and subsequent reduced decontamination capacity. Cumulatively, the aggregate performance across day case and electives continues to be above plan, driven by strong day case activity.

- Non-elective activity overall is 1.8% (70 spells) above the month 11 plan. In the year to date non elective activity is just slightly below planned levels by 0.5% mainly due to long stay admissions.

- A&E has seen activity reduce further in month 11. Activity is 5.6% (663 attendances) below plan but cumulatively remains above plan by 2.2% (3,034 attendances) above plan.

- Outpatient activity has continued to over-perform seeing a further increase of 1.2% (313 attendances) above the month 11 plan. The over-performance is largely in follow-up attendances. Cumulatively outpatient activity is now 4.3% (13,194 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 11.2% (690 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 has now finalised a year end agreement with our two main Commissioners that reflects both our forecast activity and commissioner coding challenges, providing a secure forecast income position and a reduction of risk for both parties.

The 2016-17 plan was inclusive of £1.97m of System Resilience funding. As part of the year end agreement the Trust has now agreed not to pursue this funding. The projects that were expected to be supported by this funding are already committed and embedded recurrently to aid improved patient flow and capacity in the context of pressures in the social care sector and as such the Trust has had to absorb the health economy risk. Receipt of this funding is now not assumed in the forecast.

Other income

Overall other income is above plan by £0.42m in month 11 and £2.40m 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 £0.81m cumulatively and the Trust's Pharmacy Manufacturing Unit (PMU) income is £0.41m lower than planned levels.

Operating expenditure

There was a cumulative £5.30m adverse variance from plan within operating expenditure across the following areas:

Pay costs	(£3.78m) adverse variance
Drugs costs	£2.57m favourable variance
Clinical supply and other costs	(£4.09m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £3.78m 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 £21.59m. The combined overspend against qualified nursing and support to nursing (Healthcare Assistants) is £4.55m 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 £12.86m, 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 remain of the highest priority to the Trust and work continues with colleagues in NHSI to ensure the implementation of best practice.

Total agency spend in month was £1.68m; £0.27m lower than the previous month, but higher than the values recorded in November and December. The year to date agency expenditure remains comfortably beneath the revised trajectory submitted to NHSI, particularly once £0.2m 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 divisional year to date pay overspend is £5.81m. 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 which is available to counteract any risks that might crystalize in Month 12. 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 £2.57m below the planned level. The income and corresponding spend on ‘pass through’ high cost drugs is £2.59m below plan. Underlying drug budgets are therefore overspent by £0.02m.

Clinical supply and other costs

Clinical Support costs are £2.34m above the plan. This overspend reflects activity related factors such as ward consumables and diagnostic test costs. 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 £0.43m above the planned level, compensated directly by income.

An element of the overspend in this area is driven by purely technical reasons. The annual plan includes £2.0m of contingency reserves all of which was planned as pay spend. There has been a release of £1.36m contingency reserves to the bottom line in the year to date position; a provision has been made against the £0.64m balance 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. This accounts for £0.64m of the total £1.75m overspend against other costs.

An increase in the Bad Debt provision to account for the risk of non settlement of some high risk income stream is creating an overspend of £1.93m in the year to date position. The majority of this increase relates to System Resilience Funding which was under dispute with commissioners, now that a year end settlement has been agreed this provision will reduce at month 12. These

pressures are offset by lower than planned premises costs of £1.37m year to date. In February the favourable variance is due in part to a Rates rebate that forms part of this premises underspend.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.38m 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 interest payments has reduced in February 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 £0.17m have been incurred in the year to date to fund redundancy costs which will deliver savings in future periods.

Cost Improvement Programme (CIP) delivery

In the year to date, £13.67m of CIP has been delivered against a plan of £12.41m, an over performance of £1.26m. As was highlighted in previous months, whilst the level of over performance is positive news it should be noted that the over performance in early months is now being counterbalanced to some extent by under delivery in the latter half of the year. The £1.26m 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 11, these continuing pressures were offset by some technical / non recurrent benefits.

The year end forecast CIP delivery reduced by £0.1m compared to last month's forecast at £14.96m, this over-performance against plan is offsetting other pressures and does not therefore translate to an improvement in the overall year end forecast. It should also be noted that £4.5m of the total forecast CIP has been identified non-recurrently and this is creating an additional burden which is adding to a larger CIP target for 17/18.

Work is ongoing to ensure that CIP delivery in the final month of the year is secured alongside the additional savings opportunities that are required to deliver the overall financial control total of a £16.1m deficit.

Statement of Financial Position and Cash Flow

At the end of February 2017 the Trust had a cash balance of £2.69m against a planned position of £1.94m, a favourable variance of £0.75m. In month the variance was higher than forecast due to: a number of large receipts including contract overtrade invoices and a Rates rebate, 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 February.

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	1.71
	Non cash flows in operating deficit	(0.44)
	Other working capital movements	(7.89)
	Sub Total	**(6.62)**
Investing activities	Capital expenditure	11.38
	Movement in capital creditors / Other	0.39
	Sub Total	**11.77**
Financing activities	Drawdown of external DoH cash support	(4.66)
	Other financing activities	0.26
	Sub Total	**(4.40)**
	Grand Total	**0.75**

Operating activities

Operating activities show an adverse £6.62m variance against the plan. The favourable cash impact of the I&E position of £1.27m (£1.71m favourable I&E variance and £0.44m non-cash flows in operating deficit) is coupled with a £7.89m adverse working capital variance from plan. The working capital variance reflects the catch up of payments to suppliers, combined with the accrued STF for Quarter 3 of £2.83m which was planned to be received in M11. The performance against the Better Payment Practice Code remained above target with 95.47% 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 £5.32m, an increase on last month. The remaining value includes; charges for Care Packages to local CCGs; contract overtrade invoices to local and other commissioners; invoices for Out of Area Activity 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. The System Resilience Funding invoices and associated bad debt provision will be unwound at month 12 now that a year end agreement has been reached with commissioners.

Investing activities (Capital)

Capital expenditure in the year to date is £14.58m, £11.38m below the planned level of £25.96m.

Against the Estates element of the total, year to date expenditure is £4.53m against a planned £10.51m. The main areas of spend in month were: the Laundry, Fire compartmentation, Fire Detection, Boilers in the Learning centre, Asbestos, HRI Pipework and Air Handling units.

IM&T investments total £6.11m against a plan of £7.52m. The main area of spend in month was the continuation of the Electronic Patient Record, but this is also the main area of underspend year to date against plan, with the delay in the 'go live' date. This project is now forecast to spend £9.45m versus a plan of £4.74 due to the additional costs of the timing difference for implementation and a planned change in treatment meaning further costs will now be capitalised.

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

Financing activities

Financing activities show a £4.40m adverse variance from the original plan, of which £4.66m is due to cash support through borrowing being less than originally planned. This is offset by a £0.26m

favorable variance on other financing activities: PDC received to support the Accelerator Zone (£0.47m) offset by 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. 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 £0.30m.

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 £0.23m. 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 £16.07m, a £0.08m favourable variance, (excluding the matching of this variance through STF finance incentive fund payments).

This position assumes delivery of £14.96m CIP and that recovery plans continue to be delivered to offset ongoing pressures and risks.

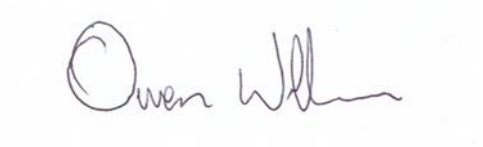
The Trust has achieved the performance criteria to secure the first 3 quarters of the Sustainability and Transformation Funding and continues to forecast achievement for Q4 and the £11.3m funding which is intrinsic to delivery of plan. Whilst operational challenges remain, the in-month improvement in Divisional financial positions has provided further assurance that the £16.15m Control Total is achievable. Contingency Reserves of £0.67m remain in place to offset Month 12 pressures and a year-end agreement with lead Commissioners which includes agreement on coding challenges and penalties in line with previous forecasts, ensures that we can accurately predict our Contract Income for the final weeks of the year and reduces the Trust's exposure to Commissioner affordability risk.

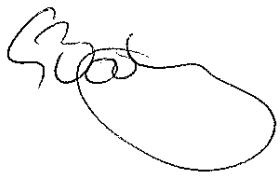
Some risks do remain, particularly around EPR implementation costs and our ability to absorb these within the current I&E and Capital forecasts. Securing safe staffing levels continues to provide a challenge in terms of agency usage and there may also be some financial implications of the Endoscopy fire at CRH that will need to be accounted for in this financial year once confirmed.

Forecast – Capital and cash

Following discussions with NHS Improvement and acknowledging the limited availability of capital funding nationally, the Trust has reviewed its Capital Expenditure and deferred schemes with a value of £2m into 17/18. In overall terms the capital expenditure is currently forecast at £24.12m, £4.10m 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 £4.78m, there has however been some further re prioritisation of the capital plan, resulting in reduced spend on the Estate and Equipment and slippage some of which has been captured in the 1718 Capital Plan. The additional £2m of schemes that have been deferred were not included within the submitted plan for 17/18 and the Trust continues to seek assurance from NHS Improvement that capital and cash funding will be available early in 17/18 to support this pre-committed investment.

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.





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, 6th April 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, 27.2.17 and and verbal update from 3.4.17
- Finance and Performance - minutes 28.2.17 and verbal update from 4.4.17
- Workforce Well-Led Committee - minutes from 16.2.17 and 16.3.17
- Draft Nomination and Remuneration Committee (MC) - minutes from 8.3.17.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the updates and minutes from each of the sub-committees as above.

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES ETC..pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

QUALITY COMMITTEE

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

PRESENT

Linda Patterson	Non-Executive Director ***(Chair for rest of the meeting)***
Jan Wilson	Non-Executive Director ***(Chair for first 30 minutes)***
David Birkenhead	Medical Director
Brendan Brown	Executive Director of Nursing
Juliette Cosgrove	Assistant Director for Nursing and Quality
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
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)***

In attendance

Dr Tim Jackson	Consultant Anaesthetist and Clinical Lead for CVAD, Vascular Access, Organ Donation and Sepsis (for item 031/17 only)

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.

023/17	**ACTION LOG AND MATTERS ARISING** ▪ Terms of Reference An email to be sent to the Committee explaining the proposed changes once the terms of reference have been approved at the Board of Directors on Thursday, 5th February 2017. ▪ NICE Compliance Report A request has been made for the NICE compliance report to be deferred to the April meeting (Wednesday, 3rd May 2017) in order for the update to be presented by Mr Martin DeBono, who will be in attendance. There are currently no risks or concerns with NICE compliance. ▪ Stroke Services Update Report See item 032/17 ▪ Invited Service Reviews **ACTION:** To be deferred to the next meeting. ▪ Mortality Summary Report **ACTION:** To be deferred to the next meeting. ▪ 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, with Safe achieving a Green rating following improvement in harm free care, and without the impact of November's never event. Caring and responsive domains are just short of a green rating. – *Safe* - Work is ongoing with complaints processes within divisions now that the number of closed complaints has decreased. – *Caring* – Work is ongoing with compliance of the friends and family test community survey from a physiotherapy perspective. – *Effective* – One case of MRSA in December 2016 - the importance of the documentation of MRSA swabs on admission has been reiterated to all relevant staff. **OUTCOME**: The Quality Committee received and noted the content of the report.
025/17	**QUALITY QUARTERLY REPORTING** Juliette Cosgrove (Assistant Director for Nursing and Quality) reported on the circulated paper (Appendix D1) which proposed a changed approach to quality reporting to the Committee. A presentation (Appendix D2) on the quality highlights for Quarter 3 (October to December 2016) was also given describing some of the work being undertaken with quality improvement projects, and the flu CQUIN being achieved. Discussion ensued on colleagues who may have declined the flu vaccination being at risk due to wards being closed due to flu outbreaks. **ACTION:** Message to be circulated to colleagues both in hospital and in the community in relation to flu vaccination and ward closures. **OUTCOME**: The Quality Committee received and noted the content of the report.

026/17	**BOARD ASSURANCE FRAMEWORK** The Quality Committee noted the Board Assurance Framework (Appendix E1 and E2) and aware of the two risks with an increase score and two risks with a reduced score. **OUTCOME**: The Quality Committee reviewed 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 the eight new serious incidents reported to the Clinical Commissioning Group (CCG) in December 2016: – 6 occurring in the Medical Division – 1 occurring in the Surgery and Anaesthetics Division – 1 occurring in the Community Division A breakdown of the incidents was reported as well as two case summaries submitted to the CCG indicating the root causes and learning. This learning will also be shared within the divisions' Patient Safety and Quality Boards. **OUTCOME**: The Quality Committee received and noted the content of the report.
028/17	**RISK REGISTER (CORPORATE)** Andrea McCourt (Head of Governance and Risk) reported on the circulated papers (Appendix G1 and G2) which gave a summary of changes in the risk register since last month: ▪ 7 top risks of: – Over-reliance on locum middle grade doctors in A&E – Staffing risk, nursing and medical – Service reconfiguration – Urgent estates schemes not undertaken – Delivery of Electronic Patient Record Programme – Non-delivery of 2016/17 financial plan – Cash flow risk ▪ No risks with increased score during January 2017 ▪ No risks with a reduced score during January 2017 ▪ No new risks added to the high level risk register during January 2017. A risk relating to the collective environmental and estates issues within ICU at HRI will be discussed at the Risk and Compliance Group on 14 February 2017. ▪ No removed or closed risks during January 2017. A copy of the risk register was also available to the Committee. **OUTCOME**: The Quality Committee received and noted the content of the report.
029/17	**SAFEGUARDING ADULTS AND CHILDREN'S COMMITTEE REPORT** Lindsay Rudge (Associate Director of Nursing) reported on the safeguarding adults and children's committee report (Appendix H1), which updated information on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009), safeguarding training compliance, mandatory children's safeguarding supervision requirements and actions; recent CQC inspections including the actions plans in response to the Calderdale Safeguarding and Looked After Children Review and imminent or potential inspections. The

	report also outlines innovative developments and further plans and arrangements for safeguarding adults and children. The Committee were asked to approve the reports and appendices (Appendix H2 to H9), and Lindsay also agreed to present the report at the Membership Council meeting. **OUTCOME**: The Quality Committee received and noted the content of the report.
030/17	**HEALTH AND SAFETY COMMITTEE REPORT** Lesley Hill (Executive Director of Planning, Performance, Estates and Facilities) reported on Appendix I which gave a summary from the last Health and Safety Committee meeting held on 18th January 2017: ▪ Fire update – 1833 colleagues still need to attend mandatory fire awareness training by the end of March 2017. ▪ Policies: – Health & Safety Policy has been reviewed, updated and undergone consultation. It is attached to this paper for approval by the Quality Committee. – First Aid Policy has been reviewed and updated. – Emergency Preparedness, Resilience and Response (EPRR) Policy has been reviewed. This will go to Operational Directors for comment before coming to the Quality Committee. ▪ Manual handling – compliance with training is currently 29%, due to colleagues being unable to attend due to work pressures and the lack of trainers. Additional funding has been sought in order to provide more trainers. ▪ Security update – Six taster sessions of conflict resolution training will take place in January, March and May 2017. ▪ Incidents – There were 160 staff or visitor health and safety incidents in December 2016. One of these incidents was reportable to the Health and Safety Executive (HSE) under RIDDOR (Reporting of Incidents, Diseases and Dangerous Occurrences Regulations).The main incident causes were: Infrastructure or resources (staffing, facilities and environment), abusive or violent behaviour and accidents that may result in personal injury (e.g. Slips, trips and falls, contact with sharps). The Committee were asked to note: – The staff training attendance, with staff (mainly clinical) unable to attend training, including manual handling and medical devices, due to work pressures on wards. – Additional facilitators needed for manual handling training – Two recent incidents regarding equipment, where porters needed to administer oxygen to x-ray patients as medical staff stated they were unable to do this. **OUTCOME**: The Quality Committee received and noted the content of the report, and approved the attached Health and Safety Policy (v6).
031/17	**ORGAN DONATION REPORT** Dr Tim Jackson (Clinical Lead for CVAD, Vascular Access, Organ Donation and Sepsis) was in attendance to give an update on the circulated paper (Appendix J). The paper highlighted the Trust's detailed categorisation of donation activity from level 2 data (between 5 and 12 donors per year). Dr Jackson and his team were thanked for the work done in getting the Trust to the current position, and it was suggested that the organ donation team would be a good place for the CQC relationship team to visit when next at CHFT.

	Dr Jackson reported that the annual report will be presented once the report is available, and the Quality Committee agreed that Dr Jackson will attend twice a year. It was also agreed that it would be helpful to hear any stories from staff and/or patients on how the service is working. A patient story will be provided at the Board of Directors in June 2017. **OUTCOME**: The Quality Committee received and noted the content of the report.
032/17	**STROKE SERVICES REPORT** Juliette Cosgrove (Assistant Director for Nursing and Quality) reported on the circulated stroke paper (Appendix K). The directorate underwent a successful Independent Service Review (ISR) on the 8th and 9th December 2016. The verbal feedback was positive and the team were very impressed with the highly motivated and engaged staff from all departments that worked closely with the stroke patients. The written report will hopefully be with the Trust in February 2017; once this is available a detailed action plan will be formulated. **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 Monday, 29th December 2016: ▪ *Sepsis* - The collaborative has been re-established with leadership from the Medical Divisional Director. Communications have gone out to clinicians to focus on screening and use of BUFALO (**B**lood cultures; **U**rine output; **F**luids; **A**ntibiotics; **L**actate; **O**xygen) to prompt interventions. The Matrons are checking all patients daily with NEWS 5 or above. ▪ *Mortality HSMR / SHMI* – Hospital Standardised Mortality Ratio (October 15- September 16) = 102.94 – Summary Hospital-level Mortality Indicator (April 15- March 16) = 113.8 ▪ *Investigating mortality* - 8 Consultants have volunteered to assist with first level reviews ahead of job planning. Training is being provided by the Improvement Academy using a train the trainer approach for new National Mortality review Programme. ▪ *End of Life* – the steering group has been reinstated with the Deputy Director of Nursing leading the group. It was reported that the regional medical director for NHS Improvement North – Vince Connelly - is interested in CHFTs SHMI position**,** and has been assured of the work taking place, and would like to visit the Trust, which will be facilitated. **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 Monday, 9th January 2017: ▪ *Mortality reviews* - in the last 12 months, there have been a 1,576 deaths, of these, 729 (45.4%) have been reviewed by the team of first level reviewers. ▪ *National Programme* – a joint training day with Bradford Trust which was due to be held on 16th January 2017 and led by the Improvement Academy was cancelled, and due to be re-arranged.

	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 N1) which gave a six month update on research and development activity since the previous report. In the last July 2016 update, it was reported that the Trust received its research funding allocation from the Yorkshire and Humber Clinical Research Network (CRN) for 2016-17 to support NIHR (National Institute for Health Research) adopted research. The total funding received to support this work is £758,555. The 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 the initial allocation, a further amount for £3,870 was made to directly support ophthalmology/medical illustrations. The Trust is required to provide a quarterly expenditure report to the CRN, and to date, the Trust has submitted a balanced position and expects the same at the end of the financial year. The current report highlights the activity and performance, recruitment to research studies and the 2017-18 priority and plans. Discussion ensued on the second paper (Appendix N2) which gave an update on progress against strategic objectives, and the development of nursing research and related activities, to raise the 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 movements in the action plan, which were detailed in the report, as recommended by CQC Response Group; and support for the revised completion dates for the actions currently not delivering against the plan. Priorities for the remainder of the financial year were also detailed in the report. It was reported that the CQC response group meetings will continue to be held on a fortnightly basis, with a move to having bi-monthly meetings with the Risk and Compliance Group from April 2017, which will focus on risk one month and compliance in another month. There have been changes to the CQC relationship team lead inspector; however, CHFT is still keen to keep the relationship meeting. It was also reported that a mock CQC inspection has taken place in maternity services, the report for which will be submitted to this Committee. A mock inspection has also been planned in February 2017 for paediatric services, and an inspection being arranged for the Intensive Therapy Unit (ITU). A copy of the action plan was also circulated (Appendix O2). **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** Copies of self-assessment checklists (Appendix P) were circulated to the Committee for completion, to be included in the Quality Committee annual report. All checklists to be completed and returned by Friday, 17th February 2017.

038/17	**ANY OTHER BUSINESS** There was no other business.
039/17	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** ▪ Detailed safeguarding report received. ▪ Quality Committee agreed to recommendations from the CQC Response Group ▪ Research and Development report received and noted volume of work taken place ▪ Recommendations from the Quality Quarterly Report approved. ▪ Further presentation received from Organ donation, and a patient story was suggested to be submitted to the 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	

QUALITY COMMITTEE

Monday, 27th February 2017
Discussion Room 2, Learning Centre, Huddersfield Royal Infirmary

PRESENT

Linda Patterson	Non-Executive Director ***(Chair)***
Karen Barnett	Assistant Divisional Director, Community Division
David Birkenhead	Medical Director
Juliette Cosgrove	Assistant Director for Nursing and Quality
Anne-Marie Henshaw	Associate Nurse Director/Head of Midwifery, FSS Division
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Joanne Middleton	Associate Nurse Director, Surgery and Anaesthetic Services
George Richardson	Membership Councillor
Lindsay Rudge	Associate Director of Nursing
Ashwin Verma	Divisional Director, Medical Division
Jan Wilson	Non-Executive Director
Michelle Augustine	Governance Administrator ***(Minutes)***

ITEM NO

041/17 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

042/17 **APOLOGIES**

Dr David Anderson	Non-Executive Director
Brendan Brown	Executive Director of Nursing
Diane Catlow	Associate Nurse Director, Community Division
Martin DeBono	Divisional Director, FSS Division and Associate Medical Director
Peter Middleton	Membership Councillor
Julie O'Riordan	Divisional Director, Surgical Division

043/17 **DECLARATIONS OF INTEREST**

There were no declarations of interest to note

044/17 **MINUTES OF THE LAST MEETING**

The minutes of the last meeting held on Monday, 30th January 2017 were approved as a correct record.

045/17 **ACTION LOG AND MATTERS ARISING**

- Terms of Reference
  Email sent to members explaining the proposed changes to the Committee.

- Invited Service Reviews
  To be deferred to the next meeting.

- Mortality Summary Report
  See item 053/17

- Serious Incident Report – Maternity Learning
  To be deferred to the next meeting

- Quality Quarterly Reporting – CQUIN
  This has now been completed.

046/17 **COMMUNITY DIVISION PSQB REPORT**

Karen Barnett (Assistant Divisional Director, Community Division) provided a summary of the Q3 divisional report; the full report can be found at Appendix C:

- Risk, Governance and Quality
  - Divisional Patient Safety and Quality Board (PSQB) meetings take place monthly with a core agenda. The division developed a compliance register which has not been able to be developed further due to a gap in governance support. The PSQB is supported by adult and children's sub-PSQB meetings, and work continues to strengthen the reporting process.
  - Serious Incident (SI) investigations - root cause analysis and investigation reports are completed for SIs and orange graded incidents. The division holds weekly orange / pressure ulcer panel meetings which are committed to trend analysis of pressure ulcers, and are well supported by the Tissue Viability Nurses.
  - Complaints are monitored at weekly meetings. The small number of complaints in the division reflects the work being done by frontline staff and managers to resolve complaints before they become formal. Learning from complaints is shared across the organisation.
  - The division received a CQC rating of 'Good' across all areas, and since the visit, a CQC action plan is in place for the must and should dos and for areas identified by the division and CQC report as requiring further work.

- Patient Experience
  - CQUIN – The results from the outpatient physiotherapy questionnaire have been collated, and on the whole, the results are positive. The service is currently developing an action plan to address specific areas for improvement. The current CQUIN for therapies is on target, and the orthotics service started to collect data.
  - Friends and Family Test (FFT) – the division have had support to change the way FFT responses are collected in the next year, which is expected to provide more robust information. A web-based form will be the choice of collection from April 2017, with card collection being used as an alternative.

- Clinical Effectiveness
  - NICE and National Guidance – There are currently 6 guidelines awaiting assessment, and the division have developed a NICE group to discuss and review.
  - Risk register – the five top risks and one new risk were summarised

- Workforce
  - Mandatory training – compliance with the division is reasonable although there are area of focus including information governance, infection control and fire safety. Appraisal continues to be monitored through the divisional performance meetings.
  - Sickness – long-term sickness has dropped for the third month in a row, short-term absence is above target, and stress and anxiety continues to be the biggest cause of sickness in the division
  - Recruitment and retention – physiotherapy recruitment is most challenging. Discussions with Mid Yorkshire Hospitals have taken place to explore the possibility of a Service Level Agreement for staff that are currently underutilised in their Trust. The division now have two days of governance support within the division.

- Responsive
  - Waiting times – 18 week Referral to Treatment (RTT) – the position has improved to 98.6%, and the main area where waiting times are becoming an issue are in outpatient physiotherapy where there are an increasing number of vacancies.

Discussion ensued on how local authority pressures are impacting on community. People waiting for capacity within homecare have impacted on community nursing and hospital or intermediate care, and has been a continuous challenge over the winter period. An extensive review of intermediate services is to take place to look at demand and capacity

and the future model, and this will be reported in the next quarterly report. Discussion also ensued on the Safer programme, and it was agreed that a brief update will also be provided in the next quarterly report.

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

047/17 **ESTATES AND FACILITIES PSQB REPORT**

Lesley Hill (Executive Director of Planning, Performance, Estates and Facilities) provided a summary of the Q3 divisional report; the full report can be found at Appendix D:

- Travel study - A survey will be conducted in February 2017 to understand colleagues' travel preferences to, from and within work, with an aim to explore more sustainable and active travel options. Estates and Facilities will also be working with divisions in regard to red and green parking permits.
- Business continuity plans – Work is ongoing with divisions to ensure robust plans are in place for Electronic Patient Records (EPR).
- Patient-led Assessments of the Care Environment (PLACE) inspections are due for 2017, the first taking place at Calderdale at the beginning of March 2017. A mix of patients and colleagues will be undertaking these.
- The division now has its own monthly Quality Performance Report, which reflects the reports of clinical divisions. The report was well-received, and the first time that all information is held in one place
- Work resulting from the CQC inspection is being completed on signage – this includes new directories introduced in entrances and updates on corridors and lifts at the Huddersfield site and new external signage at the Calderdale site.
- The division achieved a Celebrating Success award from the 'must do' category for the refurbishment of main theatres at Huddersfield. The division had six shortlisted entries.
- A member of the cleaning services team received the award of Healthcare Cleaning Profession of the Year at the North East region's British Institute of Cleaning Sciences (BICS) recognition awards
- Catering Services at Calderdale achieved the Soil Association Food for Life Silver catering mark
- Ongoing work with West Yorkshire Association of Acute Trusts (WYAAT) regarding patient menus. A food tasting event took place in early February in Bradford, which included 10 people from the Trust, including membership councillors.
- Patient experience – the division reported on in-patient survey results from the period of 10th January to 2nd February 2017, where 37 surveys were completed. Comments from each survey were included in the report. Complaints continue to be received regarding car parking at Acre Mill, and it was reported that funding has now been agreed to install a barrier parking system, which will be made available by the end of March 2017.
- Well-led – sickness in the division has decreased and tighter managing of long-term sickness. A significant amount of engagement work has taken place and this is starting to make an impact. Mandatory training and appraisals were also noted.
- Responsive – Work is ongoing to merge the porters and estates helpdesk to improve service and provide a 24-hour helpdesk via the HRI switchboard team.
- Learning – Feedback from concerns raised by staff and patients at Calderdale regarding broken entertainment systems on several wards has resulted in the majority of the televisions being repaired.

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

048/17 **FAMILIES AND SPECIALIST SERVICES PSQB REPORT**

Anne-Marie Henshaw (Associate Nurse Director and Head of Midwifery, FSS Division) provided a summary of the Q3 divisional report; the full report can be found at Appendix E:

- Laboratories have been re-accredited against new standards, and did very well through accreditation.
- The Diagnostic and Therapeutic Services (DaTS) and Children, Women and Families

(CWF) services now have separate Patient Safety and Quality Board (PSQB) monthly meetings.

- Blood Sciences – the risk of compromising patient safety caused by not following correct procedures for sample collection, labelling and administration of blood (Risk 6011) now has a process to manage the risk through a business case.
- Pharmacy aseptic unit – the risk of insufficient capacity to prepare ready-to-administer injectable medicines with a short expiry (Risk 6829) has a business case submitted to complete the work required
- Radiology – there are multiple radiology risks on the risk register related to demand, staffing, equipment and environment. These have been combined into an overarching service risk, which has been submitted to the Risk and Compliance group for consideration.
- CQC action plan for medicines management – the current status is action complete (green) and work is taking place to embed the actions throughout the organisation by quarter 4 (January to March 2017) and to test out the actions where improvements have been made.
- Maternity – work commenced with Improvement Academy to examine the service safety culture, and this report will be available in the quarter 4 PSQB report. A Healthwatch survey was also conducted to explore service user experience of providing feedback. This report will also be available in the quarter 4 PSQB report.
- Children's Services – stakeholder engagement events about future model of children's services are taking place, and a paper will be submitted to the Executive Board in March 2017.
- Pathology is continuing to make progress with the Pathology Quality Assurance Dashboard (PQAD), which is used to track performance.
- Phlebotomy – ward training is underway to reduce haemolysis rates on in-patients, and a reduction in samples has been noted in the last few months.
- Women's – since the new structure, the Women's Governance Board has met three times and there is ongoing work to ensure that the terms of reference are met and that assurance is provided to the PSQB. The Supervisor of Midwives will no longer be statute from 31st March 2017, and areas highlighted a possible gaps are out of hours leadership provision, loss of statutory supervision knowledge, and advocacy for women out of protocol. This is on the risk register and an action plan has been developed to ensure gaps are address.
- Claims – the division are trying to understand why there are so many claims, and several relate to communication. There is a maternity patient experience group which may need to review what needs to be done regarding attitudes.
- Friends and Family Test (FFT) – the division's response rate was summarised and it was stated that the majority of wards and departments continue to meet targets in month.
- External visits / inspections - the final annual Local Supervising Authority audit of midwifery and midwifery practice took place on 8 June 2016. Legislative changes leading to the disestablishment of the statutory supervision of midwives from April 2017 mean that there will be no further LSA audits. All actions from the audit action plan have been completed; evidence is outstanding for actions not within the control of the Trust.
- Learning: Blood transfusion - Following a clinical incident last year, a small group of designed a 'real time' multi-professional simulation scenario using a high fidelity mannequin (SimMan3G) in Calderdale theatres. This was based on major obstetric haemorrhage and involved several groups of people working together throughout the event. The management of the scenario was evaluated and the importance of multi-professional teamwork, communication and task management in major obstetric haemorrhage was clearly identified, as was the positive impact of multi-professional teaching and training.

Discussion ensued on:

- Gillick competencies within the CQC action plan, and it was asked whether this had now been revised - this will need refining following a mock CQC inspection which took place.

- Increased attendance at the birthing unit at Huddersfield – it was stated that a report will be submitted to the Performance Review Meeting (PRM) to discuss options

- Extra theatre access in and out of hours – this was covered in the CQC report and discussion with the Royal College of Obstetricians and Gynaecologists (RCOG), who were supportive of the physical space that is currently available and areas that could be explored to improve the service further.

- Mock CQC inspection in outpatients in April 2017 which will include an external assessor.

- Recruitment sessions for nurses held over the weekend – no recruitments were made in midwifery, however, there were some for paediatrics, trauma orthopaedics, emergency medicine and rotational posts. Some work has been done to attract emergency medicine nurses to work with children's wards.

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

049/17 **SURGERY AND ANAESTHETICS PSQB REPORT**

Joanne Middleton (Associate Nurse Director, Surgery and Anaesthetic Services) provided a summary of the Q3 divisional report; the full report can be found at Appendix F:

- Complaints - Significant improvement has been made in the closing of complaints and thanks were conveyed to colleagues for this achievement. Numbers of complaints has decreased by 30%, with revised Standard Operating Procedures (SOPs) in place. Colleagues are now being worked with on what a 'good' complaints response looks like.

- Bundles - Sepsis and Acute Kidney Injury (AKI) bundle compliance requires improvement, and is to be escalated to surgeons and urologists for a plan to be in place.

- Ophthalmology - The glaucoma service pathway is to be reviewed and the backlog of serious incidents to be discussed at divisional board. The service is being reviewed as a whole, with the addition of a service lead. There is no matron for the head and neck service as such, but is in need of some support.

- Head nurse for the division has now appointed, whose portfolio will include a lead on bespoke quality improvement work which will involve unpicking themes from complaints and targeting actions.

- Risk Register – the process for submission onto the risk register is working well with risks discussed at Divisional Management Team (DMT) meetings. Work is ongoing with the division's governance lead to understand how risk registers can be streamlined whilst archiving information.

- Fractured Neck of femur – performance remained a challenge during quarter 3:
  - October - time to theatre 76% - overall performance 76%
  - November - time to theatre 72% - overall performance 72%
  - December - time to theatre 67% - overall performance 65%

  Theatre 6 coming online has made a difference, but is still struggling from a staffing perspective. January and February performance (89%) has seen an improvement, and needs to get to a sustainable position. It was stated that there was a presentation at the Executive Board meeting last week – this will be made available with the minutes.

- Visit to Boston Spa NHS Trust - A visit to Boston Spa, Lincolnshire, was undertaken by members of the orthopaedic clinical and management team to see how fractured neck of femur performance was being achieved. The visit was both interesting and inspiring, and lots of ideas were generated form the visit, which the team are now working through to understand what changes can be transferable to the Trust to improve this pathway.

- Patient Safety
  - Serious incidents – One serious incident was opened in quarter 3, and has been addressed.
  - Patient Safety Walkround / Visits - Surgical matrons continue to visit every ward on a daily basis between 8:00 and 10:00 am. The focus of this walkround is to identify any safety issues and ensure support and action.
  - Safety Huddles in ICU and theatres are working well, with safety culture becoming embedded into daily practice, and helping to understand capacity.
  - Infection Control – Issues were identified with hand hygiene compliance, particularly medical staff. Teams continue to challenge and support has been requested from the infection control lead to manage messages and escalate recurrent issues. Discussion ensued on whether there were any consequences for medical colleagues not being compliant with hand hygiene. It was stated that if colleagues continue to defy reasonable instructions, and if a patient comes to harm, colleagues will be facing a disciplinary.

- Clinical effectiveness
  - External visits – The West Yorkshire Critical Care Network (WYCCN) Peer Review visited the critical care directorate in December 2016, and identified the same issues highlighted by the CQC last year. The division is working through

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

050/17 **MEDICAL DIVISION PSQB REPORT**

Juliette Cosgrove (Assistant Director for Nursing and Quality) provided a summary of the Q3 divisional report; the full report can be found at Appendix G:

- Sepsis CQUIN - In relation to timely identification and treatment of sepsis in Emergency Departments, adults are achieving 90% and paediatrics are achieving 50%, against the target of 60%.The non-compliance relates to 5 adults who were not screened and 1 Paediatric who was not screened. Awareness is being driven in departments by both medical and nursing leads. Discussion ensued on sepsis as a whole, stating that work is ongoing on how to prevent sepsis. It was also stated that while the current sepsis policy is in date, it is not reflective of the current required process, and work is ongoing to review the policy. The chair requested a full report on progress of sepsis at the meeting in June.
  ACTION: That a progress report on sepsis is presented at the June meeting.

- Harm falls - The division continues to experience a high volume of falls, and a consistent number of which have resulted in harm. As a result, the falls collaborative has been reinvigorated and is led by Dr Andy Hardy (Consultant for acute medicine). The collaborative will work closely with the Improvement Academy with a view to visiting Harrogate NHS hospital to meet with their falls lead as they have had great success in reducing their numbers of falls.

- Frailty – The service has joined the NHS Elect Acute Frailty Network (AFN) and established a task and finish group with partner organisations to support delivery of the recommendations from this collaborative. Membership consists of a variety of staff from CHFT acute & community, Social Services, Locala and Commissioners.

- Governance – The division has reviewed its governance processes and initiated a new governance structure that enables a new improved PSQB to report to divisional board. It is expected that this will improve both assurance and learning through the directorates and services.

- Deteriorating Patient – The division is working in partnership with the surgical division to

initiate tests of change to provide response to deteriorating patients. This should show further improvement in quarter 4.

- Infection control – The Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia patient on ward 8c in December 2016 did not have an MRSA screening completed on admission, nor on the subsequent transfer. The patient made a full recovery and has been discharged home with social care support.

- CQC update – The action plan has been shared widely across the division and leads, and is progressing current actions within planned timescales. The key risk – Clinical Decision Unit (CDU) - is now green (action complete) / blue (delivered and sustained), and all checks show that patients are appropriately managed in CDU.

Discussion ensued on whether the division was getting the support it needed, and it was requested that a report on falls is presented at this meeting in 3 months' time.
ACTION: That a progress report on falls is presented at the May meeting.

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

051/17 **QUALITY AND PERFORMANCE REPORT**

The Quality and Performance Report was circulated at Appendix H. January 2017's performance score is 64% for the Trust with the safe domain maintaining a green rating. The 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.

- Harm Free Care - 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.
- Friends and Family Test (FFT) Community Survey - FFT reports 3% of people would not recommend services, and 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.
- Hospital Standardised Mortality Rate (HSMR) - 12 month rolling data has improved to 102, and performance is expected to continue to improve over the coming months.
- Local Summary Hospital-level Mortality Indicator (SHMI) - The latest 12 month rolling data of 113 is expected to improve based on local intelligence. Modelling suggests that this will fall to 107 by the next release; however, the Trust may still be an outlier. It was reported that 9 out of 10 best performing Trusts were in London, and their link was a younger patient population.

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

052/17 **INVITED SERVICE REVIEWS**

ACTION: To be deferred to the next meeting

053/17 **MORTALITY REPORT**

David Birkenhead (Medical Director) provided a summary of the mortality report; the full report can be found at Appendix J:

In August 2016, the CQC conducted a survey to review how Trusts were identifying, reporting, investigating and learning from deaths. The findings of this survey were published in December in the report 'Learning, candour and accountability: a review of the way NHS Trusts review and investigate the deaths of patients in England'. The CQC has stated that it will continue to be actively involved in translating the seven recommendations in the report into actions through the National Quality Board, as well as strengthen the CQC's assessment of learning from deaths. This paper provides:

- A brief overview of the CQC paper and the data collection process used to inform this –

the full paper can be found at: http://www.cqc.org.uk/content/learning-candour-and-accountability
- A brief overview of current work on mortality in the context of the CQC report
- A proposed Trust response to the recommendations in the CQC report

It was noted that the Serious Incident Review Group will monitor progress with actions as detailed in the paper.

ACTION: Paper to be submitted at meeting in April to reflect guidance from NHS England.

OUTCOME: The Committee received and noted the content of the report, and awaiting further guidance from NHS England.

054/17 **CARE QUALITY COMMISSION (CQC) REPORT**

Juliette Cosgrove (Assistant Director for Nursing and Quality) provided a summary of the CQC report; the full report can be found at Appendix K:

The CQC Response Group is continuing to make progress with action plans and the Group recommend the following BRAG rating movements in the plan:

MD6	Mortality reviews	BRAG rating from **Green** to **Blue**
MD9	Interpreter and written information (community)	BRAG rating from **Green** to **Blue**
MD18	GI bleed rota	BRAG rating from **Green** to **Blue**
SD2	Psychological support (critical care)	BRAG rating from **Green** to **Blue**
SD12	Performance data (community)	BRAG rating from **Green** to **Blue**
SD8	Seven day working in radiology	BRAG rating from **Amber** to **Green**

There is one remaining amber action on the plan:

- **MD3** - Mandatory Training and Appraisals - the deadline for the delivery of this action is the end of March 2017. Actions continue to be progressed led through the Workforce (well led) Committee, working with the Divisions to promote requirements, validate current records and cleanse the data in order to achieve the year-end target of 100%.

Extension requests were made for two of the embedded dates, and the CQC Response Group meeting on 7th February 2017 considered the reasons for the delays and proposed the following extension to the deadlines and recommended the further actions to be taken:

MD14	Critical care – use of theatre recovery	**Issue:** Need to scope the possibility of providing a supernumerary co-ordinator post out of hours (able to provide support to theatre recovery if required) **Further actions:** Calculate costs and identify potential funding ***Recommendation: Move embedded deadline from 31.12.16 to 31.3.17, BRAG rating remain green***
SD10	Midwifery / health visitor pathway	▪ **Issue:** Whist regular monthly meetings are now being held between teams, feedback from midwifery colleagues is required to assess the impact ▪ **Further actions:** Carry out re-audit with the midwifery team and undertake a 'go see' ***Recommendation: Move embedded deadline from 31.1.17 to 17.3.17, BRAG rating remain green***

The CQC Response Group proposed that meetings continue to be held every two weeks until the end of March 2017. From April 2017, oversight of the plan will transfer to the Risk and Compliance Group where the focus will be:

- Monitoring the impact of the actions delivered through the plan,
- Delivery of the CQC fundamental standards and associated regulations
- Responding to the revised inspection regimes.

OUTCOME: The Quality Committee noted the content of the report and agreed the changes

and recommendations made by the CQC Response Group, and support the proposal for the future management of the plan.

055/17 **SERIOUS INCIDENT REVIEW GROUP MINUTES**

The minutes of the Serious Incident Review Group from 14th November 2016 were received. A copy of the draft terms of reference were also shared, with amendments made to the objectives, membership of the group, and a view to the meetings being held on a quarterly basis.

OUTCOME: The Quality Committee noted the content of the minutes and approved the changes to the terms of reference.

056/17 **ANY OTHER BUSINESS**

There was no other business.

039/17 **MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS**

- FSS Report - Accreditation from microbiology and histopathology
- Surgery Report - Good news on complaints improved
- Surgery Report - Ongoing work on fractured neck of femur
- Medical Report - Ongoing work on sepsis
- Mortality Report - received paper investigating mortality and recommendations made
- CQC Report - Signed off plan and proposal that group is integrated into existing process

040/17 **QUALITY COMMITTEE WORK PLAN**

A copy of the Quality Committee's work plan for 2017 was circulated (Appendix M) for information.

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

NEXT MEETING

Monday, 3rd April 2017
3:00 – 5:30 pm
Board Room
Huddersfield Royal Infirmary

APP A

Minutes of the Finance & Performance Committee held on Tuesday 28 February 2017 at 9.00am in Discussion Room 2, Learning Centre, Huddersfield Royal Infirmary

PRESENT

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

IN ATTENDANCE

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

ITEM

WELCOME AND INTRODUCTIONS

039/17 The Chair welcomed attendees to the meeting.

Due to EPR go-live, it was agreed that the meeting scheduled for Tuesday, 2nd May will include Phil Oldfield, Chair, Richard Hopkin, Non-Executive Director and Gary Boothby, Director of Finance only; everyone else can stand down.

040/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
David Birkenhead – Medical Director
Brendan Brown – Director of Nursing
Andrew Haigh – Chair of the Trust
Richard Hopkin – Non-Executive Director
Ian Warren - Director of Workforce & Organisational Development

041/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

042/17 MINUTES OF THE MEETING HELD 31 JANUARY 2016

The minutes of the last meeting were reviewed and with an amend to Minute 031/17 page 6, bullet point 8, which should read “we are looking to get a better **acuity** proxy to share with the contract groups” the minutes were then approved as an accurate record.

ACTION: The Chief Operating Officer confirmed that this work had been done and that a paper would be presented to the Committee at the next meeting – **HB**

043/17 MATTERS ARISING AND ACTION LOG

156/16: Review the Commissioner Requested Services (CRS) – The minute for this item was recorded under the 'Private Session' of this Committee meeting.

170/16: Outpatient Productivity – Following discussions at the last meeting the Chief Operating Officer presented the Committee with a slide which detailed the Outpatient Productivity which showed a positive position. The Chair of the Committee requested further information in relation to utilisation which would show how many more outpatients we are seeing, Helen Barker agreed to provide this information.

In addition, it was noted that NHSI have asked if the Trust would want to take part in Financial Improvement 2, it was felt that this would not be of benefit at this point in time. The Committee agreed that an appraisal of the work undertaken recently by Newton, FourEyes and Inverto would be helpful.

ACTIONS:

To provide further information in relation to utilisation which would show how many more outpatients we are seeing **- HB**

To provide an appraisal of the financial benefits to the Trust following the work of the consultants against the spend - **GB**

025/17: Review the Role of the Cash Committee – The Deputy Director of Finance took the Committee through the proposal and work plan for future Cash Committee meetings. It was proposed that the Cash Committee would formally meet each quarter end and that in the intervening months there would be one area of focussed work per month on a task and finish basis. Attendees would be tailored to the task and actions would be fed back to the formal quarterly meeting. It was also agreed that new members may bring new ideas to the table.

It was noted that an external organisation and two NHS organisations have been approached with regard to the 'Go-See', in addition it was suggested that perhaps a manufacturing and distribution organisation may be worth adding to the list and the Chair would look to provide contact details.

To ensure that the recommendations of the KPMG report are fulfilled the Chief Executive requested that the Director of Finance should keep him updated at their 1:1s with regard to the cash position.

The Committee noted the paper and agreed the proposed approach and work plan.

FINANCE AND PERFORMANCE

044/17 MONTH 10 FINANCE REPORT

The Director of Finance, took the Committee through the Finance Report for Month 10, the following headlines were noted:

- As at January, year to date, we are reporting a £70k favourable variance position predominantly driven by an over-performance in income.
- The total agency costs have increased in month, which includes spend

against the Accelerator Zone funding.

- Capital, year to date spend is significantly below plan, driven by our commitment to EPR. Discussions are still taking place with NHSI to agree what capital can be deferred into next year and in order to do so, the Trust is seeking assurance from NHSI that capital funding will be available in 17/18.
- We continue to forecast a £16.1m deficit and we are on track to deliver this in line with the plan.

045/17 FINANCIAL FORECAST AND ASSUMPTIONS AT MONTH 10

The Director of Finance took the Committee through the paper, it was noted that there had been some in-month benefits which have improved our forecast position. This has allowed the removal of the assumptions of the potential risk of contributions from either SRG negotiations or Accelerator Zone funding.

It was also noted that a year-end income position has been agreed with the Commissioners which covers risks relating to income penalties, counting and coding challenges and failure to deliver CQUINN. The remaining risks include full receipt of STF at Month 12 and the ISS rebate.

The ISS contract extension was discussed in the 'Private Session' of the meeting.

The Committee noted the financial forecast along with the assumptions.

The Director of Health Informatics, Mandy Griffin, joined the meeting.

046/17 BUDGET BOOK SIGN-OFF

The Director of Finance tabled the Budget Book for 2017/18. It was noted that governance requires sign-off by the Board and Finance & Performance Committee of the Plan. The Plan has been to Board for approval, and the Budget Book is a different way of presenting that information to the Finance & Performance Committee. It was noted that at this moment in time the Control Total has not been discussed with NHSI and assumes the £15.94m Control Total is accepted, subject to appeal. Also, with regard to the capital plan, this has not been approved with NHSI and any capital expenditure committed to prior to receiving this approval would be ultra vires.

The Trust have been informed that we are required to re-submit our Plans in March and hopefully discussions will take place with NHSI to clarify our position with the Control Total and capital expenditure.

A caveat with regard to 'Right Care, Right Time, Right Place' was requested to be included and with this amend the Finance & Performance Committee noted the contents and assumptions. The Budget Book will be circulated electronically to the Finance & Performance Committee and Board for information.

ACTION: To amend and circulate the Budget Book 17/18 – **GB**
Post-Meeting Note: Budget Book circulated 1 March 2017.

STRATEGIC ITEMS

047/17 CIP UPDATE

The Chief Executive updated the Committee with regard to the 17/18 position. The key headlines were noted as follows:-

- Schemes have been identified to the value of £12m
- £80k are at GW2
- £10m are at GW1, with £2m additional opportunities to work up
- Further ideas which will potentially add to additional scope/GW1
- Session held 15 February 2017 to identify where we are
- The deadline for completion to GW2 is the end of March
- GW1 and GW2 numbers should be available for the next meeting
- Exec Directors have a session on the 13 March to review the gap.
- Help to provide support to Divisions continues.
- £17m target remains a real risk
- The focus of the workshop on the 15 February was on cross-cutting schemes and to provide Divisions with the time to identify schemes, it was noted that the PMO team are supporting Divisions to complete the workbooks.

048/17 EPR

The 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. Challenges regarding the accounting treatment for EPR have been discussed at this forum previously, it was noted that there is still an issue with regard to VAT for agency and discussions with our advisors continue. A further challenge was also highlighted with regard to IR35, and whether or not we have liability for the tax and national insurance contributions for the contractors working on EPR. Work is progressing to understand what the potential implications of IR35 will be for the Trust.

The Director of Health Informatics reported that with regard to BTHFT the financial forecast supports a go-live date of July, however, it is likely to be August and that there will be a need to re-forecast. It was also noted that we are 60 days from the CHFT go-live date. A "full dress rehearsal" was entered into yesterday which will last for 3 weeks, this will test everything that will take place during the cut-over period at the end of April. This is technically based but will also test the system with end users and will test the command control. A training schedule is due to be signed off and testing of the kit will take place at the end of this week. In excess of 4,000 people have signed up for EPR training and a full update will be presented to the Executive Board this week.

The GE review concluded that we are rated Amber/Green = Probable/Highly Probable which is a much improved position. The review also highlighted 3 critical areas which are being actioned.

GOVERNANCE

049/17 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported that the Trust's performance score for January stands at 64% which is a slight dip with the main area being Workforce and the Mandatory Training matrix. Emergency Care is still rated RED as this is measured

against the full regulatory 95%, our position for January was 92.2% and our trajectory for February is 93%. Within the Carter dashboard there have been increases in Length of Stay and Green Cross patients, a deep-dive is being carried out for the next Exec. Board and this will be included in the papers for the next Finance & Performance Committee.

ACTION: To provide a report following the deep-dive into Length of Stay and Green Cross patients – **HB**

The performance in January for #NoF had a significant drop in performance in December which will have an effect on Best Practice Tariff, in addition to a longer length of stay for patients it has been identified that staffing levels had not been managed correctly. The Stroke performance has improved, being one point from an 'A' grade on Sentinel Stroke National Audit Programme (SSNAP), work has commenced to enable achievement and sustainability of an 'A' grade.

Radiology demand is now included within the IPR which shows an increasing trend, focus work with Divisions at their PRMs will be carried out to agree what actions can be taken to help with their variations.

It was noted that there had been a fire within the Endoscopy unit at CRH which has reduced current capacity by 44%. The Division are exploring alternative capacity for cleaning scopes. There are concerns regarding the equipment at HRI which is the same age and was provided by the same company. NHSI have also been informed that as a consequence of the fire we may miss our diagnostic target for February and March.

It was agreed by the Committee that rather than take a retrospective view, from a CQC point of view, the Board should be made aware of the possible lack of compliance of Mandatory Training during the EPR go-live period, the Board will be notified that EPR Training will take precedence over Mandatory Training during this period, it was agreed that this should be minuted at the Board Meeting.

ACTION: To ensure the Mandatory Training position during EPR Training and go-live is minuted at the Board Meeting - **HB**

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

050/17 MONTH 10 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 January 2017 which has been submitted to NHSI.

The Committee noted the contents.

051/17 MINUTES FROM SUB-COMMITTEES:

Cash Committee – Draft Minutes of meeting held 17 January 2017

Commercial Investment & Strategy Committee – Draft Minutes of meeting held 25 January 2017

Capital Management Group – Draft Minutes of meeting held 9 February 2017

The Committee received the Minutes and noted the contents.

052/17 WORK PLAN

The Work Plan was received by the Committee. It was noted that this may need to be reviewed to take account of the change to the meeting on the 2nd May 2017.

053/17 MATTERS FOR THE BOARD AND OTHER COMMITTEES

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

- Commissioner Requested Services and SLR
- Outpatient productivity
- Cash Committee Terms of Reference
- Capital/year end/commissioners/STF
- Budget Book – changes/circulation
- CIP – risk continues
- EPR
- IPR – Mandatory Training
- Loan Approval – recommend to Board

054/17 ANY OTHER BUSINESS

Uncommitted Loan – The Director of Finance explained the paper which outlined that integral to the Trust's 17/18 financial plan, as submitted to NHSI in December 2016, is the requirement to secure interim support funding to support our revenue working capital needs. The financial plan has not yet been approved by NHSI and a further submission is expected to be required by the end of March. Outlined within the current financial plan is the Trust's requirement to receive £20.22m of cash support from April 2017. This borrowing will be from the Department of Health in the form of Uncommitted Single Currency Interim Revenue Support Facility agreement. A new loan will be issued each month and a Board resolution will be required, the paper will go to the Board of Directors meeting taking place on the 2nd March 2017.

The Committee recommend the Board of Directors approve the Board Resolution to support the Uncommitted Interim Revenue Support Facility

DATE AND TIME OF NEXT MEETING

Tuesday 4 April 2017, 9.00am – 12.00noon,
Discussion Room 1, Learning Centre, HRI

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.

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.

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:-

Physical Activity – 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 at the March 2017 Committee meeting 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**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 16 March 2017, 2.00pm – 4.00pm in Discussion Room 1, Learning and Development Centre, Huddersfield Royal Infirmary

PRESENT:

Helen Barker	Chief Operating Officer
Brendan Brown	Executive Director of Nursing / Deputy Chief Executive
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Andrew Haigh	Chair of the Board of Directors
David Anderson	Non-Executive Director
Karen Heaton	Non-Executive Director (Chair)
Rosemary Hedges	Membership Councillor
Ian Warren	Executive Director of Workforce and Organisational Development
Jan Wilson	Non-Executive Director

IN ATTENDANCE:

Kirsty Archer	Deputy Director of Finance
Chris Burton	Chair of Staff Side
Sue Burton	Medical Education Manager for agenda item 48/17
Samantha Lindl	Personal Assistant, Workforce and Organisational Development Deputy
Jackie Murphy	Director of Nursing, Modernisation
Julie O'Riordan	Clinical Director, Surgery and Anaesthetics for agenda item 53/17
Charlotte North	Assistant Director of Human Resources for agenda item 53/17
Vicky Pickles	Company Secretary
Philippa Russell	Assistant Director of Finance for agenda item 57/17
Kristina Rutherford	Director of Operations, Surgery and Anaesthetics for agenda item 53/17
Claire Wilson	Assistant Director of Human Resources
Pamela Wood	Apprenticeship Lead for agenda item 57/17

43/17 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

44/17 **APOLOGIES FOR ABSENCE:**

David Birkenhead, Medical Director
Anne-Marie Henshaw, Associate Director of Nursing, Families and Specialist Services
Ashwin Verma, Divisional Director

45/17 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

46/17 **MINUTES OF MEETING HELD ON 16 FEBRUARY 2017:**

The minutes of the meeting held on 16 February 2017 were approved as a true record.

47/17 **ACTION LOG (items due this month)**

Modernisation Programme Board
(Safer Staffing, Workforce Utilisation and Efficiency Programme)

ACTION: Circulate to WWLC the self-assessment tool + Trust's original self-assessment submission to Executive Board

Formally request Surgery and Anaesthetic Division attendance at March 2017 Committee meeting

Identify any additional agency cost associated to opening of additional beds. To be picked up in the discussion.

ACTION: Further work is required in Divisions.

Medical Division – Assuring the Workforce Plans and Strategy

ACTION: Progress plan for a deep dive of one Medical ward

Review of EPR Training Schedule

ACTION: Provide a summary paper and an update in respect of the process regarding change in roles

Workforce Performance Report

ACTION: Undertake sickness analysis deep dive and build a 13 month trajectory

2016 Staff Survey

ACTION: Provide the full Staff Survey report along with details for the action plan

List of Acronyms

ACTION: Attach to each agenda a list of Trust acronyms

MAIN AGENDA ITEMS

FOR ASSURANCE

48/17 **DOCTOR IN TRAINING FEEDBACK SUMMARY 2016**

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

GMC National Trainee Survey 2016

SB attending on behalf of AL and provided an overview of the report.

An annual GMC National Trainee Survey, which feeds into Health Education England (HEE), conducted between 22 March 2016 and 11 May 2016 showed CHFT received the fourth highest rating out of 14 Trusts in the region.

In addition, CHFT rated best for overall satisfaction across the Yorkshire and Humber region for Emergency Medicine, Acute Internal Medicine, Stroke Medicine, General Surgery and Vascular Surgery.

The response rate for CHFT was 100% which was the highest in the region for the fourth year running.

Positive outliers were identified for Emergency Medicine FY1 and GPST specialists. Negative outliers were identified in Ophthalmology due to issues with supervision and Anaesthetics (higher trainees). A subsequent visit from HEE took place in Ophthalmology and no serious concerns were raised.

The GMC National Trainee Survey will launch on 21 March 2017.

Yorkshire and Humber Trainee Survey 2016

The response rate in the region was 45%. CHFT have been advised that the scores rate well in comparison to others. A consistent number of positive comments were documented outlining the overwhelming support they have received.

A number of gaps were identified in the rotas and work is progressing to appoint an Obstetrics and Gynaecology Physician Associate role.

JM suggested that a comparison of satisfaction rates for doctors in training be collated following the implementation of EPR.

JE queried the feedback received from Doctors in training in relation to the implementation of the new contract and the potential impact on the next survey. SB advised the FY1 doctors have been accepting of the contract. The remainder group of trainees have made limited comments. It is anticipated a drop may be reflected in the survey results.

IW reported a Multidisciplinary Education Committee will be formulated which will cover this aspect and include nursing and other professional groups.

KH noted that the survey was extremely positive and clarified the position on the impact this can have towards the allocation of additional posts. SB confirmed an additional CT3 in Emergency Medicine will be commencing with the CHFT.

ACTION: SB to share the results of the GMC National Trainee 2017 Survey and Yorkshire Humber Trainee 2017 Survey results as early as possible.

ACTION: IW to share an update on the progress of the Multidisciplinary Education Committee to the May 2017 Committee meeting.

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

49/17 **EPR CHANGE AND ACTIVITY UPDATE**

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

JM provided the Committee with an update on the EPR project's change and engagement approach.

Areas utilising EPR alongside more than one electronic system and / or papers systems, known as fractured workflow areas, have taken precedence to ensure continuity to patient care. The change team are working with wards and department to provide bespoke training sessions and responding to needs. Work is progressing to look at the cross organisational workforce.

The Committee were asked to note the plan described to ensure a safe and effective cutover, go live and early live support and consider further investment in the change team.

In addition, the Committee were asked to note the immediate roles identified by the programme team as most likely to change due to the organisation becoming paper light.

IW suggested work be progressed in terms of job profiles for the skills of those roles identified at risk alongside HR Business Partners.

AH raised a query in relation to the ability to make any changes to the EPR system identified after 'Go Live'. JM confirmed changes can only be implemented ahead of the Bradford 'Go Live' date. It was noted information would be collated on an on-going basis to inform the decision.

JW raised concern with poor practice being recognised and how soon this could be rectified. JM confirmed the change team will work alongside colleagues to ensure information is input correctly at cutover and early go live.

HB reported a Joint Operation Board will be formed with CHFT and Bradford alongside the Programme Board.

In addition, a presentation with HR Business Partners and the Director of Operations took place to utilise the Calderdale Framework to agree a way forward to design new roles fit for the organisation.

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

Review of EPR Training Schedule

JM provide an overview of the EPR training schedule:-

- Over 1300 colleagues have received their EPR training
- Doctors and nurses are being encouraged to book / attend the training sessions
- 10.9 % DNA rate at training sessions
- 16 colleagues failed the assessment. Support will continue to be offered to colleagues to ensure competency
- A number of issues are arising and being dealt with at training sessions
- Users are expecting to receive operational and service change guidance from the trainers however this is not part of the training programme. Leaders and managers will pick this up separately.

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

50/17 **2017/2018 MANDATORY TRAINING**

JE reported Executive Board received and approved a recommendation paper on 9 March 2017 for the 2017/2018 service year to focus on a limited number of mandatory training elements from the suite of 10 due to the implementation of EPR. The 5 elements are Fire Safety, Infection Control, Information Governance, Moving and Handling, Safeguarding for Adults and Children. Compliance will return to completion of all 10 elements post EPR and Go Live.

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

51/17 **MODERNISATION PROGRAMME BOARD UPDATE**

IW provided a verbal update. A Programme Manager will be appointed and the membership confirmed following approval from the Directors. It was noted, this approach will be delayed until after the implementation of EPR.

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

52/17 **AGENCY SPEND DIAGNOSTIC TOOL**

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

JE informed the Committee a paper had been received by Executive Board at its meeting on 16 March 2017. The paper provided an updated position of the status of CHFT against good practice of activity in other NHS organisations.

It was noted, the table top approach did not included wider Divisional or Director engagement. A comparison of the assessed position across 5 domains at July 2016 and March 2017 describes good practice, however, it identifies little movement from an assessed position of Amber to Red which suggest the controls are not as tight as the July 2016 position. The nursing position is further ahead than the doctor position and this is also the national picture.

The next steps identified are for a full validation exercise engaging with Directors and Divisional colleagues to rate the position of CHFT. It is anticipated the exercise will take 2 weeks to undertake. An action plan with delivery dates for Leads will be presented to Executive Board in April 2017.

A 'Go See' event is being scheduled to Sherwood Forest Foundation Trust which has been identified as a site of good practice by NHS Improvement.

A capacity issue has been identified and discussions with colleagues in Divisions will take place to develop a proposal to increase capacity and to achieve the position and practices at Sherwood Forest Foundation Trust.

ACTION: IW and Divisions to provide a report and an action plan to the Committee in May 2017 following the data validation exercise.

ACTION: IW to provide a verbal report to Finance and Performance and Turnaround Executive following the data validation exercise.

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

53/17 **SURGERY AND ANAESTHETICS DIVISION – ASSURING THE WORKFORCE PLANS AND STRATEGY**

JO'R, KR and CN tabled a presentation to outline Surgery and Anaesthetics priorities in order to support the delivery of the Workforce Strategy.

The result the Surgery and Anaesthetics Division is working toward is to provide 'a workforce of the right shape and size with commitment, capability and capacity to deliver safe, efficient, high quality patient care that delivers the Divisions Strategy'.

An overview of the workforce plan to aid delivery is:-

To have in place a stable workforce from 2016/2017 baseline to 2017/2018. Costs out from non-contractual pay (WLI/APA's)

A plan for every vacancy including a plan for turnover
Reduce agency spend from £4.6m in 2016/2017 to £4.08m
Drive down vacancy, turnover and absence by 4.75% which equates to 58 more staff available to negate non-contractual cover costs
Proactive approach to workforce planning and new roles
Improve the impact of workforce which currently stands at 1125 FTE with 72 vacancies - 43 are in nursing posts. 46 WTE additional staff are in post compared to 2015/2016.

Turnover has reduced from 12.10% in 2015/2016 to 9.16% in 2016/2017.

The division will support the CHFT's Workforce Strategy through the implementation of the 7 buckets.

The agency trajectory is mainly with consultant posts particularly in Ophthalmology. Vacancies are also present in ENT. Nursing agency is reviewed trust wide across medical and surgery wards.

The AUE (Availability, Utilisation, Effectiveness) model is being used for workforce planning identified in the strategy. New roles are being reviewed to assist with filling vacancies. Job plans will be reviewed on an ongoing basis to challenge the job plans and make sure they fit the purpose and to provide support where it is required. The Calderdale Framework will be implemented to ensure it fits into services.

The Division reported difficulty with colleague engagement. It was reported face to face engagement worked most effectively. The area identified as requiring attention is Organisational Development and Leadership:-

- A current lack of succession planning
- A challenge to secure the present and future workforce in a difficult labour market
- To create and nurture our future leaders
- To understand colleagues career aspirations
- To improve the quality of appraisals.

The key priorities for the division over the next 3 months is:-

- Staff Engagement - linking with the NHS staff survey
- Continued improvement Recruitment and Retention
- Organisational Development and Training to develop new roles
- A reduction in agency staffing
- Improve attendance
- Proactive and systematic workforce planning.

VP reported a 'Go See' visit with surgery colleagues to Wrightington, Wigan and Leigh NHS Foundation Trust. VP recommended a clinical team driven approach to staff engagement be adopted.

KH reported that the Workforce Strategy had provided the framework for the Division's analysis and outline plans. This signalled that there was acceptance of the Workforce Strategy and the key themes.

ACTION: Following a discussion with Health Education England (HEE), IW agreed to liaise with CN to discuss the support required to implement new roles which are competency based.

ACTION: KH reported it would be beneficial for a review in 12 months' time to see what effect the actions have had within the Division.

ACTION: SL to circulate the slides to the Committee.

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

PERFORMANCE

54/17 **WORKFORCE PERFORMANCE REPORT (FEBRUARY 2017)**

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

CW highlighted the key performance indicators (KPi) :-

- Turnover has reduced to 11.61%
- Previously nursing and midwifery staffing groups have reported as being the highest turnover group. This month identifies Healthcare Scientists across all divisions as the highest turnover at 13.75%
- Appraisal rate for February 2017 is currently reporting at 86.3%

CW reported the equality and diversity data had been removed from the report as the demographics were stagnant. It was recommended the data be included in the report on a bi-annual basis.

CHFT is engaging with the NHS Leadership Academy who will provide mentor training and support to senior colleagues. Going forward, support will be provided to Black, Asian and Minority Ethnic (BAME) groups with career development and career progression.

CHFT is working in partnership with Bradford District Care Trust (BDCT) to offer 10 places on the Moving Forward Programme to Band 5 and 6 BAME colleagues following a successful bid from the staff lottery.

The Leadership Academy is offering a development programme called Stepping Up. All eligible BAME colleagues at Band 5 through to 7 have been offered the opportunity to apply.

IW advised the report is showing a significant improvement in the turnover rate. It was agreed work would be carried out to try to establish why this has improved. A review of the previous 12 months will be undertaken. A number of colleagues had TUPE transferred out of the organisation due to Care Closer 2 Home. A review will take place to ensure these figures have been included.

AH queried if data is available to show expected turnover with regard to the retirement age demographics and the changes made to pensions.

BB recommended a review of colleagues who have left CHFT and return.

ACTION: CW to review the significant improvement in turnover and provide an update to the May 2017 Committee.

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

SICKNESS ANALYSIS

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

DM provided a summary of the key points with regard to the feasibility of reducing sickness absence from 4% to 3.5% over the next 5 years:-

- May 2014 recorded the lowest figure in the previous 3 years as 3.67%
- The highest recorded figure of 5.3% was in December 2015.

The last 12 months provides for more accurate data as ESR is now the source for reporting sickness and e-rostering flows into ESR.

An overall reduction has been reported each month to its lowest figure was recorded in September 2016 at 3.92%. Due to seasonal trends this has increased to 4.71% in December 2016.

In addition, the length of short term absence decreased to its lowest figure of 1.21% in September 2016. This figure also increased to 1.78% in December 2016 due to seasonal trends. Short term absence has reduced from an average of 120 days to 70 days over last 12 months.

Yorkshire and Humber comparison data shows CHFT at mid table. Hull and East Yorkshire NHS Trust are the only Trust below 4%.

To reduce sickness further work will continue with consideration given to additional schemes such as ensuring mandatory compliance with return to work colleagues, introducing incentives to staff who have no absence in 12 months and mandatory health and wellbeing courses for staff to ensure colleagues are supported at times of sickness absence.

ACTION: DM to identify sickness as a cost per person from each team in addition to the percentage rate.

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

INFORMATION

55/17 **2016 STAFF SURVEY RESULTS**

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

VP provided an overview of the staff survey results.

The action plan will be revised following a 'Go See' at Wrightington, Wigan and Leigh NHS Foundation Trust.

ACTION: LC to provide an action plan to the Committee through Executive Board in May 2017 in addition to quarterly reports on progress being provided to the Board of Directors.

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

56/17 **WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS (WYAAT) WORKFORCE AND OD COLLABORATION**

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

IW informed the discussion in relation to key areas:-

- CHFT is engaging with West Yorkshire Association of Acute Trusts (WYATT) to standardised opportunities in Occupational Health (OH). The outcome will be

presented to the Board of Directors for consideration

- CHFT is working in collaboration with Leeds Teaching Hospitals NHS Trust (LTHT). Payroll colleagues will be working within the Trust for an initial period of 6 months to put in place robust systems
- A business case is being developed to provide a regional bank for medical staff named 'Allocate'
- Additionally opportunities will be identified in relation to back office functions and pathology services.

ACTION: IW to provide a quarterly update to the group.

ACTION: TR to amend the workplan.

ACTION: SL to upload additional papers on to BoardPad.

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

57/17 **APPRENTICE LEVY GUIDANCE 2017/2018**

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

PR and PW provided an overview of the paper. From April 2017 CHFT will be required to pay the new Apprentice Levy from which it can draw down. The funds will remain available for 2 years at which date they will expire. In addition, the Government will apply a 10% top up on a monthly basis. A target number of apprentices will be set each NHS organisation each year calculated at 2.3% of the workforce headcount, approximately 133 for CHFT.

The funding can be utilised against the cost of apprenticeship training and end point assessment only. Plans to utilise the levy include increasing the number of non-clinical apprentices and considering the use of an apprentice for all Band 1 and 2 vacancies.

In addition, the number of clinical apprentices will increase to 6 intakes per year. Monies can be used to sub-contract a Further Education provider to assist with the delivery. Alternatively, a successful bid to secure Employer Provider status will allow payment form the levy pot to cover in-house costs associated with delivery.

A further option is for CHFT to explore opportunities to develop its existing staff with apprenticeship standards covering job roles from entry level to degree level. A higher levy payment of up to £30,000 will be available for Assistant Practitioners, Nurse Associates and Registered Nurses.

The challenge is to fully utilise the resource available without incurring additional unbudgeted staffing costs whilst continuing to offer a quality apprenticeship. KH stated that the quality of the apprenticeship was very important to the Trust whilst utilising as much of the levy as possible.

HB suggested that the literature be developed to promote general recruitment. It was reported there is a need to develop the clinical and operational management teams and monies could be used to accelerate this position.

ACTION: PW / PR to provide an update to the Committee in October 2017.

ACTION: TR to amend the workplan.

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

ITEMS TO RECEIVE AND NOTE

58/17 **ANY OTHER BUSINESS:**

No other business was raised.

ACTION: SL to cancel the Committee meeting scheduled take place on 13 April 2017 due to implementation of EPR and its associated training programme.

59/17 **MATTERS FOR ESCALATION:**

There were no matters identified for escalation to the Board of Directors

DATE AND TIME OF NEXT MEETING:

Thursday 11 May 2017, 2.00 pm – 4.00 pm, Chief Executive's Office, Huddersfield **NOTE CHANGE OF VENUE**

~~APP C~~

NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)

TERMS OF REFERENCE

Version:	1.1 First draft circulated for review to Chair – 13.10.15 1.2 Draft submitted to Membership Council for approval – 4.11.15 1.3 Draft submitted to Board for approval – 26.11.15 1.4 Reviewed by Noms and Rems Committee 8 March 2017
Approved by:	Board of Directors & Membership Council
Date approved:	~~4.11.15 and 26.11.15~~ 5.4.17 (MC) & 6.4.17 (BOD)
Date issued:	
Review date:	March 2018

NOMINATION AND REMUNERATION COMMITTEE TERMS OF REFERENCE (MEMBERSHIP COUNCIL)

1. Constitution

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

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

2. Authority

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

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

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

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

3. Conflicts of Interest

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

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

4. Nominations role

The Committee will:

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

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

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

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

expertise needed on the Board of Directors in the future.

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

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

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

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

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

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

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

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

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

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

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

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

5. Remuneration role

The Committee will:

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

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

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

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

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

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

5.4.2 reflect the time commitment and responsibilities of the roles;

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

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

5.5 Oversee other related arrangements for Non-Executive Directors.

6. Membership and attendance

6.1 The membership of the committee shall consist of at least six Membership Councillors appointed by the Membership Council, four of whom must be public Membership Councillors.

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

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

7. Secretary

7.1 The Board Secretary shall be the secretary to the Committee

8. Attendance

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

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

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

9. Frequency of Meetings

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

10. Minutes and Reporting

10.1 Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to all members of the Membership Council unless a

conflict of interest, or matter of confidentiality exists.

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

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

11. Performance Evaluation

11.1 The Committee shall review annually its collective performance.

12. Review

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

/KB/MC-NOMREM-TOR
~~NOVEMBER 2015~~MARCH 2017