Board of Directors

Schedule	Thursday 2 May 2019, 9:00 — 12:00 BST
Venue	Boardroom, Huddersfield Royal Infirmary
Organiser	Amber Fox

Agenda

10:23	15.	Fire Safety Annual Report 2018-19 To Approve - Presented by Lesley Hill	220
		Annual Fire Report 2019-20.pdf	221
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10:28	16.	Integrated Performance Report – March 2019 To Note - Presented by Helen Barker	230
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10:38	17.	Governance Report a) Scheme of Delegation Review b) Board of Directors Attendance Register 2018-19 c) Board Committees and Revised Governance Structure d) Sub-Committees Self-Effectiveness e) Updated Quality Committee Terms of Reference f) Constitutional Changes - Proposal to appoint an additional Partnership Governor g) Compliance with Code of Governance h) Compliance with NHS Improvement (Monitor) License Conditions To Approve - Presented by Andrea McCourt	246
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		APP K1 - SCHEME OF DELEGATION - G-3-2010 (v3 april 19).doc	251
		APP K2 - ATTENDANCE REGISTER - 1.4.18 - 31.3.19.doc	279
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10:53	18.	Month 12 Financial Summary To Note - Presented by Gary Boothby	290
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11:03	19.	Gender Pay Gap Reporting To Note - Presented by Suzanne Dunkley	293
		GENDER PAY GAP REPORTING.pdf	294
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11:13	20.	Update from sub-committees and receipt of minutes & papers • Finance and Performance Committee – minutes from meeting held 29.3.19 • Quality Committee – minutes from meeting held 4.3.19 • Council of Governors – minutes from meeting held 11.4.19 • Workforce Committee - minutes from meeting held 8.4.19 • Charitable Funds Committee – minutes from meeting held 22.5.19 • A&E Delivery Board Minutes – 12.3.19 To Note	311
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		APP N4 - Notes Quality & Performance Report - Workforce 8 April 2019.pdf	340
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		APP N6 - A&E Delivery Board Notes from 12th March 2019 DRAFT3.docx	346
11:18	21.	Date and time of next meeting Thursday 4 July 2019, 9:00 am Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital To Note - Presented by Philip Lewer	355

1. Welcome and introductions:

Lindsay Rudge, Deputy Director of Nursing (on behalf of Jackie Murphy, Chief Nurse)

Donna Cole, Ward Manager, Ward 17 (Patient Story)

To Note

Presented by Philip Lewer

2. Apologies for absence:

Jackie Murphy, Chief Nurse

Linda Patterson, Non-Executive Director

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 7 March 2019

To Approve

Presented by Philip Lewer

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Public Board Meeting held on Thursday 7 March 2019 at 9am in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Gary Boothby	Executive Director of Finance
Alastair Graham (AG)	Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director
Jackie Murphy	Chief Nurse
Phil Oldfield (PO)	Non-Executive Director
Dr Linda Patterson (LP)	Non-Executive Director
Suzanne Dunkley	Executive Director of Workforce and Organisational Development (OD)
Dr David Birkenhead	Executive Medical Director
Karen Heaton (KH)	Non-Executive Director
Andy Nelson (AN)	Non-Executive Director

IN ATTENDANCE

Amber Fox	Corporate Governance Manager (minutes)
Andrea McCourt	Company Secretary
Ruth Mason	Associate Director of Organisational Development (OD)
Jason Eddleston	Deputy Director of Workforce and Organisational Development (OD)
Rob Aitchison	Director of Operations, Families and Specialist Services Division
Rob Birkett	Assistant Director, Information Management
Dr Anu Rajgopal	Consultant Microbiologist (for item 35/19)

OBSERVERS

Paul Butterworth	Public Elected Governor
Ruth Day	Hempsons
Karen Kendall-Smith	Hempsons
Linzi Smith	Staff Elected Governor
Christine Mills	Public Elected Governor
Fiona Kaye	Nurse Manager, Surgery
John O'Sullivan	Investors in People Assessor

22/19 Welcome and introductions:
The Chair welcomed everyone to the Public Board of Directors meeting.

23/19 Apologies for absence:
Apologies were received from Mandy Griffin, Helen Barker and Anna Basford.

24/19 Declaration of Interests
Alastair Graham, Non-Executive Director declared an interest in item 42/19, Calderdale and Huddersfield Solutions Ltd Update.

25/19 Minutes of the previous meeting held on 3 January 2019
The minutes of the previous meeting held on 3 January 2019 were approved as a correct record subject to the following amendments;

- Change of wording from 'an initiative to support child sexual exploitation' to 'an initiative to address child sexual exploitation' (page 2)
- Change 'scrutiny' to 'Joint Health Scrutiny Committee'

- Since the meeting the Data Quality paper went to Audit and Risk Committee, rather than the Quality Committee (page 8)
- Capital Plan Overview – change '£1.8m revenue impact' to '£1.8m capital impact' (page 10)
- Remove 'Dr' from Barbara Schofield and add title 'Nurse Consultant for Dementia'
- Change 'delirium' to 'dementia' (page 3 and action log)

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 3 January 2019.

26/19 Action log and matters arising

AN highlighted in the minutes held 3.1.19, he asked for a more detailed report on how the £20m capital works will be spent on resources for the business case.

LP confirmed the never events were brought to the Quality Committee and immediate actions were taken and work is ongoing to ensure corrective action is in place.

The action log was revised and updated accordingly.

27/19 Chair's Report

The Chair updated the Board on the activity he has been involved in since the last meeting on 3 January 2019.

- Spent two half days with Joyce Graham, Macmillan Nurse Consultant in Breast Care to witness a broad spectrum of their work
- Spent a day with prescribing pharmacists focused on digitalisation and readiness for discharge
- Supported Tea Trolley rounds which are positively received by staff and other Trusts are keen to use our approach
- Attended a West Yorkshire and Harrogate Partnership Board Development Session on 5 March 2019, the West Yorkshire Association of Acute Trusts attended, there was discussion on working more closely together
- The first public meeting of the Integrated Care System is scheduled to take place on Tuesday 4th June 2019
- Met with the MPs, Holly Lynch and Thelma Walker in the last quarter with the Chief Executive

The Chair reported at the last Council of Governors meeting, one of the Governors expressed concern that the views of the governors had not been considered when the Board took its decision in December with regards to increasing the car parking charges. The Chair confirmed that a summary of the governors' views had been shared with all Board members prior to the meeting and he believed that the Board took these in to consideration when making the decision. It was not a consensus view from the Council of Governors; although, overall there was significant concern about the increase in charges for both patients and staff.

28/19 Chief Executive's Report

The Chief Executive referred to the Topol Review report from NHS Health Education England. The key highlights from this report were:

- Connects with the 10-year strategy and plan
- Describes the role digital will play, it is important that the patient is at the centre of care with healthcare technology
- Describes the clinical changes for staff who interact with patient care directly, important to understand what this means

The Chief Executive recently attended a Foundation Year 1 (FY1) question and answer session and when asked for their thoughts about rotating to a non-digital, the FY1's were

not looking forward to working at a paper-based organisation. He added the introduction of the Electronic Patient Record (EPR) has created an opportunity for international colleagues to enhance their contribution to care as part of our digital maturity.

The Chief Nurse suggested it is important to look at the governance in relation to digital technology and highlighted the ethical debates in the Topol report. She added it is positive to stand in the future in some of the roles that will be available for doctors, nurses and colleagues.

The Chief Executive explained how the Trust has started to use new technology to monitor rehabilitation movement at home. This allows patients to be discharged much quicker and receive care closer to home.

An interactive session with Pennine GP Alliance clinical colleagues is taking place Friday 8 March 2019. The session will focus on how technology can be used to improve urgent and emergency pathways.

AG asked if there is an opportunity to consider private sector partnership on a national or international scale. The Chief Executive responded the Trust is currently being approached by organisations with this idea.

The Assistant Director for Information Management feedback from an event at the Royal Society of Medicine following release of the report and suggested investment needs to be recurrent, with development investment on top of this. The Chief Executive acknowledged benefits realisation could always be improved. The Director for Workforce and OD is leading on a piece of work around voice recognition for the Trust.

The Trust is aiming for the use of technology to reduce the time for confirmed diagnosis. The Chief Executive re-iterated the importance of digital and the patient, staff and fiscal benefits.

29/19 **Progress on the Organisational Development Strategy and Staff Survey Results**

Karen Heaton introduced the progress update on the Organisational Development Strategy and welcomed the Deputy Director and Associate Director of Workforce and OD to present this piece of work.

The Deputy Director of Workforce and OD presented the national staff survey themes and high-level action plan. The key points to note were:

- Data quality issues on staff survey results are being discussed with Picker
- Overall performance in the survey was shared across the 10 dimensions based on 89 trusts
- The Trust is below the average in 5 dimensions, at average in 3 dimensions and above average in 2 dimensions
- 51% response rate from colleagues eligible to participate, an 8% increase from our response rate in 2017
- Areas requiring more attention includes effectiveness of appraisals
- Tea Trolley rounds activity has been a successful initiative, the team are developing new questions for the tea trolley rounds at the Hot House event on 8 April 2019

The Associate Director of OD presented the OD Strategy ‘The Cupboard’ which is a web based interactive tool; http://cupboardstage.wpengine.com.

The assessor for Investors in People, John O’Sullivan commented ‘The Cupboard’ follows best practice methodology and measures on how we are achieving these.

KH commented that as 'The Cupboard' was shaped through engagement it has a greater chance of success and noted the staff survey results identify where improvements can be made e.g. appraisals.

AG commended the approach to developing 'The Cupboard', he gave positive feedback on the tea trolley rounds he has attended and suggested the responses to the tea trolley rounds are fed into 'The Cupboard'. The Associate Director of OD explained there is an animated map of where the tea trolley rounds have been with pictures and comments.

The Associate Director of OD explained that 'The Cupboard' will be used in recruiting overseas staff and phase 2 of 'The Cupboard' will include feedback on actions taken e.g. 'You said, we did…'.

AN asked what the next stage of the OD strategy and plan will be. The Associate Director of OD explained all the ingredients have a section titled 'how will this look?' which describes the next steps. The Investors in People (IIP) high performance roadmap will capture the actions and outcomes in one place.

KH explained that work on 'The Cupboard' is ongoing and thanked the Director of Workforce and OD, Associate Director of OD and Deputy Director of OD for leading on this piece of work and staff and governors for actively engaging in this piece of work which is an exciting opportunity.

The Chief Executive concluded by saying this tells a strong organisational story, is a real opportunity to work as a system and it is important for the Trust to 'live by this'. He suggested thinking about how the Trust interact with partners and those who supply a service to us.

OUTCOME: The Board **NOTED** the progress on the Organisational Development Strategy and key themes and high-level action plan for the Staff Survey results.

30/19 Care Quality Commission (CQC) Update

The Chief Nurse stated the Trust were rated as 'Good' at the last CQC inspection in June 2018 with 9 'must do' actions and 54 'should do' actions. The Trust's ambition is to achieve an overall rating of 'outstanding' at the next inspection.

The key updates noted were:

- 1 'must do' action is not progressing to plan regarding Medical Staffing (CRH/Critical Care)
- Action plan was reviewed by the CQC at the relationship meeting on 21 January 2019 and CQC were satisfied with progress to date with the action plan
- CQC Relationship Manager has indicated that completion of the Trust's regulatory planning document will begin May 2019, this will begin the cycle of the next planned inspection visit and trigger release of the Provider Information Request
- CCQ Response Group is monitoring progress on the action plan and a Quality Summit is planned for 18 April 2019
- A list of where CQC colleagues are shadowing upcoming meetings has been agreed

RH asked for an update on the red 'must do' action for medical staffing. The Chief Nurse confirmed there are two papers being presented to Executive Board to address the interim plan which are:

1. Reconfiguration to safely staff both emergency departments, describing the mitigations, risk assessment and patient experience
2. Paper to describe the current mitigation based around the recommendation on having consultant cover from Intensive Care Unit (CRH), noting that no harm or

incidents have occurred as a result of not having dedicated anaesthetists cover at CRH.

AN pointed out 'use of resources' requires improvement. The Director of Finance responded several areas have improved to outstanding and clarified use is resources is broader than financial resources. RH suggested the Board receive feedback from the Finance and Performance Committee on how this is progressing.

The Chief Executive referred to a public article highlighting concerns around quality of care from friends and relatives with a focus on Huddersfield Royal Infirmary. The Trust have reviewed 4 of the 10 cases which will be brought to Quality Committee for assurance. The Trust has not been able to identify the remaining 6 cases despite attempts to do so. There are good governance and systems in place to review these cases.

OUTCOME: The Board **NOTED** the CQC update and **APPROVED** the movements in plan.

31/19 Q3 Quality Report

The Chief Nurse presented the quarter 3 quality report which details quality improvement across the Trust, CQUINS and the 2018/19 quality account priorities.

Some of the key points to note were:

- Implementation of NEWS2 and nervecentre upgrades are complete
- Safe Domain ligature free rooms now in place in Emergency Department at both sites for safety of patients with mental health issues
- There have been four never events in relation to the administration of oxygen and air, a silver command process, action plan and additional barriers are in place
- Caring – complaints performance continues to fluctuate; the Chief Executive will be meeting with complaint handlers who have missed the response time
- Well Led - Investors in People Silver Award received

AG highlighted the reduction in the number of beds used for long stay patients since August 2018 is positive. AG asked if the Trust is promoting end of life care plans. The Chief Nurse confirmed there is lots of work taking place with district nurse colleagues, outpatients and specialist nurse colleagues on the advanced care plan to introduce this as part of their care before they arrive at hospital.

AN raised that audits commissioned as part of the Trust response to the Gosport report had limited assurance at the Audit and Risk Committee; however, showed a positive story at Board. He asked why the internal audit report was different. LP confirmed the limited assurance report related to Gosport are being monitored through Quality Committee who are satisfied with the actions on the audit report and this will continue to be on the agenda.

The Executive Medical Director announced it is the first time the Trust have been graded A in the National stroke survey. Calderdale and Huddersfield NHS Foundation Trust are the first Trust in West Yorkshire to achieve this. The Executive Medical Director passed on congratulations to the team.

OUTCOME: The Board **APPROVED** the Q3 Quality Report.

32/19 High Level Risk Register

The Chief Nurse presented the High-Level Risk Register as of 22nd February 2019. Four new risks have been added to the Risk Register:

- 7345 (16) - risk regarding referrals of discharged patients to District Nursing Services

- 7396 (15) - risk relating to connection of tubing for patients prescribed oxygen to air flow meter
- 7413 (16) - risk relating to fire compartmentation at Huddersfield Royal Infirmary, HRI
- 7414 (15) - risk relating to external structure at HRI

6903 and 7271 (20) - The Estates/Resus risk at Huddersfield Royal Infirmary and ICU collective infrastructure have been discussed at various meetings with an agreement a more appropriate risk score would be 15. This is awaiting sign-off by the Chief Operating Officer. In terms of the long-term financial risk 7278, there was agreement at the Finance and Performance Committee this would be reduced to a score of 9 for this year.

RH asked for an update on risk 7240 for surgery and anaesthetics expenditure. The Executive Director of Finance confirmed this risk is due to the Division being overspent and will come off the risk register as of 1st April.

RH asked if the fire risk has been notified to insurers. The Chief Executive advised that a paper for discussion will be at the next Board workshop in April 2019 and formal paper presented to Board in May 2019. The Chief Executive will keep the Board informed on this particular risk.

AN recognised the risk register has improved and escalation through the organisation is strong; however, he noted a number of NHS Trusts had no movement on the risk register, there is more work to do to tighten the process, improve the narrative and review risk scores. AN mentioned there are some risks with no actions on the risk register. The Company Secretary responded to confirm the action plan column has recently been added to the risk register and work is ongoing with colleagues to populate this column.

In relation to the falls risk 5862, AN challenged the score of 16 given a significant rise in falls and asked if this should be increased. LP referenced the Falls Collaborative and assured the Board that this is on the radar and is monitored closely. The Chief Nurse explained there is a natural variation and falls is now on a downward trajectory. The Chief Executive highlighted this was also raised at the Finance and Performance Committee where it was agreed it was higher than normal.
Action: Circulate a chart of falls throughout the year to see the variation – Chief Nurse

RH asked if a further Board workshop can be arranged focused on risk register and the Board Assurance Framework.
Action: Board Workshop on the Risk Register and Board Assurance Framework to be organised – Company Secretary

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

33/19 Learning from Deaths Quarterly Report

The Executive Medical Director presented the Learning from Deaths quarterly report. The key points noted were:

- Development of an online initial screening review tool
- Learning from Deaths policy has been reviewed and updated, including additional links to raise concerns
- Tea Trolley rounds and Quality Friday visits are useful to obtain information from staff and be aware of any instances on wards
- Disseminate learning across the Trust by video linked to Trust news, Intranet, PSQB and audit meetings
- Align learning from deaths to the new Medical Examiner role if approved

The Chief Executive asked if the Board can review the learning at a future Board workshop.

Action: Board Workshop on Learning from Deaths to be scheduled – Company Secretary

The Executive Medical Director explained this is a developing process. The speciality focused initial screening reviews are small and still only 30% are reviewed. The numbers will start to improve once this process has been rolled out to all areas.

KH asked if the Medical Examiner role had been defined. The Executive Medical Director responded that there are currently 5-6 people completing reviews throughout the week. Therefore, the lead Medical Examiner will have a number of medically qualified deputies to review death certificates and review notes. If any anomaly is identified in the reviews, the lead Medical Examiner would have a conversation with the certified doctor.

AG asked what the learning outcomes of the reviews are and if there are any changes in practice. The Executive Medical Director explained these are quality of care reviews and are not looking for causes of death. The key learning outcomes are communication between staff groups have been reviewed, quality of documentation and reducing delayed observations and medication. A formal thematic review will be presented to the next Board meeting.

Action: Thematic review of learning from deaths presented to the next Board

LP highlighted hospital standardised mortality ratio (HSMR) has reduced dramatically and she highlighted the Trust started to review deaths before there was a national requirement to do so.

OUTCOME: The Board **APPROVED** the Learning from Deaths Quarterly Report.

34/19 Care of the Acutely Ill Patient

The Executive Medical Director presented the Care of the Acutely Ill Patient update. The key points to highlight were:

- NEWS2 – significant piece of work moving forward
- Improved position for summary hospital-level mortality indicator (SHMI) and HSMR - positive outlier
- Lots of work is taking place for end of life care
- Development of the frailty services based at Huddersfield, particular over winter

RH recognised the acute frailty service is a relatively new development and is making good progress. The Chief Nurse added an experienced and skills multidisciplinary team are delivering the frailty service. This is focused on the Emergency Departments and assessment wards. The Trust are working together to get results with community colleagues.

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

35/19 Guardians of Safe Working Report

Anu Rajgopal, Consultant Microbiologist presented the quarter 4 report on Guardians of Safe Working Hours (GOSWH).

The key updates are:

- Guardians of Safe Working Hours article is in the trainee newsletter
- Face-to-face engagement at teaching sessions (FY grade)
- Face-to-face supervisor teaching at audit sessions
- GOSWH intranet page
- Ad hoc ward visits as GOSWH

The main issues mentioned in exceptions are:

- Medicine - low levels of staffing
- Surgery - A number of exceptions due to busy post-take days
- Microbiology - 3 exceptions due to breach in stipulated period of rest

OUTCOME: The Board **NOTED** the Guardians of Safe Working Report.

36/19 Integrated Performance Report

The Director of Operations for FSS presented the key updates for January 2019, which were:

- January's performance score has fallen to 68% this month
- Emergency care standard was 89.5% for February 2019 and currently 91% in March 2019
- Achieved all key cancer targets for the third year running
- % Diagnostic Waiting List Within 6 Weeks - target missed in 2 out of last 3 months due to staffing issues with Echocardiography and were not recorded on the electronic referral system, this is being reviewed and will be monitored

The Chief Nurse explained the higher number of falls within surgery was at a time when the ward was reconfigured, and the Surgical Assessment Unit moved to an area where visibility of patients was significantly reduced. A Senior Nurse acted on this quickly and addressed the issue.

PO recognised the strong performance in referral to treatment, cancer and A&E and stated the Trust are 8th across the whole of the U.K in terms of performance. The A&E performance is 9th across the country.

KH asked why appraisals are down at 63% in January. The Executive Medical Director responded the percentage is always around this level and at the end of the year and all doctors who should have an appraisal will have one. He re-assured the Board only one appraisal was missed last year.

OUTCOME: The Board **APPROVED** the Integrated Performance Report.

37/19 Governance Report

The Company Secretary highlighted several governance items for review and approval by the Board.

KH asked that the 'Workforce Organisational Development Strategy' is moved to an annual item for Board and added to the workplan.

AN asked that 'Digital Health' is made a regular item at Board, a minimum of twice a year.

Action: Updated Board Workplan to be circulated

<u>Updates to the Constitution and Standing Orders</u>

The constitution will be reviewed later in the year based on updated Foundation Trust Code of Governance. The updates will come back to Board later in the year.

OUTCOME: The Board **APPROVED** the following:

- Board Workplan
- Board of Directors Declarations of Interest
- Fit and Proper Person Self-Declaration Register
- Board of Directors Terms of Reference
- Changes to the Trust Constitution and Standing Orders

OUTCOME: The Board is **NOTED** the following:

- Use of Trust Seal
- Non-Executive Directors (NEDs) tenure and review of roles
- Guidance for reserving matters to a private session of the Board of Directors
- New UK Corporate Governance Code
- Board to ward visits feedback

38/19 Plan on a Page Strategy Update

The Chief Executive presented the year end progress that has been made to implement the 2018-19 strategic plan on a page and highlighted five of the eighteen deliverables have been fully completed.

RH asked why the launch of the Quality Improvement Strategy had not been completed. The Chief Nurses confirmed this was tied into the work on 'The Cupboard'. The aim is for this action to be fully completed at the next update.

OUTCOME: The Board **APPROVED** the Plan on a Page Strategy update.

39/19 19/20 Annual Plan Update

The Executive Director of Finance delivered a presentation on the 2019/2020 Annual Plan.

PO added the discussion at the Finance and Performance Committee was it is a challenging but achievable plan and it would be recommended. This would be a big improvement driven by additional funding.

AG asked for clarity on the HRI cladding and emergency funding of £2m. The Executive Director of Finance stated this is an ongoing process and is reliant on the latest 6 facet survey report. He added £2m was an indicative number to continue to provide services. There is an element of risk in the £197m, some of the £20m was around cladding.

AG asked if there is a limit of £5m on the emergency bid. The Executive Director of Finance stated there is not a limit; however, there is an approval process and the Trust were advised to keep this at £5m.

AG asked if there is an investment in technology and capability to drive this. The Executive Director of Finance responded a separate resource has not been identified for these developments and he is involved in a piece of work with the Director of Partnerships and Transformation to scope this with the Managing Director for Digital Health. The Director of Partnerships and Transformation is also speaking to colleagues at Leeds Teaching Hospitals regarding reconfiguration.

OUTCOME: The Board **APPROVED** the 2019/2020 Annual Plan.

40/19 Month 10 Financial Summary

The Executive Director of Finance presented the month 10 financial summary, the key updates were:

- Year to date deficit of £36.5m
- Picked up expenditure higher than forecast – in relation to high cost energy costs
- Clinical waste contract is costing significantly more than anticipated
- Additional income with commissioners – North Kirklees
- Settled long-term debts is favourable
- Remain on track to deliver for the Cost Improvement Programme (CIP) and capital plan for the year
- Reduced the in year financial risk 7278 from a 20 to a 9

OUTCOME: The Board **NOTED** the Month 10 Financial Summary.

41/19 Public Sector Equality Duty (PSED) Annual Report

The Executive Director of Workforce and OD presented the PSED annual report. In 2019 the Trust will give renewed focus to its "Putting Patients First, a strategy for involvement and equality". This wider strategy identifies actions to enhance the patient experience, and to address specific needs of those with a protected characteristic.

The Executive Director of Workforce and OD highlighted section 4 of the report which details actions from the Equality and Diversity workforce with more positive, ambitious language.

Appendix 1 provides the current breakdown of equality in our workforce.

OUTCOME: The Board **APPROVED** the Public Sector Equality Duty (Equality, Diversity and Inclusion) Annual Report for 2018.

42/19 Calderdale and Huddersfield Solutions (CHS) Update

AG declared an interest in this agenda item as Chair of the Calderdale and Huddersfield Solutions Ltd Board.

The Director of Finance provided the key updates on CHS:

- Joint Liaison Committee has taken place and the terms of reference and governance process has been agreed
- Service Level Agreements (SLAs) have been agreed
- In the process of monitoring key performance indicators (KPIs)
- Efficiencies from CHS for next financial year have been agreed
- The targeted savings for the Board is achieved for this year
- CHS have successfully recruited a new Non-Executive Director, subject to approval

OUTCOME: The Board **NOTED** the update on Calderdale and Huddersfield Solutions Ltd.

43/19 Update from sub-committees and receipt of minutes & papers

<u>Finance and Performance Committee – minutes from the meeting 28.9.18 and verbal update from meeting 1/2/19</u>

Key points from the previous Finance and Performance Committee were circulated with the papers from PO, Chair of the Finance and Performance Committee.

<u>Audit & Risk Committee – minutes from meeting 23.01.19</u>

RH, Chair of the Audit and Risk Committee provided an update from the last meeting, the main areas to bring to the Boards attention were:

- Presentation at the January meeting on data quality issues, a further report will be provided in 3 months'
- The annual reporting timetable and audit plan of KPMG was discussed, there was concern regarding timings with the departure of the Company Secretary
- Brexit risks were discussed at the last meeting

<u>Quality Committee – minutes from meeting 2.1.19</u>

LP, Chair of the Quality Committee provided a verbal update from the last meeting. The key points to note were:

- Meeting on 4 February 2019 received a report on Research, the Committee are keeping on top of this agenda and there is a new Medication and Safety Compliance Group
- A report from Dr Bill Kirkup who led work on serious service failures was discussed, LP presented a paper that will be circulated to the Board

- Report on compliance with NICE guidelines and how these are monitored, Linda Patterson thanked the Associate Medical Director, Neeraj Bhasin, Network Director for Vascular Surgery for pulling these reports together

Council of Governors meeting – minutes were received from the meeting held 24.1.19
The Chair provided a verbal update from the last meeting, the key points to note were:

- Meeting held 24 January 2019 was well attended and the minutes have been circulated
- The next Council of Governors meeting is on 11 April 2019
- There have been good suggestions from a range of governors to improve the Council of Governors meetings both verbally and written, this will be reviewed, and feedback will be provided on some of this at the next meeting, the Chair thanked the governors for providing their comments

Workforce Committee – minutes from meeting 11.2.19
KH, Chair of the Workforce Committee provided a verbal update from the last meeting, the key points to note were:

- Return to work interviews was discussed as there are two different ways of recording and only one way to extract data, looking at any anomalies
- Time to recruit was a discussion
- Deep Dive into employee relations cases

Charitable Funds Committee – minutes from meeting 27.2.19
The minutes of the previous meeting held 27 February 2019 were received.

Any Other Business
There was no other business to note.

Date and time of next meeting
Thursday 2 May 2019, 9:00 am
Venue: Boardroom, Huddersfield Royal Infirmary

5. Action log and matters arising

For Comment

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 7 March 2019 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
7.3.19 33/19	**Learning from Deaths** Thematic review of learning from deaths presented to the next Board	DB		May 2019		
7.3.19 33/19	**Learning from Deaths** Board Workshop on Learning from Deaths to be scheduled	AM		May 2019		
7.3.19 32/19	**High Level Risk Register** Board Workshop on the Risk Register and Board Assurance Framework to be organised	AM	To be scheduled for the Board Workshop on 3 October 2019.	May 2019		
7.3.19 32/19	**High Level Risk Register** Circulate a chart of falls throughout the year to see the variation	JM		May 2019		
3.1.19 17/19	**GOVERNANCE REPORT** Security and Resilience Group to be added to the Governance Structure	AM / NEDs	Non-Executive Directors are meeting on 7th March to agree reporting arrangements. An updated structure and proposal will be come back in May 2019.	May 2019		
	Review the Board to Ward visits with the Quality Friday visits to link these two together	JM/HB	The Board to Ward visits have been combined with the Quality Friday visits	March 2019		7.3.19
	Non-Executives to share feedback on Trust Board packs, reports and structure (self-assessment)	NEDs	Feedback has been received and a new cover sheet has been developed and used from May 2019.			7.3.19
3.1.19 12/19	**GMC SURVEY 2019** Medical Director to work with the Managing Director for CHS on out of hours facilities for Jr Drs	DB	Catering Retail Survey circulated under matters arising on 7.3.19.	May 2019		7.3.19
3.1.19 10/19	**HIGH LEVEL RISK REGISTER** Circulate revised wording for risk 5511 'Collective Fire Risk' to the Board following the Risk and Compliance Committee on 14 January 2019	JM		January 2019		7.3.19

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 7 March 2019 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
3.1.19 8/19	**FRAILTY TEAM** Work with Renee Comerford and the mental health team to review dementia screening so patients don't leave undiagnosed Expedite the use of SystmOne with Locala so the Community Team can write advanced care plans	JM / HB		March 2019		7.3.19

Date of Meeting:	Thursday 7 March 2019
Meeting:	Board of Directors – Action Log (7.3.19)
Title:	Circulate a chart of falls throughout the year to see the variation
Author:	Jackie Murphy, Chief Nurse Lindsay Rudge, Deputy Director of Nursing
Previous Forums:	Board of Directors

Actions Requested:

- To circulate a chart of falls throughout the year to see the variation

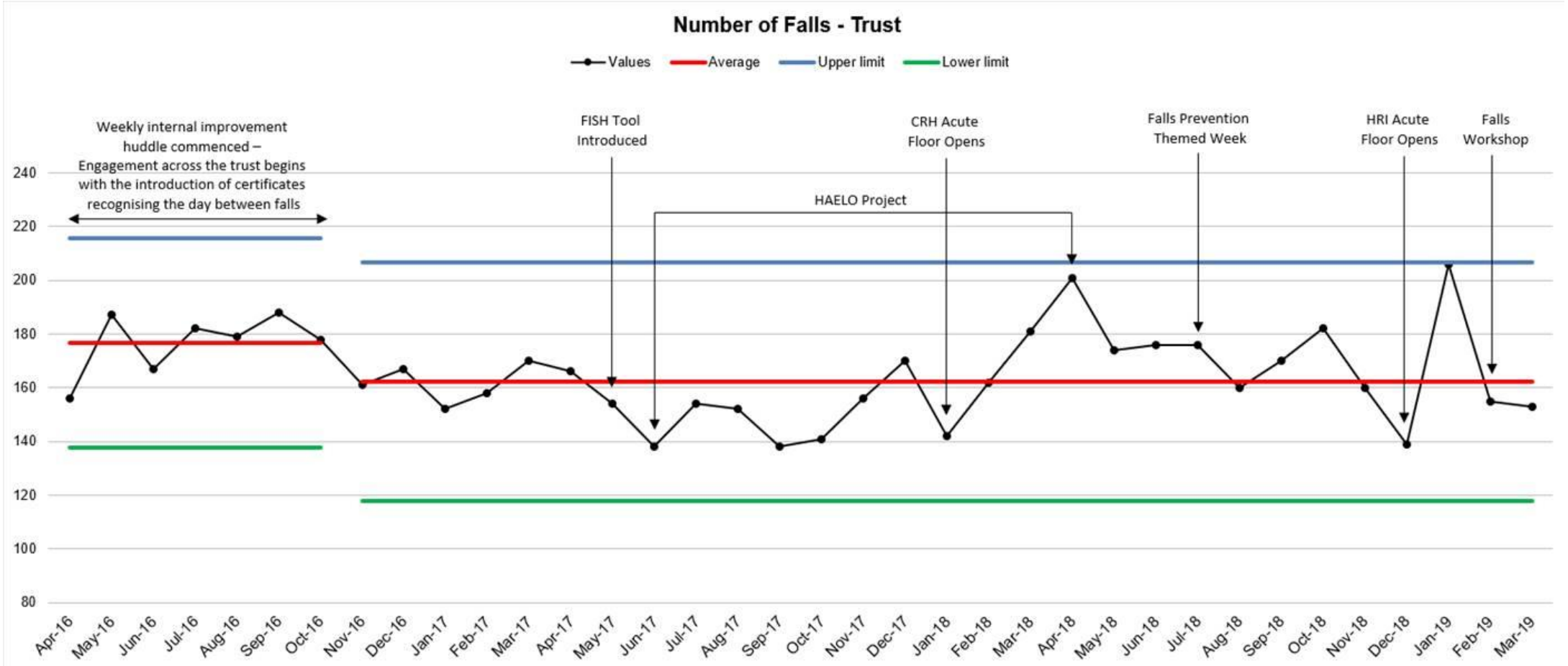
Purpose of the Report

The chart below updates the Board on the position regarding falls and demonstrates the changes and improvement initiatives from April 2016 – March 2019.

Recommendation

The Board are asked to note the position regarding falls.

Falls Chart – Variation
April 2016 – March 2019



6. Chair’s Report

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

To Note

Presented by Owen Williams

8. Reconfiguration of Hospital Services Strategic Outline Case

To Note

Presented by Anna Basford

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2 May 2019
Meeting:	Board of Directors
Title:	Reconfiguration of Hospital Services: Strategic Outline Case
Author:	Anna Basford, Director of Transformation & Partnerships
Previous Forums:	The Strategic Outline Case (SOC) for the Reconfiguration of Hospital Services was approved (subject to agreed minor amendments) by the Trust Board at a meeting held in private on Friday 22 March 2019. At the meeting held on 22 March 2019 members of the Board of Directors confirmed that in approving the SOC they had taken account of the findings of the Quality and Equality Health Impact Assessment of the service proposals described within the SOC. The amendments that were requested by the Board of Directors have been incorporated in the attached version of the SOC. Letters of support from Calderdale CCG, Greater Huddersfield CCG and the West Yorkshire and Harrogate Health and Care Partnership lead Chief Executive have also been provided and are included in the SOC.
Action requested: To note	

Purpose of the report

In December 2018 the Department of Health and Social Care (DHSC) announced that capital funding of £196.6m has been allocated for the proposed reconfiguration of hospital services in Calderdale and Huddersfield.

Following this the DHSC also confirmed that approval of a Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) by NHS Improvement, DHSC, Ministers and HM Treasury would be required. An outline timeline and process for development of the business cases is included within the SOC.

The attached SOC has been submitted to NHS Improvement. The content of the SOC is consistent with information that has previously been published in progress reports submitted to the Secretary of State for Health and Social Care.

Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)

Clinical, workforce and financial sustainability risks have been identified if there is no change to the current configuration of CHFT hospital services. These risks and their potential solutions have been debated for a number of years.

The draft SOC describes how the proposed reconfiguration of hospital services enabled by capital investment will improve the clinical quality of hospital services;
improve the efficiency of service delivery; reduce the running cost of services and thereby support local and regional system affordability; improve compliance with statutory, regulatory and accepted best practice; make the best use of the available hospital estate.

The Trust recognises the impacts of service changes on staff, patients and the public and is committed to working hard to understand and mitigate these impacts where possible. The Trust will continue to fully engage and involve staff, local people, campaign groups, key stakeholders and the Joint Health Scrutiny Committee in the next steps to deliver the proposed future model for hospital services across Calderdale and Huddersfield. The SOC includes description of the plans for on-going public and stakeholder engagement and these were discussed at a public meeting of the Joint Health Scrutiny Committee held on the 15 February 2019.

EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)

In July 2018 CHFT undertook quality and equality impact assessment of the proposed (revised) service changes. This built on previous detailed EQIA assessments independently undertaken in 2016 by the Midlands and Lancashire Commissioning Support Unit that concluded there was no indication of differential impact that would lead to unlawful discrimination linked to the proposals; the proposals set out health services to address the needs of the whole population, including those who currently experience disadvantage and the plans are intended to help improve access, experience and outcomes for all.

The findings of the updated EQIA undertaken in July 2018 were presented to CHFT Quality Committee on the 20 July 2018 and to the Board of Directors on the 2 August 2018, and as set out above, were considered at the meeting on 22 March 2019. The conclusion of this assessment was that the proposed changes do not generate differential discriminatory equality impacts. The clinical service model described in the attached draft SOC has not changed since the updated EQIA was undertaken in July 2018.

The SOC describes how the Trust is developing the use of digital technology, and that this will support and amplify the benefits of the proposed service reconfiguration. As the proposals for service reconfiguration and the use of digital technology are further developed, the Trust will consider whether there is the need to undertake a Data Protection Impact Assessment (DPIA).

Recommendation

Members of the Board of Directors are requested to receive in public the SOC that was previously approved by the Board of Directors on 22 March 2019.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Reconfiguration of Hospital Services

STRATEGIC OUTLINE CASE 2019

compassionate care

CONTENTS

1. EXECUTIVE SUMMARY

1.1 Introduction

Calderdale and Huddersfield NHS Foundation Trust (CHFT) is an integrated Trust that provides acute and community health services. Hospital services are provided at Calderdale Royal Hospital (CRH) and at Huddersfield Royal Infirmary (HRI). The distance between the two hospitals is just over five miles. The Trust provides community services in the Calderdale area.

Clinical, workforce and financial risks have been identified if there is no change to the current configuration of services. These risks and their potential solutions have been debated for a number of years. This includes formal public consultation on proposed future arrangements for the configuration of services during 2016, referral of the proposals to the Secretary of State for Health and Social Care by Calderdale and Kirklees Joint Health Scrutiny Committee in 2017 and review of the proposals by the Independent Reconfiguration Panel in 2018. Whilst the Trust has day to day operational plans in place to ensure the care and safety of patients, a sustainable solution is urgently needed.

This Strategic Outline Case (SOC) addresses feedback from staff, patients and the public and the recommendations of the Independent Reconfiguration Panel (IRP). The Trust has the opportunity to reshape services, a track record that demonstrates capability to deliver, and a clear proposal which provides the basis for delivering safe, sustainable services.

The West Yorkshire and Harrogate Health and Care Partnership has confirmed that the proposals described in this SOC fit with the overall strategy for the development of better health and care services for West Yorkshire and Harrogate and that these proposals are their highest priority for public capital investment. In December 2018 the Department of Health and Social Care (DHSC) announced that 100% public capital funding of £196.5m had been allocated to support implementation of the proposals described in this SOC.

1.2 Strategic Context

People in Calderdale and Huddersfield are living longer. More people are likely to have multiple long term conditions thereby increasing the demand on the health and social system.

Nationally growing shortages of qualified clinical staff has increased use of agency and other temporary workers to fill vacancies, and this has increased NHS expenditure and made services less stable. This national workforce pressure is exacerbated at CHFT with the current two site configuration of most services, making it difficult to recruit and retain staff leading to a reliance on temporary and agency staffing to sustain service delivery.

CHFT has consistently delivered a high level of performance against national access targets and was given an overall rating of "Good" by the Care Quality Commission (CQC) in 2018 (this combined rating included "Requires Improvement" for the Use of Resources). Over the last two years across the combined and ranked metrics of Referral to Treatment Times (RTT), Emergency Care Standard (ECS) and Cancer waiting time less than 62 Days, CHFT has consistently been one of the best performing Trusts in England.

CHFT is one of the most digitally advanced Trusts in the country and this is key to enabling delivery of high standards of performance. However ensuring delivery of high standards of performance is fragile as the current dual site configuration is reliant on continued use of agency and temporary staffing (and the higher costs associated with this).

The Trust carries a very high risk in terms of the condition and reliability of buildings at Huddersfield Royal Infirmary (HRI). Overall the estate is in poor condition with significant backlog of maintenance for time expired buildings. There are statutory requirements across the site that demand immediate remedial action and a significant investment is required to resolve the functional suitability of the estate, with some buildings not clinically fit for purpose.

The Trust has a financial deficit and is reliant on financial support from the Department of Health and Social Care (DHSC). Structural costs associated with the dual site configuration of services (which require higher workforce expenditure) is a key factor driving the underlying deficit.

1.3 Clinical Case for Change

There is a compelling clinical case for the reconfiguration of the Trust's services to improve the safety and quality of services and ensure the sustainable provision of acute and emergency services in the future. The current dual site model of hospital services does not, and cannot, meet national guidance.

A number of independent reviews and inspections of services have recommended that the status quo (i.e. to do nothing) is not an option and that changes to the configuration of services are needed to improve outcomes and safety. This includes: the National Clinical Advisory Team; the Calderdale Council People's Commission; the Royal College of Physicians; Yorkshire and the Humber Clinical Senate; NHS England (NHSE); NHS Improvement (NHSI); the Independent Reconfiguration Panel (IRP), the West Yorkshire and Harrogate Health and Care Partnership, and; the Calderdale and Kirklees Joint Health Scrutiny Committee.

1.4 Future Hospital Services Model

The proposed future model of hospital services will support and enable delivery of the vision and ambitions described in the NHS Long Term Plan that was published in January 2019. Digital technology will have a central role in transforming services supporting more people to have care at, or closer to, home. This will be complemented by a hospital model that provides essential clinical adjacencies and the critical mass required to sustain staff recruitment and retention, ensure quality and deliver revenue savings.

The proposed model will make use of both existing hospitals. Both sites will provide 24/7 A&E services and a range of day-case, outpatient and diagnostic services - although whenever possible, services will be delivered in the community and closer to people's homes. The total number of hospital beds will remain broadly as they are now whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.

- HRI and CRH will provide 24/7 consultant-led A&E services;
- A&E at CRH will receive all blue light emergency ambulances for patients that have serious life-threatening conditions and all patients likely to require hospital admission;
- CRH and HRI will provide medically led 24/7 urgent care;
- Critical care services, emergency surgery and paediatric surgery will be provided at CRH;

- Physician-led inpatient care for people who do not require the most acute clinical inpatient healthcare will be provided at HRI;
- Midwifery led maternity services will be provided on both hospital sites;
- Consultant-led obstetrics and neo-natal care will be provided at CRH;
- Planned surgery and care will be provided at HRI.
- Patients that require complex surgery or it is known that they will require critical care after surgery will be treated at CRH.
- Digital Health capability, such as the electronic patient record and patient portals will enable 'real-time' review and advice on patient's care to be provided by specialist staff where required.

1.5 Estate Plan

The West Yorkshire & Harrogate Health and Care Partnership has agreed the proposals described in this SOC as their top priority for capital funding and the DHSC announced in December 2018 that 100% public capital funding of £196.5m has been allocated to support implementation of the proposals. This will be used for:

- £20m investment at HRI to enable adaptation of existing buildings and to address the most critical backlog maintenance requirements enabling the continued use of some buildings on the HRI existing site.
- £177m for expansion and new build at CRH.

These proposals do not fully address the backlog maintenance requirements at HRI and the Trust will therefore continue to manage a very high risk in terms of the condition and reliability of buildings at HRI.

1.6 Economic Case

An assessment of the financial and non-financial benefits of the proposed service and estate model compared to continuing the existing service model and, in relation to the capital funding source, has been undertaken. The Economic Case analysis demonstrates the case for change and that the proposed service model provides economic, value for money (VFM) advantage compared to the existing service model.

1.7 Financial Case and Affordability

The financial case demonstrates affordability of the investment into the Trust's estate and reconfiguration of services. The modelled clinical activity and revenue has been agreed as affordable for the local health sector and this is confirmed by Greater Huddersfield and Calderdale Clinical Commissioning Groups (CCGs).

The investment provides medium term sustainability for the Trust and mitigates significant estate and service risk that exists within the Business As Usual and the Do Minimum case. The Agreed option delivers a net £10m financial efficiency and sees the Trust return to financial balance without Financial Recovery Fund revenue in FY27. The cumulative deficit position is favourable at FY27 compared with both the Business As Usual and the Do Minimum options and this position improves further at FY45.

1.8 Stakeholder Engagement

This SOC builds on significant public, stakeholder and clinical engagement since 2012. This SOC is an evolution of the proposals informed by the extensive previous clinical and public engagement and the formal public consultation undertaken in 2016. There are a number of areas where the proposed service model is unchanged from that which was previously the subject of public consultation. Where changes have been made these have sought to respond to the views of stakeholders and to the recommendations of the Independent Reconfiguration Panel.

In developing this SOC discussions have involved engagement with primary and secondary care senior clinicians; external clinical review via NHSE; system meetings with regional leads for NHSI, NHSE and the Integrated Care System; Health & Wellbeing Boards; Joint Health Scrutiny and Local Medical Committees (LMCs). It is planned to continue to fully engage and involve local people, voluntary organisations and key stakeholders in the next steps to deliver the proposed future model for hospital services across Calderdale and Huddersfield.

1.9 Conclusion

This SOC proposes a plan that will improve the quality and safety of hospital services; improve the recruitment and retention of staff; eliminate the Trust's underlying financial deficit; and deliver economic and affordability benefits compared to continuing with the existing model of hospital care. The West Yorkshire and Harrogate Health and Care Partnership has confirmed the proposals described in this SOC as their highest priority. NHS Improvement and NHS England are requested to support and recommend to the Department of Health and Social Care and the Treasury approval of this SOC.

2. BACKGROUND & INTRODUCTION

Calderdale and Huddersfield NHS Foundation Trust (CHFT) has two District General Hospital sites, Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH), located 5 miles apart in Huddersfield and Halifax.

There is a compelling quality and financial case for change in the local health and care system. Work to develop a safe and sustainable model of hospital and community care in Calderdale and Huddersfield has been underway since July 2012. Formal public consultation on proposed future arrangements took place during 2016. In September 2017 the Calderdale and Kirklees Joint Health Scrutiny Committee referred the proposals to the previous Secretary of State for Health and Social Care and his recommendations and the advice of the Independent Reconfiguration Panel (IRP) were published in May 2018. This set out that further work focusing on out of hospital care, hospital capacity and the availability of capital funding was required by the NHS before a conclusion could be reached.

During the summer of 2018 significant work was therefore undertaken by local NHS organisations, working with NHS England (NHSE) and NHS Improvement (NHSI) and engaging the Chairs of the Joint Health Scrutiny Committee, Health and Wellbeing Boards, and the Local Medical Committees (LMCs), to develop an enhanced proposal for the future model of care. The enhanced proposal sought to ensure the best possible clinical outcomes for patients within available resources and to address the issues identified by the Independent Reconfiguration Panel (IRP) in its report. An update describing the enhanced proposal (and the stakeholder engagement undertaken that informed this) was sent to the Secretary of State for Health and Social Care in August 2018.

During the summer of 2018 West Yorkshire & Harrogate Health and Care Partnership supported the national capital funding prioritisation process and agreed these proposals as its top priority. The Partnership confirmed that the proposals fit with the overall strategy for the development of better health and care services for West Yorkshire and Harrogate as a whole.

In September 2018 the Secretary of State for Health and Social Care confirmed that he was pleased that rapid progress had been made, with the active involvement of stakeholders, and on 7th December 2018 the Department of Health and Social Care (DHSC) announced that capital funding of £196.5m had been allocated to support implementation of the enhanced proposal. This capital funding allocation was included as part of the Government's major multi-year £2.9 billion funding package of additional capital investment in the NHS to provide better service models for patients, integrate care services and renew aging facilities.

Following the DHSC announcement of capital funding availability it was also confirmed by DHSC that approval of a Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) by NHSI, DHSC, Ministers and HM Treasury would be required. The business cases will be approved by CHFT Trust Board prior to submission to NHSI and letters of support from CCG Governing Bodies, and the West Yorkshire & Harrogate Health and Care Partnership Lead Chief Executive will also be required at each stage of approval. The content of the SOC, OBC and FBC will take account of Her Majesty's Treasury (HMT) Green

Book guidance on appraisal and evaluation and the supplementary Guide to Developing the Project Business Case (2018) and guidance from NHSI.

Based on these requirements and the associated governance processes the table below provides an indicative outline timeline for this development.

Stage	Submitted to NHSI	NHSI, DHSC, Ministers & HMT Approval
SOC	April 2019	December 2019
OBC	February 2020	October 2020
FBC	January 2022	September 2022
Commence Build	January 2023	
Complete Build	January 2025	

This document therefore provides the Strategic Outline Case (SOC) for the reconfiguration of hospital services in Calderdale and Huddersfield. It describes the plans to improve the safety and sustainability of hospital patient services provided by CHFT, building on the feedback provided by staff, patients, the public and the IRP. The local NHS has worked with the Calderdale and Kirklees Joint Health Scrutiny Committee throughout the development of the plans described. Informal workshops and meetings took place in July and August 2018 and the proposals were discussed at the formal public meeting of the Joint Committee that took place on 7th September 2018. Since then further informal meetings with the Chairs of the Joint Committee were held on 1st October 2018, 5th November 2018 and 22nd January 2019 and a formal public meeting of the Joint Committee was held on 15th February 2019 to further discuss the proposals.

The proposed future model of hospital services in Calderdale and Huddersfield will support and enable delivery of the vision and ambitions described in the NHS Long Term Plan. Digital technology will have a central role in transforming services in order to support more people to have care at, or closer to, home. This will be complemented by a hospital model that provides essential clinical adjacencies and the critical mass required to sustain staff recruitment and retention, ensure quality and deliver revenue savings.

There are a number of areas where the proposed model described in this SOC are unchanged from that which was previously the subject of public consultation (this includes: urgent care; maternity and midwifery services; paediatrics; planned surgery; acute inpatient medical care; critical care; acute and complex surgery, and; outpatient services). Where changes have been made to the proposed future hospital service model this has sought to respond to the views of stakeholders and to the recommendations of the IRP. The key changes are: the continued provision of 24/7 consultant-led A&E services at both sites; the provision of physician-led

inpatient care at HRI, and; a commitment to maintain the number of hospital beds broadly as they are now whilst services are developed in the community.

This SOC is structured to explain the proposed service changes from 5 interdependent dimensions – known as the Five Case Model i.e.

Strategic Case	**What is the case for change?** What is the current situation? What is to be done? What outcomes are expected? How do these fit with wider government policies and objectives?
Economic Case	**What is the net value to society (the social value) of the intervention compared to continuing with Business As Usual?** What are the risks and their costs, and how are they best managed? Which option reflects the optimal net value to society?
Commercial Case	**Can a realistic and credible commercial deal be struck?** Who will manage which risks?
Financial Case	**What is the impact of the proposal on the public sector budget in terms of the total cost of both capital and revenue?**
Management Case	**Are there realistic and robust delivery plans?** How can the proposal be delivered?

This SOC describes how the proposed reconfiguration of hospital services enabled by capital investment will:

- Improve the clinical quality of hospital services;
- Improve the efficiency of service delivery and thereby support local and regional system affordability;
- Improve compliance with statutory, regulatory and accepted best practice;
- Make the best use of the available hospital estate.

The Trust recognises the impact of service changes on staff, patients and the public and is committed to working hard to understand and mitigate this impact where possible. The Trust will continue to fully engage and involve staff, local people, campaign groups, key stakeholders and the Joint Health Scrutiny Committee in the next steps to deliver the proposed future model for hospital services across Calderdale and Huddersfield.

3. THE STRATEGIC CONTEXT

This section provides an overview of the 'as is' strategic context for the development of this SOC and provides information in relation to:

- The health needs of people resident in Calderdale and Huddersfield;
- NHS national plans;
- West Yorkshire & Harrogate Health and Care Partnership;
- NHSE Specialised Service Commissioning;
- Calderdale and Greater Huddersfield Clinical Commissioners;
- Calderdale and Kirklees Councils;
- Care Closer to Home;
- Digital Technology
- CHFT current service provision and performance;
- Summary of timeline, key documents and stakeholder engagement previously undertaken.

3.1 Health Needs in Calderdale and Huddersfield

The resident population of Huddersfield and Calderdale is approximately 453,000. People in Calderdale and Greater Huddersfield are living longer lives than in the past, however, more people are likely to have multiple long term conditions and thereby increase the demands on the health and social system. Life expectancy at birth in Calderdale and Kirklees is lower than the England average. As a result, there is a growing population, with more complex health needs, putting more demand on healthcare services in both Calderdale and Huddersfield (see figure 1).

Figure 1	Calderdale	Greater Huddersfield
Population Growth	The population is increasing and will continue to grow, especially in the over 65 and the 0-15 year old age group. It is expected that the population that Calderdale CCG commission services for will increase by 10% over the next 25 years.	The population is increasing and will continue to grow, especially in the over 65 and the 0-15 year old age group. Estimates suggest that by 2030 the population will be 278,700 (an increase of >15.2% since 2010).
Mental health and dementia	In Calderdale it is estimated there are 2,300 people living with dementia and this is forecast to increase by about 75% over the next 15 years.	In Kirklees it is estimated there are 4,000 people living with dementia and this is forecast to increase by about 75% over the next 15 years. 1 in 5 adults are reported to be suffering from depression, anxiety or other mental health conditions.

Figure 1	Calderdale	Greater Huddersfield
Deprivation	Fuel poverty is estimated to affect a quarter of all households in Calderdale. An estimated 1 in 5 children are living in poverty. Higher rates of infant mortality are associated with higher levels of deprivation, and the infant mortality rate (MR) for Calderdale is significantly higher than the England average (7.53 per 1,000 live births compared to 4.69 per 1,000 births).	There are high poverty and deprivation levels in Greater Huddersfield with higher rates of unhealthy behaviours and higher disease burden. Long term pain, depression and anxiety have the largest impact on local health.
Lifestyle factors and obesity	Behavioural factors which relate to health are not improving. Smoking prevalence and the harm caused by alcohol and obesity is increasing. There is rising childhood obesity and it is estimated that 40% of all illness in Calderdale can be attributed to lifestyle factors.	Lifestyle choices have a significant impact on the major causes of ill health and premature death in Greater Huddersfield. 53% of adults in the Greater Huddersfield area are overweight or obese, and 1 in 5 children are overweight or obese.
Life expectancy and inequalities	More people are living longer with multiple health problems. There is a growing health gap, with those living in Calderdale's most disadvantaged communities experiencing greater ill health than elsewhere in the district (there is a life expectancy gap within wards within Calderdale of up to 11 years).	More people are living longer with multiple health problems. Life expectancy varies across Greater Huddersfield, with the gap in life expectancy at birth at 3.4 years for men and 3 years for women. Average life expectancy at birth is also lower than the national average: 78.1 year for men (78.5 national) and 81.8 for women (82.5 national).
Source: National Census Data 2011, Kirklees Joint Strategic Needs Assessment, Calderdale Joint Strategic Needs Assessment , Calderdale Public Health Annual Report 2017/18, Kirklees Public Health Annual Report 2017/18		

Preventing avoidable illness (through actions such as smoking cessation, obesity reduction, and lower air pollution) as well as providing better support for patients, carers and volunteers to self-manage long-term health conditions, will be essential to address the health needs of the local population.

3.2 The NHS Long Term Plan

In 2018 the Government announced a £20.5bn annual real terms uplift for the NHS by 2023/24 and in January 2019 the NHS long term plan was published. The Plan describes ambitions over the next ten years to ensure the NHS is fit for the future and details improvements to be delivered in the following key areas:

- Improving out-of-hospital care (primary and community services);
- Strengthening the NHS contribution to prevention and reducing health inequalities;
- Reducing pressure on emergency hospital services;
- Delivering person-centred care;
- Delivering digitally enabled primary and outpatient care;
- Focusing on population health and local partnerships with Integrated Care Systems having a central role in the delivery of the Plan.

The proposed future model of hospital services in Calderdale and Huddersfield described in this SOC will support and enable delivery of the vision and ambitions described in the NHS Long Term Plan. In particular, the NHS Long Term Plan confirms that:

"separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing complex, urgent care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. So we will continue to back hospitals that wish to pursue this model."

3.3 West Yorkshire & Harrogate Health and Care Partnership

Integrated Care Systems (ICSs) will be central to the delivery of the NHS Long Term Plan. They bring together local organisations to redesign care and improve population health, creating shared leadership and action. The West Yorkshire and Harrogate Health and Care Partnership (ICS) is the second largest in the country covering a population of 2.6 million people and a budget of over £5 billion. The purpose of the partnership is to deliver the best possible health and care for everyone living in the areas of: Calderdale; Kirklees; Bradford District and Craven; Leeds; Wakefield; Harrogate. The Partnership is made up of care providers, commissioners, voluntary organisations and Councils working closely together to plan health and care.

During 2018 West Yorkshire and Harrogate Health and Care Partnership supported the national capital funding prioritisation process and agreed the proposals described in this SOC as their top priority confirming that the Partnership was confident that these proposals fit with the overall strategy for the development of better health and care services for West Yorkshire and Harrogate as a whole.

The ICS has supported the developments in Calderdale and Huddersfield throughout the process of developing this SOC in a material and meaningful way:

- All organisations across the partnership made investment in Calderdale and Huddersfield the number one priority for capital bids in the last round. This helped secure funding for the system.
- The ICS has funded additional work to develop the models that will be required to support more people within communities and accelerate the development of local care networks.
- The ICS is playing a lead role in the Local Health Care Record Exemplar (LHCRE) programme, which is both supporting the work within Calderdale and Huddersfield, and learning from the work to inform progress across the whole region.
- The ICS has been fully involved in local scrutiny discussions, as well as political discussions at a local and national level.

A letter of support from the West Yorkshire Health and Care Partnership for this SOC is provided at section 13.

3.4 NHSE Specialised Service Commissioning

NHS England (NHSE) commissions 149 specialised services across England. Specialised services are provided in relatively few hospitals and accessed by comparatively small numbers of patients, but usually with catchment populations of more than one million. CHFT currently provides the following specialised services:

- Vascular surgery and vascular interventional radiology services;
- Neonatal intensive care;
- HIV;
- Chemotherapy;
- Bone anchored hearing aids (BAHA);
- Cardiac MRI;
- Implantable cardiac device.

During 2016/17 NHSE undertook a review of vascular specialised services across Yorkshire and Humber and recommended that West Yorkshire should move from 3 to 2 vascular arterial surgery centres, with one at Leeds due to the major trauma centre and one at either Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) or Calderdale and Huddersfield NHS Foundation Trust. At the request of NHS England, the West Yorkshire Association of Acute Trusts (WYAAT) worked with vascular clinicians from across West Yorkshire to make a recommendation on its preferred option for the future location of arterial centres and in April 2017 the WYAAT Committee in Common (CIC) unanimously agreed to recommend BTHFT as WYAAT's preferred option to NHS England.

NHS England is currently progressing engagement and dialogue to take forward this recommendation. This SOC has been developed on the assumption that CHFT in the future will not provide acute vascular arterial surgery (this means that the development of a hybrid theatre has not been included in the proposed estate development).

3.5 Calderdale and Greater Huddersfield Clinical Commissioners

NHS Calderdale and NHS Greater Huddersfield Clinical Commissioning Groups (CCGs) commission the majority of hospital and community health services for the Calderdale and Greater Huddersfield populations. Both CCGs are progressing plans to improve: the quality and safety of care; outcomes for patients; service affordability and sustainability. The

Governing Bodies of Calderdale CCG and Greater Huddersfield CCG have previously agreed that there is a compelling case for changing the way that local health services are provided and that if the local system is unable to redesign and transform services in a way that drives up quality, then patients will experience poorer outcomes as a result.

Working closely with Kirklees and Calderdale Health and Wellbeing Boards and local stakeholders, both CCG plans include: the development of care closer to home (described in more detail below); the reconfiguration of hospital services; and the increased use of digital technology.

During 2016 the CCGs led the Right Care, Right Time, Right Place formal public consultation on proposed future arrangements for hospital and community health services in Calderdale and Greater Huddersfield. Since 2016 the CCGs have continued to work closely with Calderdale and Kirklees Joint Health Scrutiny Committee and local stakeholders to respond to the findings of the Public Consultation and to the issues raised by the Independent Reconfiguration Panel. The outputs from this work have informed and are reflected in the proposals described in this SOC.

The CCGs will formally consider this SOC during April to determine whether the proposals described will improve clinical care and outcomes for the Calderdale and Greater Huddersfield population; that the proposals are affordable to Commissioners, and that the proposals will improve and achieve the financial sustainability of the Calderdale and Greater Huddersfield system of care.

Letters of support from Calderdale and Greater Huddersfield CCGs for this SOC are provided at section 13.

3.6 Local Councils and Committees

3.6.1 Calderdale and Kirklees Councils

There has been on-going engagement with Calderdale and Kirklees Councils in relation to the revised proposals described in this SOC. The view of each Council is shown below.

"Calderdale Council has supported the proposals and agreed that they are wholly consistent with the Council's strategic intent and plans. The Council has confirmed it will take all necessary action to work with the local health system to realise the full impact of the investment and the delivery of a sustainable health and social care system in the future. This work fits with Calderdale's 2024 Vision and its focus caring for local people as a part of Calderdale Cares."

"Kirklees Council recognises that there are quality, cost and sustainability pressures across the whole health and care system and that change will be required to address this. These pressures face all the healthcare providers that support Kirklees residents and considering only one of these providers will not result in the best solution for Kirklees. The configuration of services delivered by CHFT cannot be considered in isolation from those delivered by Mid Yorkshire Trust which also experiences pressures, has re-configured services but will need to further re-configure including those services currently delivered in Kirklees. The Council believes that the exact configuration of services should be determined through a comprehensive review of all health and social care services and facilities across Kirklees including community provision because we know that a number of our community facilities are not ideal. This process should be supported by a single plan for Kirklees rather than individual organisations planning in isolation from each other. The Council considers that there is scope for operational and financial efficiency if the 2 acute providers that serve Kirklees were to collaborate and work together to re-configure services

within Kirklees. This feels to be much more in line with the concept of an ICS than the current approach of organisational silos. Whilst the Council welcomes investment into local health services and recognises that there are some urgent short term estates issues, the Council would not want to see investment in solutions that constrain future change, particularly knowing that the re-configuration proposals made by CHFT are only a short term solution and not a sustainable long term plan. The Council also believes that significant investment is required in prevention, staying well and helping people to manage their own health conditions effectively. This includes investment in community health care services, social care and voluntary sector capacity, all of which have seen significantly less focus and investment than the primary, mental health and acute care sectors. It is helpful to see that the NHS 10 Year Plan recognises this and we welcome the opportunity to work with local commissioners and providers to make this happen"

3.6.2 Calderdale and Kirklees Local Medical Committees

Calderdale Local Medical Committee (LMC) has previously expressed its position that *"maintaining the status quo in regards to the configuration of local health services is not an option and that the revised proposals in response to the IRP is well considered and positive".*

Kirklees Local Medical Committee (LMC) has advised: *"We still believe that a joint and collaborative exercise to devise a more practical solution for the delivery of health, social and community care in our area is necessary and desirable, utilising both Calderdale and Huddersfield's hospital sites, for the benefit of our populations over at least the next two generations."*

3.7 Care Closer to Home

Significant progress has already been made in both Calderdale and Kirklees in the development and delivery of care closer to home.

In Calderdale, as a consequence of strengthened partnership approach operating between the CCG, the Local Authority and CHFT, the system's performance on Delayed Transfers of Care (DTOC), has moved from being amongst the weakest performing systems nationally to being consistently amongst the best. (Calderdale Local Authority as at January 2019 ranks 21st out of 151 nationally for all delays and 12th out of 151 nationally for NHS only delays.)

Greater Huddersfield CCG is one of seven national Intensive Support Sites, with the intention of increasing GP retention and strengthening the out of hospital workforce. Through this programme, support for practices is developing, for example by increasing the number of training practices in the Kirklees area, and for individual GPs through GP mentorship, coaching and leadership development. This is also supported by wider system initiatives, such as work to understand the impact on workload at the interface between primary and secondary care. These initiatives are in addition to significant investment by NHS England to attract new GPs to practices, including providing more training places and an international recruitment programme.

In both Calderdale and Kirklees, networks of GP practices have been brought together, to serve and design care for 'localities' of 30,000-50,000 people, in line with the NHS Long Term Plan. This structure is expected to form the basis of community care and public health service provision within both places providing a place-based framework for Health and Social Care where organisations work together and share resources to deliver holistic person-centred care. The aim is to make it easier for people to access care when closer to home, with a consistent and high quality experience for patients as they move between different parts of the integrated system.

The current plans, and those of the wider system, for out-of-hospital care, could reduce acute hospital bed days by 10% over five years, if they reach their full potential. This would more than absorb the forecast increase in hospital usage from demographic growth.

To significantly improve the care and population health management out of the acute setting, a wider transformation of services is required. Health systems around the world are moving to a model of care outside of the hospital that integrates all primary care, community, mental health and social care services. Best-performing systems fully integrate their services (including nursing, social care and community care) within their localities, co-locating front-line staff within integrated community hubs. This approach enables better co-ordination of care, and better identification and provision of appropriate packages of care to patients according to their individual need. This improved care means people do not have to go to hospital so frequently and once there can leave it more quickly. This delivery model would enable us to deliver all of the components of integrated care systems, tailored as appropriate to the needs of our individual patients.

As care in Calderdale and Kirklees is redesigned around the localities, there is an opportunity to follow best-performing out-of-hospital systems in the UK and worldwide, by designing packages of care around the needs of the population and joining up and co-locating delivery of community, primary and social care services through teams that comprise a range of staff such as GPs, mental health professionals, pharmacists, district nurses, community geriatricians, dementia workers and Allied Health Professionals such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector.

The West Yorkshire & Harrogate Health and Care Partnership has supported the CCGs to undertake detailed capacity modelling to compare the existing models of care closer to home with examples of best practice and to quantify the future community and primary care workforce and facilities capacity that will be required to achieve an optimal reduction in demand for hospital services. The best of these integrated care systems in both England and internationally have 20-40% fewer non-elective bed days per head of population than Calderdale and Greater Huddersfield CCGs. These systems, starting from a similar baseline, have in a number of cases made these improvements through substantial transformations of their services over 4-6 years.

From the evidence base, set out in detail in the report, the CCGs have set an aspiration to reduce non-elective bed days for the population by 30% over 5 years. This would make Calderdale and Greater Huddersfield CCGs some of the best-performing areas in the UK for this measure. A summary of the report is provided at Annex A.

This modelling will inform future CCG investment decisions in primary and community services to address demand pressures, enable workforce expansion, and develop new services to meet the needs of the population. The total number of hospital beds will continue to remain broadly as they are now whilst these integrated services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.

The CCGs will continue to work closely with Kirklees and Calderdale Health and Wellbeing Boards and local stakeholders to progress the plans for development of care closer to home.

3.8 Digital Technology

The development of digital technology in Calderdale and Greater Huddersfield over the last few years has been significant. CHFT is now one of the most digitally advanced Trusts in the country. CHFT in partnership with Bradford Teaching Hospital Trust has successfully implemented the Cerner electronic patient record across well over a third of the population of the West Yorkshire

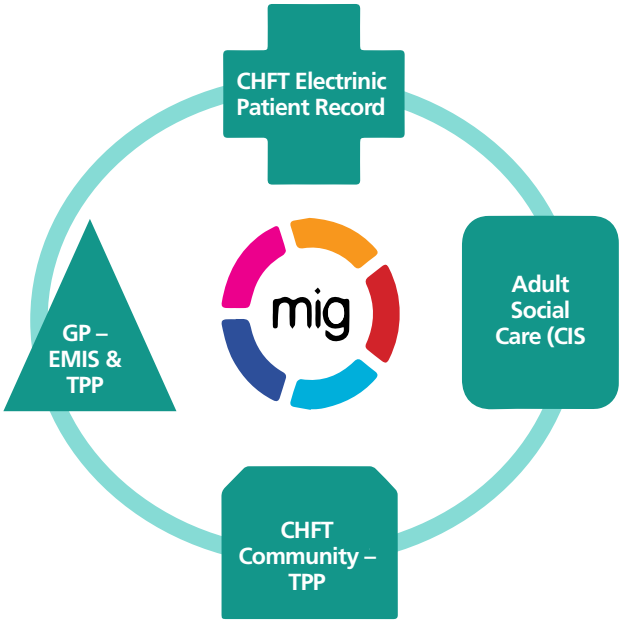
& Harrogate Health and Care Partnership footprint. In addition to this and as a part the West Yorkshire Association of Acute Trusts programme there has been work done on developing a regional imaging collaborative as well as interoperability across laboratory information management systems, some of which involves national genomics testing on behalf of NHSE.

CHFT has some of the highest utility of the national electronic staff record (ESR) and has been successfully using an App (application software) for recruitment of bank staff for several months, as well as leading the way nationally on implementing the K2 Athena maternity patient record and recently the same system went live in Leeds Teaching Hospitals Trust again providing consistency of approach in West Yorkshire.

Working in partnership with commissioners and fellow providers, CHFT has been able to demonstrate progress when measured against NHS England's Digital Maturity Assessment resulting in a movement to joint third of the 41 groupings in England.

Digital technology is currently enabling clinicians to access and interact with 'real-time' patient records and care plans wherever they are. The Trust's aim is to ensure that staff and patients have access to the right information and data, at the right time, to optimise the delivery of effective, safe, high quality care. To achieve this we are working towards enabling digital systems to talk to each other, so that data can flow seamlessly across health and care settings.
During 2018 the Trust has:

- Used the Cerner Health Information Exchange (HIE) and the Medical Interoperability Gateway (MIG) to enable 'real-time' patient information to be shared across GP practices and the hospital. All GPs in Calderdale and Greater Huddersfield can now view the hospital electronic patient record in their system of choice (SystmOne and EMIS) - this is a real time view and not via a separate portal. Hospital clinicians can also now view the GP record for all Calderdale and Greater Huddersfield patients within the hospital Cerner electronic patient record. Calderdale Community Service staff can also view the Calderdale GP record for both SystmOne and EMIS. Work has also commenced to progress digital inter-operability with the Calderdale Social Care System via the MIG. This development will enable integration of the adult health and social care records in the future. The progress being made to connect digital health and care systems is illustrated below;



- Continued to implement the use of digital technology to enable transformation of out-patient services and the provision of virtual clinics that mean patients don't have to make unnecessary visits to hospital and offer more efficient, convenient and timely access to services;
- Implemented a digital Electrocardiogram (ECG) management system that means ECG carts are now fully integrated with the electronic patient record. This has improved the efficiency of requesting ECGs and enabled the immediate availability of digital ECG test results for clinical review. This is enabling more timely clinical decision making and subsequent treatment and intervention to support patient care;
- Implemented digital blood tracking system (Haemonetics) that means all blood products are barcoded and identifiable. This system will improve safety and efficiency and in the future will enable the safe remote vending of blood products across the two hospital sites.

Work in Calderdale and Greater Huddersfield is also being progressed to develop digital health solutions such as telecare, telehealth tele-monitoring and direct booking of appointments from 111 to GPs.

These local developments in the use of digital technology are fully aligned with and support the work of the Yorkshire & Humber Local Health and Care Record Exemplar (LHCRE) project. The aim of the LHCRE project is to join up clinical systems across the region to support integrated care and to empower patients to take control of their condition by providing access to their own healthcare records. The Trust will work with NHSX to progress implementation of local digital innovation and developments to improve health and social care.

3.9 Calderdale and Huddersfield NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust (CHFT) is an integrated Trust that provides acute and community health services. The Trust serves two populations; Greater Huddersfield which has a population of 248,000 people and Calderdale with a population of 205,300 people. The Trust operates acute services from two main hospitals; Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI). The distance between the two hospitals is 5 miles. The Trust also provides community services in the Calderdale area. The Trust has approximately 800 beds, and 6,000 staff and an annual planned operating expenditure in 2019/20 of £408m.

HRI is an aging 1960s District General Hospital (DGH) with significant estates maintenance challenges and the Trust carries a very high risk in terms of the condition and reliability of its buildings at HRI. The age and condition of the estate means that some buildings are not clinically fit for purpose and without a significant capital injection there is a very high risk of failure of critical estate services and consequent impact on service delivery. An updated 6 Facet Estate Survey is currently being undertaken to assess the condition and reliability of the buildings and the engineering services infrastructure at HRI.

CRH opened in 2001. It was built using PFI funding and remains a DGH suitable for modern models of healthcare provision. Acre Mills, adjacent to HRI, is a modern base for out-patient appointments, and opened in February 2015.

Both hospitals currently provide accident and emergency services, outpatient and day-case services, acute inpatient medical services and intensive care for adults. Some services are

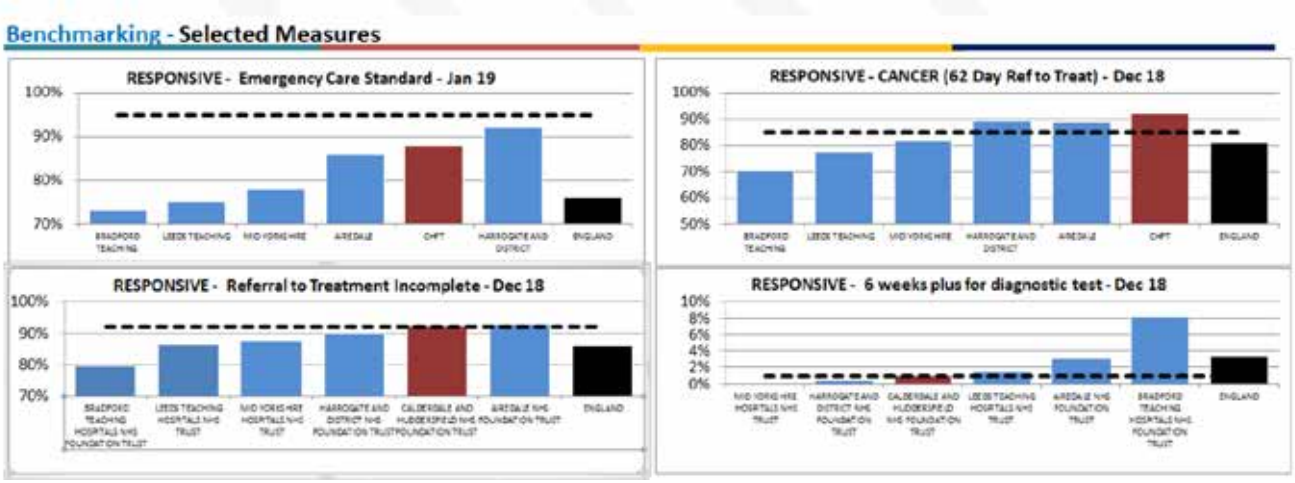
delivered at one site only (e.g. stroke, trauma, and maternity services). For a number of years CHFT has experienced clinical, operational and financial challenges associated with the dual site provision of services.

Nationally there has been a rapid rise in the demand for hospital nurses and other health professionals, and difficulties in recruiting consultants in several specialties. Growing shortages of qualified clinical staff has increased use of agency and other temporary workers to fill vacancies, and this has increased NHS expenditure and made services less stable. This national workforce pressure is further amplified at CHFT due to the dual site configuration of most services which makes it difficult to recruit and retain staff and has resulted in a reliance on temporary and agency staffing to sustain service delivery.

The aim of the Trust's workforce strategy is to 'ensure a workforce of the right shape and size with the commitment, capability and capacity to deliver safe, efficient, high quality patient care'. A key enabler for this will be the reconfiguration of hospital services to reduce dual site working.

The Trust has a significant financial deficit and is reliant on loans and funding support from the Department of Health and Social Care. Structural costs associated with the dual site configuration of services (which requires higher workforce expenditure) is a key factor driving the Trust's underlying deficit.

Over the last two years across the combined and ranked metrics of Referral to Treatment Times (RTT), Emergency Care Standard (ECS) and Cancer waiting time less than 62 Days, CHFT has consistently been one of the best performing Trusts in England.



In 2018 CHFT was inspected by the CQC and received an overall rating of "Good" for the services it provides and "Requires Improvement" for the Use of Resources. The CQC assessment commented that *"The trust recognises that its current configuration of two acute sites is not financially sustainable. Operationally this places limitations on the trust's ability to make best use of resources" and "The trust has a very strong model of CIP (cost improvement planning) governance arrangements in its systems and processes which have been promoted as an exemplar for others to adopt".*

Maintaining good standards of performance at CHFT is fragile as it is reliant on the continued use of temporary and agency staff and the costs associated with this. Nationally standards are also being raised, including the expectation that services are offered 7 days a week. These changes will lead to better outcomes – people living longer and healthier lives – but they present a challenge in trying to deliver a comprehensive set of services across the current two site configuration, at sufficient scale to meet standards 7 days a week.

The Trust's Vision – **"Together we will deliver outstanding compassionate care to the communities we serve"** – provides the context for the current and proposed future clinical and operating models described in this SOC.

This vision is underpinned by four fundamental behaviours that guide all Trust employees in the way they work:

The Trust's current 5 Year Strategy is shown below.

5 Year Strategy on a Page

Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Our patients and the public will be involved in their treatment and we will use their feedback to develop services for the future	We will have achieved a CQC rating of outstanding	We will have a workforce of the right shape and size with the capability and capacity to deliver safe, high quality services	We will have implemented the five year plan
	We will have commenced implementation of an agreed reconfiguration of integrated hospital and community services	We will be compliant with NHS Improvement standards	We will be widely recognised as an employer of choice through growing our own and attracting talented people to join our team	We will be financially sustainable with the ability to invest for the future
	We will meet all relevant 7 day working standards and our SHMI will be 100 or less	We will consistently achieve all national and local patient performance targets	Engaging our people and involving them in decisions that affect the Trust will be the norm	We will understand our markets and have a clear plan of how we grow our business
	We will have a robust interoperable electronic patient record which is used by patients and clinicians alike	We will be fully compliant with health and safety standards		

3.10 Timeline of Previous Work and Stakeholder Engagement

This SOC builds on significant work and stakeholder engagement that has been undertaken over the past five years. A summary of the timeline and key documents that have informed the development of this SOC is provided below.

2013
- The National Clinical Advisory Team (NCAT) recommended that a one acute care site option is the best for the future safety, value and sustainability of health services.

2014
- The Calderdale and Huddersfield Strategic Review undertook public engagement (Call to Action: Engagement Report for Calderdale and Huddersfield Strategic Review).

2014
- CHFT published a SOC and subsequently an OBC proposing reconfiguration of hospital services based on NCAT recommendations. Interviews with over 150 doctors, nurses, and therapists confirmed overwhelming support that this would improve patient experience and safety.

2014
- Calderdale Council implemented a People's Commission Review to give local people an opportunity to debate what services are needed now and in the future and subsequenly the Council produced a report of findings.

2015
- Calderdale and Greater Huddersfield CCGs undertook pre-consultation public engagement and published a report of findings.

2015
- Calderdale and Greater Huddersfield CCGs and CHFT agreed a model of care (clinical consensus) on the future configuration of hospital and community services and this was endorsed by the Yorkshire and Humber Clinical Senate.

2016
- The CCGs published a Pre-Consultation Business Case and undertook formal Public Consultation on the proposed changes to services. The Consultation Institute confirmed the consultation was consistent with good practice standards.

2017
- Calderdale and Kirklees Joint Scrutiny Committe referred the proposals for the future hospital reconfiguration to the Secretary of State for Health and Social Care.

2018
- Work was undertaken by the local NHS to develop a revised proposal (described in this SOC) responding to the concerns and views raised by the Independent Reconfiguration Panel, Secretary of State and stakeholders.

3.11 Key Documents Previously Published

- National Clinical Advisory Team (NCAT) Report - Calderdale and Huddersfield NHS Foundation Trust Accident and Emergency Services (2013)
- Call to Action: Engagement Report for Calderdale and Huddersfield Strategic Review (2014)
- Right Care, Right Time, Right Place - Strategic Outline Case - Transforming Services in Greater Huddersfield and Calderdale (2014)
- Right Care, Right Time, Right Place - Outline Business Case - Transforming Services in Greater Huddersfield and Calderdale (2014)
- People's Commission Calderdale Council (2015)
- Hospital Services Potential Outline Future Model Of Care - Clinical Consensus Model (2015)
- Yorkshire and the Humber Clinical Senate Review of the Future Model of Hospital Services for Calderdale and Greater Huddersfield CCGs (2015)
- Calderdale and Huddersfield NHS Foundation Trust (CHFT) implementation of the potential outline future model of care for hospital services: Quality Impact Assessment (2015)
- 5 Year Strategic Plan for Calderdale and Huddersfield NHS Foundation Trust (2016)
- Right Care, Right Time, Right Place - Pre-Consultation Business Case (2016)
- Right Care, Right Time, Right Place - Public Consultation On Proposed Future Arrangements for Hospital and Community Health Services (2016)
- Independent Report of the Findings of the Right Care, Right Time, Right Place Public Consultation (2016)
- Equality & Health Inequality Impact Assessment - Right Care, Right Time, Right Place (2016)
- Reconfiguration of Calderdale and Huddersfield NHS Foundation Trust - Full Business Case (2017)
- Calderdale and Kirklees Joint Heath Scrutiny Committee Referral of Proposed future arrangements for hospital and community health services in Calderdale and Greater Huddersfield to the Secretary of State for Health (2017)
- Right, Care Right Time, Right Place - Calderdale and Greater Huddersfield Travel and Transport Review - Report of the Independent Chair (2018)
- Advice of the Independent Reconfiguration Panel On The Right Care, Right Time, Right Place – Proposed Future Arrangements for Hospital and Community Health Services In Calderdale and Greater Huddersfield (2018)
- NHS Progress Reports submitted to the Secretary of State for Health and Social Care in August 2018 and January 2019
- Letter of clinical advice from Dr David Black – Medical Director (Joint) – North Region (Yorkshire and the Humber) and Deputy National Medical Director Specialised Commissioning NHSE (2018)

4. THE CASE FOR CHANGE

There is a compelling quality, workforce, estates and financial case for change in the local health system.

4.1 Quality

For people that have a serious life-threatening illness or injury and need emergency services it is not currently possible to guarantee the consistent presence of senior doctors seven days a week. The Trust is experiencing the effects of a national shortage of emergency doctors at both consultant and middle grade levels. The current consultant pool is stretched covering vacancies which the Trust is unable to recruit to. As a result, the two emergency departments are heavily reliant on cover from locum middle grade doctors.

The two emergency departments at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) are non-compliant with many of the standards for Children and Young People in Emergency Care settings with regards to having ready access to paediatric specialist trained staff. Paediatric medicine and surgery are not co-located on the same hospital site and this means that for children who have urgent medical and surgical needs there are challenges in providing shared care from a consultant surgeon and a paediatrician.

There is often a need for transfer of patients between sites due to not all the expertise needed to manage certain conditions being co-located. Also, for people with multiple medical problems when they are admitted to hospital, too many people experience a number of moves between wards, a longer length of stay in hospital, and increased risk of a poor experience and outcomes.

Some planned operations are cancelled at short notice because staff and facilities are needed to respond to meet the needs of emergency patients.

Without change too many people will:

- Be admitted to residential or nursing home care;
- Stay longer in hospital than is clinically necessary (which can be a factor which contributes to deteriorating health);
- Be admitted to hospital with a long term condition;
- Be readmitted within 30 days;
- Report that they do not have a good experience when they attend A&E and leave A&E without having been seen;
- Have their planned operations cancelled to release staff and facilities to meet the needs of emergency patients;
- Need to be moved between the two hospitals increasing the risk of a poor experience and outcomes.

4.2 Workforce

The Trust faces considerable workforce challenges which undermine the resilience of clinical services, staff satisfaction and wellbeing, and the Trust's finances, this includes:

- Non-compliance with Royal College of Emergency Medicine workforce recommendations and the standards for Children and Young People in Emergency Care settings with regards to having ready access to paediatric specialist trained staff;
- Non-compliance with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards as consultants have other areas of responsibility when on call;
- Intense and fragile clinical rotas;
- Recruitment and retention challenges resulting in a heavy reliance on locum and agency staff (and additional expenditure of circa £14m per annum).

These challenges are largely due to the current dual-site service model as well as national workforce shortages. As a result the Trust is not able to substantively recruit to meet the medical rotas of the two sites, and a number of recruitment processes have failed due to lack of applicants.

Consultant staff have chosen to leave the Trust in Emergency Medicine, Radiology and other Medical specialties. The reason given for this is the current configuration of Trust services across two sites. This compromises the quality of care that can be provided, and impacts on workload and frequency of on-call responsibilities.

Dual site running, particularly in relation to out of hours rotas, is increasing the reliance on junior and/or temporary staff. The reliance on middle grade doctors results in less timely specialist input into patient care. The widespread use of locums / temporary staff can also result in a lack of continuity of care, and a negative impact on staff morale and sickness absence rates.

The following specialties are examples of where the Trust is currently experiencing significant recruitment and retention challenges; Emergency Medicine, Gastroenterology, Urology, Radiology, Dermatology, Rheumatology, Ophthalmology, Critical Care, and Acute Medicine.

4.3 Estates

Huddersfield Royal Infirmary (HRI) is an aging 1960s District General Hospital (DGH) with significant estates maintenance challenges and the Trust carries a very high risk in terms of the condition and reliability of its buildings at HRI. The age and condition of the estate means that some buildings are not clinically fit for purpose and without a significant capital injection there is a very high risk of failure of critical estate services and consequent impact on service delivery. An updated 6 Facet Estate Survey is currently being undertaken to assess the condition and reliability of the buildings and the engineering services infrastructure at HRI. This will inform future priorities for investment and is likely to include: upgrade of A&E resuscitation, upgrade of ward areas, replacement of windows, stone cladding, air handling, pipe work, fire safety, drains and asbestos removal.

4.4. Finances

The Trust's forecast year-end financial position for 2018/19 is delivery of the position at the planned level, a deficit of £43.1m. Securing this position has been challenging in requiring delivery of a Cost Improvement Programme (CIP) of £18.0m, of which the full year effect carried forwards into 2019/20 stands at 86%. Transformational savings programmes and cross system working have been enabled by an Aligned Incentive Contract agreed with the Trust's two main commissioners, Greater Huddersfield CCG and Calderdale CCG. This successful approach to contracting will continue in 2019/20. In year pressures have been contained through a recovery programme and reinforcing budget holder accountability which will lay a strong foundation for 2019/20. In this context the Trust has confirmed its acceptance of the 2019/20 Control Total of £37.9m. Taking into account the Marginal Rate Emergency Tariff (MRET) allocation at £6.1m, Provider Sustainability Funding (PSF) of £7.3m and Financial Recovery Fund access at £14.8m, the Trust will plan for an overall deficit of £9.7m in 2019/20.

Delivery of this expectation will be stretching from a financial perspective and require implementing transformational change, a focus on budgetary accountability and taking full advantage of efficiency opportunities to deliver CIP of £11.0m (3%).

The local NHS cannot continue to spend above the funding allocated to it and an efficient model of service delivery is required to ensure that the quality and safety of services are protected whilst spending is brought back into balance. CHFT has significant structural deficits. The proposals described in this SOC will eliminate CHFT's underlying deficit and thereby will support the financial sustainability of the West Yorkshire and Harrogate Health and Care Partnership.

4.5 External Review Findings and Recommendations

A number of independent reviews and inspections of services have recognised the operational, quality, and workforce challenges described above. This includes: the National Clinical Advisory Team; the Calderdale Council People's Commission; the Royal College of Physicians; Yorkshire and Humber Clinical Senate; NHS England; NHS Improvement; the Independent Reconfiguration Panel, the West Yorkshire and Harrogate Health and Care Partnership, and; the Calderdale and Kirklees Joint Health Scrutiny Committee. All of these independent reviews have recommended that the status quo i.e. to do nothing is not an option and that changes to the configuration of services are needed to improve outcomes and safety.

- The National Clinical Advisory Team (NCAT) recommended that *'a one acute care site option was the best for the future safety, value and sustainability of health care'*.
- The Yorkshire and Humber Clinical Senate confirmed *'that a clear argument is made that the current configuration of services does not and cannot meet national guidance and that staying the same is not an option'*.
- Calderdale and Kirklees Joint Health Scrutiny Committee have confirmed *'the Committee accepts that the status quo is not an option and wishes to see improvements in the quality of services provided through hospitals, care closer to home provision and primary care'*.
- NHS Improvement and NHS England Regional Directors for the North of England have confirmed that the *'status quo is not sustainable and the health economy will need to reconfigure to ensure clinical and financial sustainability'*.

- The Independent Reconfiguration Panel (IRP) confirmed that '*maintaining the status quo is not an option' and that 'it is only reasonable to continue to pursue the proposals in more detail in the interests of local health services'*. The IRP also commented that there was *"real concern and a sense of urgency as it has becomes increasingly difficult to recruit and retain key medical staff stretched across two sites"*.
- The West Yorkshire & Harrogate Health and Care Partnership has agreed the proposals for reconfiguration as their top priority confirming that the Partnership is confident this will support the overall strategy for the development of better health and care services for West Yorkshire and Harrogate as a whole.

4.6 Alignment with NHS Long Term

The proposals for service reconfiguration described in this SOC fully align with the NHS Long Term Plan published in January 2019 which states:

"separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing complex, urgent care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. So we will continue to back hospitals that wish to pursue this model."

4.7 Clinical Support

Senior doctors, nurses and therapists that currently provide the services in hospital and in the community have identified the need for service and system change to improve the safety and effectiveness of care for patients in the future. Over a number of years clinical colleagues across primary, community, ambulance, social care and hospital services have been engaged and the proposals described in this SOC reflect their views and a wide body of clinical support for the changes proposed.

4.8 Constraints, Dependencies and Risks

Based on the information that has already been described in relation to the strategic context (chapter 3) and the case for change, a number of high level project constraints, dependencies and risks have been identified. These are summarised below and have been taken into account in the subsequent chapters of this business case.

4.8.1 Constraints

- The Trust must make best use of its estate including the full utilisation of the existing CRH PFI estate.
- The preferred funding source is 100% Public Dividend Capital (there is no agreement to private finance initiatives).
- The capital cost of the scheme must not exceed £196.6m.
- The clinical service model must be consistent with the model described in reports submitted to the Secretary of State for Health and Social Care in August 2018 and January 2019. (This model incorporates changes that respond to the recommendations of the Independent Reconfiguration Panel).
- The proposed service changes must be affordable to Commissioners and to the wider system.

- The proposed service changes must improve efficiency and enable the Trust to eliminate its financial deficit.

4.8.2 Dependencies

- Progression of the project is dependent on the Trust maintaining the strategic support of the West Yorkshire and Harrogate Health and Care Partnership and support from Calderdale and Greater Huddersfield CCGs.
- Realising the optimal benefits from this project will be dependent on the use of digital technology to enable interoperability across primary. social care and secondary care systems (see section 3.8).
- The project is dependent on the agreement of clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds.
- The project is dependent on the Trust securing necessary agreements with the existing PFI provider regarding the interface of the existing PFI buildings and site for the development of new build at CRH.
- The project will require agreement with other local Trusts where there may be impact on the numbers of patients attending A&E services.
- The project is dependent on effective on-going public and stakeholder involvement and engagement.
- The project is dependent on effective on-going consultation with the Calderdale and Kirklees Joint Health Scrutiny Committee.

4.8.3 Risks

- The Trust carries a very high risk in terms of the condition and reliability of buildings at HRI. An updated 6 Facet Estate Survey is being undertaken to assess the condition and reliability of the buildings and the engineering services infrastructure at HRI. The findings from this could impact on the timing of investments required at the HRI site.
- The Programme Board will ensure that robust arrangements for the on-going management of risk during the key phases of the programme are established. A list of the likely areas of risk management that will be included on the programme risk register is provided at section 11.3.

4.9 Conclusion of the Case for Change

NHS services within Calderdale and Huddersfield face an increasing challenge of delivering high quality, safe and sustainable services. This is within a climate of rising demand and significant workforce recruitment and capacity challenges. These challenges and their potential solutions have been debated for a number of years in Calderdale and Huddersfield and whilst day to day operational plans are in place to ensure the care and safety of patients within the Trust's clinical services, a sustainable solution is urgently needed.

5. PROPOSED SERVICE MODEL

5.1 Hospital Services

The proposed future model of hospital services in Calderdale and Greater Huddersfield will support and enable delivery of the vision and ambitions described in the NHS Long Term Plan. Digital technology will have a central role in transforming services supporting more people to have care at, or closer to home complemented by a hospital model that provides essential clinical adjacencies and the critical mass required to sustain staff recruitment and retention, ensure quality and deliver revenue savings.

The proposed model will make use of both existing hospitals. Both sites will provide 24/7 A&E services and a range of day-case, outpatient and diagnostic services - although where possible services will be delivered in the community and closer to people's homes. The total number of hospital beds will remain broadly as they are now whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care. Digital Health capability such as the electronic patient record and patient portals will enable 'real-time' review and advice on patient's care to be provided by specialist staff where required.

Tertiary services will continue as now to be provided in Leeds and at other specialised service providers.

5.2 The Detailed Hospital Services Plan

- Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) will both provide 24/7 consultant-led A&E services. As is the case now this will mean a 24/7 presence of middle grade Emergency Doctors on each site and Consultant staff on-site for a proportion of each day with 24/7 on call responsibility.

- The A&E at CRH will receive all blue light emergency ambulances for patients that have serious life-threatening conditions and all patients likely to require hospital admission following triage by the Yorkshire Ambulance Service (YAS). The A&E at HRI will receive self-presenting patients. All patients requiring acute inpatient admission will be transferred by ambulance from HRI to CRH. Digital technology will ensure that specialist advice will always be available across both sites, therefore creating more service resilience and enhancing patient safety.

- CRH and HRI will both provide medically led 24/7 urgent care and will be able to treat children 5 years and older with minor illness or injuries and those children considered to have minor illness after triage by 111. Children, who are more seriously ill, have serious injury or are under 5 years old will be quickly triaged, stabilised and if necessary, transported to CRH. Paediatric emergency care and all inpatient paediatric services will be provided at CRH.

- 24/7 anaesthetic cover will be provided at HRI to enable the safe delivery of accident and emergency services. As is the case now this this will mean a 24/7 presence of middle grade Anaesthetists, and Consultant staff on-site for a proportion of each day with 24/7 on call responsibility.

- Critical care services, emergency surgical and paediatric surgical services will be provided at CRH;
- Physician-led inpatient care will be provided at HRI. This is for people who do not require the most acute clinical inpatient healthcare but do require extra support whilst arrangements are made to meet their future needs;
- The total number of hospital beds will remain broadly as they are now whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.
- Extended ante-natal, intra partum and post-natal care will be provided in the community where possible and choice will be offered in relation to where the birth takes place. Midwifery led maternity services will be provided on both hospital sites. Consultant led obstetrics and neo-natal care will be provided at CRH.
- Planned surgery and care will be provided at HRI. Patients that require complex surgery or it is known that they will require critical care after surgery will be treated at CRH.

An overview of the proposed service configuration is shown below:

Huddersfield Royal Infirmary

- 24/7 A&E and clinical decision unit
- 24/7 urgent care centre
- 24/7 anaesthetic cover
- diagnostics
- planned medical & surgical procedures
- outpatient services and therapies
- midwifery-led maternity unit
- physician-led step-down inpatient care.

Calderdale Royal Hospital

- 24/7 A&E and clinical decision unit
- paediatric emergency centre
- 24/7 urgent care centre
- 24/7 anaesthetic cover
- diagnostics
- critical care unit
- inpatient paediatrics (medical and surgical care)
- outpatient services and therapies
- obstetrics & midwifery led maternity care
- acute inpatient medical admissions and care (e.g. respiratory, stroke, cardiology).
- acute emergency and complex surgery services

The proposed model will sustainably address quality, operational and workforce challenges and deliver a number of expected benefits that include:

- Local access to urgent and A&E services at both hospital sites;
- Maintaining the total number of hospital beds broadly as they are now whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care;
- Ensuring paediatric medicine and surgery are co-located on one site facilitating the provision of shared senior paediatric and surgical care for children and young people. This will enable the Royal College standards for Children and Young people in Emergency Care settings to be met.
- A single critical care unit will enable consolidation of the specialist medical and nursing critical care workforce and improve outcomes for patients by ensuring timely senior decision making.
- The reconfiguration of acute inpatient medicine onto one site will reduce the need for the transfer of acutely unwell inpatients across sites. This will improve the safety, experience and outcomes of care.
- The provision of planned surgery and medical procedures at one site will support improved access and reduce waiting times for planned treatment and surgery by minimising the risk of disruption from emergency admissions.
- Consolidation of all blue light ambulance attendances will enable the Trust to improve patient access to the right clinical expertise and better meet the Royal College of Emergency Medicine workforce recommendations. This will improve the likelihood of survival and a good recovery for patients that have life-threatening conditions.
- The realignment of services across the two sites will enable the Trust to deploy staff more efficiently and support meeting standards around 7-day working in the future and the ability to provide specialty rotas. In turn, this will reduce workload pressures on staff and impact favourably on the Trust's ability to recruit and retain staff reducing the current reliance on temporary staffing.

5.3 Community Services

Many people have said they would wish to be cared for in their own home rather than be admitted to hospital. We also know that for many people their outcomes are often better if they can avoid an unnecessary admission to hospital.

As described in section 3.7, in both Calderdale and Kirklees, integrated community and primary care services are being developed to meet the different levels of need of the local populations. Community based services will be led by multidisciplinary teams of health and care professionals, working together to meet the needs of people who have short-term health needs, individuals with long term conditions and those requiring specialist care for severe or complex needs.

These services will be delivered to populations of 30,000 to 50,000 people in a way that makes it easier for people to access care when closer to home, with a consistent and high quality experience for patients as they move between different parts of the integrated system.

This SOC is based on the commitment that the hospital bed capacity in Calderdale and Huddersfield will remain broadly as it is now whilst services are developed in the community and until it can fully be demonstrated that there has been a sustainable reduction in the

demand for in-patient hospital care. This approach is in keeping with the commitment made in the NHS Long Term Plan which states:

"the balance of need for hospital beds will be a product of continuing pressures from an ageing population partially balanced against further gains from changing the model of care. We have not built-in as a core assumption potential offsets in hospital beds from increased investment in community health and primary care. Instead we have provided both for the hospital funding and the staffing as if trends over the past three years continue. So to the extent that local areas are able to do better than recent emergency hospitalisation trends that will deliver for them an additional local financial, hospital capacity and staffing upside dividend."

5.4 Digital Technology

As described in section 3.8, the development of digital technology in Calderdale and Huddersfield over the last few years has been significant which means CHFT is now one of the most digitally advanced Trusts in the country. Digital technology is currently enabling clinicians to access and interact with 'real-time' patient records and care plans wherever they are. The Trust's aim is to ensure that staff and patients have access to the right information and data, at the right time, to optimise the delivery of effective, safe, high quality care. To achieve this, the Trust is working with partners towards enabling digital systems to talk to each other, so that data can flow seamlessly across health and care settings.

Digital technology is a key enabler that will amplify and transmit the benefits associated with the service reconfiguration changes described in this SOC. The changes to service configuration will ensure the Trust has robust clinical service adjacencies and digital technology will support optimising the benefits from this. For services that are provided on a separate hospital site or in the community digital technology will ensure access to "real-time" clinical information and advice. This includes digital inter-operability and multiple access capability across GP, hospital, social care, mental health and community records.

5.5 Quality and Equality Impact Assessment

Prior to public consultation in 2016, an Equality Analysis Report was completed in relation to the protected groups likely to be affected by the proposals; the communities it would be important to reach, and; the variety of formats required to ensure the consultation document was accessible. Post consultation, additional dedicated expert support from the Midlands and Lancashire Commissioning Support Unit was secured to deliver a comprehensive equality and health inequalities impact assessment of the proposals for the consolidation of planned and unplanned hospital services as described in the "Right Care Right Time Right Place" proposals. This concluded that:

- There was no indication of differential impact that would lead to unlawful discrimination linked to the proposals;
- The proposals set out health services to address the needs of the whole population, including those who currently experience disadvantage and the plans are intended to help improve access, experience and outcomes for all;
- The model proposed could have a significant impact on health inequalities for adults, children and young people and those who experience disadvantage by ensuring improved access to more services in the community. This should lead to an improvement in the management of conditions, prevent more extreme intervention being needed and reduce waiting times for urgent care, emergency and acute services.

This SOC builds on feedback from staff, patients, the public and the advice from the Independent Reconfiguration Panel (IRP). There are a number of areas where the proposed model described in this SOC are unchanged from that which was previously the subject of public consultation and an equality and health inequality impact assessment (they include: urgent care; maternity and midwifery services; paediatrics; planned surgery; acute inpatient medical care; critical care; acute and complex surgery, and; outpatient services). Where changes have been made to the proposed future hospital service model, they have sought to respond to the views of stakeholders and to the recommendations of the IRP. The key changes are: the continued provision of 24/7 consultant-led A&E services at both sites; the provision of physician-led inpatient care at HRI, and; a commitment to maintain the number of hospital beds broadly as they are now whilst services are developed in the community.

In July 2018 CHFT therefore undertook further quality and equality impact assessment of the changes that had been made to the proposed model. The findings were presented to CHFT Quality Committee on the 20th July 2018 and to the Board of Directors on the 2nd August 2018. The conclusion of this assessment was that the proposed changes do not generate differential discriminatory equality or health inequality impacts.

5.6 Data Protection Impact Assessment

Section 3.8 described how the Trust is developing the use of digital technology, and that this will support and amplify the benefits of the proposed service reconfiguration. As the proposals are further developed the Trust will consider whether there is the need to undertake a Data Protection Impact Assessment (DPIA).

5.7 NHS England Independent Clinical Advice

During July 2018 NHS Improvement asked NHS England to arrange for independent clinical advice to be given on the proposed clinical model. The NHS England Medical Director for the North Region (Yorkshire and the Humber) arranged for this to be provided by an independent team of eleven clinical colleagues (this included specialists in emergency medicine, acute medicine, mental health, primary and community services). The advice and conclusions of the review confirmed support for the proposed model.

6. CAPACITY IMPACT OF THE PROPOSED MODEL

The Trust has previously been supported by a Senior Economist and an Intelligence Analyst at NHSI to undertake very detailed long-term activity capacity modelling work. This modelling was based on extensive engagement and involvement of clinical colleagues in the Trust across every specialty to review the planning assumptions that were used. For this SOC a high level review and refresh of the previous work has been undertaken. The Trust and commissioners are aligned on the modelling of activity. Further detailed activity and capacity modelling will be undertaken in the development of the Outline Business Case following approval of this SOC.

6.1 Activity Growth Assumptions

The approach taken jointly between CHFT and both Calderdale and Greater Huddersfield CCGs to determine activity growth was based on review of 3-year activity trends.

The 3-year trend analysis initially suggested the following:

- Flat growth for day case, elective and outpatient activity;
- 2% growth for A&E;
- A 5% growth in non-elective short-stay admissions and a 2% growth in non-elective long-stay admissions (net growth of 3.8% across all non-elective admissions).

Within this, consideration was then given to the shift seen into ambulatory pathways which had driven a higher growth in emergency short-stay admissions over the past 2-years which is not expected to continue at that same high level. The following growth levels were jointly agreed:

- Flat growth for day case, elective and outpatient activity;
- 2% growth for A&E;
- A 4% growth in non-elective short-stay admissions and a 1% growth in non-elective long-stay admissions (net growth of 2.7% across all non-elective admissions);
- 2% growth in community.

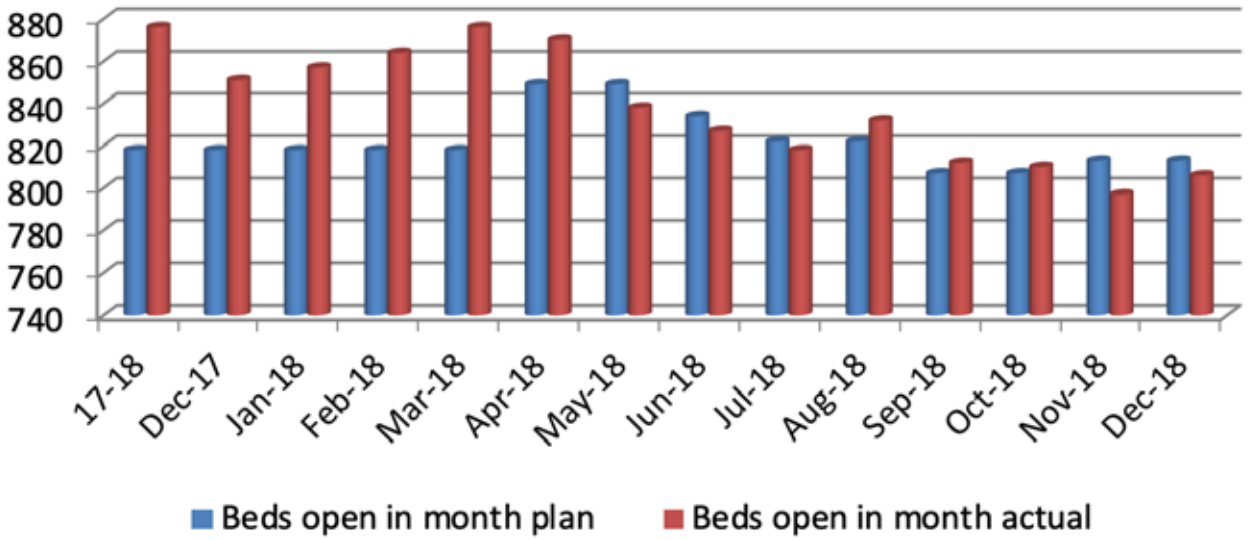
This was jointly agreed at point of delivery level and not based upon individual specialty level growth assessments – however, it should be noted that Obstetric and Midwifery non-elective admissions were excluded from this as this had been reviewed separately based on birth rates and known booking rates.

The proposed service changes described in this SOC mean that all blue light ambulance attendances and acute admissions will be diverted to the CRH site. Further work will need to be taken undertaken (subsequent to approval to progress this SOC) that will be informed by discussion with Yorkshire Ambulance Service regarding clinical protocols for ambulance diverts and this will inform future modelling of the volume of A&E and urgent care activity on each hospital site.

6.2 Bed Capacity Assumptions

The Trust currently has potential estate capacity for a total of circa 870 inpatient beds (420 at HRI and 450 at CRH). The Trust manages the number of beds open during the year dependent on patient demand and this is illustrated in the chart below that shows the variation in number of beds open during the previous year.

As at December 2018 the Trust had 806 beds open across HRI and CRH and the average number of beds open during the past 12 months (Dec 2017 – Dec 2018) was 838 beds.



This SOC is based on the commitment that the Trust will continue to provide broadly the same bed capacity whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.

Based on modelling previously undertaken in 2017 it is anticipated that the proposed hospital model will require circa 676 acute inpatient beds at CRH and therefore to maintain the total bed capacity broadly as it is now (on average 838) means that circa 162 inpatient beds will be required at HRI for planned care and step-down medical care. A detailed review and updated modelling of bed requirements on each site will be undertaken during development of the Outline Business Case.

As described in section 3.7, the CCGs, supported by the West Yorkshire and Harrogate Health and Care Partnership, have undertaken modelling work that has demonstrated the current plans, and those of the wider system, for out-of-hospital care, could reduce acute hospital bed days by 10% over five years, if they reach their full potential. This would more than absorb the forecast increase in hospital usage from demographic growth. In addition improved efficiency of the delivery of care within the hospital enabled by the use of technology and service reconfiguration (e.g. reducing duplication, transfer of patients between hospitals and delays in accessing specialist advice and diagnostics) will also further mitigate the impact of demographic growth.

6.3 Theatre Capacity

The future theatre capacity requirement is for 8 theatres at HRI and 11 at CRH. This is a growth of one theatre compared to the current 18 provided across HRI and CRH. This is based on elective theatres operating two four hour sessions per day, 5 days per week over 49 weeks. This theatre capacity includes a dedicated 24 hour emergency theatre, a trauma theatre and one emergency obstetrics and gynaecology theatre.

6.4 Impact on other providers

6.4.1 Other Hospitals

Yorkshire Ambulance Service (YAS) and the CCGs have previously calculated patient travel times to both the Calderdale and Huddersfield A&E sites and to neighbouring emergency care providers based on patient postcodes. This modelling showed that the potential impact of CRH being the hospital site for blue light admissions could lead to some patients being diverted and subsequently admitted to a neighbouring emergency care provider (where their ambulance travel time to an alternate provider is less than the travel time to CRH). The impact of this was calculated in 2016 as equating to a total of circa 15 additional beds being required across neighbouring Trusts. This information has previously been shared with all the hospitals affected and the West Yorkshire Association of Acute Trusts.

During 2018/19 service changes that have been implemented by Mid-Yorkshire Hospitals Trust at Dewsbury General Hospital A&E have resulted in some patients from North Kirklees attending the HRI A&E department instead and subsequently being admitted for inpatient care at HRI. This has generated an additional 18 bed capacity requirement at HRI.

Following agreement of this SOC, more detailed work will be undertaken, working with YAS and the West Yorkshire Association of Acute Trusts, to update the modelling assumptions of the anticipated number of ambulance attendances at A&E sites and how this may change as a result of the proposed service model at CHFT and other relevant service changes at neighbouring Trusts.

6.4.2 Yorkshire Ambulance Service

In 2017 Greater Huddersfield CCG and Calderdale CCG commissioned an independent review of the impact of proposed changes in the configuration of hospital services on ambulance services (this updated work previously undertaken in 2015).

The analysis used patient transport data extracted from the Yorkshire Ambulance Service transport management system, covering both emergency calls where a patient is taken to a hospital Emergency Department and the Patient Transport Service (PTS) where patients are taken home from a hospital Emergency Department.

The analysis identified that the impact of the proposal for ‘blue light’ ambulances to travel to the emergency department at Calderdale Royal Hospital would generate requirement for 5,300 hours of additional ambulance time availability per annum.

A further update of this analysis will be undertaken during development of the Outline Business Case and will take account of known changes in demographic demand, changes as a result of the enhanced proposals and any service changes that may have been implemented

by the Yorkshire Ambulance Service and at surrounding hospitals since 2017 that could impact on the volume of patients that in the future will travel by ambulance to CRH. The impact of additional ambulance capacity required will be taken into account by commissioners during future contracting discussions with the Yorkshire Ambulance Service.

6.5 Workforce Assumptions

As previously described the Trust faces considerable workforce challenges which undermine the resilience of clinical services, staff satisfaction and wellbeing, and the Trust's finances. This SOC has assumed that the reconfiguration of clinical services across the two hospital sites will enable the Trust to:

- Reduce duplicate staffing costs through the consolidation of some services;
- Improve clinical rota resilience and reduce the frequency of on-call;
- Allow greater opportunities for sub-specialisation of the workforce;
- Improve the recruitment and retention of clinical staff;
- Reduce reliance on Agency staffing;
- Enable development of new roles and improved workforce skill mix;
- Enable optimised use of digital technology to support delivery of care;
- Improve workforce productivity including theatre utilisation;
- Improve junior doctor and other staff training experience and supervision.

As a result of the above the reconfiguration of services will deliver a more efficient and effective use of workforce resource.

6.6 Travel Assumptions

In May 2017 a Travel and Transport Group was established with an independent Chairperson and wide ranging membership to consider and develop plans to address the implications of any proposed changes in the configuration of hospital services in relation to public access, travel, parking and transport.

This SOC aims wherever possible to maintain services on both hospital sites to provide the best access for local people, unless this means that we cannot provide the best quality of care. A final report was published by Travel and Transport Group in January 2018. The report described the changes in travel times likely to be experienced (by car, taxi and public transport) to CRH and HRI as shown below.

Private Transport comparative Journey Times (80% of patients or visitors travel to hospital by car or taxi)

Travel by car/taxi from:	Maximum average journey times in minutes			
	Based on actual data		Based on modelled data assuming people travel to a different location	
Calderdale postcodes	To CRH	17.6 minutes	To HRI	24 minutes
Kirklees postcodes	To HRI	15.1 minutes	To CRH	20.5 minutes

Public Transport comparative Journey Times (20% of patients or visitors travel to hospital by public transport)

Travel by public transport from:	Maximum average journey times in minutes			
	Based on actual data		Based on modelled data assuming people travel to a different location	
Calderdale postcodes	To CRH	52.7 minutes	To HRI	66.1 minutes
Kirklees postcodes	To HRI	46.3 minutes	To CRH	65.8 minutes

The review also noted that the average journey time along the A629 section between the two hospitals is approximately 13 minutes and that journey times should improve following the upgrade of the A629 (currently in progress) and reduce travel times by 4 to 4.5 minutes.

The Travel and Transport Group noted that an Equality Impact Assessment had determined there was no indication of differential impact that would lead to unlawful discrimination and concluded that work on changes in the configuration of hospital services should continue to be progressed.

The Travel and Transport Group recommended a number of actions to be taken in relation to parking, access, travel between hospitals, public transport, reducing need to travel, hospital discharge, patient travel and greener transport. The list of recommendations is shown below.

Report of the Independent Chair of the Travel and Transport Group – 30 January 2018

Recommendations
1) That the strategic direction set in Right Care, Right Time, Right Place, continues to be implemented with an emphasis on shifting the focus of health and social care services closer to home reducing reliance on Acute Health Service setting at local Hospitals.

2) Regular updates of the progress being made on implementation of Care Closer to Home, the A629 upgrade and a local Travel and Transport Plan should be highlighted in the local NHS Communication Strategy.

3) That the Calderdale and Greater Huddersfield CCGs continue to work through their existing engagement channels in line with each CCGs' 'Engagement and Experience Strategy for local people' to seek advice and feedback on Travel and Transport issues to influence the implementation of the report's recommendations.

4) The upgrade of the road network and the proposed reconfiguration of health services are challenging and complex parallel projects which require active management throughout the 5 year transition period. We recommend the local NHS consider identifying a Board Level Transport Champion to work in partnership with Calderdale and Kirklees Councils, WYCA and other key players to develop a coherent travel plan which sets out strategy, measures, action plans and targets to maximise alignment of both projects and to develop a sustainable and integrated Transport Strategy.

5) The West Yorkshire Combined Authority should bring to the attention of Commercial Bus Companies the opportunities created by the Road Transport Upgrade and the proposed reconfiguration of health services to secure more direct and frequent services between the hospitals and local transport hubs promoting a more integrated transport system.

6) The action plan outlined for short term and longer term action to address parking issues should be implemented and the feasibility of additional multi-storey car parking at CRH evaluated.

7) We recommend that the Shuttlebus service is upgraded with:
a) Immediate action on advertising the service, signage and timetables, adequate weatherproof shelters and enhanced patient and public experience.
b) A more equitable service is developed meeting the needs of vulnerable people, people with disability and wheelchair users as well as infants, children and their parents / carers.
c) Consideration of a more frequent service with greater capacity and exploration of links between both Hospitals and local transport hubs to contribute to a more integrated transport system.

8) Improvements to the Patient Transport Service outlined in the Future Action section are implemented in a timely way consistent with Patient and Public feedback.

Greater Huddersfield CCG and Calderdale CCG are currently leading work with partners to address and implement actions in response to these recommendations. This includes establishing a steering group to oversee the work. The Trust will be a member of this Group and support necessary actions in response to the recommendations.

7. ESTATE OPTIONS AND ASSUMPTIONS

The Trust is a community and hospital multi-site organisation. It provides services from a number of buildings across Calderdale and Greater Huddersfield. Acute hospital services are provided from two sites which are approximately 5 miles apart: Huddersfield Royal Infirmary (HRI) in Huddersfield and Calderdale Royal Hospital (CRH) in Halifax.

Pennine Property Partnership (a property joint venture of the Trust with Henry Boot Developments) undertook the development of Acre Mill (which is located across the road from HRI). Acre Mill was opened as an outpatient centre in 2015. Both hospital sites contain clinical and non-clinical accommodation which varies considerably in terms of type, age and quality.

7.1 Calderdale Royal Hospital – Overview of Current Estate

Calderdale Royal Hospital (CRH) has a gross floor area of 59,817m2 across a site with land area of 7.36 acres. CRH is located close to Halifax town centre and opened in 2001. The hospital offers a full range of outpatient facilities as well as inpatient areas including Surgical, Medical, Maternity, ICU, Coronary Care and Children's wards. CRH currently has circa 450 beds and 9 theatres including 8 main theatres and an emergency Obstetrics theatre. The Dales Unit on the CRH site is occupied by South West Yorkshire Partnership Foundation Trust and includes three in-patient wards as well as a number of outpatient services. The site was one of the first hospitals built through Private Finance Initiatives (PFI).

Work commenced in January 1999 and the building was handed over to the Trust in March 2001. Parts of the old Halifax General Hospital buildings were retained and refurbished and in general these are used for office accommodation. The hospital was built by the Catalyst Healthcare consortium, which then comprised the Lend Lease Corporation, Bovis Lend Lease Limited, ISS Mediclean Limited, the British Linen Bank Limited and the French bank Societe Generale. Bovis Lend Lease provided the design and construction services.

As part of the PFI agreements are in place with Engie for estates maintenance, life cycle and variation work and with ISS for the provision of catering, cleaning, portering, security, car park management, switchboard and linen distribution. The Trust works closely with all parties to ensure close and open partnership working. In 2005 the car parking facility was extended to include the South Car Park and barrier car parking was introduced to try to assist with access to the hospital for patients and visitors. In 2010 a new Endoscopy Unit was completed and two years later saw the development of a new angio suite incorporating state of the art catheter lab at Calderdale. In 2013 the installation of a new CT Scanner took place and a year later a new coronary care advanced pacing theatre opened. In 2015 the child development unit was completely refurbished to allow the merger of the services from Huddersfield and Calderdale. Through the Engie life cycle programme new chiller units were installed in the roof plant area in 2009 bringing improved efficiency and noise management by modern pump technology and controls. In the last 5 years, Theatre operating lights; Passenger Lift cars; CCTV; Security Access systems; Fire detection; Doors & Windows have all received replacement and upgrade through Planned Life Cycle investment. The whole site is subject to planned replacement of flooring; fitted furniture and redecoration. In January 2016 Engie began a medical gas plant replacement programme which has seen the upgrade of 4bar medical air, 7bar surgical air and vacuum plant bringing new equipment and increased resilience to the site. This work also coincided with the upgrade and replacement of critical ventilation systems incorporating requirements of the most recent healthcare technical guidance.

The revenue costs of the site include interest and hard and soft facilities management. The total annual revenue cost is circa £23m. The backlog maintenance is managed through the PFI contract and supported by regular capital lifecycle payments into the PFI provider. Building maintenance is managed through the SPC and funded through regular planned lifecycle payments. There is limited backlog maintenance of note and the building is compliant to NHS Estates Code condition B.

7.2 Huddersfield Royal Infirmary – Overview of Current Estate

Huddersfield Royal Infirmary (HRI) has a gross floor area of 67,493m2 across a site with land area of 16.77 acres. Huddersfield Royal Infirmary is about two miles from Huddersfield town centre. The main hospital opened in 1965 and since then many millions have been invested in the site to modernise and extend it.

The hospital offers a full range of day case and outpatient services; an accident and emergency department, and critical care. It is currently the centre for emergency surgery, planned complex surgery and emergency paediatric surgery for the people of Greater Huddersfield and Calderdale (these services are not currently provided at CRH). It also provides a full range of diagnostic services including magnetic resonance imaging (MRI). There are approximately 420 beds at HRI.

Recent major developments have included the opening of a £3.4 million urology unit and investment in a £500,000 state-of-the-art CT (computerised tomography) scanner and suite. Early in 2008 the new Huddersfield Family Birth Centre opened at the hospital, offering a warm and friendly environment for women and their partners. In 2008 an £8 million pharmacy manufacturing unit opened on the site which produces pharmaceutical products for people across the country and is expected to continue to provide services in the future.
A new state of the art endoscopy unit was built in 2011 and the Trust embarked on a scheme to replace the ageing calorifiers with plate heat exchangers which was completed in 2015. In 2016 a full upgrade of services for oncology outpatients and day-case patients in the newly named Greenlea Ward was completed.

A full refurbishment of inpatient theatres was completed in 2017, bringing the main theatres into a fully compliant state. The Trust owns the Acre Mill site opposite Huddersfield Royal Infirmary and this new development for out patients' services was opened in 2015.

The Trust has upgraded many of the inpatient wards, giving additional single rooms with ensuite facilities. Although there has been significant investment, the core building is considered to be beyond its useful life and is time expired. Financial pressures have placed significant restraints on capital investment in recent years and, as a result, the backlog of maintenance for time expired buildings requirement has grown.

Backlog maintenance, with regards to the HRI site, refers to the costs associated with time expired buildings. The cost described in this section is the minimum investment required to bring the estate to a category B level. In 2013 the Trust commissioned a 6 facet survey from NIFES Consulting Group; this was updated by Lendlease Consulting in 2015. It identified the extent of capital works required to bring HRI to condition B status in accordance with the Department of Health Estate code. The survey concluded that the Estate is overall in poor condition with significant backlog of maintenance for time expired buildings. The survey identified

statutory items across the site that required immediate remedial action in large parts of the estate as well as key factor impacting on operational performance. A significant investment is required to resolve the functional suitability of the estate. This has been driven through changes in service provision and size of teams that has meant the parts of the current estate are too small or were constructed and designed for another function which does not provide a suitable layout and space for services.

The Trust carries a very high risk in terms of the condition and reliability of buildings at HRI. Some are not clinically fit for purpose and without capital injection there is a very high risk of failure of critical estate services and consequent impact on service delivery. The 2015 updated survey estimated the costs to bring the estate to a level B at £95m. Since 2015 there has been a further deterioration of the estates building and engineering service infrastructure and space/ functional suitability. An updated 6 facet survey has been commissioned and the report from this will be available in 2019 and will inform the development of the Outline Business Case.

7.3 Estate options considered to deliver the Hospital Service Model

The proposed future model of hospital services described in this SOC will make use of both existing hospitals as follows:

- Both hospitals will provide 24/7 A&E services and a range of day-case, outpatient and diagnostic services.
- One hospital will receive all blue light emergency ambulances for patients that have serious life-threatening conditions and all patients likely to require acute non-elective hospital admission.
- One hospital will provide elective services and surgery as well as providing step-down medical inpatient beds.

Consideration of which hospital site should focus on unplanned inpatient care and which site on planned care has been debated for a number of years. In 2015 the Trust, supported by Monitor and Ernst Young, developed the Trust's Five Year Strategic Plan. This work included an appraisal of eleven possible estate options for the future development of a planned and unplanned hospital site. The clinical service model is not site dependent and, therefore, an appraisal of whether unplanned inpatient care would be provided at the CRH or HRI site was required.

On the basis of the qualitative and financial appraisal undertaken, the choice of CRH as the unplanned site and HRI as the planned site was approved by the Trust Board in 2015 and was the single estate option on which public consultation was undertaken in 2016.

The service model on which the estate option appraisal was previously undertaken in 2015 has been modified in this SOC to take account of the views and concerns of stakeholders and the IRP. However, the question of which site should be developed to provide unplanned acute inpatient services and which to provide planned inpatient care services remains the same. This SOC has therefore used the significant work previously undertaken to assess estate options and is based on CRH being expanded to provide unplanned inpatient care and HRI providing planned inpatient care services.

7.4 The Estate Cost Model

A total capital investment requirement of £196.5m has been identified that is based on:

- £20m at HRI to enable adaptation of existing buildings and to address immediately the most critical maintenance requirements to enable the continued use of some of the HRI existing site thereby deferring new build at this site for at least 10 years. The detailed use of this investment will be informed by the updated 6 Facet Survey that is currently being undertaken. Key areas of investment are likely to include the upgrade of A&E resuscitation, ward areas, windows, stone cladding, air handling, pipe work, fire safety, drains and asbestos removal.
- £176.5m for expansion and new build at CRH – this estate cost is based on work undertaken in May 2017 by Lendlease Consulting that provided the Trust with a Feasibility Cost Model of the expected build costs for the future development of the CRH site. The cost estimates were based on the gross internal floor areas derived from a schedule of accommodation prepared by a Healthcare Planner in discussion with the Trust on the required clinical activity and capacity.

The cost of the future model at CRH and at HRI is shown in the table below. This is based on estate feasibility costing previously undertaken by Lendlease in 2017. This has been reviewed (with advice provided by NHS England Project Appraisal Unit) to update the assumptions used for inflation in building costs and fees and the level of optimism bias that has been applied.

Element	CRH Cost (£)	HRI Cost (£)	Total Cost (£)
CRH	£74,695,800		£74,695,800
Site infrastructure	£2,975,360		£2,975,360
Traffic management	£115,948		£115,948
External works	£700,120		£700,120
Service diversions	£140,000		£140,000
Access and logistics	£173,922		£173,922
Links	£1,575,000		£1,575,000
Sustainability	£686,756		£686,756
Section 106/278	£772,988		£772,988
Sub-total	**£81,835,894**		**£81,835,894**
Preliminaries	£12,661,445		£12,661,445
Fees	£13,912,102		£13,912,102
Non works costs	£1,546,505		£1,546,505
Equipment costs	£5,155,017		£5,155,017
Planning contingency	£16,612,686		£16,612,686
Optimism bias (%)	£26,344,730		£26,344,730
Sub-total	**£158,068,379**		**£158,068,379**
Inflation	£18,478,194		£18,478,194
VAT	£35,309,315		£35,309,315
VAT recovery	-£35,309,315		-£35,309,315
Total	**£176,546,573**		**£176,546,573**
Backlog maintenance	**-**	**£20,000,000**	**£20,000,000**
Total (including backlog)	**£176,546,573**	**£20,000,000**	**£196,546,573**
Disposals	-	-	0
Total capital requirement	**£176,546,573**	**£20,000,000**	**£196,546,573**

The estate cost model provides for:

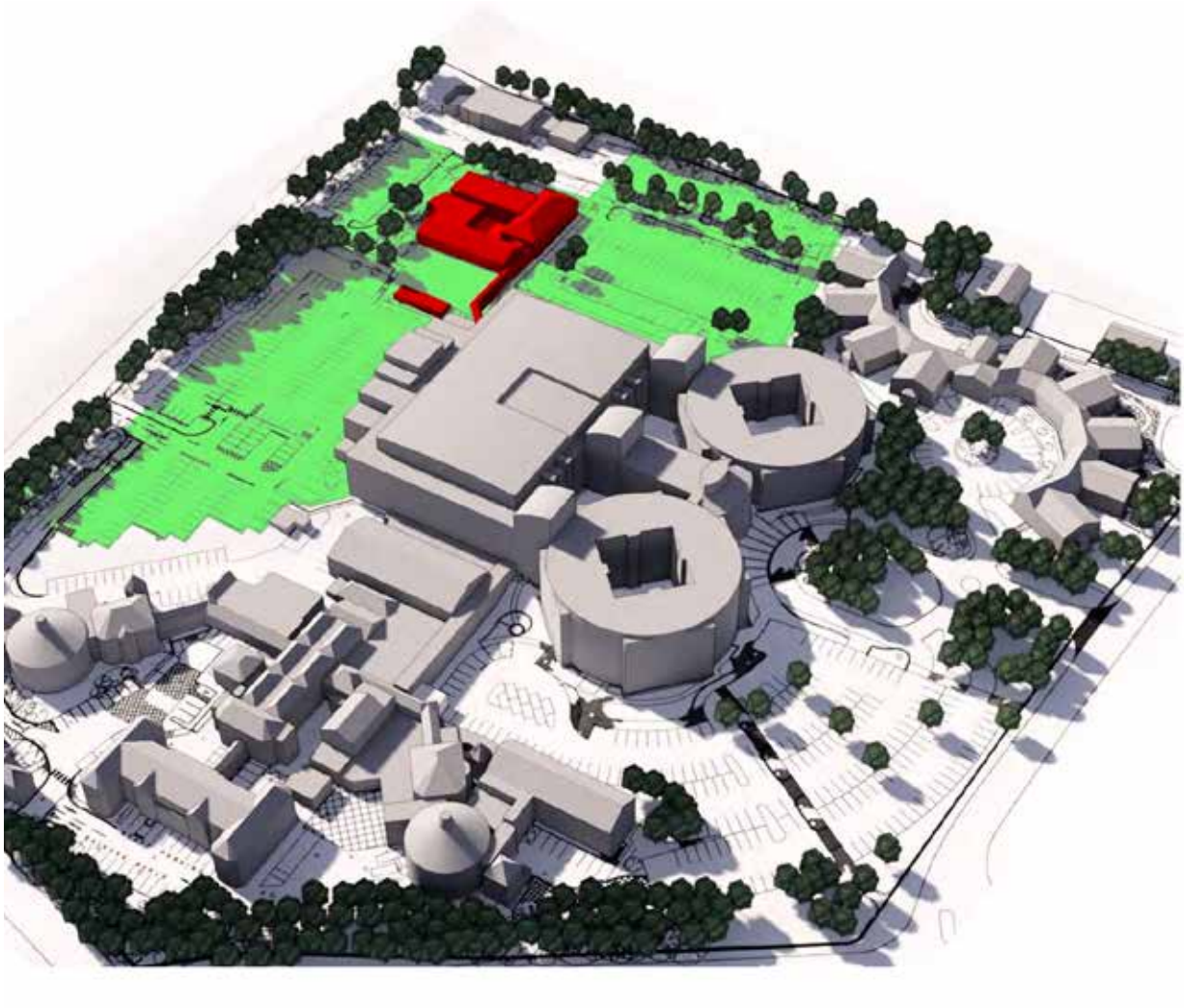
- **Beds:** A total capacity of circa 840 beds (broadly the same as current) across the two sites. The number of beds open at any point in time will fluctuate dependent on demand through the year. Within this total are included 18 ICU beds with the ability to increase this to 22 in future years.
- **Theatres:** A total of 19 theatres (11 at CRH and 8 at HRI). This will provide an additional emergency obstetric theatre at CRH which was recommended by the CQC. As explained in section 3.4 no provision has been included for the development of a hybrid vascular theatre.

Based on advice provided by NHS Improvement additional car parking at CRH will be developed through alternate sources of capital funding via a partnership with either a public or commercial joint venture. CRH currently has 787 car parking spaces. The proposed development will provide an additional 600 space multi-storey car park at CRH, and establish an additional 80 spaces at Dryclough Close (both subject to planning permissions). This would give a total of 1467 spaces. It is estimated that the development of the CRH site would result in a loss of 134 spaces. The net total parking spaces would therefore be 1,333 representing a growth of 546 compared to current (787).

7.5 Feasibility of the New Build Development at CRH

During February and March 2019 the Trust has undertaken work to confirm feasibility of the scale of the estate new build development required at the CRH site. This work has been informed by professional external engineering and architecture advice and has confirmed the previous work undertaken in 2017 that the proposed scale of expansion at CRH can be accommodated on the site.

The illustration below of the CRH site indicates in green where the new build expansion will be located. The learning and development centre shown in red will be re-provided within the new build accommodation. Additional multi-storey car parking will be provided at the front of the hospital.



The estate developments proposed will be designed to enable the optimal use of new technology and digital communications to enable 'real-time' review and advice on patient's care to be provided by specialist staff at either hospital site and in the community.

This will amplify the benefits of service reconfiguration and support achievement of the Trust's aim to make the best use of technology to support care closer to home, complemented by a hospital model that provides essential clinical adjacencies and the critical mass required to sustain staff recruitment, ensure quality and develop revenue savings.

8. ECONOMIC CASE

8.1 Summary

The purpose of the economic case is to identify and economically appraise the options for the delivery of the proposed service and estate model that is most likely to offer best value for money.

8.1.1 Approach to evaluation

The option appraisal described in this SOC builds on significant work jointly undertaken in a number of meetings and workshops held in 2015 by the Trust and the two Clinical Commissioning Groups (CCGs) (supported by Monitor, NHS England and Ernst Young) to identify and appraise a long list of possible estate options for the future development of a planned and unplanned hospital site – rejecting options that would not be financially, operationally or clinically viable.

The appraisal included qualitative analysis (involving commissioners and stakeholders) against the following benefits criteria:

- Clinical benefits;
- Patient pathways;
- Patient travel times;
- Capital requirements;
- Bed capacity;
- Wider health economy forecasts;
- Commissioning intentions.

The appraisal was also informed by Monitor's advice that options requiring either DH and Treasury support to buy-out the existing PFI agreement, or that would result in an under-utilisation of the high cost PFI facilities at CRH, would not be supported on the grounds of being un-economic.

8.2 The Option analysis framework

The table below describes the criteria used to appraise the long list of options.

Critical Success Factors	Description
Scope of Service	Able to deliver the full scope of the proposed service configuration i.e.: • Both hospitals will provide 24/7 A&E services and a range of day-case, outpatient and diagnostic services; • One hospital will receive all blue light emergency ambulances for patients that have serious life-threatening conditions and all patients likely to require acute non-elective hospital admission (the unplanned site); • One hospital will provide elective services and surgery as well as providing step-down medical inpatient beds (the planned site); • Bed capacity across CRH and HRI will be maintained whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.
Service solution	Makes best use of the existing estate at both hospital sites and improves the environment of care for patients.
Service Delivery	Enables the continued delivery by the Trust of core DGH services for the local population.
Service implementation	Enables the delivery of the defined scope of services in the shortest possible timescale recognising the urgency of the need for change (as referenced by the IRP).
Funding Availability	Able to be delivered within the available funding source and envelope

8.3 Estate Long List Evaluation

The following long list of twelve estate options has been considered and options discounted as shown if they do not meet the essential criteria.

Option	Configuration	Scope	Service Solution	Service Delivery	Service Implementation	Funding	Conclusion
1	**Business As Usual** Minimum change in hospital configuration across two sites but incorporates known changes that will occur in next 5 years (e.g. demographic, tariff impacts, initiatives unrelated to hospital reconfiguration), with the Trust operating its capital programme within its own generated sources e.g. prior loan level and Joint Venture investment.	✖	✖	✔	✖	✔	Carry forward
2	**Do Minimum** Minimum change in hospital configuration across two sites but incorporates known changes that will occur in next 5 years (e.g. demographic, tariff impacts, initiatives unrelated to hospital reconfiguration). Includes the expenditure on back-log maintenance of £60m to address High and Significant back-log maintenance risk, supported by emergency capital loans at £6m per annum for 10 years.	✖	✖	✔	✖	✖	Carry forward
3	**All Hospital Services at CRH** All existing hospital services provided at CRH i.e. a single hospital site proposal. Dispose of HRI and Acre Mill sites.	✖	✖	✖	✖	✖	Discount

Option	Configuration	Scope	Service Solution	Service Delivery	Service Implementation	Funding	Conclusion
4	**All Hospital Services at CRH enabled by a reduced range of services provided by CHFT** The Trust reduces activity to ensure all services can be delivered from CRH site only i.e. single hospital site proposal. Dispose of HRI and Acre Mill sites.	✖	✖	✖	✖	✖	Discount
5	**All Hospital Services at HRI – Use Break Clause to exit PFI** All hospital services provided at HRI i.e. a single hospital site proposal. Exit CRH site through use of PFI break clause at 2031.	✖	✖	✖	✖	✖	Discount
6	**All Hospital Services at HRI. Trust sublets / finds alternate use of CRH to secure income to cover PFI cost.** All hospital services provided at HRI i.e. a single hospital site proposal. Alternate use of CRH secured.	✖	✖	✖	✖	✖	Discount
7	**Intermediate Option – A&E and unplanned care at CRH. A&E and Planned care at HRI on main site.** £177m development at CRH and a £20m investment in HRI, reflecting the reduced usage of the site. A&E at both sites.	✔	✔	✔	✔	✔	Carry forward
8	**Emergency and unplanned care at CRH. Planned care at Huddersfield on Acre Mill site.** CRH provides all emergency, unplanned and high risk care. Planned services are provided in Huddersfield on Acre Mill site (dispose of main site). No A&E Department at HRI.	✖	✖	✖	✖	✖	Discount

Option	Configuration	Scope	Service Solution	Service Delivery	Service Implementation	Funding	Conclusion
9	**Emergency and unplanned care at HRI. Planned care at CRH.** HRI provides all acute and emergency care and high risk care. Planned services are provided at CRH site. No A&E Department at CRH.	✖	✖	✖	✖	✖	Discount
10	**Emergency and unplanned care at HRI. Planned care at CRH with any under-utilised PFI estate sublet.** HRI provides all acute and emergency care and high risk care. Planned care services are provided at CRH site and alternate use is found for some of the CRH estate to optimise PFI utilisation and improve affordability. No A&E Department at CRH.	✖	✖	✖	✖	✖	Discount
11	**Do Maximum - All Hospital Services in a New build** Exit CRH, HRI and Acre Mill sites and build new hospital at new site delivering all services.	✖	✖	✖	✖	✖	Discount
12	**Growth of activity and income on both sites to improve financial & clinical viability negating the need to reconfigure services.** Maximise income from both sites via increased activity and market share to enable improved income and financial viability.	✖	✖	✔	✖	✖	Discount

8.3.1 Economic Case Long List Conclusion

The Long List analysis above outlines the options that are available to the Trust to meet the service and estate requirements. In further evaluating the options available to the Trust the intention is to evaluate a short list option of:

- Base Case;
- Do Minimum; and
- Intermediate Option (Future Service Model Option) - Emergency and unplanned care at CRH. A&E and Planned care at HRI on main site.

The following sections refer to these options as Option A - Base Case; Option B - Do Minimum and Option C - Future Service Model.

8.4. Appraisal / Evaluation Methodology

Continuing with the existing service model under a Business As Usual or Do Minimum option is non-viable in the long-term as it does not meet any of the core requirements of the Trust, nor is the finance available to support the required capital investment to sustain safe services. Business As Usual and Do Minimum serve however as a baseline to assess the benefit of the evaluated option and demonstrate that the Future Model Option is the most economically advantageous option.

Each of the evaluated options has been based on:

- The base year and price year is FY20;
- Prices exclude VAT;
- Cash flows and benefits are discounted by 3.5% per annum to reflect social time preference; and
- Although, build/refurbishment timelines are different a 65 year appraisal period has been used, which reflects the re-development period plus 60 years of operation.

8.4.1 Cost

There are a number of steps involved in arriving at a proposed economic option. Traditional discounted cash flows across the following categories are considered for each option:

- Capital Outlays: for new builds or refurbishment are applied by year of spend.
- An estimate of the residual value of an asset - at the end of the lifespan to represent an estimate of an asset's value at that time, i.e. 60 years.
- Capital and revenue lifecycle costs - of maintaining estate assets.
- The Trust's capital programme - for new and replacement assets.
- Revenue cost cash flows - across clinical, non-clinical and estates costs across the lifetime.
- Transitional costs - declared separately and consider non-recurrent or ad-hoc spends.
- Externalities – costs have been reflected within the evaluation for the impact of the case on other external parties.

The sum of these discounted results creates an Equivalent Annual Cost (EAC) by option. A ranking occurs with the lowest EAC receiving the Agreed option status.

8.4.2 Revenue Costs

Revenue costs have been driven from the 2019/20 operational plan submitted to NHSI in February 2019 for the base year and reflect activity changes for future modelled years. All other options have been considered to assess the degree to which they might be different to the baseline position. Typical areas considered include:

- Transition costs for reconfiguration – non-recurring, project and dual running forecasts have been modelled. These costs are estimated at £10m;

- Project management costs across the Trust;
- Dual running staffing costs, backfill and training costs; and
- Revenue lifecycle estimates over a 65 year period.

8.4.3 Capital costs

Capital cash-flow is specific to each option and includes:

- Estimates for new capital build;
- Major refurbishment estimates;
- Capital lifecycle trajectories;
- Internal replacement capital programme forecasts;
- Internal new and replacement equipment requirements.

8.4.4 Residual Value Calculations

An estimate of the value of new build assets has been included to discount costs 65 years. Residual values for estate have been assumed to be equivalent to the value of land for each site. This assumption is consistent within all options.

8.4.5 Externalities

The impact on other organisations has been considered and modelled within the economic assessment.

The economic case excludes the impact on commissioners of QIPP delivery as the cost of enabling QIPP delivery is unknown at this point. This is excluded in all options and therefore does not become a differentiator within the economic assessment. Equally if QIPP delivery costs become known it is anticipated that they would be allocated by the same amount across each option.

8.5 Net Present Cost and Equivalent Annual Cost Analysis

The table below provides a summary of the Net Present Cost (NPC) for each of the options under evaluation, assessed over 65 years.

£m	Business As Usual	Do Minimum	Future Service
	Option A	Option B	Option C
	£m	£m	£m
Net Present Cost (NPC)	(£10,256.86)	(£10,213.19)	(£10,449.52)
Rank	2	1	3

8.5.1 Net Present Cost conclusion

The conclusion from the Net Present Cost assessment is that the Do Minimum Option has the lowest Net Present Cost. This conclusion is drawn when assessed at 65 years. The evaluation of risks and benefits are assessed below.

8.6. Benefits overview

8.6.1. Approach

The identified benefits are based on key benefits deliverable across the period of the business case and have been developed with the Economic Adviser from the Department of Health. The benefits identified are classified between cash releasing benefits and societal benefits and include:

- Pay savings, efficiency and productivity;
- New roles and models of care;
- Reduction in estate costs;
- Reduction in length of stay through efficiency;
- Reduced patient transport between sites;
- Societal benefits delivered through reduced length of stay.

The identified benefits will be further developed, with additional benefits identified as the Trust completes the procurement, financing, management case, risk management and benefits realisation as the Trust moves to the next steps to develop the business case.

£m	Business As Usual	Do Minimum	Future Service Model
	Option A	Option B	Option C
	NPC	NPC	NPC
Sunk costs	-		£1.6
Appraisal– Cash releasing benefits	-	£93.58	£241.1
Sub-total and variance to Business As Usual	-	***£93.58***	***£242.7***
Societal benefits	-		£7.76
Total benefits and Variance to Business As Usual	**-**	**£93.58**	**£250.46**
Variance to Do Minimum	(93.58)		156.88
Rank	**3**	**2**	**1**

8.6.1.1 Do Minimum Benefits

Within the Do Minimum case additional cash releasing benefits are required to be delivered to ensure the Trust remains in financial balance, to off-set the cost of the spend on back-log maintenance. The ability of the Trust to realise these savings is considered within the risk section below.

8.6.1.2 Future Service Model Benefits

Within the Future Service Model is a financial benefit associated with the design costs for the redevelopment. These are sunk costs that are a benefit in continuing with the Future Service Model option.

Identified cash releasing benefits enabled through the reconfiguration of services are quantified benefits. These benefits are:

- Skills mix and reduction in agency premium;
- Improved operational efficiency including staffing rotas;
- Reduced estate costs and transport costs.

Identified societal benefits from reconfiguration are:
- Job creation in the local area;
- Improvement in lives and well-being;
- Improved patient care outcomes;
- Reduced patient and staff transfers.

Each of the benefits above have been quantified and included within the economic evaluation.

8.6.2 Benefits Review Conclusion

The identified benefits outline a favourable cash releasing and societal benefits delivered through the Future Service Model option when compared to both the Business As Usual and Do Minimum options.

8.7. Risk overview

8.7.1. Approach

An exercise has been undertaken to assess identified risks associated with the reconfiguration of services across the Calderdale Royal Hospital and Huddersfield Royal Infirmary. The Trust quantified the risk by assessing the weighting, probability and risk retention/transfer of the following risk categories:

- Design Risks;
- Construction and Development Risks;
- Performance Risks;
- Operating Cost Risks;
- Variability of Revenue Risks;
- Termination Risks;
- Technology and Obsolescence Risks;
- Control risks;
- Residual Value Risks;
- Other Project Risks;
- Additional Project Risks.

The output of this assessment has informed the Net Present Cost (NPC) for each evaluated option.

8.7.2 Risk Assessment

£m	Business As Usual	Do Minimum	Future Service Model
	Option A	Option B	Option C
	NPC	NPC	NPC
Design Risks	£0.00	£0.00	(£7.33)
Construction and Development Risks	£0.00	£0.00	(£18.88)
Performance Risks	£0.00	£0.00	(£12.79)
Operating Cost Risks	£0.00	£0.00	(£9.59)
Variability of Revenue Risks	(£118.59)	(£118.59)	(£118.59)
Termination Risks	£0.00	£0.00	£0.00
Technology and Obsolescence Risks	(£69.09)	(£69.09)	(£69.09)
Control risks	£0.00	£0.00	£0.00
Residual Value Risks	£0.00	£0.00	£0.00
Other Risks	£0.00	£0.00	(£0.03)
Additional Project Risks	(£628.26)	(£555.90)	(£268.04)
Risk adjusted NPC	**(£815.94)**	**(£743.59)**	**(£504.36)**

8.7.3 Quantified Risk Overview

The key variation to the Business As Usual and Do Minimum options are the risks associated with the capital investment i.e. the design, construction, performance and operating cost risk associated with a new build. These have been quantified and are adverse risks within the Future Service Model.

Additional project risks include:

- Requirement for Emergency Capital expenditure;
- Inability deliver additional CIP savings without reconfiguration;
- Requirement for a new build development at HRI;
- Operational service impact of building failure at HRI.

Of the additional project risks greater quantified risk exists within the Business As Usual and Do Minimum options as the Trust reflects the risk of not investing within the aging HRI estate. Whilst the quantified risk is lower in the Do Minimum case, reflecting the investment within the existing site, this remains higher than the Future Service Model due to the reconfiguration of services and the focused investment in the HRI site.

8.7.4 Risks Review Conclusion

The risk assessment identifies that the Future Service Model is a lower cost risk model and is favourable when compared to the Business As Usual and the Do Minimum options.

8.8. Conclusions from the Economic Case

The table below provides the economic case conclusion of Net Present Cost and Equivalent Annual Cost Analysis, Risk Assessment and Benefits Analysis:

	Business As Usual	Do Minimum	Future Service Model
	Option A	Option B	Option C
	£m	£m	£m
Net Present Cost (NPC)	(£10,256.86)	(£10,213.19)	(£10,449.52)
Rank	**2**	**1**	**3**
Benefits Adjustment (NPC)		£93.58	£250.46
Benefits Adjusted Net Present Cost (NPC)	**(£10,256.86)**	**(£10,119.61)**	**(£10,199.06)**
Benefits Adjusted Rank	**3**	**1**	**2**
NPC Risk Adjustment	(£815.94)	(£743.59)	(£504.36)
Risk and Benefits Adjusted Net Present Cost (NPC)	**(£11,072.80)**	**(£10,863.20)**	**(£10,703.42)**
Benefits and Risk Adjusted Rank	**3**	**2**	**1**

It is concluded that Option C (Future Service Model) is the Agreed option. The Economic Case analysis reaffirms the case for change set out within the Case for Change, i.e. that the development of CRH as the unplanned hospital, with a planned hospital and emergency care centre development at HRI provides economic, value for money (VFM) advantage compared to the Business As Usual and Do Minimum options. Further evaluation of risks and benefits will be carried out as the reconfiguration business case develops.

9. COMMERCIAL CASE

The Commercial Case described in this chapter provides a high level approach to the procurement of the capital development works. This will be developed in more detail in the Outline Business Case.

The DHSC has announced 100% public capital funding is available and this is the preferred funding route for the development. The choice of a procurement route must meet the Trust's needs, project requirements and ensure the optimal management of risk for the Trust. The Trust also wishes to ensure that the procurement strategy and contract(s) support the development of collaborative relationships between the Trust and its suppliers.

The Trust has considered the elements of capital works required for the proposed development. This requirement can be described as:

- Reconfiguration of the existing CRH PFI site; infrastructure works required to the existing CRH building to integrate the existing site into the new build, including the expansion of hospital areas e.g. Emergency Department.
- New build works at CRH outside the scope of the PFI project; to increase the estate footprint to accommodate the increase in unplanned care on the CRH site.
- Capital investment at HRI; to enable adaptation of existing buildings and to address immediately the most critical maintenance requirements to enable the continued use of some of the existing site.

There are two important issues the Trust has considered in determining the preferred procurement route and subsequent contract management for the delivery of these capital estate developments:

I. The role of Calderdale and Huddersfield Solutions Ltd (CHS);
II. The Trust's current legal and contractual arrangements for the existing PFI at Calderdale Royal Hospital.

9.1 The Potential Role of CHS Ltd in the Procurement and Contract Management

Calderdale and Huddersfield Solutions Ltd (CHS) was incorporated as a registered company limited by shares on 15th March 2018. The sole shareholder is CHFT and CHS is therefore a wholly owned subsidiary of the Trust. CHS provides a fully managed suite of healthcare facilities for use by CHFT and provides value to CHFT through its specific service offering and through its ability to manage developments and operational risk for the Trust and other parties. CHS is led by a directly employed Managing Director and employs approximately 450 staff providing specialist estates, facilities, procurement and contract management services on behalf of CHFT and other customers. CHS's status as a "Teckal" trading company means that the Trust is able to contract directly with CHS without the need for a competitive procurement process.

The Trust's preferred approach at this stage is to instruct CHS to act on behalf of the Trust to deliver the necessary procurement(s) and subsequent contract management of suppliers to deliver the estate capital development works described above.

This approach will be further defined in the Outline Business Case and will include consideration of the procurement options available to the Trust to ensure it secures best value in the future provision of services.

9.2 The Trust's Current Legal and Contractual Arrangements for the Existing PFI

The Trust has sought to understand the options available for the procurement of the capital works to ensure that they are feasible in relation to the existing PFI contractual and legal arrangements and the Trust has concluded that:

- The reconfiguration of the existing CRH facilities will be procured by way of a variation of the existing PFI Project;
- The Trust has flexibility to deliver its proposals in respect of the new build works at CRH and the work at HRI under a single procurement process which would: avoid duplicating procurement costs; improve the likelihood of delivering both developments in accordance with a timetable determined by the Trust; and create a single counterparty for the Trust to deal with. However, it is possible for them to be procured separately and to follow different models. The procurement approach will therefore allow for flexibility and provide the opportunity for suppliers to bid for CRH; HRI; or CRH & HRI.

9.3 Statutory and Regulatory Procurement Compliance

The Trust will as necessary secure specialist advice to ensure the Trust takes full account of, changes in procurement legislation and processes post Brexit.

9.4 Market Soundings

The ability of the Trust to secure value for money through procurement will be influenced by the ability to attract sufficient credible bidders to generate and maintain meaningful competition throughout the procurement process. Accordingly, the Project will be carefully marketed to attract potential bidders. This will include pre-market engagement to enable discussion about scope and commercial issues; to ensure that the project is attractive to bidders; to explain proposed design methodology, including timescales so that bidders can resource it; and discuss proposed bid deliverables and evaluation criteria at each stage.

9.5 Trust Capability and Approach

The Trust has previous experience of delivering major procurement projects on a competitive dialogue basis. This includes for example:

- Procurement of the Cerner Electronic Patient Record, across two Trusts working with Bradford Teaching Hospitals NHS Foundation Trust;
- Establishing the Pennine Property Partnership (a property joint venture of the Trust with Henry Boot Developments) to undertake the development of Acre Mill (which is located across the road from HRI). Acre Mill was opened as an outpatient centre in 2015.

Trust Board members and other senior leaders in the Trust have a breadth of relevant experience that will support and enable delivery of the project.

This includes, for example, experience of leading and delivering the following major projects:

- Broad Street Complex (Halifax);
- Shay Stadium (Halifax);
- Piece Hall (Halifax);
- Brighouse & Sowerby Bridge Leisure facilities;
- Large Scale Voluntary Transfer (LSVT) of Housing (Rossendale);
- Independent Sector Treatment Centre for North Bradford PCT;
- Community hospitals for North Bradford PCT;
- Integration of the three NHS Leeds CCGs to create one Commissioning organization;
- Acre Mills Outpatient development - Pennine Property Partnership;
- Establishing Calderdale and Huddersfield Solutions Ltd (CHS) – a wholly owned subsidiary of CHFT;
- North of England Housing Market Renewal Regeneration;
- Major development and refurbishment programmes for a National Housing Association;
- Development of Calderdale Royal Hospital through a PFI initiative;
- Transforming Community Services - Calderdale Community Services;
- Hospital redevelopment at Nuffield Cambridge, Bristol, Newcastle-upon-Tyne, Chester;
- High Bay Warehouse at Trentham Gardens Stoke-on-Trent;
- Factory extension at Scunthorpe;
- Tesco new store development;
- Hospice at Peterborough;
- Global £500m transformation programme for a major insurance company;
- Procurement and management of multiple large outsourcing contracts in the private and public sector;
- Major IT programmes in support of major changes in public services;
- 'Building Better Health for Bolton' NHS LIFT Programme;
- Leading the establishment and development of the Commission for Health Improvement;
- Metrolink expansion programme;
- International relocation of a professional services (dot com) company;
- Previous significant experience of service reconfiguration including major trauma services in West Yorkshire.

Project management and governance arrangements will be established. The Trust will seek legal and specialist advice as necessary to plan and navigate through the Procurement approach.

10. FINANCIAL CASE

10.1 Introduction

The purpose of the financial case is to set out the indicative financial implications of the Agreed option as concluded within the Economic Case. The financial case is underpinned by the Trust's FY20 operational plan as submitted to NHSI in February 2019.

The preparation of the 'Agreed Service Option' modelled within the financial case have been modelled based on the NHS Operational Planning and Contracting Guidance 2019-20 with assumptions made to evaluate the financial case over a 25 year period.

The Trust recognises its current deficit financial position and that the Business As Usual and Do Minimum modelled options leave the Trust with an unsustainable clinical model and an unsustainable level of estate risk.

The financial models and assumptions used within the financial case are derived from the Trust's activity trajectories which are integrated within the Trust's operational plans.

The Agreed Service Option demonstrates a return on investment and enables the Trust to return to a cash generating financial position, an improved longer term financially sustainable position that addresses the key service and estate risks.

The Financial Case is based on Option C (Agreed Service Model) however it includes Option A (Business As Usual) and Option B (Do Minimum) for comparative purposes.

10.2 Impact on the Trust's Income and Expenditure Account

The summary financial impact of the Agreed Service Option is outlined in the table below:

	FY27	FY45
	Agreed Service	Agreed Service
	Option C	Option C
	£m	£m
Total Revenue	437.0	576.9
Total Operating Expenditure	(396.3)	(529.2)
EBITDA	**40.7**	**47.7**
Total Non-operating Expenses	(36.5)	(28.9)
Net Surplus / (Deficit)	**4.2**	**18.8**
Net Surplus / (Deficit) margin (%)	*1%*	*3%*

10.3 FY19 Financial Performance – Forecast to 31 March 2019

The Trust continues to forecast delivery of the planned deficit of £43.1m. The key risks associated with delivery of the FY19 plan are:

- The high risk associated with CIP schemes to the value of £0.24m;
- The costs associated with additional winter pressures have been included within the plan and forecast, but there remains a small risk that these exceed the available budget.

10.4 Financial Assumptions Overview

10.4.1 Key Assumptions Underpinning the Financial Case

The Financial Case modelled is based on the Trust's FY20 Operational Plan submitted to NHSI in February 2019. The other key assumptions within the Financial Case are detailed below.

10.4.2 Key Income & Expenditure (I&E) Assumptions

The key assumptions within the forecast are:

- That the Trust will receive £7.33m Provider Sustainability Fund (PSF) allocation. This is assumed in FY20 only in line with current Trust plans;
- That the Trust will receive £14.807m Financial Recovery Fund (FRF) allocation. This is assumed in FY20 in line with current Trust plans and it is assumed that a further £7.33m (previously received as PSF) is received from FY21 in future years to the value the Trust is in deficit, but not greater than £22.137m in total;
- The Trust will receive Marginal Rate Emergency Tariff (MRET) at £6.147m in 2019/20 only. This funding, at the same value is assumed to have transferred within PbR tariff from 2020/21 onwards;
- The Trust will deliver CIP efficiency savings of between 1.1% and 3.0% per annum throughout the financial case, with £10m net reconfiguration savings delivered post reconfiguration;
- Transitional costs of £10m will be incurred over the period of reconfiguration.

10.4.3 Key Growth Assumptions

Growth assumptions have been modelled within the financial plan for future years based on a review of three year historic growth trends and commissioner intentions over future years. The following growth assumptions are assumed for future years:

- Day case – 0%
- Elective – 0%
- Outpatient activity – 0%
- Emergency Department – 2%
- Non-elective short-stay admissions – 4%
- Non-elective long-stay admissions – 1%
- Community – 2%

These growth assumptions drive the income assumptions for the Trust from Greater Huddersfield CCG and Calderdale CCG. This is shown in the next section.

10.4.4 Commissioner Affordability

The Trust has shared the activity, growth and inflation assumptions of the SOC with its two key commissioners for transparency and to ensure overall affordability of the SOC for the West Yorkshire healthcare sector. The following table sets out the clinical income values per commissioner over the five year period.

£m	FY20	FY21*	FY22	FY23	FY24	FY25
Year	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5**
CHFT Calderdale CCG Income	145.4	151.5	154.9	158.5	162.1	165.8
CHFT Greater Huddersfield CCG Income	130.2	135.7	138.6	141.7	144.9	148.1
CHFT Clinical Income	**275.6**	**287.2**	**293.5**	**300.2**	**307.0**	**313.9**
Calderdale CCG	145.4	151.5	154.9	158.5	162.1	165.8
Greater Huddersfield CCG	130.2	135.7	138.6	141.7	144.9	148.1
CHFT Clinical Income	**275.6**	**287.2**	**293.5**	**300.2**	**307.0**	**313.9**
Greater Huddersfield CCG variance	-	-	-	-	-	-
Calderdale CCG variance	-	-	-	-	-	-
Difference	**-**	**-**	**-**	**-**	**-**	**-**

* In FY21 the Trust has assumed that Marginal Rate Emergency Tariff (MRET) received in FY20 of £6.417m is transferred within PbR tariff from FY21 onwards and is received in CCG allocations and the Trust is funded by the CCG's to the same value.

For FY19 and FY20 the Trust and Commissioners agreed an Aligned Incentive Contract for the year. The contract recognises the unsustainable financial position of the West Yorkshire health economy and overall financial constraints of the NHS. The key principles of the contract are to reduce the overall cost of healthcare to the health economy through collaborative working and innovation.

The Trust is committed to delivering a financially sustainable solution for the health sector in West Yorkshire. Through the Partnership Transformation Board the Trust is working with commissioners to identify and deliver QIPP that delivers financial savings for the health system i.e. both the commissioners', and providers', expenditure is reduced through the delivery of the QIPP, supporting the AIC contractual relationship.

10.4.5 Financial Assumptions

The projections laid out in the Financial Case include a number of assumptions around how the Trust operates:

- **Pay/Non-pay split –** where costs have not been able to be directly attributed to pay and non-pay categories, these have been split on a proportionate basis to pay/non-pay expenditure.
- **Marginal cost –** the assumption has been that any growth or movement in activity will have a marginal cost impact of 70% in line with the Trusts current cost profile
- **Working capital –** none of the options is assumed to have any significant impact on the Trust's working capital policy (i.e. payables and receivables days remain constant throughout the Plan period).

10.4.6 Economic Assumptions

The Trust has also made a number of economic assumptions governing cost inflation and tariff deflation. These are presented below.

	FY21-FY45
Year	Yr 1
Clinical Income	1.51%
Other Income	1.0%
Pay & Incremental drift	3.1%
Drugs	0.6%
CNST	1.0%
Clinical Supplies & Other non-pay	1.8%

These assumptions are based on the recurrent inflationary factors within the FY20 national PbR tariff. Any changes that may arise on these assumptions in the future will not materially impact the financial option appraisal since changes to such assumptions will impact the Existing Service model and Agreed Service Option materially equally.

10.4.7 Capital Assumptions

Estimates for capital expenditure were obtained from the work undertaken by Lendlease Consulting for the costs associated with CRH. Capital expenditure estimates are based on the gross internal floor areas of the development, taken from the Schedule of Accommodation produced by the Healthcare Planner following confirmation of the proposed service changes under the Proposed Option. HRI capital costs are estimated costs based on current known back-log maintenance risks. These costings were reviewed also by the Project Assessment Unit of NHS England.

10.4.7.1 Impairment of Capital Expenditure

A 15% impairment of the expenditure on new works at CRH (i.e. capital expenditure excluding backlog maintenance) is assumed on completion of the works (in FY25). HRI is assumed to be impaired by 50% in value post reconfiguration, reflecting the reduced utilisation of the estate (in FY26).

10.4.7.2 Depreciation policy for capital expenditure

- Reconfiguration capital – depreciated over 40 years;
- Backlog maintenance capital – depreciated over 34 years (current average for HRI).

10.4.7.3 Asset Disposals

There are no asset disposals planned beyond those planned in FY20.

10.4.7.4 Capital Estimate Inclusions

All of the below are pro-rated across the breakdown of capital provided by the Quantity Surveyor:

- Preliminary costs – 15%;
- Professional fees – 17%;
- Non-works costs – 1.9%;
- Capital equipment costs – 6.3%;
- Planning contingency – 20.3%;
- Optimism bias – 20%;
- Inflation – 11.7%;
- Value Added Tax (VAT) – 20%.

10.4.7.5 Revaluations

Revaluations have been assumed to occur to the Trust's estate. The estate is first revalued in FY21, and then annually thereafter to maintain the estimated market value of the estate.

10.4.8 Cash Assumptions

Throughout each of the modelled options the Trust is reliant on additional Revenue Support Loans in the period prior to returning to financial surplus. This has been modelled with an interest charge of 1.5%, which is the current rate of the borrowing for the Trust for this facility. As existing loans are repaid these are assumed as replaced at new loans at 1.5%. The Trust's Revenue Support Loan is assumed to be repayable over 35 years, based on cash availability to the Trust to make loan repayments.

10.4.9 Financing Assumptions

10.4.9.1 Option A – Business As Usual

Investment to address HRI back-log maintenance is delivered within the internally generated capital resource from FY21 onwards. FY20 includes emergency capital funding at £2.4m in line with the Trust's FY20 Operational Plan.

10.4.9.2 Option B – Do Minimum

- Back-log maintenance investment addresses the High and Significant at a cost of £60m over 10 years, funded through Emergency Capital loans.
- Emergency Capital loans are funded at 1.94% over 10 years.

10.4.9.3 Option C – Agreed Option

- £196.6m development funded through PDC.
- Interim capital loans utilised prior to the approval of the FBC, which are repaid once PDC is received.

10.5 Summary Financial Expenditure

The summary financial impact of the Agreed Service Option (Option C) is outlined in the table below:

£m	FY27	FY45
	Agreed Service	Agreed Service
	Option C	Option C
	£m	£m
Total Revenue	437.0	576.9
Total Operating Expenditure	(396.3)	(529.2)
EBITDA	**40.7**	**47.7**
Total Non-operating Expenses	(36.5)	(28.9)
Net Surplus / (Deficit)	**4.2**	**18.8**
Net Surplus / (Deficit) margin (%)	*1%*	*3%*

The total capital expenditure on the reconfiguration of services is £196.6m of capital expenditure.

10.6 Capital Costs

The table below is the capital expenditure plans submitted to NHS Improvement, with the addition of the expenditure planned on the Option C strategic reconfiguration. Detailed capital planning has been performed by the Trust for FY20 and outline plans identified for FY21-FY25.

£m	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
HRI Estates and backlog maintenance	2.4	5.0	4.0	3.6	3.0	2.0						
CRH Strategic Reconfiguration	1.6	3.0	2.0	44.9	82.6	42.5						
NPEx*	1.3											
NHS Energy Efficiency Fund (NEEF)*	0.7											
PFI – Lifecycle	1.7	1.8	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Programme**	13.7	7.6	7.6	8.3	8.2	8.1	11.1	10.8	10.3	9.9	9.4	15.3
Donated Assets	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.3
Total	**21.6**	**17.6**	**14.0**	**56.9**	**94.0**	**52.8**	**11.3**	**11.0**	**10.5**	**10.1**	**9.6**	**16.6**

*NPEX development and NHS Energy Efficiency Fund (LED installation across HRI and CRH) are subject to receipt of additional capital resource through PDC.
**Capital Programme excludes any emergency capital loans required to support developments beyond FY21.

10.6.1 Detailed Capital Plan – Agreed Service Model Option C

The table below provides a detailed analysis of the costs associated with the Agreed Service option.

Element	CRH Cost (£)	HRI Cost (£)	Total Cost (£)
CRH	£74,695,800		£74,695,800
Site infrastructure	£2,975,360		£2,975,360
Traffic management	£115,948		£115,948
External works	£700,120		£700,120
Service diversions	£140,000		£140,000
Access and logistics	£173,922		£173,922
Links	£1,575,000		£1,575,000
Sustainability	£686,756		£686,756
Section 106/278	£772,988		£772,988
Sub-total	**£81,835,894**		**£81,835,894**
Preliminaries	£12,661,445		£12,661,445
Fees	£13,912,102		£13,912,102
Non works costs	£1,546,505		£1,546,505
Equipment costs	£5,155,017		£5,155,017
Planning contingency	£16,612,686		£16,612,686
Optimism bias (13%)	£26,344,730		£26,344,730
Sub-total	**£158,068,379**		**£158,068,379**
Inflation	£18,478,194		£18,478,194
VAT	£35,309,315		£35,309,315
VAT recovery	(£35,309,315)		(£35,309,315)
Total	**£176,546,573**		**£176,546,573**
Backlog maintenance	**-**	**£20,000,000**	**£20,000,000**
Total (including backlog)	**£176,546,573**	**£20,000,000**	**£196,546,573**
Disposals	-	-	0
Total capital requirement	**£176,546,573**	**£20,000,000**	**£196,546,573**

Backlog maintenance at HRI will seek to address the very high risk areas of the estate that require action in the short to medium term. The expenditure will be focused on resuscitation, intensive care unit, four ward areas and external building works. The Trust will utilise its available capital resource in future years to maintain the site beyond the short/medium term.

10.6.2 Impairment

£m	FY25	FY26
CRH Unplanned site	(26.5)	-
HRI site	-	(36.8)
Revaluation reserve	-	20.5
Impairment Charge to I&E	**(26.5)**	**(16.3)**

The capital investment in new buildings typically costs more than the value of the building. The assumption used within the financial model is a reduction in asset value of 15%. In addition an impairment of the existing HRI site, recognising the reduced utilisation of the HRI footprint has been assumed to be 50% of the value. This is consistent with the Trust's experience of impairments on significant new build costs.

The impairment charge arising from reconfiguration has been treated as an exceptional item within the financial model.

10.7 Detailed Financial Expenditure – Affordability (Option C – Agreed Option)

The activity, workforce and capital plans are modelled within the financial expenditure table below:

10.7.1 Income and Expenditure Account

		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Clinical Revenue	319.3	332.7	345.4	352.2	359.3	366.6	374.1	380.2	386.3	392.7	398.8	405.1	514.0
Non Protected/Non Mandatory Clinical Revenue	7.3	6.2	6.3	6.5	6.6	6.8	6.9	7.1	7.3	7.4	7.6	7.8	11.0
Other Revenue	39.0	40.5	40.9	41.3	41.7	42.1	42.5	43.0	43.4	43.8	44.3	44.7	51.9
PSF / FRF		28.3	22.1	19.2	12.1	7.0	9.4	2.2	0.0	0.0	0.0	0.0	0.0
Total Revenue	**365.6**	**407.6**	**414.7**	**419.2**	**419.8**	**422.6**	**433.0**	**432.4**	**437.0**	**443.9**	**450.7**	**457.6**	**576.9**
Employee Benefit Expenses	(253.3)	(259.5)	(260.4)	(261.8)	(262.4)	(264.1)	(272.5)	(268.6)	(269.2)	(271.4)	(276.9)	(282.6)	(383.1)
Drugs	(37.2)	(38.1)	(37.5)	(37.0)	(36.4)	(35.8)	(35.3)	(35.0)	(34.6)	(34.5)	(34.3)	(34.2)	(32.2)
Clinical Supplies & Services	(30.0)	(29.5)	(29.4)	(29.4)	(29.3)	(29.2)	(29.2)	(29.3)	(29.3)	(29.5)	(29.8)	(30.0)	(33.8)
Other Expenses	(51.2)	(50.5)	(49.8)	(49.1)	(49.1)	(47.3)	(47.2)	(47.1)	(47.0)	(47.1)	(47.4)	(47.8)	(80.2)
PFI Operating Expenses	(12.8)	(13.3)	(13.6)	(13.7)	(14.1)	(14.6)	(15.0)	(15.5)	(16.1)	(16.3)	(16.7)	(17.3)	(0.0)
Total Operating Expenditure	**(384.4)**	**(391.0)**	**(390.8)**	**(391.0)**	**(391.2)**	**(391.1)**	**(399.3)**	**(395.5)**	**(396.2)**	**(398.7)**	**(405.2)**	**(411.8)**	**(529.2)**
EBITDA	**(18.8)**	**16.6**	**23.9**	**28.2**	**28.5**	**31.5**	**33.7**	**36.9**	**40.7**	**45.2**	**45.5**	**45.8**	**47.7**
EBITDA Margin (%)	*(5.1%)*	*4.1%*	*5.8%*	*6.7%*	*6.8%*	*7.5%*	*7.8%*	*8.5%*	*9.3%*	*10.2%*	*10.1%*	*10.0%*	*8.3%*
Gain/(loss) on asset disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment Losses (Reversals) net	0.0	0.0	0.0	0.0	0.0	0.0	(26.5)	(16.3)	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	(11.7)	(11.5)	(11.6)	(11.8)	(12.0)	(12.1)	(12.1)	(15.3)	(15.3)	(15.3)	(15.3)	(15.3)	(15.3)
Interest / Contingent Rent	(10.4)	(11.6)	(12.2)	(12.9)	(13.3)	(13.7)	(14.0)	(14.2)	(14.5)	(14.8)	(15.0)	(15.2)	(0.0)
Interest payable on Loans	(2.4)	(3.2)	(3.4)	(3.2)	(2.7)	(2.5)	(2.4)	(2.3)	(2.2)	(2.1)	(2.0)	(1.9)	(1.0)
PDC Dividend	0.0	(0.0)	(0.0)	(0.0)	(0.3)	(3.0)	(5.0)	(4.8)	(4.3)	(4.7)	(5.1)	(5.6)	(12.4)
Other Non-Operating	0.3	0.0	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Total Non-operating	**(24.2)**	**(26.3)**	**(27.4)**	**(28.1)**	**(28.4)**	**(31.4)**	**(60.0)**	**(53.2)**	**(36.5)**	**(37.1)**	**(37.7)**	**(38.2)**	**(28.9)**
Net Surplus / (Deficit)	**(43.0)**	**(9.6)**	**(3.5)**	**0.1**	**0.1**	**0.1**	**(26.4)**	**(16.3)**	**4.2**	**8.1**	**7.8**	**7.6**	**18.8**
Net Surplus / (Deficit) margin (%)	*(12%)*	*(2%)*	*(1%)*	*0%*	*0%*	*0%*	*(6%)*	*(4%)*	*1%*	*2%*	*2%*	*2%*	*3%*
Normalised (excluding impairments / Disposals)	**(43.0)**	**(9.6)**	**(3.5)**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**4.2**	**8.1**	**7.8**	**7.6**	**18.8**

FY25 is based on the Trusts experience of new works valuations.

10.7.1.1 Option C – Agreed Service Model Financial overview

Financial modelling of the Agreed Service model option shows the Trust return to financial surplus in FY22 however the Trust remains reliant on Financial Recovery Fund (FRF) until FY26. The Trust returns to a financial surplus on a recurrent basis in FY27 as the benefits of reconfiguration are realised and the Trust delivers CIP recurrently.

Revenue increases year on year by the growth in activity assumed along with the clinical income tariff increases. This is somewhat offset by efficiency improvements in length of stay to maintain activity within the Trust's existing bed base from FY26. The Trust's expenditure decreases in real terms in FY26-FY28 through realisation of reconfiguration benefits and CIP across the period, including delivery of skills mix to ensure the Trust has a workforce to meet the clinical requirements. Other changes in the income and cost base are driven by the economic assumptions.

Impairments arise in the financial plan in FY25 and FY26 as a consequence of estate reconfiguration. Impairment arises from impairing the existing HRI site and new capital build on completion.

10.7.2 Cost Improvement Programme (CIP)

The Trust has strong governance processes for the planning, monitoring and delivery of CIP and a track record of achievement. This was confirmed by NHSI following their CIP 'deep-dive' visit to the Trust in June 2017 and Use of Resources assessment in March 2018.

The Trust allocates CIP targets to operational and corporate divisions using a range of national and local benchmarking data in a deliberate approach to ensure allocation of CIP targets is based on evidence of where there may be efficiency opportunity (as opposed to simply a pro-rata share of target to budgets). 'Portfolio' opportunities (cross cutting or transformational schemes that impact on more than one operational division or require external partnerships) are led by a Director who is accountable for delivery.

Based on the targets allocated individual CIP schemes are progressed through detailed planning stages with weekly formal review of progress undertaken by the Trust's Turnaround Executive and monthly review at the Trust's Finance and Performance Committee.

In the three years FY17 to FY19 annual CIP delivery has ranged between £15m and £18m per annum resulting in a total of £50.9m efficiency savings realised across the three year period.

The FY20 CIP plan assumes the Trust delivers £11m in CIP and revenue generation schemes. It is in the context of successful historic delivery of CIP; long term strategic change enabled by the reconfiguration plans; and the future opportunities afforded the organisation by working collaboratively across the region that the Trust will strive to achieve the financial plan for FY20.

The FY20 CIP plan assumes delivery of £11.0m CIP and internal, as well as West Yorkshire wide, planning will support this.

The CIP programme for FY20 has now been identified in full.

10.7.2.1 Reconfiguration Benefits

Reconfiguration allows the delivery of services in a more sustainable way and supports the deployment of both reduced and alternative workforce models. Overall the proposed reconfiguration releases a further £10m of costs over and above existing CIP plans. The majority of the costs relate to clinical workforce costs.
The clinical model proposed does increase the establishment required for the delivery of Emergency Departments to support improved clinical rotas and increased consultant presence. This is achieved through skill mix of the entire workforce and use of new roles. Consultant establishment will be increased in line with Royal College Guidance to support both the increased un-planned activity on the CRH site but also the remaining activity on the HRI site. This will lead to more favorable rotas, recruitment and ultimately less reliance on agency and high cost temporary staffing.

Elsewhere within medical specialties, the proposed model centralises services and removes the need for a number of sub-specialty out of hours rotas. This again supports recruitment and reduction in overall agency and temporary staffing costs. Other material benefits arise from the investment in modern ward and bed stock. Ward sizes are planned at optimal efficiency bed numbers rather than existing 1960s configured wards which do not support efficient nurse to bed ratios.

The creation of one single critical care unit will deliver efficiencies through skill mix and the move to a planned activity site at HRI releases theatre costs both out of hours but also in supporting improved productivity. This improved productivity will create capacity to repatriate work from private sector and can then be absorbed within existing theatre capacity.

Whilst overall clinical rotas for anesthetists remain the same as present, increasing rotas at CRH and reduced rotas at HRI allows for deployment of new clinical roles at CRH such as Physicians Associates. This is a further efficiency that is not deliverable in the current configuration. As for medical specialties, the development of a planned site at HRI enables centralisation of a number of sub specialty surgical rotas on the unplanned care site at CRH.

The Trusts continued investment in digital technology enables further efficiency within support services within the proposed new clinical model. Out of hours support at HRI is reduced and the site is supported either remotely or through use of point of care testing and automatic release of blood through Blood Track. The investment into the new clinical model will ensure a modernised approach to delivery of outpatient activity. Digital technology will be used to reduce the need to attend hospital and further enhance the Trusts ambition to improve outpatient flow and experience. This releases additional costs and drives further outpatient efficiency.

Investment into the HRI site will be made to both make the site safe but also to reduce the operational footprint at HRI and disengage elements of the site that are both beyond useful life and economic repair. This will allow reduced costs both in terms of maintenance, upkeep and capital charges.

10.7.2.2 Other Initiatives

From FY21 the local system will have embedded new ways of working in Greater Huddersfield and Calderdale across community and hospital services. This collaboration will enable efficiencies to be achieved in relation to administration, management, and property costs.

10.7.3 Cost Improvement Programme (CIP)

The table below outlines the required CIP across the period FY20 – FY45.

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
CIP	18.0	11.0	9.0	9.0	9.0	9.0	9.0	5.7	5.6	3.9	3.9	4.0	5.4
Reconfiguration benefits								2.0	4.0	4.0			
WYAAT			2.1	2.0	3.1	2.1							
TOTAL – Planned efficiencies	**18.0**	**11.0**	**11.1**	**11.0**	**12.1**	**11.1**	**9.0**	**7.7**	**9.6**	**7.9**	**3.9**	**4.0**	**5.4**
Planned cumulative efficiencies	18	29.0	40.1	51.1	63.2	74.4	83.4	91.1	100.7	108.6	112.5	116.4	185.6
Efficiency % of Operating Expenditure	4.7%	2.8%	2.8%	2.8%	3.1%	2.8%	2.3%	1.9%	2.4%	2%	1%	1%	1%

Between FY20 and FY45, CHFT will need to identify new cost reductions amounting to £185.6m to meet the CIP efficiency requirement.

10.7.4 Use of Resources (UoR) metrics – Single Oversight Framework NHS Improvement

NHSI has introduced the Single Oversight Framework (SOF). Where previously a separate Finance rating (the FSRR) and Governance rating were issued, these are brought together under the SOF. This considers 5 themes: Quality of Care; Finance and use of resources; Operational performance; Strategic change; Leadership and improvement capability. The Finance element of this system is the Use of Resources score and the constituent parts of this measure are described below.

- **Liquidity:** days of operating costs held in cash or cash-equivalent forms (cash in the bank less payables plus receivables, on the presumption these can be immediately converted into cash);
- **Capital servicing capacity:** the degree to which the organisation's generated income covers its financing obligations a measure of the Trust's ability to afford its debt - in this sense payments against debts include PDC payments, interest and loan repayments and PFI interest, PFI contingent rent and PFI capital repayments;
- **Income and expenditure (I&E) margin:** the degree to which the organisation is operating at a surplus/deficit (measured against the Control Total which excludes impairments, gains/losses on disposal and donated assets);
- **Variance from plan in relation to I&E margin:** variance between a foundation Trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year (again measured against the Control Total which excludes impairments, gains/losses on disposal and donated assets);
- **Agency:** measurement of actual agency usage against the original agency ceiling set by NHSI at the planning stage. A distance from target of greater than 50% results in the lowest rating of 4 against this metric.

	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
Liquidity	4	4	4	4	4	4	4	4	4	4	3	3	1
Capital servicing capacity	4	4	4	4	4	4	4	3	3	3	3	3	1
I&E Margin	4	4	3	2	2	2	2	2	2	1	1	1	1
I&E Margin variance	1	1	1	1	1	1	1	1	1	1	1	1	1
Agency	1	1	1	1	1	1	1	1	1	1	1	1	1
Overall UoR score	**3**	**3**	**3**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**1**

The financial plan within the case improves the Trust's I&E Margin post reconfiguration as the Trust moves to financial surplus in FY22. This drives an overall improvement in the Use of Resources score to a 2. The financial plan assumes the Trust remains within the agency ceiling throughout the financial plan, therefore scoring a 1 throughout the plan in line with historical delivery against the agency ceiling.

10.7.5 Statement of Financial Position over 25 years (FY20 – FY45)

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Property, Plant and Equipment	**227.8**	**236.4**	**243.9**	**249.5**	**297.5**	**382.7**	**400.3**	**363.0**	**362.6**	**362.2**	**361.8**	**361.3**	**360.9**
Inventories	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1
NHS Trade Receivables	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4
Non NHS Trade Receivables	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5
Other Current Assets	6.1	13.8	13.8	12.8	10.3	8.5	9.3	6.8	6.1	6.1	6.1	6.1	6.1
Cash and Cash Equivalents	1.9	1.9	2.0	2.0	3.0	2.9	2.8	2.7	6.6	10.7	14.5	18.1	21.5
Current assets	**32.9**	**40.7**	**40.7**	**39.7**	**38.2**	**36.4**	**37.1**	**34.4**	**37.6**	**41.7**	**45.5**	**49.1**	**52.5**
Total assets	**260.7**	**277.0**	**284.7**	**289.2**	**335.8**	**419.0**	**437.4**	**397.5**	**400.2**	**403.9**	**407.3**	**410.4**	**413.4**
Current Liabilities	**(43.5)**	**(44.0)**	**(45.5)**	**(45.5)**	**(45.4)**	**(45.6)**	**(45.7)**	**(45.9)**	**(46.3)**	**(46.6)**	**(47.0)**	**(47.4)**	**(46.9)**
Non-Current Liabilities	**(217.9)**	**(240.3)**	**(248.5)**	**(249.5)**	**(226.6)**	**(220.8)**	**(217.5)**	**(210.6)**	**(204.9)**	**(195.7)**	**(186.1)**	**(175.9)**	**(168.9)**
Total Liabilities	**(261.5)**	**(284.3)**	**(293.9)**	**(295.0)**	**(272.0)**	**(266.4)**	**(263.2)**	**(256.4)**	**(251.2)**	**(242.3)**	**(233.1)**	**(223.3)**	**(215.8)**
Net assets employed	**(0.8)**	**(7.3)**	**(9.2)**	**(5.8)**	**63.8**	**152.7**	**174.2**	**141.0**	**149.1**	**161.5**	**174.2**	**187.1**	**197.6**
Public dividend capital	117.0	120.1	120.1	120.1	186.5	272.1	316.6	316.6	316.6	316.6	316.6	316.6	316.6
Retained Earnings (Accumulated Losses)	(156.6)	(166.2)	(169.7)	(169.6)	(169.5)	(169.4)	(195.8)	(212.1)	(207.9)	(199.8)	(192.0)	(184.4)	(176.9)
Revaluation reserve	38.8	38.8	40.3	43.7	46.8	50.0	53.4	36.5	40.3	44.7	49.5	54.8	57.9
Total taxpayers' equity	**(0.8)**	**(7.3)**	**(9.2)**	**(5.8)**	**63.8**	**152.7**	**174.2**	**141.0**	**149.1**	**161.5**	**174.2**	**187.1**	**197.6**

The Statement of Financial Position (SoFP) working capital is assumed consistent throughout the financial plan. The key movements within the SoFP arise in FY23 as the capital investment is reflected on the SoFP, prior to the impairment in FY25. The Trust returns to financial surplus in FY22 the SoFP improves year on year.

10.7.6 Cash Flow Statement

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Cash flows from operating activities	(19.0)	16.2	23.5	27.8	28.1	31.1	33.2	36.9	40.3	44.8	45.1	45.4	47.2
Cash generated from (used in) operations	2.5	(10.0)	0.2	1.2	2.5	1.8	(0.8)	2.4	0.9	0.0	0.0	0.0	0.0
Cash generated from (used in) investing activities	(10.5)	(17.6)	(17.4)	(13.8)	(56.7)	(93.8)	(52.5)	(11.0)	(10.8)	(10.3)	(9.8)	(9.4)	(15.3)
Cash generated from (used in) financing activities	26.9	11.3	(6.3)	(15.2)	27.1	60.8	20.0	(28.3)	(27.2)	(31.1)	(32.1)	(33.1)	(17.6)
Increase/ (decrease) in cash and cash equivalents	(0.1)	0.0	0.1	0.0	1.0	(0.1)	(0.1)	(0.0)	3.3	3.4	3.1	2.9	14.4

The cash position of the Trust, detailed above shows the improvement in generated cash as a consequence of the Trust returning to financial balance in FY27 and completion of the significant investment in the capital development.

FY23-FY25 sees an increase in cash used in investing activities and financing activities, driven by the investment in the capital build with the associated cash inflow from financing activities as PDC is received to fund the capital development.

10.7.7 Sensitivity Analysis

The Trust has considered variants to the business case as sensitivities based on the potential opportunities and risks that may arise within the local health economy. The following table highlights the bottom line deficit projections for the Agreed Service option. In the table below, the following non recurrent items have then been stripped out of these deficits to show the underlying (recurrent) deficit positions in each year:

- Net I&E Impairments of £26.5m in FY25 and £16.3m in FY26; and
- Non-recurrent costs of £10m;

Deficit £m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr10	Yr 25
Agreed option (deficit)/surplus	**(43.0)**	**(9.6)**	**(3.5)**	**0.1**	**0.1**	**0.1**	**(26.4)**	**(16.3)**	**4.2**	**8.1**	**7.8**	**7.6**	**18.8**
Impairments (I&E impact)							26.5	16.3					
Non-recurrent costs				0.3	1.5	1.1	6.9	0.2					
Normalised (deficit)/surplus	**(43.0)**	**(9.6)**	**(3.5)**	**0.4**	**1.6**	**1.2**	**7.0**	**0.2**	**4.2**	**8.1**	**7.8**	**7.6**	**18.8**

The downside and upside sensitivities bridge from the normalised financials indicated above.

10.7.7.1 Downside Sensitivities

The following downside scenarios have been considered by the Trust:

- **Downside 1 – Financial Recovery Fund (FRF) reduction**

FRF income is non-recurrent revenue that is only confirmed in FY20 however the Trust has assumed receipt of £72.0m across FY21-FY26. If the Trust was limited to 50% of the assumed FRF across the same period the Trust would remain in deficit until FY24, returning to surplus in FY25 for one year, report a deficit in FY26 and then deliver recurrent surpluses from FY27 onwards.

- **Downside 2 – Increase in Dual Running Costs**

The Trust has assumed non-recurrent transition costs of £10m associated with the reconfiguration. These are assumed as pay costs, consistent with the 5 Year Strategic Plan to support transitional project management. These costs are based on an initial assessment however this estimate could increase over and above, for the sensitivity this has been assumed to increase to £15.1m.

- **Downside 3 – Increase in cost basis arising due to external factors**

The Trust has modelled inflationary factors within the financial case as outlined in section 12.5.6. Due to current political uncertainty surrounding the UK and its relationship with the EU post BREXIT, there remains a risk that a rise in costs could occur above the assumed inflationary factors, or fall in the value of the pound, which is not funded through national tariff. Each 1% increase in non-pay costs would create a £1.3m cost pressure to the Trust from FY20. This cost pressure has been assumed to exist for three years, a cumulative impact of £3.9m.

- **Downside 4 – Marginal Rate Emergency Tariff decrease**

The Trust is assuming that MRET will transfer into PbR tariff from FY21 onwards in full at £6.147m. A risk exists that this value does not transfer in full, potentially up to £2m per annum.

- **Downside 5 – Non-delivery of WYAAT CIP initiatives**

The Trust through collaboration with WYAAT has identified a number of CIP initiatives that could deliver financial efficiencies for the Trust totaling £9.2m. WYAAT are committed to working collaborative to operate efficiencies non-delivery of these schemes are potential downside to the Trust's financial position.

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
Normalised (deficit)/ surplus	**(43.0)**	**(9.6)**	**(3.5)**	**0.4**	**1.6**	**1.2**	**7.0**	**0.2**	**4.2**	**8.1**	**7.8**	**7.6**	**18.8**
Reduction in FRF income by 50%			(11.1)	(9.6)	(6.1)	(3.5)	(4.7)	(1.1)					
Increase in dual running site costs						(1.0)	(2.0)	(2.0)					
Increase in cost basis arising due to external factors			(1.3)	(2.6)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)
MRET decrease						(2.0)	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)
Non-delivery of WYAAT CIP initiatives			(2.1)	(2.0)	(3.1)	(2.1)							
Sub - total movement			***(14.5)***	***(14.2)***	***(13.1)***	***(12.5)***	***(12.6)***	***(9.0)***	***(5.9)***	***(5.9)***	***(5.9)***	***(5.9)***	***(5.9)***
Downside case surplus/ (deficit)	**(43.0)**	**(9.6)**	**(18.0)**	**(13.8)**	**(11.5)**	**(11.3)**	**(5.6)**	**(8.8)**	**(1.7)**	**2.2**	**1.9**	**1.7**	**12.9**

The table highlights the overall impact of the above downside sensitivities on the underlying financial position, increasing the cost base across the financial plan. The Trust would look to mitigate any of these scenarios through additional cost savings.

10.7.7.2 Upside Sensitivities

The following upside scenarios have been considered by the Trust:

- **Upside 1 Increased CIP**

The Trust has forecast increased CIP delivery in FY26-FY28 post reconfiguration. A potential upside is that the Trust can increase CIP delivery post reconfiguration rather than the three years currently modelled. This would deliver £3.4m in FY28 and an additional £3.4m in FY29, a total cumulative benefit of £6.8m

- **Upside 2 – Realisation of LoS, QIPP and Community benefits**

The Trust has an opportunity to improve its length of stay (LoS) from the current performance to the upper quartile, realised through the benefits of reconfiguring services across its Halifax and Huddersfield sites. The benefits of this are an £8m improvement to the Calderdale and Huddersfield health economy. The Trust has assumed that £5m of this benefit remains with the Trust to contribute to the Trust's overall deficit position. This has been assumed to be realised from FY25.

- **Upside 3 – Aligned Incentive Delivery**

The Trust has an aligned incentive contract with its two key commissioners. The contract seeks to maximise the efficiency of delivery of healthcare for our local population with benefits of the contract shared between the Trust and the CCG's. Through working together, further cost reduction for the healthcare system could exceed current plans, with a further benefit to the Trust. A potential upside could be a share benefit of 1% of the contract value per annum.

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
Normalised (deficit)/ surplus	**(43.0)**	**(9.6)**	**(3.5)**	**0.4**	**1.6**	**1.2**	**7.0**	**0.2**	**4.2**	**8.1**	**7.8**	**7.6**	**18.8**
Increased CIP delivery post reconfiguration											3.4	6.8	6.8
Improvement in LoS following reconfiguration								1.0	3.0	5.0	5.0	5.0	5.0
Aligned Incentive contract benefit			2.9	2.9	3.0	3.1	3.1	3.2	3.2	3.3	3.3	3.4	3.4
Sub - total movement			***2.9***	***2.9***	***3.0***	***3.1***	***3.1***	***4.2***	***6.2***	***8.3***	***11.7***	***15.2***	***15.2***
Upside case surplus/ (deficit)	**(43.0)**	**(9.6)**	**(0.6)**	**3.3**	**4.6**	**4.3**	**10.1**	**4.4**	**10.4**	**16.4**	**19.5**	**22.8**	**34.0**

The table highlights the overall impact of the above upside sensitivities on the financial position, improving the financial position to a greater surplus in FY22. Should the upside arise the Trust would require £19.2m less Financial Recovery Fund revenue in the period to FY26.

10.8 Detailed Financial Expenditure – Affordability (Option A – Business as Usual)

For comparison, the activity, workforce and capital plans for the Business As Usual Option are modelled within the financial expenditure table below:

10.8.1 Income and Expenditure Account

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Clinical Revenue	319.3	332.7	345.4	352.2	359.3	366.6	374.3	380.0	385.8	391.8	397.9	404.2	512.5
Non Protected/Non Mandatory Clinical Revenue	7.3	6.2	6.3	6.5	6.6	6.8	6.9	7.1	7.3	7.4	7.6	7.8	11.0
Other Revenue	39.0	40.5	40.9	41.3	41.7	42.1	42.5	43.0	43.4	43.8	44.3	44.7	51.9
PSF / FRF		28.3	22.1	18.4	9.8	2.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Revenue	**365.6**	**407.6**	**414.7**	**418.4**	**417.4**	**417.9**	**423.8**	**430.1**	**436.5**	**443.1**	**449.8**	**456.7**	**575.4**
Employee Benefit Expenses	(253.3)	(259.5)	(260.4)	(261.5)	(261.9)	(263.0)	(267.9)	(272.0)	(276.1)	(281.5)	(286.9)	(292.5)	(390.8)
Drugs	(37.2)	(38.1)	(37.5)	(37.0)	(36.4)	(35.8)	(35.6)	(35.3)	(34.9)	(34.8)	(34.6)	(34.4)	(31.9)
Clinical Supplies & Services	(30.0)	(29.5)	(29.4)	(29.4)	(29.3)	(29.2)	(29.4)	(29.5)	(29.6)	(29.8)	(30.0)	(30.2)	(33.5)
Other Expenses	(51.2)	(50.5)	(49.8)	(49.1)	(48.1)	(47.3)	(47.5)	(47.7)	(48.0)	(48.3)	(48.7)	(49.0)	(81.0)
PFI Operating Expenses	(12.8)	(13.3)	(13.6)	(13.7)	(14.1)	(14.6)	(15.0)	(15.5)	(16.1)	(16.3)	(16.7)	(17.3)	(0.0)
Total Operating Expenditure	**(384.4)**	**(391.0)**	**(390.8)**	**(390.7)**	**(389.7)**	**(390.0)**	**(395.5)**	**(400.1)**	**(404.7)**	**(410.6)**	**(416.9)**	**(423.3)**	**(537.3)**
EBITDA	**(18.8)**	**16.6**	**23.9**	**27.7**	**27.7**	**27.9**	**28.2**	**30.0**	**31.8**	**32.5**	**32.9**	**33.3**	**38.1**
EBITDA Margin (%)	*(5.1%)*	*4.1%*	*5.8%*	*6.6%*	*6.6%*	*6.7%*	*6.7%*	*7.0%*	*7.3%*	*7.3%*	*7.3%*	*7.3%*	*6.6%*
Gain/(loss) on asset disposals	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment Losses (Reversals) net	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	(11.7)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)
Interest / Contingent Rent	(10.4)	(11.6)	(12.2)	(12.9)	(13.3)	(13.7)	(14.0)	(14.2)	(14.5)	(14.8)	(15.0)	(15.2)	(0.0)
Interest payable on Loans	(2.4)	(3.2)	(3.3)	(3.0)	(2.6)	(2.5)	(2.4)	(2.3)	(2.2)	(2.1)	(2.0)	(1.9)	(1.0)
PDC Dividend	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.4)	(0.7)	(6.4)
Other Non-Operating	0.3	0.0	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Total Non-operating	**(24.2)**	**(26.3)**	**(27.2)**	**(27.6)**	**(27.6)**	**(27.8)**	**(28.0)**	**(28.2)**	**(28.4)**	**(28.7)**	**(29.1)**	**(29.4)**	**(19.1)**
Net Surplus / (Deficit)	**(43.0)**	**(9.6)**	**(3.3)**	**0.1**	**0.1**	**0.1**	**0.2**	**1.8**	**3.4**	**3.8**	**3.9**	**3.9**	**19.0**
Net Surplus / (Deficit) margin (%)	*(12%)*	*(2%)*	*(1%)*	*0%*	*0%*	*0%*	*0%*	*0%*	*1%*	*1%*	*1%*	*1%*	*3%*
Normalised (excluding impairments / Disposals)	**(43.0)**	**(9.6)**	**(3.3)**	**0.1**	**0.1**	**0.1**	**0.2**	**1.8**	**3.4**	**3.8**	**3.9**	**3.9**	**19.0**

10.8.2 Option A – Business As Usual

The financial deficit position of the Trust improves from the current FY19 deficit of £43.0m as a consequence of national funding for Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) Marginal Rate Emergency Tariff (MRET). This alongside the delivery of CIP sees the Trust return to financial surplus in FY22 and return to financial surplus without national non-recurrent FRF funding in FY25. The total required FRF under the Business As Usual is £52.7m (FY21-FY24) compared with £72m (FY21-FY26).

The financial modelling for the Business As Usual option is financially favourable as the Trust would return to financial balance without FRF two years earlier, in FY25 compared with FY27 under the Agreed Option. The key driver for this is the non-recurrent costs required to deliver the service reconfiguration, increased PDC charges under the Agreed Option to support the investment into the estate and the associated depreciation charge on this investment.

The financial modelling does not reflect the estate and service risk that the Trust would be carrying in the short-medium term as within the Business As Usual modelling the estate does not receive any investment to address the £95m backlog maintenance. This risk is unsustainable and therefore the investment within the Agreed Option is required.

10.8.3 Impact on the Statement of Comprehensive Income (incremental) – Agreed vs. Business As Usual

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Revenue (Excluding PSF / FRF)	0.0	0.0	0.0	0.0	(0.0)	0.0	(0.2)	0.1	0.5	0.9	0.9	0.9	1.5
PSF / FRF	0.0	0.0	0.0	0.8	2.3	4.7	9.4	2.2	0.0	0.0	0.0	0.0	0.0
Revenue costs													
Employee Benefit Expenses	0.0	0.0	0.0	(0.3)	(0.5)	(1.1)	(4.6)	3.4	6.9	10.1	10.0	9.9	7.8
Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3	0.3	0.3	0.2	0.2	(0.3)
Clinical Supplies & Services	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3	0.3	0.2	0.2	0.2	(0.3)
Other Expenses	0.0	0.0	0.0	0.0	(1.0)	0.0	0.3	0.6	0.9	1.3	1.2	1.2	0.8
PFI Operating Expenses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Revenue Costs	**0.0**	**0.0**	**0.0**	**(0.3)**	**(1.5)**	**(1.1)**	**(3.8)**	**4.5**	**8.4**	**11.9**	**11.7**	**11.5**	**8.1**
Gain/(loss) on asset disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment Losses (Reversals) net	0.0	0.0	0.0	0.0	0.0	0.0	(26.5)	(16.3)	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	0.0	0.0	(0.1)	(0.3)	(0.5)	(0.6)	(0.6)	(3.8)	(3.8)	(3.8)	(3.8)	(3.8)	(3.8)
Interest / Contingent Rent on PFI leases & liabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest payable on Loans	0.0	0.0	(0.1)	(0.2)	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
PDC Dividend	0.0	0.0	0.0	0.0	(0.3)	(3.0)	(5.0)	(4.8)	(4.3)	(4.6)	(4.8)	(4.9)	(5.9)
Other Non-Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non-Operating Costs	**0.0**	**0.0**	**(0.1)**	**(0.5)**	**(0.9)**	**(3.6)**	**(32.0)**	**(24.9)**	**(8.1)**	**(8.4)**	**(8.6)**	**(8.7)**	**(9.8)**
Incremental impact on I&E surplus/ (deficit)	**0.0**	**0.0**	**(0.1)**	**0.0**	**(0.0)**	**(0.0)**	**(26.6)**	**(18.0)**	**0.8**	**4.3**	**4.0**	**3.7**	**(0.2)**
less Impairments	0.0	0.0	0.0	0.0	0.0	0.0	26.5	16.3	0.0	0.0	0.0	0.0	0.0
less Non-recurrent costs	0.0	0.0	0.3	0.5	2.1	6.9	0.2						
Incremental impact on I&E surplus / (deficit)	**0.0**	**0.0**	**0.2**	**0.5**	**2.1**	**6.9**	**0.0**	**(1.7)**	**0.8**	**4.3**	**4.0**	**3.7**	**(0.2)**

The incremental impact on the SoCI is outlined in the table above show the non-recurrent investment in employee benefit expenses in FY22-FY25 with the incremental increase in FRF income to support the Trust's financial recovery. Additional benefits post reconfiguration are reflected in FY26 onwards offset by the increase in PDC Dividend investment in the Trust's estate. FY25 and FY26 have exceptional impairments within the Agreed Option.

10.8.4 Impact on Cash Flow (incremental) – Agreed vs. Business as Usual

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Capital costs	0.0	0.0	(8.1)	(6.0)	(49.3)	(86.6)	(45.5)	(4.2)	(4.2)	(4.2)	(4.2)	(4.2)	(3.8)
Revenue costs (excl Depreciation)	0.0	0.0	(0.1)	0.3	0.5	0.6	0.4	2.1	4.6	8.1	7.8	7.5	3.6
PWLB Capital Loan	0.0	0.0	8.0	6.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Revenue Support Loan	0.0	0.0	0.2	0.3	0.8	1.6	3.3	0.8	0.0	0.0	0.0	0.0	0.0
PFI Finance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC	0.0	0.0	0.0	0.0	66.4	85.6	44.5	0.0	0.0	0.0	0.0	0.0	0.0
Loan repayments	0.0	0.0	0.0	(0.3)	(16.8)	(0.4)	(1.2)	(2.9)	(0.4)	0.4	0.4	0.4	(0.0)
PFI Lease repayments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Incremental impact on Cash	0.0	0.0	0.1	0.3	1.7	0.8	1.5	(4.2)	0.0	4.3	4.0	3.7	(0.2)
Cumulative impact on Cash Flow	**0.0**	**0.0**	**0.1**	**0.4**	**2.0**	**2.8**	**4.3**	**0.1**	**0.1**	**4.4**	**8.4**	**12.1**	**40.9**

The incremental cash flow outlined above highlights the incremental investment in the capital estate for the reconfiguration alongside the receipt of PDC in FY23-FY25. This is off-set by emergency capital investment at £6m per annum for 10 years. In future years, post reconfiguration the Trust has an increased capital resource available to it for investment in the estate, equipment and IM&T as a consequence of a higher asset value and increased depreciation charge.

10.8.5 Statement of financial position (incremental) – Agreed vs. Business as Usual

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Property plant and equipment	**0.0**	**0.0**	**8.0**	**14.0**	**62.4**	**148.0**	**166.1**	**129.2**	**129.2**	**129.2**	**129.2**	**129.2**	**129.2**
Cash and cash equivalents	0.0	0.0	0.1	0.1	1.2	1.2	1.0	(0.7)	0.1	4.4	8.4	12.1	40.9
Loans	0.0	0.0	(8.2)	(14.2)	1.8	0.5	(1.5)	0.6	1.0	0.6	0.2	(0.2)	(0.1)
PFI Lease	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Taxpayers Equity	**0.0**	**0.0**	**(0.1)**	**0.2**	**66.2**	**151.4**	**168.9**	**129.9**	**130.3**	**134.2**	**137.8**	**141.1**	**170.0**

The incremental Statement of Financial Position outlines a higher asset base in the Agreed option as a consequence of the investment into the Trust estate to address the existing service and capital risks. This shows the improved Statement of Financial Position as a consequence of this investment. In the long term the financial cash position of the Trust overall is healthier due to the improved financial position.

10.9 Detailed Financial Expenditure – Affordability (Option B – Do Minimum)

For comparison, the activity, workforce and capital plans for the Existing Model Option are modelled within the financial expenditure table below:

10.9.1 Income and Expenditure Account

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Clinical Revenue	319.3	332.7	345.4	352.2	359.3	366.6	374.2	379.9	385.7	391.8	397.9	404.1	512.2
Non Protected/Non Mandatory Clinical Revenue	7.3	6.2	6.3	6.5	6.6	6.8	6.9	7.1	7.3	7.4	7.6	7.8	11.0
Other Revenue	39.0	40.5	40.9	41.3	41.7	42.1	42.5	43.0	43.4	43.8	44.3	44.7	51.9
PSF / FRF		28.3	22.1	18.7	10.4	3.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Revenue	**365.6**	**407.6**	**414.7**	**418.7**	**418.1**	**418.8**	**423.7**	**430.0**	**436.4**	**443.0**	**449.7**	**456.6**	**575.1**
Employee Benefit Expenses	(253.3)	(259.5)	(260.4)	(261.5)	(261.9)	(263.0)	(267.0)	(271.0)	(275.2)	(280.5)	(285.9)	(291.5)	(385.2)
Drugs	(37.2)	(38.1)	(37.5)	(37.0)	(36.4)	(35.8)	(35.5)	(35.2)	(34.8)	(34.6)	(34.5)	(34.3)	(31.5)
Clinical Supplies & Services	(30.0)	(29.5)	(29.4)	(29.4)	(29.3)	(29.2)	(29.3)	(29.4)	(29.5)	(29.7)	(29.9)	(30.1)	(33.0)
Other Expenses	(51.2)	(50.5)	(49.8)	(49.1)	(48.1)	(47.3)	(47.4)	(47.6)	(47.8)	(48.2)	(48.5)	(48.9)	(80.5)
PFI Operating Expenses	(12.8)	(13.3)	(13.6)	(13.7)	(14.1)	(14.6)	(15.0)	(15.5)	(16.1)	(16.3)	(16.7)	(17.3)	(0.0)
Total Operating Expenditure	**(384.4)**	**(391.0)**	**(390.8)**	**(390.7)**	**(389.7)**	**(390.0)**	**(394.2)**	**(398.8)**	**(403.4)**	**(409.3)**	**(415.5)**	**(422.0)**	**(530.2)**
EBITDA	**(18.8)**	**16.6**	**23.9**	**28.1**	**28.4**	**28.8**	**29.5**	**31.2**	**33.0**	**33.7**	**34.2**	**34.6**	**44.9**
EBITDA Margin (%)	*(5.1%)*	*4.1%*	*5.8%*	*6.7%*	*6.8%*	*6.9%*	*7.0%*	*7.3%*	*7.6%*	*7.6%*	*7.6%*	*7.6%*	*7.8%*
Gain/(loss) on asset disposals	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment Losses (Reversals) net	0.0	0.0	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	0.0
Total Depreciation & Amortisation	(11.7)	(11.5)	(11.5)	(11.7)	(11.8)	(12.0)	(12.1)	(12.3)	(12.4)	(12.6)	(12.7)	(12.9)	(13.0)
Interest / Contingent Rent	(10.4)	(11.6)	(12.2)	(12.9)	(13.3)	(13.7)	(14.0)	(14.2)	(14.5)	(14.8)	(15.0)	(15.2)	(0.0)
Interest payable on Loans	(2.4)	(3.2)	(3.4)	(3.2)	(3.0)	(3.0)	(3.0)	(3.1)	(3.1)	(3.1)	(3.1)	(3.1)	(1.4)
PDC Dividend	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.3)	(0.6)	(8.1)
Other Non-Operating	0.3	0.0	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Total Non-operating	**(24.2)**	**(26.3)**	**(28.2)**	**(28.9)**	**(29.2)**	**(29.6)**	**(30.1)**	**(30.6)**	**(31.1)**	**(31.5)**	**(32.2)**	**(32.8)**	**(22.6)**
Net Surplus / (Deficit)	**(43.0)**	**(9.6)**	**(4.3)**	**(0.8)**	**(0.8)**	**(0.8)**	**(0.7)**	**0.6**	**2.0**	**2.2**	**2.0**	**1.9**	**22.3**
Net Surplus / (Deficit) margin (%)	*(12%)*	*(2%)*	*(1%)*	*(0%)*	*(0%)*	*(0%)*	*(0%)*	*0%*	*0%*	*0%*	*0%*	*0%*	*4%*
Normalised (excluding impairments / Disposals)	**(43.0)**	**(9.6)**	**(3.4)**	**0.1**	**0.1**	**0.1**	**0.2**	**1.5**	**2.9**	**3.1**	**2.9**	**2.8**	**22.3**

10.9.2 Option B – Do Minimum

The financial deficit position of the Trust improves from the current FY19 deficit of £43.0m as a consequence of national funding for Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) Marginal Rate Emergency Tariff (MRET). This alongside the delivery of CIP sees the Trust return to financial surplus in FY22 and return to financial surplus without national non-recurrent FRF funding in FY25. The total required FRF under the Business As Usual is £54.5m (FY21-FY24) compared with £72m (FY21-FY26).

The financial modelling for the Do Minimum option is financially favourable as the Trust would return to financial balance without FRF two years earlier, in FY25 compared with FY27 under the Agreed Option. The key driver for this is the non-recurrent costs required to deliver the service reconfiguration, increased PDC charges under the Agreed Option to support the investment into the estate and the associated depreciation charge on this investment.

The financial modelling only partially reflects the estate and service risk that the Trust would be carrying in the short-medium term as within the Do Minimum modelling the estate does receives partial investment of £60m to address the £95m backlog maintenance. This risk is unsustainable and therefore the investment within the Agreed Option is required.

10.9.3 Impact on the Statement of Comprehensive Income (incremental) – Agreed vs. Do Minimum

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Revenue (Excluding PSF / FRF)	0.0	0.0	0.0	(0.0)	0.0	(0.0)	(0.1)	0.2	0.6	0.9	1.0	1.0	1.8
PSF / FRF	0.0	0.0	0.0	0.4	1.7	3.7	9.4	2.2	0.0	0.0	0.0	0.0	0.0
Revenue costs													
Employee Benefit Expenses	0.0	0.0	0.0	(0.3)	(0.5)	(1.1)	(5.6)	2.4	6.0	9.1	9.0	8.9	2.1
Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.2	0.1	0.1	0.1	(0.7)
Clinical Supplies & Services	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	(0.8)
Other Expenses	0.0	0.0	0.0	0.0	(1.0)	0.0	0.2	0.5	0.8	1.1	1.1	1.1	0.3
PFI Operating Expenses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Revenue Costs	**0.0**	**0.0**	**0.0**	**(0.3)**	**(1.5)**	**(1.1)**	**(5.1)**	**3.2**	**7.1**	**10.5**	**10.3**	**10.1**	**1.0**
Gain/(loss) on asset disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment Losses (Reversals) net	0.0	0.0	0.9	0.9	0.9	0.9	(25.6)	(15.4)	0.9	0.9	0.9	0.9	0.0
Total Depreciation & Amortisation	0.0	0.0	(0.1)	(0.2)	(0.2)	(0.1)	0.0	(3.1)	(2.9)	(2.8)	(2.6)	(2.5)	(2.3)
Interest / Contingent Rent on PFI leases & liabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest payable on Loans	0.0	0.0	0.0	0.0	0.3	0.5	0.6	0.7	0.9	1.0	1.1	1.2	0.4
PDC Dividend	0.0	0.0	0.0	0.0	(0.3)	(3.0)	(5.0)	(4.8)	(4.3)	(4.7)	(4.8)	(5.0)	(4.3)
Other Non-Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non-Operating Costs	**0.0**	**0.0**	**0.8**	**0.8**	**0.7**	**(1.8)**	**(29.9)**	**(22.6)**	**(5.5)**	**(5.6)**	**(5.5)**	**(5.4)**	**(6.2)**
Incremental impact on I&E surplus/ (deficit)	**0.0**	**0.0**	**0.8**	**0.9**	**0.9**	**0.9**	**(25.7)**	**(16.9)**	**2.2**	**5.9**	**5.8**	**5.8**	**(3.5)**
less Impairments	0.0	0.0	(0.9)	(0.9)	(0.9)	(0.9)	25.6	15.4	(0.9)	(0.9)	(0.9)	(0.9)	0.0
less Non-recurrent costs	0.0	0.0	0.3	0.5	2.1	6.9	0.2						
Incremental impact on I&E surplus / (deficit)	**0.0**	**0.0**	**0.2**	**0.5**	**2.1**	**6.9**	**0.1**	**(1.4)**	**1.3**	**5.0**	**4.9**	**4.9**	**(3.5)**

The incremental impact on the SoCI is outlined in the table above show the non-recurrent investment in employee benefit expenses in FY22-FY25 with the incremental increase in FRF income to support the Trust's financial recovery. Additional benefits post reconfiguration are reflected in FY26 onwards offset by the increase in PDC Dividend investment in the Trust's estate. FY25 and FY26 have exceptional impairments within the Agreed Option.

10.9.4 Impact on Cash Flow (incremental) – Agreed vs. Do Minimum

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Capital costs	0.0	0.0	(2.1)	(0.1)	(43.5)	(80.8)	(39.9)	1.3	1.2	1.1	1.1	1.0	(4.7)
Revenue costs (excl Depreciation)	0.0	0.0	0.0	0.1	0.2	0.1	(0.2)	1.6	4.2	7.8	7.5	7.3	(1.2)
PWLB Capital Loan	0.0	0.0	2.0	0.0	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)	0.0
Revenue Support Loan	0.0	0.0	0.1	0.1	0.6	1.3	3.3	0.8	0.0	0.0	0.0	0.0	(0.0)
PFI Finance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC	0.0	0.0	0.0	0.0	66.4	85.6	44.5	0.0	0.0	0.0	0.0	0.0	0.0
Loan repayments	0.0	0.0	0.0	(0.1)	(16.1)	0.5	0.1	(1.7)	1.1	2.1	2.3	2.6	2.4
PFI Lease repayments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Incremental impact on Cash Flow	0.0	0.0	(0.0)	0.1	1.5	0.7	1.8	(3.9)	0.5	5.0	4.9	4.9	(3.5)
Cumulative impact on Cash Flow	**0.0**	**0.0**	**(0.0)**	**0.1**	**1.7**	**2.4**	**4.2**	**0.3**	**0.8**	**5.8**	**10.7**	**15.5**	**28.0**

The incremental cash flow outlined above highlights the incremental investment in the capital estate for the reconfiguration alongside the receipt of PDC in FY23-FY25. This is off-set by emergency capital investment at £6m per annum for 10 years. In future years, post reconfiguration the Trust has an increased capital resource available to it for investment in the estate, equipment and IM&T as a consequence of a higher asset value and increased depreciation charge.

10.9.5 Statement of financial position (incremental) – Agreed vs. Do Minimum

£m	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY45
		Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Property plant and equipment	**0.0**	**0.0**	**2.9**	**3.8**	**47.1**	**127.6**	**140.6**	**98.6**	**93.5**	**88.4**	**83.3**	**78.2**	**78.2**
Cash and cash equivalents	0.0	0.0	0.1	0.1	1.1	1.0	0.8	(0.6)	0.7	5.7	10.6	15.4	27.9
Loans	0.0	0.0	(2.1)	(2.1)	19.4	23.6	26.3	33.2	38.1	42.0	45.7	49.1	13.2
PFI Lease	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Taxpayers Equity	**0.0**	**0.0**	**0.8**	**1.8**	**68.2**	**153.6**	**171.0**	**132.0**	**132.4**	**136.2**	**139.7**	**142.9**	**119.4**

The incremental Statement of Financial Position outlines a higher asset base in the Agreed option as a consequence of the investment into the Trust estate to address the existing service and capital risks. This shows the improved Statement of Financial Position as a consequence of this investment. In the long term the financial cash position of the Trust overall is healthier due to the improved financial position.

10.10 Financial Affordability Conclusion

The table below provides a comparison of the affordability compared to the Existing Service Model position.

10.10.1 Income and Expenditure Business As Usual vs. Do Minimum vs. Agreed Option

£m	FY27	FY27	FY27	FY27	FY27	FY45	FY45	FY45	FY45	FY45
	Business As Usual	Do Minimum	Agreed	Business As Usual Variance	Do Minimum Variance	Business As Usual	Do Minimum	Agreed	Business As Usual Variance	Do Minimum Variance
	Option A	Option B	Option C			Option A	Option B	Option C		
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Revenue	436.5	436.4	437.0	0.5	0.6	575.4	575.1	576.9	1.5	1.8
Total Operating Expenditure	(404.7)	(403.4)	(396.2)	8.4	7.1	(537.3)	(530.2)	(529.2)	8.1	1.0
EBITDA	**31.8**	**33.0**	**40.7**	**8.9**	**7.7**	**38.1**	**44.9**	**47.7**	**9.5**	**2.7**
Total Non-operating Expenses	(28.4)	(31.1)	(36.5)	(8.1)	(5.5)	(19.1)	(22.6)	(28.9)	(9.8)	(6.2)
Net Surplus / (Deficit)	**3.4**	**2.0**	**4.2**	**0.8**	**2.2**	**19.0**	**22.3**	**18.8**	**(0.2)**	**(3.5)**
Net Surplus / (Deficit) margin (%)	*0.0*	*0.0*	*0.0*	*0.2%*	*0.5%*	*3.3%*	*3.9%*	*3.3%*	*0.0%*	*-0.6%*
FY27 Cumulative normalised Surplus / (Deficit)	**(50.2)**	**(51.0)**	**(41.4)**	**8.8**	**9.6**					
FY45 Cumulative normalised Surplus / (Deficit)						**97.3**	**115.1**	**131.9**	**34.7**	**16.8**

The Financial Case proves affordability of the investment into the Trust's estate and reconfiguration of services. The investment into the estate provides medium term sustainability for the Trust and mitigates significant estate and service risk that exists within the Business As Usual and the Do Minimum case.

The Agreed option case delivers a net £10m financial efficiency and sees the Trust return to financial balance without Financial Recovery Fund revenue in FY27. The cumulative deficit position is favourable at FY27 compared with both the Business As Usual (£8.8m) and the Do Minimum options (£9.6m) and this position improves further at FY45 to £34.7m and £16.8m respectively.

10.10.2 Statement of Financial Position Business As Usual and Do Minimum vs. Agreed Option

£m	FY27	FY27	FY27	FY27	FY27	FY45	FY45	FY45	FY45	FY45
	Business As Usual	Do Minimum	Agreed	Business As Usual Variance	Do Minimum Variance	Business As Usual	Do Minimum	Agreed	Business As Usual Variance	Do Minimum Variance
	Option A	Option B	Option C	Option A vs. Option C	Option B vs. Option C	Option A	Option B	Option C	Option A vs. Option C	Option B vs. Option C
	£	£	£	£	£m	£m	£m	£m	£m	£m
Property, Plant and Equipment	233.4	269.1	362.6	129.2	93.5	230.5	281.5	359.7	129.2	78.2
Current Assets	37.5	36.9	37.6	0.1	0.7	94.4	107.4	135.3	40.9	27.9
Total Assets	**270.9**	**306.0**	**400.2**	**129.3**	**94.2**	**324.8**	**388.8**	**494.9**	**170.1**	**106.1**
Current Liabilities	(46.4)	(47.3)	(46.3)	0.1	1.1	(43.1)	(43.6)	(43.0)	0.1	0.6
Non-Current Liabilities	(205.8)	(242.0)	(204.9)	0.9	37.1	(67.6)	(80.4)	(67.8)	(0.2)	12.6
Total Liabilities	**(252.1)**	**(289.3)**	**(251.2)**	**1.0**	**38.2**	**(110.7)**	**(124.1)**	**(110.8)**	**(0.1)**	**13.3**
Net Assets employed	**18.8**	**16.7**	**149.1**	**130.3**	**132.4**	**214.1**	**264.7**	**384.1**	**170.0**	**119.4**
Public dividend capital	120.1	120.1	316.6	196.5	196.5	120.1	120.1	316.6	196.5	196.5
Retained Earnings (Accumulated Losses)	(163.8)	(171.0)	(207.9)	(44.1)	(36.9)	(16.4)	(7.5)	(34.5)	(18.2)	(27.0)
Revaluation reserve	62.5	67.5	40.3	(22.2)	(27.2)	110.4	152.2	102.0	(8.4)	(50.2)
Total taxpayers' equity	**18.8**	**16.7**	**149.1**	**130.3**	**132.4**	**214.1**	**264.7**	**384.1**	**170.0**	**119.4**

The Statement of Financial Position is favourable when compared to both the Business As Usual and the Do Minimum options primarily due to the PDC investment in the estate at £196.6m and the improved cumulative surpluses that arise in the Agreed Option. The investment in the estate addresses the clinical and estate risk for the Trust.

10.10.3 Funding Requirements Business As Usual and Do Minimum vs. Agreed Option

£m	FY45	FY45	FY45	FY45	FY45
	Business As Usual	Do Minimum	Agreed Option	Business As Usual Variance	Do Minimum Variance
	Option A	Option B	Option C		
PWLB Capital Loan	0.0	(13.2)	0.0	(0.0)	13.2
Revenue Support Loan	(64.5)	(64.6)	(64.6)	(0.1)	(0.0)
Emergency Capital	(2.6)	(2.6)	(2.6)	0.0	0.0
PDC funding	0.0	0.0	(196.5)	(196.5)	(196.5)
Total funding requirement	**(67.1)**	**(80.4)**	**(263.7)**	**(196.4)**	**(£183.3)**

The funding requirement analysis outlines that the Agreed option requires additional funding of £196.5m, received as PDC, offset by reduced PWLB capital loan.

Additional revenue loans only required for 2 years from FY20 in all cases due to assumed FRF returning the Trust to financial surplus in FY22 in all cases. Any other borrowing is for timing of cash flow as FRF is received quarterly in arrears and in line with a working capital loan and is repaid on receipt of the FRF funding.

The net cost of the investment is £196.4m when compared to the Business As Usual case and £183.4m compared to the Do Minimum case at FY45.

10.11 Conclusions of the Financial Case

It is concluded that Option C is the favourable option. The Agreed Service Option demonstrates overall affordability for the investment and enables the Trust to deliver additional financial efficiencies.

The financial plan demonstrates that savings enabled through reconfiguration present a favourable case compared to the Business As Usual and Do Minimum. Downside scenarios test the sensitivity of the plan however the Trust retains overall affordability within the financial plan. Potential upside sensitivities offer the Trust the opportunity to return to financial balance in FY22 years and reduces the required Financial Recovery Fund monies by £19.2m to FY26.

The modelled clinical activity and revenue has been agreed as affordable for the local health sector, with the Trusts key commissioners outlining that the plans are affordable.

The CIP is consistent with the national efficiency requirements reflecting assumptions of cost inflation and price deflation. The additional investment in the estate enables greater efficiencies to be realised in years FY26-FY28 through greater operational efficiency and transformation.

11. MANAGEMENT CASE

The purpose of this section is to describe the systems and processes that will be established to ensure the successful implementation of the proposed option for the configuration of the Trust's hospital services. This is structured across the following key areas:

- **Programme management and governance -** how the programme will be managed including reporting and accountability arrangements and the use of special advisors
- **Programme Timeline -** the key phases of work and the programme timeline
- **Risk Management -** the approach to management of risk and the risk register
- **Benefits Realisation and Post Project Evaluation -** arrangements for ongoing review of benefits.

11.1 Management and Governance

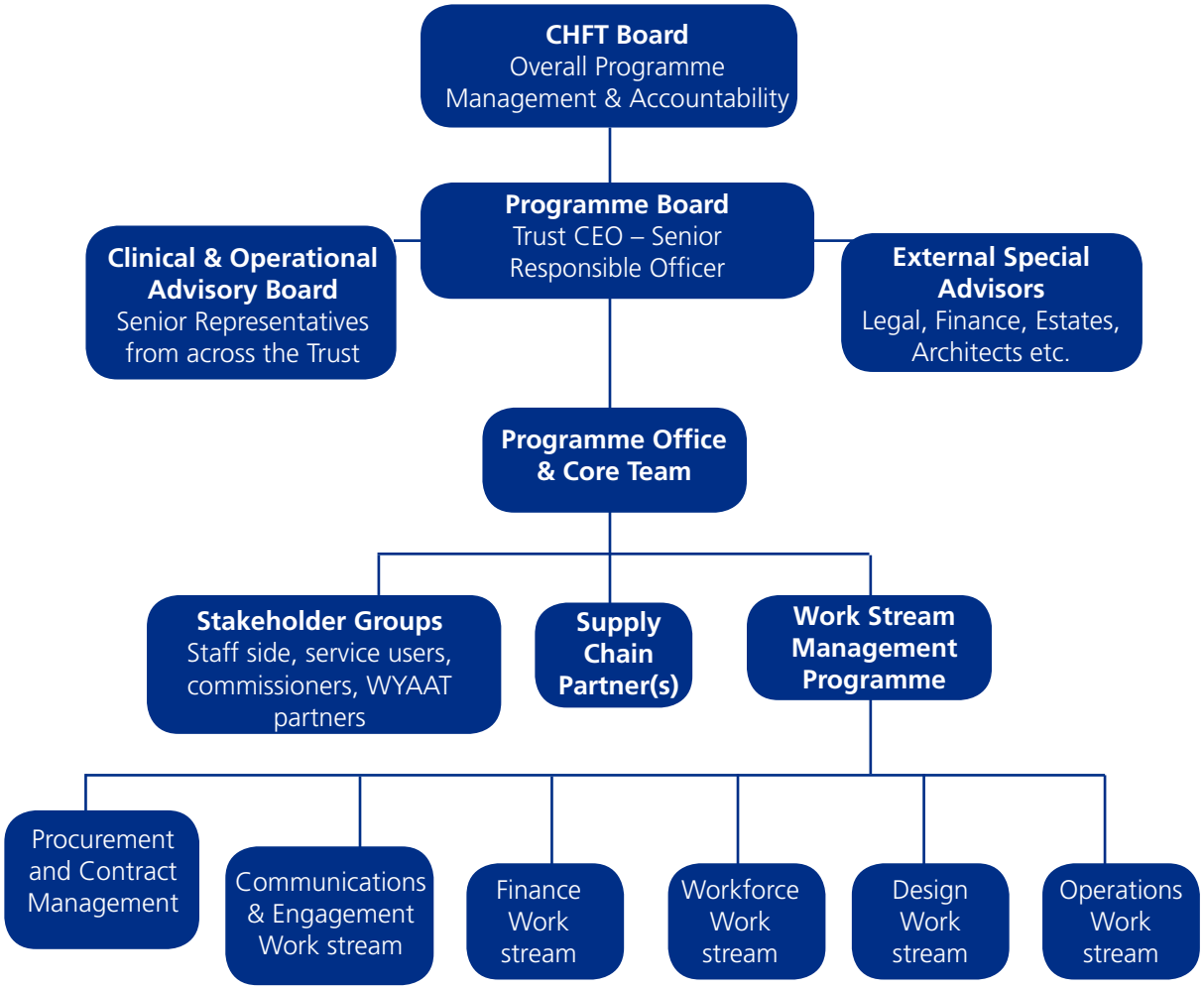
The Trust's management and governance of the programme will be aligned with best practice described in the Treasury recommended methodology for programme management i.e. Managing Successful Programmes (MSP). The over-arching programme management will focus on the delivery of the key financial and non-financial benefits and outcomes associated with the reconfiguration of hospital services.

PRINCE 2 project methodology will be used to manage underpinning project life cycles from start-up to closure to ensure project planning and monitoring are carried out rigorously. The project management will focus on delivery of the key enabling actions and outputs that support achievement of the overarching programme benefits and outcomes.

Subject to Treasury approval to implement the FBC an Integrated Assurance and Approval Plan (IAAP) will be developed. This will detail the planning, coordination and provision of assurance activities and Treasury approval points (gateways) throughout the programme.

11.1.1 Governance Structure

The following diagram provides an overview of the programme structure. The structure is designed to ensure there is one overall Senior Responsible Owner, one Programme Director and one Programme Manager each with the required authority and responsibility to manage the programme on behalf of the Trust. The programme structure is explained in more detail below.



Examples of work-streams are shown here. Digital working will be a key enabler in all work-streams.

CHFT Board will have overall responsibility and accountability for the programme ensuring that the project has a viable and affordable business case that will deliver value for money and best quality healthcare through effective management of the procurement process and implementation of the proposed configuration of services. The Board will seek assurance from the Senior Responsible Owner and Programme Board on any aspect of the programme that may pose a risk to successfully achieving the investment objectives and realisation of the expected benefits.

The **Programme Board** will be chaired by an independent chair. The Chief Executive of CHFT will be the Senior Responsible Owner (SRO) and will lead the programme implementation. The Programme Board will have Non-Executive and Executive Directors (including the Programme Director) as members and also include representation from Trust senior clinicians, Calderdale and Huddersfield Solutions Ltd (CHS) and external specialist / technical advisors. Representatives from NHSE, NHSI, DH, CCGs and the West Yorkshire and Harrogate Health and Care Partnership will be invited to be members of the Programme Board as well as two patient representatives.

The Programme Board will approve and manage the programme plan and sign off the key outputs and decisions at each stage of the project including:

- Patient and staff communications and engagement;
- The competitive dialogue process and procurement;
- Review of all the key deliverables and the activities required to deliver them;
- The activities required to validate the quality of the deliverables;
- The resources and time needed for all activities and any need for people with specific capabilities and competencies;
- The dependencies between activities and any associated constraints when activities will occur;
- The points at which progress will be monitored, controlled and reviewed;
- The provision of regular reports, updates and assurance to CHFT Board, NHSI and Treasury;
- Maintenance of a detailed risk register and mitigation of risk factors affecting the successful delivery of the project;
- Maintenance of a benefits realisation register and monitoring of delivery;
- Considering and recommending to the Trust Board any changes to the project scope, budget or timescale if required;
- Review of serious issues, which have reached threshold level;
- Broker relationships with stakeholders within and outside the project to maintain positive support for the programme;
- Maintain awareness of the broader strategic perspective advising the SRO on how it may affect the project.

Specialist Advisors – implementation of the proposed configuration will require a complex programme of work and the Trust will secure the necessary external specialist expertise and advice that is required. This will include, for example: legal, procurement, project management, private finance, estates, architects, health planning, facilities management, equipping, town planning, engineering, traffic and transport, quantity surveying, life cycle analysis, health and safety etc. The external advisors will provide advice to the SRO, the Programme Director, the Programme Board, and the Trust Board and will advise and inform work undertaken by the project work stream groups. The Trust will also appoint internal 'Clinical Subject Matter Experts' in key areas to inform the work of the programme, this will provide dedicated time of clinical staff to inform the development and will cover areas such as emergency and urgent care, acute inpatient medical care, planned surgery, paediatric services, maternity services, outpatient services.

Clinical and Operational Advisory Board – this will be a clinical and operational leadership committee comprising senior representatives of the Clinical Divisions who manage the operational services of the Trust; General Practice doctors; Directors of Social Care; and Executive Directors (DoN, MD, COO). They will provide leadership within the organisation to ensure successful delivery of the project and assurance to the Programme Board and the Trust Board about the project. The group will provide guidance to the Project Director and ensure that Trust operational resources will be available to support the project. The group will:

- Provide leadership, mandate and focus within the Trust ensuring that clinical objectives inform and drive effective delivery of the competitive dialogue process;
- Provide advice to the Programme Director, Programme Board and Trust Board, raising any concerns and providing expert opinion to support decision making;
- Support resolution of issues at organisational level when required;

- Support resolution of issues which impact on the Trust involving senior external stakeholders, the press; Government, arm's length bodies etc.;
- Provide assessment of serious issues;
- Ensure that project plans are achievable and facilitate delivery as required;
- Review the risk register on a quarterly basis and / or at key milestones and advise the Programme Board prior to approval and help to mitigate risks at organisational level.

The **Programme Office and Core Team** will be led by the Programme Director and proactively drive delivery of the programme plan and critical path. It will provide programme management support to the work streams and will be responsible for the management of all programme management processes, including preparing and managing papers for governance arrangements, proactive risk and issue management and progress reporting. The programme office will have sufficient resource capability and capacity available to effectively support the programme, recognising the scale, complexity and likely fast-paced nature of the programme. This will include a core team within the programme office with the necessary skills for:

- Planning and delivering the Competitive Dialogue and bid evaluation process and all other activities to financial close;
- Developing, maintaining and implementing project plans;
- Co-ordinating working groups and evaluation teams as required;
- Monitoring progress and reporting to the Programme Board and the Clinical and Operational Advisory Board;
- Managing issues as they arise in line with the issue management policy and escalating those above threshold to the Programme Board;
- Managing change control;
- Managing project advisors, ensuring that their contribution is well understood and that the Trust obtains best advice and value;
- Managing risks in line with project risk management strategy;
- Ensuring effective development and delivery of the Engagement and Communications Plan.

Key Stakeholder Groups – the programme office and core team will proactively work to ensure the engagement, involvement and coordination of key stakeholder groups input to the programme. Significant communication and engagement has taken place over the last two years. The programme will continue actively engaging with stakeholders through the next phases and during implementation. This will include for example:

- **Calderdale and Kirklees Health and Wellbeing Boards –** ensuring that implementation of the proposed changes are aligned with Health and Wellbeing Board's plans of how best to meet the needs of their local population and tackle local inequalities in health.
- **Calderdale and Kirklees Joint Health Scrutiny Committee –** ensuring continued public scrutiny through the period of implementation.
- **Greater Huddersfield and Calderdale CCGs –** ensuring that clinical commissioners are fully involved and informed of the implementation plans and progress.
- **CHFT Council of Governors –** ensuring that Governors are well informed about what changes are proposed and able to contribute and have a say in how they are to be delivered.
- **Patients, Public and local Healthwatch –** ensuring that patients are well informed about what changes are proposed, have a say in how they are to be delivered and, ultimately, are fully aware of which services will be delivered from which locations in the future.

- **Other Providers –** communication and involvement of other providers that are impacted by the changes and/or are critical to implementation (e.g. voluntary sector organisations, ambulance services, mental health, primary care, WYAAT and neighbouring acute hospitals, the existing CRH PFI provider).
- **NHS staff –** actively engaging with staff to ensure they are fully aware of the implementation plans and able to contribute to the plans promoting their central role in making these changes happen.
- **Clinicians –** will be actively involved in the planning and implementation of service change to ensure patient safety is not compromised as changes are made.
- **Local Authorities –** work with partners in social care to co-design and begin to deliver the transformation to Out of Hospital services which is critical to the success of the reconfiguration programme.
- **West Yorkshire and Harrogate Health and Care Partnership –** work to ensure the implementation of the proposed changes fit with West Yorkshire overall strategy for the development of better health and care services for West Yorkshire and Harrogate as a whole.

As part of the programme design and mobilisation phase the stakeholder engagement plan will be updated to provide a comprehensive view of planned events and activities throughout implementation.

Supply Chain Partner(s) – the success of the programme is reliant on effective supply chain partner(s) that will provide estates solutions to enable implementation of the proposed configuration of hospital services. The Programme Office and Core Team will, in accordance, with the 'partnering' principle, ensure there are regular meetings between senior managers in the Trust and supplier organisation(s). These meetings will formally monitor and report to the Programme Board the service streams and outputs which are being contracted for and progress against the implementation timescales which have been agreed for their delivery. As described in section 9.1 the Trust's preferred approach at this stage is to instruct Calderdale Health Solutions (CHS) to act on behalf of the Trust to deliver the necessary procurement(s) and subsequent contract management of suppliers to deliver the estate capital development works. CHS is a wholly owned subsidiary of the Trust and provides a fully managed suite of healthcare facilities for use by CHFT and provides value to CHFT through its specific service offering and through its ability to manage developments and operational risk for the Trust and other parties. CHS's status as a "Teckal" trading company means that the Trust is able to contract directly with CHS without the need for a competitive procurement process. This approach will be further defined in the Outline Business Case.

Project work streams will have a senior sponsor who will also be a member of the Programme Board. Whilst the sponsor will remain accountable for the work stream, it is expected that they will delegate responsibility for the day-to-day management of, and delivery against, the work stream plan and critical path, to a work stream lead. The Programme Manager (and other members of the Programme Office and Core Team) will support and monitor progress of the work streams against agreed milestones and report this to the Programme Board. The structural chart above shows an example of the range of work streams that may be required. This will vary at different stages of the Programme and other work streams will also be established.

11.1.2 Roles and Responsibilities

The Chief Executive Officer (Senior Responsible Owner for this project), Director of Finance, Medical Director and the Trust's Chair will ensure strong leadership for the project. The Programme will be supported by a Programme Director and a fully resourced Programme Office and Core Team, of appropriately experienced and qualified individuals. The programme will be managed in line with best practice ensuring that roles and responsibilities are clearly defined. Decision making will be transparent and will be documented to ensure a robust audit trail is maintained.

The Senior Responsible Owner (SRO)

The Chief Executive Officer undertakes the SRO role for this project. The SRO is personally accountable for the success of the project ensuring that the project meets its objectives and delivers benefits. The SRO will ensure that the project maintains business focus in a changing healthcare context and that risks are managed effectively.

The Programme Director

The Programme Director is responsible for day to day decision making on behalf of the SRO and setting high standards for delivery of the project.

The Programme Manager

The Programme Manager will coordinate the activities of the Programme Office and Core Team on a day to day basis and is responsible for ensuring that:

- Procurement and engagement runs smoothly;
- Requests for information, issues and changes are managed appropriately;
- Project standards are maintained;
- Project budget is managed effectively.

The Core Team will meet weekly, or as required, to co-ordinate the work. It reports to the Programme Board.

11.2 Timeline

A high level overview of the programme timeline up to full year ending 2025 (FY25) is shown below. During this period the capital investment and estates build work will be completed enabling the opening of the planned and unplanned hospitals. Full optimisation of the financial and quality benefits associated with the reconfiguration of hospital services will continue beyond year 5. The Trust will continue to programme manage and monitor the realisation of benefits beyond FY25.

11.2.1 High level Project Timeline

Following the DHSC confirmation in December 2018 that capital funding of £196.5m has been allocated to this development it has also been confirmed that approval of a Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) by NHS Improvement, DHSC, Ministers and HM Treasury will be required.

The SOC, OBC and FBC will need to be approved by CHFT Trust Board prior to submission to NHS Improvement and letters of support from CCG Governing Bodies, NHS England, and the West Yorkshire & Harrogate Health and Care Partnership Chief Executive will also be required at each stage of approval of the business cases. The content of the SOC, OBC and FBC will take account of Her

Majesty's Treasury (HMT) Green Book guidance on appraisal and evaluation and the supplementary Guide to Developing the Project Business Case (2018) and guidance from NHS Improvement.

Based on these requirements and the associated governance processes, the table below provides an indicative outline timeline for this development. This timeline will require the effective management of existing estate and clinical service risks over this period and is reliant therefore on the assumption that these risks do not escalate at a faster rate. Opportunities to expedite the timeline will also be explored if it is possible to do so whilst ensuring robust governance and stakeholder involvement.

Phases	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Notes
SOC Business Case Approval								approved by DHSC & Treasury December 2019
Development and Approval of OBC								OBC approved by DHSC & Treasury October 2020
Development and Approval of FBC								FBC approved by DHSC & Treasury September 2022
Planning consents								
Estate Procurement								
Construction Works								Two year build
Scheme completed								Build commissioned and operational

11.3 Risk Management

11.3.1 Programme Risks

The Programme Board will ensure that robust arrangements for the on-going management of risk during the key phases of the programme are established. This will include independent assessment and audit activities. Strategies for the active and effective management of risk will include:

- Identifying possible risks in advance and putting mechanisms in place to minimise the likelihood of them materialising with adverse effects;
- Having rigorous processes in place to monitor the risks, and access to reliable, up to-date
- Information about the risks;
- Having agreed actions to control or mitigate against the adverse consequences of the risks, if they should materialise;
- Ensuring that decision-making processes during the programme are supported by a framework for risk analysis and evaluation.

To identify the specific risks the programme will use a number of approaches that will include:

- Structured review meetings involving the programme board, the clinical and operational advisory board and the programme management team. This will encourage participation and ownership of the risks by key personnel;
- Risk audit interviews – conducted by experienced managers and/or external specialist advisers, with all those involved in the programme;
- Risk workshops – including all members of the project team and wider staff and stakeholder partners.

The following areas of risk will be considered to assist the identification of a comprehensive register of risks specific to the programme.

- Patient risks – the risk that patients are adversely impacted (for example in terms of patient experience, safety and outcomes of care) during transition and implementation of the proposed Agreed service model;
- Business risks – the risk that the Trust cannot meet its business imperatives (e.g. quality, safety, performance standards);
- Reputational risks – the risk that there will be an undermining of patient and public /media perception of the Trust's ability to fulfil its business requirements – for example, adverse publicity concerning an operational problem;
- Service risks – the risk that the new service model and estate solution is not fit for purpose;
- Design risks – the risk that design cannot deliver the services to the required quality standards;
- Planning risks – the risk that the implementation fails to adhere to the terms of the planning permission or that detailed planning cannot be obtained; or, if obtained, can only be implemented at costs greater than in the original budget;
- Build risks – the risk that the construction of physical assets is not completed on time, to budget and to the required specification of quality and design;
- Contractor risks – the risk(s) that external contractors may for example experience financial difficulties, may not effectively manage sub-contractors, or that the interface between different contractors on the CRH site is not effectively managed;
- Project intelligence risk – the risk that the quality of initial intelligence (for example, preliminary site investigation) will impact on the likelihood of unforeseen problems occurring;
- Decant risks – the risk arising in accommodation projects relating to the need to decant staff and patients from one site to another;
- Environmental risks – the risk that the project has a major impact on its adjacent areas;
- Procurement risks – the risk that procurement fails to identify a supply chain partner and / or secure appropriate contractual arrangements;
- Operational risks – the risk that operating costs vary from budget and that performance standards slip or that a service cannot be provided;
- Demand risks – the risk that the demand for a service does not match the levels planned, projected or assumed;
- Volume risks – the risk that actual usage of the service varies from the levels forecast;
- Maintenance risks – the risk that the costs of keeping the assets in good condition vary from Budget;
- Technology risks – the risk that changes in technology result in services being provided using sub-optimal technical solutions;
- Funding risks – the risk that the availability of funding leads to delays and reductions in scope as a result of reduced monies;
- Residual value risks – the risk relating to the uncertainty of the values of physical assets at the end of the contract period;
- Economic risks – the risk that project outcomes are sensitive to economic influences – for example, where actual inflation differs from assumed inflation rates;
- Financial and affordability risks – the risk that the project costs of transition and implementation exceed the budget plan for this. Also the risk that implementation of the proposed future model does not generate the anticipated level of efficiency savings;

- Legislative risks – the risk that legislative change increases costs;
- Policy risk – the risk of changes in policy direction leading to unforeseen change.
- Adjacency risk – the risk that services in adjacent areas will alter or be reconfigured changing the demands upon CHFT services (may be positive or negative).
- Lack of clinical staff engagement – the risk that staff currently providing the services do not engage and participate in the project and therefore key advice and input regarding the design and implementation of the service changes is not secured.

The key risks identified will be entered into a risk register. Each risk will be scored 1-5 in terms of its likelihood and the severity of its consequences this will be the inherent risk (i.e. risk exposure with no mitigation). Once a risk has been scored, the controls and mitigation actions available will be analysed and a mitigation owner identified. The actions required to mitigate the risk will be identified in the risk register, with named responsible officers and information on progress. A residual score will also be included, showing how progress on mitigation has affected the level of risk.

On a monthly basis the Programme Board will review the risk register. All programme risks with a risk score of 15 or more (calculated by multiplying likelihood by consequence) will be escalated on a monthly basis to the Trust's Audit and Risk Committee and the Trust Board. The role of the Trust Board will be to assure itself that all risks are accurately identified and mitigated adequately.

11.3.2 Current Risks

Progress of the proposed reconfiguration of hospital services is currently included on the Trust's Board Assurance Framework as a high level risk. The risk is related to not being able to progress service reconfiguration and as a consequence that there are delays in addressing important quality, safety and sustainability issues such as:

- Patient safety risks associated with dual site services and not having critical clinical service adjacencies;
- Compliance with emergency medicine standards;
- Compliance with paediatric standards;
- Compliance with critical care standards;
- Difficulties in recruiting and retaining a medical workforce (continued and increased reliance on middle grades and locums);
- Increased gaps in middle grade doctor rotas;
- Delays in the Trust's financial recovery plan and continued reliance for a longer period on financial support from the Department of Health and Social Care;
- Inability to contribute to improvement and achievement of the local and West Yorkshire system affordability;
- Inability to sustain the condition and reliability of building and engineering services infrastructure at HRI and that retrospective building regulations will be introduced;
- Risk of negative impact on the Trust's reputation.

The Trust Board will continue to regularly review these risks and the interim necessary actions that are required to mitigate these risks as far as it is possible to do so.

11.4 Benefits Realisation

The ultimate responsibility for the delivery of the programme benefits rests with the SRO for the project. The Programme Board will agree a benefits realisation strategy setting out arrangements for the identification of potential benefits, their planning, modelling and tracking. It will also include a framework that assigns responsibilities for the actual realisation of benefits throughout the key phases of the programme.

A Cost Benefit Analysis (CBA) methodology will be used during the programme and be based on best practice described in the Treasury's Green Book. The CBA will estimate the overall public value created by the programme including economic benefits to individuals and society; and wider social welfare/wellbeing benefits. It will also determine the financial impacts for the Trust and estimate the financial impacts across partner agencies affected. The Programme Board will receive regular update and review of the CBA.

All benefits will be entered into a benefits realisation register. For each benefit this will include the following information:

- Service feature (what aspect of the programme will give rise to the benefit – to facilitate monitoring);
- Potential dis-benefits;
- Activities required (to secure benefit);
- Responsible officer;
- Performance measure;
- Target improvement (expected level of change);
- Full-year value;
- Timescale for realisation of the benefit.

On a monthly basis the Programme Board will review the benefits register. Any expected benefits that are 'off-track' (i.e. not delivering as planned) will be escalated on a monthly basis to the Trust Board. The role of the Trust Board will be to assure itself that all benefits are accurately identified and their realisation is being effectively managed.

Some of the key programme benefits that will be included on the register include:

- Improving the quality of patient experience through more streamlined, efficient patient pathways as a result of the reconfiguration of services.
- Realising patient outcome benefits from co-location of acute services and consolidation of paediatrics with complex obstetrics through a more streamlined approach for providing senior medical oversight.
- Supporting the development of urgent care centres which will be equipped to care for patients with minor injuries and / or illnesses in a more timely, efficient way.
- Enabling the Trust to meet the Royal College of Emergency Medicine standards on senior medical workforce cover.
- Enabling the Trust to meet Royal College standards for Children and Young People in Emergency Care settings.
- Reducing the reliance on locum and temporary staff to cover vacancies and workforce pressures as a result of running two district general hospitals.
- Making the Trust a more attractive place to work thus improving the recruitment and retention of staff.

- Improving clinical rota resilience: rota frequency will reduce immediately with the consolidation of some services thereby reducing the workload strain on staff and improving the resilience of services.
- Enabling sub-specialisation of clinical services: the critical mass achieved through consolidating of unplanned patients and workforce onto one site will allow greater opportunities for subspecialisation of the workforce improving the attractiveness of employment at the Trust and enhanced clinical services for patients. Relevant services include paediatrics and trauma subspecialisation in emergency department, and acute medicine.
- Improving skill mix / role improvements: Advanced/Extended scope Practitioner role will be further refined and deployed in the Trust to reduce reliance on the middle-grade doctor workforce across many specialties including ED, acute medicine, and paediatrics.
- Improving junior doctor training, oversight and supervision: junior doctor training and supervision is anticipated to improve for all clinical services being consolidated on to one site given the increased throughput of activity, and the increased non-locum consultant presence on site. This will also apply to other clinicians in training.
- Reducing long term sickness absence: the benefits above will allow for more effective service planning. This, together with other measures to support staff returning from absence, will help to reduce stress for staff and reduce the Trust's long term sickness absence challenge.
- Improving the patient care and staff working environment. The capital investment at HRI will enable adaptation of existing buildings and address the most critical maintenance requirements to enable the continued use of some of the existing site.
- Elimination of the Trust's deficit and enabling wider system affordability and resilience.

12 STAKEHOLDER AND PUBLIC ENGAGEMENT

The Trust will continue to fully engage and involve local people, key stakeholders and the Joint Health Scrutiny Committee in the next steps to deliver the proposed future model for hospital services across Calderdale and Greater Huddersfield. This will be an ongoing process throughout the decision-making timeline described in section 2.

The aim of the engagement activity is to ensure the local NHS:

- Continues to engage and involve local people, and key stakeholders as more detailed plans are developed to deliver the proposed future model for hospital services across Calderdale and Greater Huddersfield;
- Continues to understand the changing demographics of our local communities and how this relates to service use, access and patient experience;
- Can demonstrate that any potential differential impact on any protected groups is captured and considered.

The local NHS will continue to work closely with the Calderdale and Kirklees Joint Health Scrutiny Committee. Informal workshops and meetings took place in July and August 2018 and the proposals were discussed at the formal public meeting of the Joint Committee that took place on 7th September 2018. Since then further informal meetings with the Joint Committee Chairs were held on 1st October 2018, 5th November 2018 and 22nd January 2019. A formal public meeting of the Joint Committee was held on the 15th February 2019 to further discuss the proposals and this included the plans described in this section for further stakeholder engagement.

There will continue to be on-going engagement with Calderdale and Kirklees Councils.

The revised hospital model is an evolution of the proposals informed by previous engagement and the significant public consultation undertaken in 2016.

There are a number of areas where the proposed model is therefore unchanged from that which was previously the subject of public consultation (this includes: urgent care; maternity and midwifery services; paediatrics; planned surgery; acute inpatient medical care; critical care; acute and complex surgery, and; outpatient services).

Where changes have been made to the proposed future hospital service model this has sought to respond to the views of stakeholders and to the recommendations of the IRP. The key changes are: the continued provision of 24/7 consultant-led A&E services at both sites; the provision of physician-led inpatient care at HRI, and; a commitment to maintain the number of hospital beds broadly as they are now whilst services are developed in the community.

The approach to engagement will be inclusive and will include a range of opportunities for the public and stakeholder groups to provide their input and insight.

The areas that are identified as requiring further involvement from local people are:

- Development of hospital services
- The design and development of buildings and estates with specific focus on;
  - The development of Calderdale Royal Hospital estate as a central emergency site (including co-design of the environment)
  - Co-design of a dedicated paediatric centre at Calderdale Royal
  - The refurbishment of Huddersfield Royal Infirmary including co-design of a children and young people friendly waiting area at A&E
- Travel, transport and parking for both hospital sites
- Use of digital technology
- Care at or closer to home

Further engagement will be based on the following principles:

- Ensuring we engage with the public, patients and carers early enough throughout this process;
- Being inclusive in our engagement activity and considering the needs of our local population;
- Ensuring that engagement is based on the right information and good communication so people feel fully informed;
- Ensuring that we are transparent in our dealings with the public and discuss things openly and honestly;
- Providing a platform for people to influence our thinking and challenge our decisions;
- Ensuring that any engagement activity is proportionate to the issue and that we provide feedback to those who have been involved in that activity;
- Ensuring we are clear about our plans and what the public can and can't influence and why;
- Making sure we engage with the right target audience and consider equality and the impact on diverse groups;
- Demonstrating that we have listened to people's views in all of our plans;
- Providing feedback on our website.

The involvement of groups protected under the Equality Act will be targeted to ensure that the needs of these groups are understood, and due regard is had to advancing equality in developing, making decisions about, and delivering the proposed changes to services in Huddersfield and Calderdale. The protected groups that will be targeted are:

- Age – specifically children and young people, older people, and frail elderly;
- Gender;
- Disability;
- Ethnicity representative of the demographics of Greater Huddersfield and Calderdale;
- Religion and religious belief;
- Sexual orientation;
- Transgender;
- Pregnancy and maternity;
- Carers.

All engagement activity will be informed by local data to assess the representativeness of the views gathered during the engagement process. An Equality Impact Assessment will be prepared.

It is planned that the engagement activity required to deliver the next stages of development will be co-created at an initial stakeholder event during the Spring 2019. This event will be used to support the design of specific involvement activities and describe the communication material required to support the approach to ensure that local people remain informed and/or involved in the next stage of development for hospital services. The engagement will therefore take place in two stages:

Stage 1 (Spring 2019) – Stakeholder involvement in developing the action plan for engagement and associated communication material.

Stage 2 (Following the stakeholder event and then ongoing throughout the decision making process) – Delivering the action plan to involve a wider audience of local people.

The Trust and the CCGs will engage, involve and respond to the Calderdale and Kirklees Joint Health Scrutiny Committee in progressing these developments.

13. LETTERS OF SUPPORT

Letters of support for the SOC have been provided by:

- Calderdale CCG
- Greater Huddersfield CCG
- West Yorkshire & Harrogate Health and Care Partnership

Copies of these letters are provided below.

NHS
Calderdale
Clinical Commissioning Group

5th Floor
F Mill
Dean Clough
Halifax
HX3 5AX

01422 307400

Richard Barker
Regional Director (North)
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

Date 12th April 2019

Reconfiguration of Hospital Services at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI): Strategic Outline Case (SOC).

Dear Richard,

In line with the requirement for letters of support from all commissioners for capital schemes, this letter provides information in relation to those services for which, as Accountable Officer for NHS Calderdale CCG, I am the responsible commissioner. In line with the requirement for the letter to be submitted to NHSI with the Business Case to enable the assurance process to start, this letter has also been copied to the Chief Executive of NHS Calderdale and Huddersfield Foundation Trust.

1) Public Consultation

Formal public consultation on proposed future arrangements took place between March and June 2016. Where changes have been made to the proposed future model of care this has sought to respond to the views of stakeholders and to the recommendations of the IRP. The changes are: the continued provision of 24/7 consultant-led A&E services at both sites; the provision of physician-led inpatient care at HRI, and; a commitment to maintain the number of hospital beds broadly as they are now whilst services are developed in the community.

The planned approach to continued engagement with stakeholders, staff and the public as the proposals are developed into more detailed plans was presented to the Calderdale and Kirklees Joint Health Scrutiny Committee at its meeting on 15th February, 2019.

2) How the proposed solution assists the health system in managing present and future issues.

There is a compelling clinical case for the reconfiguration of the Trust's services to improve the safety and quality of services and ensure the sustainable provision of acute and emergency services in the future. The current dual site model of hospital services does not, and cannot, meet national guidance. The current system if unchanged will be neither affordable or safe in the future.

A number of independent reviews and inspections of services have recommended that the status quo (i.e. to do nothing) is not an option and that changes to the configuration of services are needed to improve outcomes and safety. In support of the development of the enhanced proposal Dr David Black, Medical Director (joint) – North Region (Yorkshire and the Humber) and Deputy National Medical Director Specialised Commissioning, NHS England has provided clinical advice and support and a Quality Impact Assessment has been undertaken by CHFT.

Chair I Dr Steven Cleasby
Chief Officer I Dr Matt Walsh

5th Floor, F Mill, Dean Clough, Halifax, HX3 5AX
T: 01422 307400 I E: ccgfeedback@calderdaleccg.nhs.uk I www.calderdaleccg.nhs.uk

NHS
Calderdale
Clinical Commissioning Group

The CCGs and CHFT have agreed that further work in relation to the QIA will be progressed through a separate and continuing quality assurance process that will operate in parallel with the production of the SOC, OBC, FBC and throughout the implementation timeline.

This Quality and Safety Assurance Panel would provide peer review together with external representation from the Yorkshire and the Humber Clinical Senate and the Yorkshire Ambulance Service dependent on the area being discussed, to ensure that as the planned service line changes are developed there is a full understanding of the quality and safety impact from the perspectives of: Clinical Effectiveness; Patient Safety and System Impact; and Patient Experience, Equality & Diversity.

The reconfiguration of the Trust's services is not reliant on the investment in out of hospital services, but the operation of the Quality and Safety Assurance Panel will also enable the developing community context within which these plans will operate to be taken into account.

3. Activity assumptions and finance

For 19/20 Trust and CCG activity and finance plans align. The activity growth assumptions are in line with the CCG's aspirations and the income assumptions are deemed to be realistic and affordable.

The tariff rates used by the Trust reflect current national assumptions. The income trajectories in the business case in relation to growth do not exceed expected CCG allocations. Assumed growth is higher up until 2025/26 and then drops to 1.6% - 1.7% for the length of the business model.

The reconfiguration will improve the overall financial position of the system. The reconfiguration has estimated per annum savings of £10m for CHFT. Both CCGs are projecting to continue a break even position and CHFT is projecting to breakeven without national support in 2026/27. The reconfiguration will also help towards the removal of reliance on central support from NHS funds.

The plans do not assume that any additional funding will be provided by the CCG, other than the income growth already described above. The plans maintain the acute bed base and are therefore not reliant on out of hospital investment which will be progressed in line with affordability. Any additional costs for the Yorkshire Ambulance Service have yet to be determined but are expected to be affordable at this stage.

Matt Walsh
Accountable Officer
NHS Calderdale CCG

CC Owen Williams, Chief Executive, Calderdale and Huddersfield NHS Trust

Chair I Dr Steven Cleasby
Chief Officer I Dr Matt Walsh

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Tel: 01484 464000

Richard Barker
Regional Director (North)
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

Date 12th April 2019

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A number of independent reviews and inspections of services have recommended that the status quo (i.e. to do nothing) is not an option and that changes to the configuration of services are needed to improve outcomes and safety. In support of the development of the enhanced proposal Dr David Black, Medical Director (joint) – North Region (Yorkshire and the Humber) and Deputy National Medical Director Specialised Commissioning, NHS England has provided clinical advice and support and a Quality Impact Assessment has been undertaken by CHFT.

The CCGs and CHFT have agreed that further work in relation to the QIA will be progressed through a separate and continuing quality assurance process that will operate in parallel with the production of the SOC, OBC, FBC and throughout the implementation timeline.

This Quality and Safety Assurance Panel would provide peer review together with external representation from the Yorkshire and the Humber Clinical Senate and the Yorkshire Ambulance Service dependent on the area being discussed, to ensure that as the planned service line changes are developed there is a full understanding of the quality and safety impact from the perspectives of: Clinical Effectiveness; Patient Safety and System Impact; and Patient Experience, Equality & Diversity.

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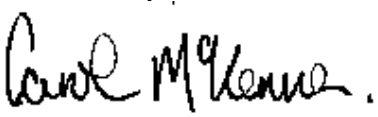
The tariff rates used by the Trust reflect current national assumptions. The income trajectories in the business case in relation to growth do not exceed expected CCG allocations. Assumed growth is higher up until 2025/26 and then drops to 1.6% - 1.7% for the length of the business model.

The reconfiguration will improve the overall financial position of the system. The reconfiguration has estimated per annum savings of £10m for CHFT. Both CCGs are projecting to continue a break even position and CHFT is projecting to breakeven without national support in 2026/27. The reconfiguration will help towards the removal of reliance on central support from NHS funds.

The plans do not assume that any additional funding will be provided by the CCG, other than the income growth already described above. The plans maintain the acute bed base and are therefore not reliant on out of hospital investment which will be progressed in line with affordability. A step change in out of hospital investment though, still remains a key part of the CCG plans and the first stage of that additional investment will commence in 2019/20. Any additional costs for the Yorkshire Ambulance Service have yet to be determined but are expected to be affordable at this stage.

Yours sincerely



Carol McKenna
Accountable Officer
NHS Greater Huddersfield CCG and NHS North Kirklees CCG

CC Owen Williams, Chief Executive, Calderdale and Huddersfield NHS Trust

West Yorkshire and Harrogate Health and Care Partnership

Owen Williams
Chief Executive
Calderdale and Huddersfield NHS Foundation Trust

(sent via email)

12 April 2019

Dear Owen

SUPPORT FOR STRATEGIC OUTLINE CASE

I am writing to confirm the support of West Yorkshire Health and Care Partnership for the proposals set out in the Strategic Outline Case (SOC) for the future arrangements for hospital and community services in Calderdale and Huddersfield.

During 2018 the Partnership supported these proposals as our top priority amongst our bids for wave four of the STP capital funding prioritisation process. We confirmed that the proposals are consistent with our overall strategy for the development of better health and care services for West Yorkshire and Harrogate as a whole.

Now that the allocation of the capital funding has been confirmed we have continued to support the development of the more detailed plans described in the SOC.

The Partnership has provided transformation funding to the local NHS bodies to support the work to develop joined up care in communities that will ensure demand is better managed across the system. The potential for this is significant and the work focuses on how we can achieve better coordinated care that sees people continue to be cared for in community settings and accelerates the development of local care networks.

The ICS is also supporting the digital transformation that will underpin these developments. In particular we a playing a lead role in the development of the Yorkshire and Humber Care Record (a Local Health Care Record Exemplar LHCRE programme), which is both supporting the work within Calderdale and Huddersfield, and learning from the work to inform progress across the whole region.

The Partnership has been fully involved in local engagement around these plans, including scrutiny discussions, and political discussions at a local and national level.

We will continue to work closely with the Trust, CCGs and Councils to support the further development of the plans and ensure that they achieve the delivery of high quality, sustainable services for the people of Calderdale and Kirklees.

Yours sincerely

Rob Webster

Lead Chief Executive
West Yorkshire and Harrogate Health and Care Partnership
Chief Executive South West Yorkshire Partnership NHS FT

cc: Carol McKenna, Accountable Officer, NHS Greater Huddersfield CCG
Matt Walsh, Accountable Officer, NHS Calderdale CCG

14 GLOSSARY

Abbreviation or Term	Meaning
A&E	Accident and Emergency Services - also known as emergency department or casualty deals with life-threatening emergencies.
Amortisation	Amortisation - refers to recognising the cost of an asset over its useful economic life.
ANP	Advanced Nurse Practitioner - a registered nurse who has acquired the expert knowledge base, decision-making skills and clinical competencies for expanded practice.
Back-office	Back Office – support services such as finance, human resources, information technology, estates etc.
Bullet Payment	Bullet Payment - payment required to purchase the existing PFI at CRH.
BTHFT	Bradford Teaching Hospital Foundation Trust
CCG	Clinical Commissioning Group - clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
CDEL	Capital Department Expenditure Limit – a Treasury control total for public spending on capital.
CEPOD	Confidential Enquiry into Patient Outcome and Death – national review of the quality of the delivery of anaesthesia and surgery and the perioperative care of patients.
CHFT	Calderdale and Huddersfield Foundation Trust
CHS	Calderdale Health Solutions – a wholly owned subsidiary of the Trust.
CIP	Cost Improvement Plan – efficiency savings.
Concessionco	Concessionco – the existing PFI provider for CRH.
CRH	Calderdale Royal Hospital

Abbreviation or Term	Meaning
CQC	Care Quality Commission - an executive non-departmental public body of the Department of Health that regulates and inspects health and social care services in England.
Depreciation	Depreciation - method of allocating the cost of a tangible asset over its useful life.
DHSC	Department of Health and Social Care – a Ministerial Department of the Government responsible for government policy on health and adult social care matters in England.
DTOC	Delayed Transfers of Care – a delayed transfer of care is when a patient is ready to be discharged from hospital and is still occupying a hospital bed.
EAC	Equivalent Annual Cost - the annual cost of owning, operating and maintaining an asset over its entire life.
EBITDA	Earnings Before Interest Tax Depreciation and Amortisation - net income with interest, taxes, depreciation and amortisation added back to it. EBITDA is used to analyse and compare profitability between Trusts because it eliminates the effects of financing and accounting decisions.
ED	Emergency Department - also known as Accident and Emergency or casualty deals with genuine life-threatening emergencies.
EPR	Electronic Patient Record - an electronic record of the health care of a single individual.
FY	Full Year – a 12 month period of time.
GP	General Practitioner - a doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital.
Hard FM	Hard Facilities Management – Hard facilities management refers to services required which relate to the physical fabric of a building and cannot be removed. They ensure the safety and welfare of employees and generally are required by law (e.g. fire safety, mechanical engineering, electrical systems).
HRI	Huddersfield Royal Infirmary

Abbreviation or Term	Meaning
ICS	Integrated Care System - NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.
ICU	Intensive Care Unit - a department of a hospital in which patients who are dangerously ill are kept under constant observation.
Impairment	Impairment – refers to an asset that has a market price less than the value listed on the company's balance sheet.
IT	Information Technology - the use of any computers, storage, networking and other physical devices, infrastructure and processes to create, process, store, secure and exchange all forms of electronic data.
I&E	Income and Expenditure – a record showing the amounts of money coming into and going out of an organisation
IM&T	Information Management & Technology – the distribution, organisation and control of technology.
ITFF	Independent Trust Financing Facility – a mechanism for the Government to give funding loans to Trusts. Trusts in receipt of ITFF incur borrowing costs.
JHSC	Joint Health Scrutiny Committee - scrutiny is a function of local authorities and Joint health scrutiny means the coming together of more than one local authority to undertake this function.
LoS	Length of Stay – how long a patient is admitted to hospital for.
LTFM	Long Term Financial Model – a strategic financial plan for a period longer than one year.
MD	Medical Director – an Executive Director with responsibilities such as leading the formation and implementation of clinical strategy, taking a lead on clinical standards, providing clinical advice to the board, and providing professional leadership and being a bridge between medical staff and the board.
MIG	Medical Interoperability Gateway – A way of sharing important patient information between different computer systems that allows health and social care professionals to have access to the information they need, when they need it.

Abbreviation or Term	Meaning
MRI	Magnetic Resonance Imaging - a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
NCAT	National Clinical Advisory Team – provided a pool of clinical experts to support, advise and guide the local NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients. NCAT has now ceased to exist and has been replaced with other mechanisms of service review.
NHSE	National Health Service England - oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England.
NHSI	National Health Service Improvement – the national regulator responsible for overseeing foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.
NPV	Net Present Value - is the difference between the present value of cash inflows and the present value of cash outflows. NPV is used in capital budgeting to analyse the profitability of a projected investment or project.
Off Balance Sheet	Off Balance Sheet - is an accounting method whereby companies record certain assets or liabilities in a way that keeps them from appearing on the balance sheet.
PDC	Public Dividend Capital - a form of long-term government finance which was initially provided to NHS Trusts when they were first formed to enable them to purchase the Trust's assets from the Secretary of State.
PFI	Private Finance Initiative - a method of providing funds for major capital investments where private firms are contracted to complete and manage public projects. Under a private finance initiative, the private company, instead of the government, handles the up-front costs.
PF2	Private Finance Two – a new approach to public private partnerships that follows the reform of the Private Finance Initiative (PFI).

Abbreviation or Term	Meaning
PPE	Property, Plant and Equipment - is a term that describes an account on the balance sheet. The PP&E account is a summation of all a company's purchases of property, manufacturing plants and pieces of equipment to that point in time, less any amortisation.
PWLB	Public Works Load Board - a statutory body of the UK Government that provides loans to public bodies from the National Loans Fund.
QIPP	Quality, Innovation, Productivity and Prevention - the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and redesign services in light of the economic climate.
Revenue Support Loan	Revenue Support Loan – financial support from the Department of Health to provide the cash to pay creditors and staff.
RTT	Referral to Treatment – this is a measure of how long patients wait for services. The waiting time starts from the point the hospital or service receives the referral and ends if a clinician or patient decides no treatment is necessary, or when the treatment begins.
SHMI	Summary Hospital-level Mortality Indicator - the ratio of the observed to expected deaths following discharge from hospital, multiplied by 100.
SOC	Strategic Outline Case - this term is used in Treasury guidance regarding the development of capital business cases. It is associated with a required framework and structure to be used to enable clear thinking about capital spending proposals and a structured process for appraising, developing and planning to deliver best public value. Business Cases are required to be developed at four sequential stages of planning – the strategic outline case, the outline business case, the full business case and the final business case.
SoFP	Statement of Financial Position - is another name for the balance sheet. It is one of the main financial statements and it reports an entity's assets, liabilities, and the difference in their totals.
Soft FM	Soft Facilities Management - refers to services which make the workplace more pleasant or secure to work in. They are not compulsory and can be added and removed as necessary (e.g. catering, cleaning).

Abbreviation or Term	Meaning
SPC	Special Purpose Company - function as subsidiary entities for larger parent organisations and are typically used to finance new operations and capital at favorable terms.
SRO	Senior Responsible Owner - the visible owner of the overall change, accountable for successful delivery and is recognised as the key leadership figure in driving the change forward.
STF	Sustainability and Transformation Funding - a fund to support financial balance and also to enable new investment in key priorities.
STP	Sustainability and Transformation Plan - five-year plans covering all aspects of NHS spending in England. Forty-four geographical areas have been identified as the geographical 'footprints' on which the plans are based.
Sub-specialisation	Sub-specialisation - a particular area of expertise within a specialism. For example vascular surgery is a subspecialty of the specialism of general surgery.
SWYPFT	South West Yorkshire Partnership Foundation Trust
Teckal Trading Company	A Teckal Trading Company is a legal term for a company that has no private financial involvement in its ownership.
TPP	Healthcare technology company that provides SystmOne.
UCC	Urgent Care Centre - a walk-in NHS service for patients whose condition is urgent enough that they cannot wait for the next GP appointment (usually within 48 hours) but who do not need emergency treatment at the emergency department (A&E).
VFM	Value for Money - the most advantageous combination of cost, quality, benefits and sustainability to meet requirements.
WTE	Whole Time Equivalent - The ratio of the total number of paid hours during a period divided by the number of available working hours in that period. The ratio units are whole time equivalent employees - one WTE is equivalent to one employee working full-time.
WYAAT	West Yorkshire Association of Acute Trusts – a collaborative association of the acute Trusts in West Yorkshire and Harrogate.
WY&H	West Yorkshire and Harrogate

ANNEX A: Care Closer to Home – Additional Information

1. BACKGROUND

In both Calderdale and Kirklees, integrated community and primary care services are being developed to meet the different levels of need of the local populations. Community based services will be led by multidisciplinary teams of health and care professionals, working together to meet the needs of people who have short-term health needs, individuals with long term conditions and those requiring specialist care for severe or complex needs. These services will be delivered over populations of 30,000 to 50,000 people in a way that makes it easier for people to access care when closer to home, with a consistent and high quality experience for patients as they move between different parts of the integrated system.

This work builds on strong existing working relationships between the GPs, community services and both Kirklees and Calderdale local authorities. Calderdale CCG has worked with Calderdale Local Authority to produce a Single Plan for Calderdale within the overarching vision of 'Calderdale Cares'. The system's strategy is to deliver an integrated, locality based, health and care offer, driven by population based commissioning and primary care led. Building on the CCG's existing approach to primary care development and Care Closer to Home approach the aim is to improve care and quality of services and move the provision of care from unplanned to planned care, and the location from hospital to community. Development and delivery of the plan is overseen by the Health and Wellbeing Board. Greater Huddersfield CCG and North Kirklees CCG have worked with Kirklees Local Authority to produce the Kirklees Health and wellbeing plan. The vision for the Kirklees health and social care system in 2020 is: "No matter where they live, people in Kirklees live their lives confidently and responsibly, in better health, for longer and experience less inequality." This place based system of care will include social care, community services and Primary Care initially and develop to include mental health, voluntary and other services and support in the future.

2. INTRODUCTION

In September 2018, with support from the West Yorkshire and Harrogate Health and Care partnership, Calderdale and Greater Huddersfield CCGs commissioned a piece of work, the aim of which was:

'To be able to clearly quantify the impact of interventions in primary and community care on reducing demand in acute settings, by being more rigorous about: which interventions work; how we could standardise their application; and the utilisation of underpinning data driven modelling to give confidence in delivery.'

Subsequent to this, a report has been produced for the CCGs that describes in detail the plans for out of hospital services and what their potential impact on acute hospital services could be. The report provides important information to support the development and delivery of the Calderdale and Kirklees place based plans.

3. SUMMARY

The report identifies:

1. The baseline position, the likely impact of currently planned pathway-based changes and the risks to their successful implementation.
2. A realistic ambition for the potential impact of the CCGs' longer term place based plans in which many or most community services would be integrated, co-located and work closely with primary care and social care to deliver care in the community from hubs serving localities of 30-50,000 people.
3. An operating model describing how care could be provided to deliver the longer term plans, utilising Population Health management to identify the potential capacity required – in terms of both staff and estate – to operate a community hub within each of the CCGs' identified localities.
4. The factors to consider as part of any implementation.

3.1 THE BASELINE POSITION

Calderdale and Greater Huddersfield CCGs serve a population of 469,000 people. This will grow to 478,000 by 2023 (0.4% per year). As this increase is concentrated in the over 50's where most of care takes place, actual demographic activity growth will be ~1% per year resulting in an expected 5% increase in activity from demographic growth over 5 years. If nothing changes, in 5 years our system will require 43 more acute beds

The current model is very fragmented in its service provision. Many different teams offer different packages to the same patients, and multiple teams will offer similar forms of care intervention but exclusively to patients with different conditions. As an example, there are over eight entry routes into community services across the two CCGs that are denoted "single points of access."

The CCGs' current plans are focussed on the populations placing greatest strain on the system (including the frail elderly, respiratory patients, and those awaiting transfers of care), and are designed to implement national best-practice in the delivery of care and design of pathways. Successful implementation of the CCGs' currently planned pathway-based changes, could reduce non-elective bed days by 10% over 5 years.

3.2. THE OPERATING MODEL

As recognised in the CCGs' place based plans, improving the health of the population and achieving the potential 30% reduction in non-elective bed days is not about running more, or a different set of initiatives. The most successful systems redesigned their out-of-hospital care with a broad integration of services and teams, including social care. This section summarises

- The model of care provided by this integrated approach;
- the method for delivering care from co-located teams operating out of community hubs and the capacity this might require in each locality

3.2.1 WHAT THE PROPOSED INTEGRATED CARE SYSTEM WOULD INVOLVE

Integrated community and social care systems provide 13 best-practice interventions or types of service to their patients. These range from individual case management and co-ordination of care services, through the rapid availability of specialist and primary care services close to

patients' homes, to intermediate care facilities. As a whole, the 13 interventions target the three main approaches to reducing hospital usage: they aim to proactively care for population health and prevent admissions; they provide care in alternative locations as appropriate; and they support quick and effective transitions of care between settings, including out of the hospital.

These 13 types of service are then tailored to the specific needs of the local population. High-need patients would receive more frequent intensive support. Patients with lower needs would receive timely access to appropriate care when needed alongside self-empowerment of care and education. To make this work, a needs-based stratification of the population is required to say both how many patients are in which need group and to identify exactly which patient needs which level of support. In this way, the right care is designed and provided for each patient. The report describes what this model might look like in terms of the care provided to a high-need, medium-need and low-need patient. This includes a description of their initial assessment by a multi-disciplinary team, the care package constructed using the 13 types of service, and what this means in terms of their average contact time with nurses, doctors and other health and care professionals.

3.2.2 HOW CARE WOULD BE DELIVERED, AND THE CAPACITY REQUIRED TO DO IT

Central to the success of the best systems is the co-location and integration of all out of-hospital services based within and around community hubs. The community hubs would serve localities with populations of 30,000-50,000 people. Care provided by the hubs would be designed and organised by a central multi-disciplinary team, with a clear point of accountability for delivery of all out of hospital care in the locality. In Calderdale and Greater Huddersfield, this would mean that the existing programmes and level of care would still be provided, but teams with similar functions (for example, the various home visiting services provided by nurses or healthcare assistants) would be unified.

Remodelling care in this fashion often means that a different mix of skills is required in the workforce, but this does not necessarily imply the levels of growth in the number of doctors or specialist nurses that would be required if we simply grew our current model of care to meet future demand. The report sets out, for each locality, the average contact time for patients with different needs per year, and the estimated workforce requirements by role, as well as our likely requirements for community beds and estate. To deliver an integrated model of care across both CCGs by 2023 would require a total of: 2000 FTEs, of which 157 would be a new role of Care Navigator; 169 community beds; and about 13,000m2 of estate. The assumptions that drive this forecast can be adjusted within each locality, to reflect the packages of care designed for each population group by the local care providers and networks of GPs. The size of each locality will affect to some extent the services that can be provided economically within each hub. For example, all elements of pro-active and preventative care (MDT assessment, case management and care co-ordination) can be provided in hubs that serve 30,000 people, but the minimum efficient scale for an urgent care centre to operate is for populations of around 50,000.

The capacity and resource requirements described in the report focus on an efficient end-state, with services provided at scale. It may be that the CCGs decide to provide sub-scale services, for example to increase provision to populations in very rural areas: this would require additional resources for care delivery.

3.3. THE FACTORS THAT WILL ENABLE THE TRANSFORMATION

The CCGs have a good track record of piloting new services, then successfully rolling them out across the area. However, to run a complete transformation of their community services, additional focus and further work would be required on seven principal enabling factors.

A. Change management for patients and staff. Re-organising community and social care will not be possible unless clinical staff and patients understand and believe in the benefits of change. Some GP networks are already engaging with the programme, but clear role modelling from committed clinicians will drive later engagement and success. Likewise, we would need to engage patients to understand how to get the most from our new model of care, empowering them to shape its development and ultimately take greater control of their own health.

B. Organisational design. Locality based hubs will lie at the centre of an integrated primary, community, mental health and social care offer in each locality. While this will inevitably involve collaborative working across different professional groups, both the development and operation of these integrated services will need to proceed under a single accountable manager who is able to manage and coordinate the activity of contributing staff. Even if care is delivered through a partnership between different providers, having a single accountable person with the authority to decide how care will be provided is a common feature of successful systems.

C. System-wide ownership and accountability. While a single manager should run the services in each locality, oversight is likely to be provided by a partnership board. This group should be able to hold the manager to account for progress and performance. Additionally, it should be a means for the manager to quickly access executive-level support when challenges arise.

D. Funding. It will be important to identify funding to ensure there is sufficient capacity within the new model of care.

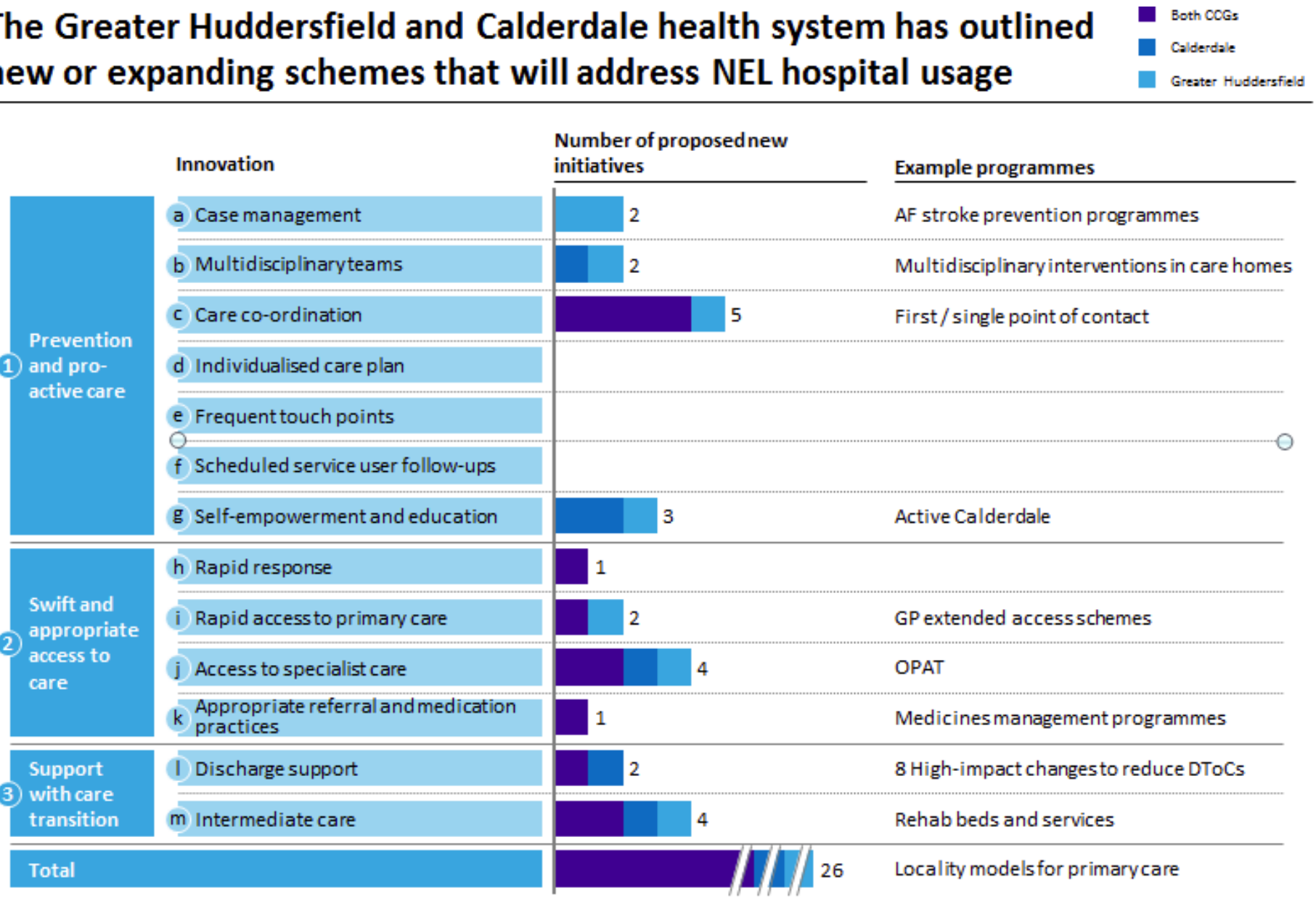
E. Ensuring contractual incentives are aligned. We will need to work closely with our providers to ensure that the balance of incentives between acute provider, primary care networks, and community care providers are aligned with us around improved and more cost-effective patient care.

F. Information sharing. Timely flow of clinical information between all relevant health professionals is a crucial enabler for our new model of care. In addition, we will need to track the performance of our new model in order to ensure that it is delivering intended benefits.

G. Digital and analytics. The completion of the Yorkshire and Humber Local Health and Care Record Exemplar programme will provide a fantastic foundation. This will give all care providers appropriate access to care records, greatly facilitating the co-ordination of patients' care. However, this is only the tip of the iceberg in terms of the potential benefits it could help us to deliver. We will need to develop our capability to provide detailed analytics and reporting as part of future improvements to care – focused on those cases that can have the biggest impact.

The diagram on the next page illustrates the new or expanding schemes across Calderdale and Greater Huddersfield that will address non-elective hospital usage.

The Greater Huddersfield and Calderdale health system has outlined new or expanding schemes that will address NEL hospital usage



compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

9. Patient Story – Donna Cole, Ward Manager, Ward 17

10. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2 May 2019
Meeting:	Board of Directors
Title:	Board Assurance Framework - April 2019
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Discussion with individual Directors
Action requested: To approve	
Purpose of the report	
The Board Assurance Framework provides Board members with an understanding of the principal risks to the achievement of the Trust's strategic objectives. Directors have updated the Board Assurance Framework during April 2019 which is presented to the Trust Board for approval.	
Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)	

The Trust has the following risk profile for the risks on the Board Assurance Framework (BAF), using the 5x5 risk matrix to assess risk likelihood and impact.

6 risks rated red, with a risk score between 15-25
7 risks rated amber, with a risk score between 8 and 12
2 risks rated green, with a risk score between 1 and 6.

There has been one risk with a reduced score, risk 03/19 which has reduced from a risk score of 8 to a current risk score of 6.

One new risk has been added, risk 15/19, relating to commercial growth scored at 9 which relates to the Trust 5 year strategy objective to understand our markets and have a clear plan of how we grow our business.

Directors have considered adding a new risk in relation to health and safety given our strategic objective of being fully compliant with health and safety standards. An external audit of health and safety is being commissioned and on receipt of this and dependent on the findings, a risk relating to this will be considered further.

An internal audit benchmarking report on Board Assurance Frameworks (BAFs) undertaken in 2018 listed the 10 most common types of risks that Trusts have on their BAFs. The Trust BAF has identified risks in all of these 10 areas. The benchmarking report also confirmed that it is best practice to record initial, current and target risk scores. These have been added for the individual risks and have now been added into the summary list to help monitoring of mitigation.

The report also confirmed that on average, Trusts have 15 risks on the BAF and the number on the Trust BAF is consistent with this average.

The benchmarking report also confirms that there was minimal movement in the reduction of risk scores when reviewing BAFs across 28 organisations. The report raises other questions for consideration regarding the BAF which will be considered when planning a Board workshop relating to the BAF in October 2019.

All risks have a new reference date of risk /19 (replacing the 17 risk) to reflect the current year.

EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)

There are no significant issues relating to equality identified in the Board Assurance Framework.

Recommendation

The Board is asked to approve the Board Assurance Framework as at April 2019.

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2019/20

Contents:

compassionate care

BOARD RISK APPETITE STATEMENT - APPROVED OCTOBER 2016

Risk Category	This means	Risk Appetite level	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to deliver high quality patient care (despite greater inherent risk).	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial / Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**
Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**
Commerical	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**
Harm and safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.	**SEEK**	**SIGNIFICANT**
Quality innovation and improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK**	**SIGNIFICANT**

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Appetite
Transforming and improving patient care							
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	15 =	**15**	AB	2827, 5806,7413,7414	Seek / Significant
02/19	Risk of non-delivery of the WYAAT programme as part of the wider West Yorkshire STP due to internal focus, lack of partnership working and capacity resulting in enforcement action and inability to achieve a rating of 'advanced'.	**10 =**	**10 =**	**5**	OW	None	Seek / Significant
03/19	Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	15	**6 ↓**	**4**	DB	None	Cautious / Moderate
04/19	Risk that the Trust does not involve and engage patients and the public in the delivery and improvement of services due to lack of clear processes, capacity and capability resulting in poor patient experience, poor quality of care and challenge to service change decisions	12	**6 =**	**4**	JM	None	Cautious / Moderate
05/19	Risk that the Trust will not realise the safety, quality and financial benefits from the implementation of the Trust's EPR due to lack of optimisation of the system.	15	**15 =**	**10 =**	MG	None	Seek / Significant
Keeping the base safe							
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**12 =**	**10**	JM	6345,7078, 5747 7345, 6715, 7396	Minimal / Low
07/19	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement resulting in enforcement action	25	**15 =**	**10**	OW	None	Cautious / Moderate
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**12 =**	**10**	HB	See sheet	Cautious / Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**20 =**	**8**	GB	5806	Minimal / Low
A workforce fit for the future							
10/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.		**20 =**		JM / DB	6345, 2827,7078, 5747, 7253	Minimal / Low
11/19	Risk of not having colleagues who are confident and competent to provide clinical and managerial leadership due to a lack of clear strategy and focus on development for current and aspiring leaders resulting in an inability to deliver the Trust's objectives and sustainable services for the future	16	**12 =**	**9**	SD	7248	Seek / Significant
12/17	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the culture of the organisation due to a lack of robust engagement mechanisms	**12 =**	**9 =**	**4**	SD	None	Seek / Significant
Financial sustainability							
13/19	Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention	16	**25 =**	12	GB	7278	Open / High
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	12 =	12	GB		Open / High
15/19	Risk that the Trust will not deliver external growth for commercial ventures resulting in potential lost financial contrbution..	**9 =**	9 !	**6**	GB		Open / High

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly likely (5)				9. Estate fit for purpose =	13. Financial delivery =
Likely (4)			14. Capital =		10. Staffing levels =
Possible (3)		3. Seven day services =	12. Staff engagement = 14. Commercial growth !	8. National and local targets = 6. Compliance with quality standards= 11. Clinical leadership =	5. EPR benefits realisation = 1. Approval of hospital reconfiguration strategic outline case 7. Compliance with NHS Improvement =
Unlikely (2)			4. Public involvement =		2. Delivery of WYAAT programme =
Rare (1)					

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
1.19	Board of Directors	Director of Transformation and Partnerships	Risk Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case (SOC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** - Delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance; Compliance with Paediatric Standards; Compliance with Critical Care Standards; Speciality level review in Medicine - Unable to meeting 7 day standards - Inabilty to recruit and retain workforce in particular medical workforce (increased reliance on Middle Grades and Locums) - Potential loss of service to	• The Trust has regular meetings with NHSI, NHSE, and DH colleagues to advise on the SOC content and assumptions used and the Trust will continue to work with colleagues to respond to queries and comments in relation to the SOC. The reconfiguration proposals have been agreed as the WY&H Health and Care Partnership's number one priority for capital investment. The DHSC has announced £196.6m capital allocation for the development. • NHSI has provided an indicative timetable for decision making. The revised clinical model and the process for development of business cases and ongoing engagement with the public has been discussed at the Joint Health Scrutiny Committee. • ED business continuity plan developed - April 2019 • Trust Submission of Strategic Outline Case to NHSE/I - May 2019 • Trust commences work on OBC • Stakeholders and Public Engagement Event - June 2019 • Public Meeting with Calderdale and Kirklees JHSC (date tbc) - June / July 2019 • Initial Feedback on SOC from NHSE/I - July 2019 • Approval decision on SOC by NHSE/I,	<u>First line</u> Estates Sustainability Committee review of business cases and response to queries that may be raised by NHSI, NHSE, DHSC <u>Second line</u> Trust Board review of business cases <u>Third line</u> Meetings with NHSI, NHSE and DHSC provide feedback. SOC approved in line with agreed timeline i.e. by December 2019.	• Difficulty in recruiting Consultants, Middle Grade and longer term locums • Estate limitations inhibit the present way of working • Consultant rotas cannot always be filled to sustain services on both sites • High use of locums	• Ongoing estate maintenance issues at HRI to be clarified through an updated Six Facet Survey due in May 2019.	**Initial** 5x5 = 25	**Current** 3x5 = 15	**Target** 2x5 = 10

Action	**Timescales**	**Lead**
Trust Submission of Strategic Outline Case (SOC) to NHSE/I	April 2019	AB for all actions
• Trust commences work on OBC	May 2019	
• Stakeholders and Public Engagement Event	June 2019	
• Public Meeting with Calderdale and Kirklees JHSC (date tbc) - June / July 2019	June/July 2019	
• Initial Feedback on SOC from NHSE/I	July 2019	
• Approval decision on SOC by NHSE/I, DHSC and Treasury	December 2019	
• Planned timescale for Trust submission of OBC to NHSE/I (subject to approval of SOC)	February 2020	

Links to risk register:
2827 - over-reliance on middle grade doctors in A&E
5806 - urgent estate work not completed
7413 - fire compartmentation risk HRI
7414 - building safety risk, HRI

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE									
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
2.19	Board of Directors	Chief Executive	**Risk** Risk of non-delivery of the WYAAT programme and Integrated Care Services (ICS) as part of the wider West Yrkshire plan due to internal focus, lack of partnership working and capacity resulting in enforcement action and inability to achieve a rating of 'advanced'. **Impact** - Reputational impact - Inability to realise benefits of partnership working - Regulatory impact related to single oversight framework requirements - Potential loss of services	• Full participation in WYAAT - • Key senior individuals engaged in programmes of work and leading on aspects of support work including governance and communications . • Chief Executive is Senior Responsible Officer (SRO) of the ICS estates and capital group • WYAAT governance arrangements reviewed and programme of work and reporting framework in place. Chief Executives and Chairs of constituent Trusts have decision-making and oversight of the WYAAT programme and ICS • Vascular and pathology board memberships • Associate medical director from CHFT appointed as vascular clinical lead	<u>First line</u> WYAAT minutes and programmes of work reported to Board WYAAT Programme Director attendance at WEB • Programme Director's report to Board alongside comparative performance report <u>Second line</u> Governance arrangements approved by the Board <u>Third line</u> Reconfiguration included within West Yorkshire plan	• Understanding of how WYAAT and ICS will work within the 10 year long term plan needed	• Competing priorities within the Trust impacting on ability to fully engage.	**Initial** **2x5 = 10**	**Current** **2x5 = 10**	**Target** **1x5 = 5**

Action	**Timescales**	**Lead**
Seek clarification of how WYAAT /ICS will work within 10 year long term plan implementation	March 2020	Via WYAAT

Links to risk register:
No high level risks with score >15

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
3.19	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Governance systems and performance indicators in place • One of two early implementer sites in the North to trial new NHSE methodology and Board assurance Programme to extend 7 day working across medical specialities - now includes elderly medicine, respiratory, cardiology and gastro with discussions progressing in palliative care Reconfiguration of medical services: elderly medicine, cardiology, respiratory, gastroenterology has facilitated the introduction of speciality on-call rotas to expand provision of 7 day speciality cover	First line HSMR and SHMI within expected range Second line Integrated Board report Benchmarked against four priority seven day standards - full compliance at most recent audit in Sept 2018. Paper received at WEB 18/10/18 Single Oversight Framework. Third line Positive feedback from NHSI/E, NHSE-led, WYAAT-wide implementation scheme	Radiology staffing pressures present risk of continued delivery of standards 5 and 6 - access to diagnostic tests and access to consultant -directed interventions	• Scope for futher implementation limited without service reconfiguration or additional investment	**Initial** 5x3 = 15	**Current** 3x2= 6	**Target** 2x2 = 4
Action					**Timescales**			**Lead**		
					April 2019 May 2019			DB/CP		
Links to risk register: No high level risks with score >15										

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
4.17	Quality Committee	Executive Director of Nursing	**Risk** Risk that the Trust does not involve and engage patients and the public in the delivery and improvement of services due to lack of clear processes, capacity and capability resulting in not designing services using patient recommendations **Impact** - Non delivery of improvements in services - Risk of legal challenge - Reputational impact	• Joint working with CCGs to support pateint engagement and sttategic intent • Working with HealthWatch on key areas of interest / concern • Patient Experience Group in place • Engagement champions in place across the Trust • Engagement toolkit been developed • Out Patient Transformation Programme • Engagement events re: Strategic Outline Case	<u>First line</u> Public involvement and engagement included in Patient Experience Group Areas of good practice identified within the Trust <u>Second line</u> Governor attends Patient Experience Group Patient Experience Group reporting to Quality Committee Project Management information on service change and engagement (PMO workbooks) <u>Third line</u> Annual reporting to CCGs CQC rating of Good. Healthwath reports (Out patients post Electrnoic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and invovlement data Co-ordination role for egnagement to be agreed. Lack of consistent approach when seeking patient input to re-designing services		**3x4 = 12**	**2x3= 6**	**1x4 = 4**
Action								**Lead**		
Central system to hold patient engaagement and involvement data					Aug-19			Sharon Appleby, PMO		

Links to risk register:
No risks on the risk register >15

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
5.17	Finance and Performance Committee	Managing Director of Digital Health	**Risk** Risk that the Trust will not realise the safety, quality and financial benefits from the implementation of the Trust's EPR due to lack of optimisation of the system. **Impact** - Non delivery of improvements in clinical outcomes - inability to realise return on investment or financial value for money	• Modernisation Programme Management and Governance structure to manage the ongoing implementation EPR system within the Trust-wide IT Modernisation Programme. • Operational Delivery Board in place with cross divisional representation • Business as Usual structure in place • Transformation Board reporting • Programme Board in place with cross trust representation	<u>First line</u> Digital Health Forum Operational Board reporting Digital open days held Digital Boards in place at divisional level <u>Second line</u> Investment and Strategy Group Assurance Board that includes Non-Executive directors. Report to Finance and Performance Committee <u>Third line</u> Improvement as part of QRM reporting arrangements	• Number of issues following implementation still to be addressed • Business as usual structure doesn't include development structure •Further work to be done on benefits realisation to ensure embedded across the Trust linked to wider work on benefits realisaton	• Lack of capital funding for developments. • Full report now cmplete on cash benefits, due to be presented at the Finance and performance committee on April 26th. The current value is £20m. Work is ongoing to document all quality and safety benfits. A proposal to improve capacity and capability is under devleopment. A new post has been created as a benefits realisation co-ordinator due to be appointed at the end of April.	3x5 = 15	3x5 = 15	2x5 = 10

Action	**Timescales**	**Lead**
Work on benefts realisation continues within annual planning arrangements	Mar-20	GB / MG

Links to risk register:
EPR related risks on the high level risk register relate to quality and safety risks of the system. Risk 7049 - EPR Financial risk
There are no high level risks realtintg to benefits realisation.

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 2 KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
6.19	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale	• Quality governance arrangements revised and strengthened • SI investigation process identifies recommendations to improve care with strong governance in place • Strengthened risk management arrangements • Risk and Compliance Group overseeing implementation of actions and preparation plans for well led inspection • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures and introduction of ward assurance tool. • Programme of quality visits in place (Quality Fridays) • Process in place for policy review and approval • Ward assurance tool rolled out, using automated information on documentation standards • 5 safety "must do's" embedded on wards • Consistent mandatory and essential training compliance	First line Staffing levels reported to WEB Clinical audit plan reviewed Assessment of compliance with NICE guidance Improvement in HSMR & SHMI Vacancy and agency use reporting Improvement in staff sickness absence Mandatory training compliance at 31.3.19. 94.95% Second line Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs in Integrated Board Report. PSQB reports to Quality Committee Infection Prevention and Control report to Board Serious incident report to Quality Committee Third line CQC rating of Good Quality Account reviewed by External Auditors and stakeholder bodies Well Led Governance review Independent assurance on clinical audit strategy Ongoing relationship with arms length regulatory bodies Independent Service Reviews (ISR) and accreditations. ISR March 2019 assurance on process for responding to NPSA alerts	• Operational and financial priorities impacting on capacity and ability to maintain consistent quality of care - • Standard of serious incident investigations needs further improvement • Estate issues identified • Acuity and dependency of patients impacting on staff morale and engagement • Completion of 2 actions from CQC action plan from 2018 well-led inspection relating to: - medical staff in the Emergency Department - critical care staffing	• CQC assessed the Trust as Good except for Safe domain which was rated as requires improvement • Staff FFT and staff survey (2018) responses show marginal improvement • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements (Allocate)	3x5 = 15	3x4= 12	2x5 = 10

Action	**Timescales**	**Lead**
Ward assurance tool to be finalised	December 2018	JM
Roll out of Allocate for Medical and Therapy staff	March 2019	CP
CQC action plan to be delivered	March 2019	JM

Links to risk register:
Risk 6345 - nurse staffing risk, risk 7078 - Medical staffing risk , risk 7345 - Referrals to district nursing service, risk 5747 interventional radiology staffing, 6715 clinical documentation, risk 7396 inadvertent connection to air flow instead of oxygen.

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
7.19	Board of Directors	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• Monthly review meeting with NHS Improvement (NHS I) • Control total for 2019/20 accepted • Corporate compliance register in place • Review of monthly NHS I bulletins to assess any required actions • PMO in place with Turnaround Executive governance around CIP • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Well Led CQC review 2018, rating of "good" • Use of Resources inspection completed and action plan being implemented Check if CCG letter of support is in SOC and add as control if is	First line Clear PMO reporting from Divisions Second line Integrated Board report showing CIP delivery CIP report to Finance and Performance Committee Board approval of 5 Year Strategic Plan Review by Quality Committee and Board of progress with CQC action plan and use of resources action plan Third line Quarterly PRM with NHS Improvement Round table meetings being held with CCGs, NHS England and NHS Improvement CCG acceptance of Strategic Outline Case	• Performance against STF standards • Challenging financial position	• Performance against key targets • Use of Resources rating of requires improvement	**Initial**	**Current**	**Target**
								5x5 = 25	**3x5 = 15**	**2x5 = 10**
Action					**Timescales**			**Lead**		
Use of resources and CQC action plan being implemented					May-19			AB / JM		
Links to risk register: Risk 7278 - Financial sustainability										

TRUST GOAL: 2. KEEPING THE BASE SAFE									
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
8.19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets **Impact** - Poor quality of care and treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders - STF withheld and financial issues	• Weekly performance monitoring and management arrangements • System wide Patient flow programme established • CQUINS compliance monitored by Q&P Web • Bronze, silver and gold command arrangements and escalation process • Associate Director of Planned Access role developed • Regular forum in place between Operations and THIS to strengthen information flows and reporting • Assitant Director of Performance in place • Director of Urgent Care in post • General Manager for Cancer services and Digital inplace • Urgent Care Board, cancer Board and Diagnostics Board estabished with Clinical Director attendance to ensure robust Medical Leadership	First line Weekly performance review with divisions. Divisional board and PRM reviews of performance with executive attendance Weekly escalation at WEB Intergrated Board report focus of one WEB each month for detailed scrutiny wtih wider representation from divisions 'Deep dive' discussions into areas of under performance Appointment slot issues action plan has resulted in reduced ASIs Delivered to regulatory requirements in 18/19 No system Silver calls winter 18/19 Review with clinical & System teams Second line Enhanced Integrated Board Report discussed at Quality Committee and Board Finance and Performance Committee monthly report on activity Report on compliance with best practice tariff Third line Urgent Care and Planned Care Boards and System Resilience group	• System responsiveness • Pressures impacting on delivery of key targets • Achievement of 4 hour emergency care standard requires micro-management. • Inability to retain enough middle grades in AED • Continued incorrect use of RTT codes increasing validation dependancy • Increasing radiology demand and reduced workforce	Further work required on RTT coding at source, requiremnt to move to mandatory education	**Initial** 4x4 = 16	**Current** 3x4 = 12	**Target** 2x5 = 10

Action	**Timescales**	**Lead**
Tactical silver meetings in place Risk 6658: patient flow to be presented at Risk and Compliance Group in May 2019 to consider as new high level risk.	April 2019 May 2019	HB

Links to risk register:
Risk 6658 - Patient flow tbc

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

Action	**Timescales**	**Lead**
Six facet survey to be completed and reported	Apr-19	CHS

Links to risk register:
Risk 6903 - Estates / ICU risk, HRI
Tisk 5806 - Urgent estate schemes not undertaken

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain
10.19	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Weekly nurse staffing escalation reports • Ongoing multifacted recruitment programme in place, including international recruitment; • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure • ED business continuity plan in place; • Vacancy Control Panel in place; • E-roster system in place. •Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place. • Risk assessments in place • Nursing and medical recruitment and retention strategy in place • Nursing and Midwifery Group, monthly meeeting reviews operational issues, strategy and seeks assurance • Medical Workforce Programme Steering Group meets bimonthly Medical recruitment and retention workstream bimonthly Segmentation approach and vacancy tracker in place to focus medical recruitment resource on clinically high risk and likelihood of appointment. Vacancy tracker maps medical workforce to medical establishment, tracks vacancies, pipeline and retention Electronic job planning in place for all consultants Junior doctor awards Adopted SAS doctor charter	First line Staffing levels, training & education compliance and development reported to WEB Divisional business meetings and PSQBs consider staffing levels as part of standard agenda IPR shows slight decrease in sickness levels, and reduction in agency spend Bi-annual review of ward nursing levels Weekly meeting on agency spend 6 additional PA posts and nursing associate posts recruited to Improvements in mortality (HSMR / SHMI).Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend Agency spend reported weekly to Turnaround Executive Medical agency spend halved in 2018/19. Vacancy tracker shows 25% reduction in medical vacancies 2018/19 Second line Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues External review of nursing chaired by Director of Nursing, Hull GMC Report on Junior Doctor Experience - CP to review	Current hotspots are: Emergency Care; Radiology; ; opthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; therapies; Recruitment and retention strategy for medical and therapy staffing required Continued spend onmedical locums and agency remains challenging. Some bank controls in place. Need to develop additional bank and additional session payments, controls E-job planning only partially implemented for SAS doctors because of time pressures on Clinical Directors Medical e-rostering to roll out from May 2019 for sub-consultant doctors and from October 2019 for consultants - dependent in part on support from Allocate	• Need to embed workforce plan

RATING		
Initial	Current	Target
4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
New allocate system to be fully implemented for medics and therapies	Sep-19	CP

Links to risk register:
Risk 6345 - overall staffing risk
Risk 2827 - Over reliance on middle grade doctors in A&E
Risk 7078 - medical staffing risk
Risk 5747 - Vascular / interventional radiology staffing
Risk 7253 - Paediatric staffing risk

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain*	**RATING**		
11.19	Quality Committee	Executive Medical Director	**Risk** Risk of not having colleagues who are confident and competent to provide clinical and managerial leadership due to a lack of clear strategy and focus on development for current and aspiring leaders resulting in an inability to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities	• Devolved clinical structure • Work together get results programme in place • Positive feedback from Junior doctors on medical training • Performance appraisal based around behaviours • Coaching circles process • All CIP schemes have clinical lead • Development of new roles across professional groups • Good revalidation compliance • Performance Management Framework agreed including job description for clinical leads. • Development of medical director's office • Development programme being rolled out - first cohorts completed	<u>First line</u> Established escalation framework to prioritise action to address week areas Clinicians leading of transformation programmes e.g. cardio /respiratory Engaged leaders toolkit in place Clinical lead particpation in star chamber approach Job planning framework approved Recruitment to key roles across the Trust <u>Second line</u> Integrated Board Report Revalidation report to board <u>Third line</u> IIP Accreditation Feedback from Royal Colleges Junior doctor GMC questionnaire feedback	• CHFT's OD Strategy The Cupboard has been co created with colleagues and will be launched on 17th April 2019. A key component of The Cupboard is the development of essential leadership and management skills for all people managers, including the continuation of the Trusts CLIP (compassionate leadership in practice) programme.	• Acquire independent assessment of clinical leadership arrangements	**Initial**	**Current**	**Target**
								4x4 = 16	**3x4 =12**	**3x3 = 9**
Action					**Timescales**			**Lead**		
OD strategy approved by Board, launched within the Trust 17/04/19 and monitored through Workforce Committee					December 2019			SD		
Links to risk register: Risk 7248 - mandatory training										

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain*	**RATING**		
								Initial	**Current**	**Target**
12.19	Well Led Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the culture of the organisation due to a lack of robust engagement mechanisms. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Leadership visibility increasing and impact of EPR work • Quarterly staff FFT in place • Work together get results programme in place • 'Ask Owen' being responded to • Good evidence of colleague engagement in OBC / FBC development • Celebrating success annual awards • Staff survey action plan • Health and wellbeing strategy • Implemented star award recognition scheme • Board to ward programme in place • LGBTQ network in place • BME network in place and well attended • Tea trolley rounds taking place across the TRust • Colleague engagement calendar in place	<u>First line</u> Divisional leadership approach CQC preparation for self assessment shows some areas reporting GOOD in well led domain Significant number of actions delivered against action plan Good involvement in Annual Planning Days Improving absence position Introdcued tea trolley rounds <u>Second line</u> Integrated Board report shows sickness absence slightly improved CQC Mock inspection feedback from focus groups <u>Third line</u> Staff FFT / staff survey provides some positive feedback IIP accrediation - Bronze award CQC rating of Good	CHFT's OD strategy The Cupboard has been co-created with colleagues and will be launched on 17th april. A series of Tea Trolley events, where colleagues collect and collate feedback from colleagues across the Trust, ensures continuous engagement. A series of 'Hot House' events which operate through the governance of the workforce committee, engage collegues and co create people related policies and procedures. Plans to coordinate all celebrating succcess activities across the Trust, including the annual awards ceremony, celebrating the positives and other events will ensure improved engagement in colleague and Trust wide improvement and success.	• Staff FFT response rate along with number of staff who would recommend the Trust as a place to work • Still a number of well led indicators on the IBR showing red • Awaiting feedback from IIP report	**3x4 = 12**	**3x3 = 9**	**1x4 = 4**

Action	**Timescales**	**Lead**
Colleague engagement calendar will be launched as part of OD strategy in April Roll out of the engagement plan will be monitored through Workforce Committee	April 2019 May 2019	SD

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

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
13.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention. **Impact** - financial sustainability - loss of STF - increased regultory scrutiny - insufficient cash to meet revenue obligation - inability to invest in patient care or estate	• Financial recovery and cost improvement programme plan in place • PMO tracking of delivery against CIP plan • Budgetary control process • Detailed income and activity contract monitoring • Bottom-up forecasting process • Star chamber process to support CIP schemes off track • Quality directorate overview of progress against delivery of CQUIN • Authorisation processes for agency spend • Standing Financial Instructions set authorisation limits • Detailed recovery plan in place including non-pay review, tightening of vacancy control panel process, controls around additional hours. • Clear communications plan around financial pressures	<u>First line</u> Divisional Board performance reports Achieving agency target Aligned incentive contract in place supporting guarnateed in year income Agreed levels of income with CCG for next 5 years within SOC 2018/19 financial plan delivered 2019/20 control total accepted <u>Second line</u> Turnaround Executive Reports NHS I scrutiny at Finance and Performance Committee and Board Integrated Board report including CQUIN delivery reporting <u>Third line</u> Monthly return to NHS I QRM meeting with NHS I NHS I review of CIP arrangements NHS I review of agency usage ICS control total to be accepted	• Deficit plan in place for 19/20 after receipt of PSF and FRF • Not all CIP identified recurrently	• Residual deficit after receipt of PSF and FRF • High risk CIP still to be delivered • Use of Resources rating of requires improvement	**Initial**	**Current**	**Target**
								4x4 = 16	5x5=25	1x4=4

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

Links to risk register:
Risk 7278 - long term risk rmeians high. Returning to balance reliant on support for SOC and OBC

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
14.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Prioritised capital programme. Small contingency remains in place to cover any further changes.	First line Reporting through WEB on capital prioritisation 2018/19 Capital Plan delivered Second line Turnaround Executive Reports Scrutiny at Finance and Performance Committee and Board Capital Management Group reports Third line Monthly return to NHS I QRM meeting with NHS I	The long term capital spend required for HRI is in excess of internally generated capital funds. The 19/20 Capital plan is reliant on land sales (Acre House and Glenacre House) plus a combination of both emergency capital bids and business case drawdown to fund a repalcement MRI and meet essential health and safety requirments at HRI in relation to both fire safety and cladding.	Land sales not yet agreed Emergency capital not yet agreed Backlog maintenance costs will remain in excess of planned capital spend.	**Initial** 4x5 = 20	**Current** 4x3 = 12	**Target** 3x4=12
Action					**Timescales**			**Lead**		
Ongoing monitoring of financial position through F&P and Board					Ongoing			GB		
Links to risk register: Risk 7062 re: capital programme is scored at 6 for the financial year 2019/20 but the longer term challenge is significantly higher.										

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
15.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Pharmacy Manufacturing Service, Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place	**First line** Individual boards and feeding into Finance and performance committee	PMU requires further capital investment to continue to grow. Business case for growth funding to be agreed at HPS Board and then Trsut Board during summer 2019 THIS continue to bid for aditional external work but at present this is not fully identified to meet the income plan for 2019/20 CHS commercial strategy still being developed	THIS has not fully identified its recurrent income challeneg for 2019/20 PMU requires capital investment to meet its ambitious growth plan for 2020/21	**Initial** 3x3 = 9	**Current** 3x3 = 9	**Target** 2x3= 6
Action					**April 2019**			**Lead**		
Ongoing monitoring of financial position through F&P and Board					Ongoing			GB		
Links to high level risk register:										

BOARD ASSURANCE FRAMEWORK RISK REVIEW
APRIL 2019

ACRONYM LIST

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

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Director of Finance
HB	Helen Barker, Associate Director of Operations
AMH	Anne-Marie Hensahw, Assistant Director of Quality and Safety
MG	Mandy Griffin, Managing Director of Digital Health
LH	Lesley Hill, Executive Director of Planning, Estates and Facilities
RM	Ruth Mason, Associate Director of Engagement and Inclusion
AM	Andrea McCourt, Company Secretary
CP	Cornelle Parker, Deputy Medical Director
SU	Sal Uka, Consultant Paediatrician and 7 day services clinical lead
OW	Owen Williams, Chief Executive
ALL	All board members

11. High Level Risk Register

To Approve

Presented by Lindsay Rudge

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2 May 2019
Meeting:	Board of Directors
Title:	High Level Risk Register
Author:	Andrea McCourt, Head of Governance and Risk
Previous Forums:	The draft high level risk register has been reviewed by members of the Risk and Compliance Group at a meeting on 8 April 2019.

Action requested:

To approve

Purpose of the report

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 as at 23 April 2019.

Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)

Movement on the high level risk register since it was presented to the Board in March is summarised in the attached paper. In brief:

1 new risk has been added by the Family and Specialist Services Division scored at 15 relating to paediatric and neonatal staffing
4 risks have been reduced to scores below the threshold for the Trust high level risk register as described in the summary paper and will be managed within the divisional risk register
1 risk has been closed

The risks removed from the high level risk register are:

7169 - achievement of in-year financial plan (2019/20)
5862 - falls risk reducing from 16 to 12 in the Medical Division
7540 - financial risk for 2018/19 in the Surgery and Anaesthetics division reducing from 20 to 9
7280 - risk re:unnecessary repeat specimen collection reduced from 15 to 12 and managed within the Family and Specialist Services (FSS) Division

1 risk has been closed, risk 6011 relating to the blood track system following implementation of the blood track system.

The risks relating to the estate at HRI for ICU (risk 7271) and resuscitation (risk 6903) have been reviewed from a CHFT operational perspective. Two new risks have been rewritten reflecting the impact on service delivery and patients and added to the divisional risk registers as these risk scores have been assessed as 12. The original risks continue to be managed on the risk register for Calderdale and Huddersfield Solutions (CHS) and reviewed within their governance structures.

Actions have been added for all risks.

EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)
No significant impact.
Recommendation
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.

High Level Risk Register Board Summary – April 2019

Risks at 23 April 2019

TOP RISKS

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

7278 (25) Longer term financial sustainability risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk

The Trust risk appetite is included below.

NEW RISKS

7253 Score 15 Family and Specialist Services Division Paediatric and Neonatal Staffing Risk

This risk relates to a shortfall on the Tier 2 medical staffing rota over the next 6 months which may result in reduced service provision for local children, young people and their families, reliance on bank and agency staff and individual's resilience both at tier 2 and Consultant level.

RISKS WITH REDUCED SCORE

7169 Score 12 (↓16) Corporate Finance

<u>In year Finance and financial plan</u>
In the March report to the Board this risk related to the 2018/19 financial plan. It has been updated for 2019/20 with a risk score of 12 due to a greater level of assurance in achieving the 2019/20 financial plan

5862 Score 12 (↓16) Medical

<u>Falls Risk</u>
Reduction in score as the risk was reviewed at falls collaborative and as there has been a consistent trend in the reduction of falls over the previous months and any increases have been identified as area specific. Work is underway to reduce therefore a decision was made to reduce the risk score

7240 Score 9 (↓20) SAS Financial Risk

<u>Surgery and Anaesthetics Financial Risk 2018/19</u>
Reduction in the score as there has been a new financial plan set for 2019/20

7280 Score 12 (↓15) FSS Risk

<u>Unnecessary repeat specimen collection Risk</u>
Reduction in score as there has been improvement to unnecessary repeat specimen collections or rejected specimens. The impact score has been reduced due to training plan on wards at HRI and improvement at CRH.

OTHER RISKS REMOVED FROM HIGH LEVEL RISK REGISTER

The following two risks, 6903 and 7271 (see below) relating to the estate at HRI which have been on the high level risk register and have now been removed from the CHFT high level risk register as these risks are being managed on the CHS risk register. The operational impacts of the two risks have been identified and added to divisional risk registers for management. Details of each risk is given below.

6903 Estates Resuscitation HRI Risk

Following discussion about the operational impact of the risk relating to patients regarding resuscitation facilities in the Emergency Department due to the age of these faciltiies and issues relating to an upgrade , the operational impact of risk 6903 on the Trust has been identified. This risk has been risk assessed as a risk of 12 and is on the Medical divisional risk register at a score of 12, risk reference 7444.

The Estates risk relating to resuscitatuion in the Emergency Department at HRI, risk 6903, remains on the Calderdale and Huddersfield Solutions (CHS) risk register at a score of 20 and will be reviewed and managed within CHS governance arrangements.

7271 Estates ICU HRI Risk

Following discussion about the operational impact of the risk relating to patients should there be reduced access to ICU for an upgrade to facilitites, the operational impact of risk 7271 on the Trust has been identified. This risk has been risk assessed as a risk of 12 and is on the Surgical and Anaesthetics divisional risk register at a score of 12, risk reference 7442.

The Estates risk relating to ICU refurbiushment / upgrade, risk 7271, remains on the Calderdale and Huddersfield Solutions risk register at a score of 20 and will be reviewed and managed within their governance arrangements

CLOSED RISKS

6011 Score 15 FSS Closed

<u>Blood track Risk</u>

This risk has been closed following implementation of the blood track system. New risks have now been opened for remaining areas yet to implement blood track (community midwifery 7448 and antenatal screening 7449).

April 2019 – SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 23/04/2019

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19
10/19	2827	Developing Our workforce	Over–reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
09/19	5806	Keeping the base safe	Urgent estate work not completed	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
05/19	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (JM)	=15	=15	=15	=15	=15	=15
10/19	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
05/19	7132	Keeping the base safe	Miscalculation of deteriorating patient scores in Emergency Department	Medical Director (DB)	=16	=16	=16	=16	=16	=16
08/19	7223	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health (MG)	=16	=16	=16	=16	=16	=16
11/19	7248	Keeping the base safe	Mandatory Training	Director of Workforce and OD (SD)	=16	=16	=16	=16	=16	=16
05/19	7338	Keeping the base safe	EPR Risk	Director of Nursing (JM)	=15	=15	=15	=15	=15	=15
06/19	7315	Keeping the base safe	Out patient appointments capacity risk	Director of Operations, FSS (RA)	=15	=15	=15	=15	=15	=15
06/19	6829	Keeping the base safe	Pharmacy Aseptic Dispensing Service	Director of Nursing (JM)	**!15**	=15	=15	=15	=15	=15
06/19	3793	Keeping the base safe	Opthalmology follow up appointment capacity risk	Divisional Director of SAS (WA)	**!16**	=16	=16	=16	=16	=16
05/19	7345	Keeping the base safe	Referral to the District Nursing Service	Director of Nursing (JM)				**!16**	=16	=16
06/19	7396	Keeping the base safe	Risk of inadvertent connection to air	Director of Nursing (JM)				**!15**	=15	=15
09/19	7414	Keeping the base safe	Buidling safety risk	Director of Finance (GB)				**!15**	=15	=15
10/19	7413	Keeping the base safe	Fire compartmentation at HRI	Director of Finance (GB)				**!15**	=15	=15
13/19	7253	Keeping the base safe	Paediatric staffing Risk	Director of Operations, FSS (RA)					**!15**	=15
FINANCE RISKS										
10/19	7278	Financial sustainability	Trust planned deficit	Director of Finance (GB)	=25	=25	=25	=25	=25	=25
WORKKFORCE RISKS										
10/19	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (JM), Director of Workforce	=20	=20	=20	=20	=20	=20
10/19	7078	Keeping the base safe	Medical Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (JM), Director of Workforce	=20	=20	=20	=20	=20	=20

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

Board Assurance Framework risks referenced above.

05/19	*Risk that the Trust will not realise the safety, quality and financial benefits from the implementation of the Trust's EPR due to lack of optimisation of the system.*
06/19	*Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.*
08/19	*Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.*
09/19	*Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.*
10/19	*Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.*
11/19	*Risk of not having colleagues who are confident and competent to provide clinical and managerial leadership due to a lack of clear strategy and focus on development for current and aspiring leaders resulting in an inability to deliver the Trust's objectives and sustainable services for the future*
13/19	*Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention*

TRUST RISK PROFILE AS AT 23/04/2019

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

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation !7253 Paediatric staffing	= 6345 Nurse Staffing = 7078 Medical Staffing	=7278 Financial sustainability
Likely (4)				=7132 Patient scores in ED =7223 Digital IT systems risk =7248 Mandatory training =6829 Pharmacy Aseptic Dispensing Service =3793 Opthalmology capacity =7345 District Nurse Referral Risk	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed =7315 Appointment Risk
Possible (3)					= 5747 Vascular /interventional radiology service =7338 EPR =7396 Inadvertent connection to air =7413 Fire compartmentation HRI =7414 Building safety risk
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE

Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial and Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**
Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**
Commercial	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of	**SEEK**	**SIGNIFICANT**

	employment, innovative resourcing and staff development models.		
Quality Innovation and Improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK**	**SIGNIFICANT**

High Level Risk Register

16/04/2019

NHS
The Health Informatics Service
Informing Healthcare

	Risk No	Div	Dir	Dep	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
Very High	7278	Corporate	Finance and Procurement	Trustwide Finance	Jun-2018	Active	Financial sustainability	Longer term financial sustainability: The Trust has a planned deficit of £37.99m (as per the NHS Improvement 19/20 control total). Acceptance of this control total gives the Trust access to £6.15m MRET funding, £7.33m Provider Sustainability Funding (PSF) and £14.81m Financial Recovery Funding (FRF), reducing the planned deficit to £9.71m. The receipt of PSF and FRF are dependant on achievement of the control total. The size of the underlying deficit raises significant concerns about the longer term financial sustainability of the Trust, particularly when combined with the growing level of debt and reliance on borrowing. The 2017/18 external audit opinion raised concerns regarding going concern and value for money. The Trust does not currently have an agreed plan to return to in year balance or surplus.	Working with partner organisations across WYAAT and STP to identify system savings and opportunities 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 Development of Business Case for reconfiguration Development of 25 year financial plans in support of Business Case Finance and Performance Committee in place to monitor performance and steer necessary actions Aligned Incentive contract with two main commissioners. On-going dialogue with NHS Improvement	Pressures on capacity planning due to external factors. Competing STP priorities for resources Progression of transformations plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors The Trust does not currently have an agreed plan to return to in year balance or surplus. No additional revenue costs have been included for the development of the Reconfiguration Business Case.	25 5 x 5	25 5 x 5	20 5 x 4	Long term Financial plan continues to be developed in conjunction with regulators and department of health with a Strategic Outline Case for reconfiguration due for submission in April. Capital plan for 19/20 includes £4m relating to reconfiguration and the development of the Business Case: £3m for HRI and £1m for Fees. Stretching CIP target of £11m (3%) for 19/20 reflects the fact that the Trust needs to find greater efficiencies than the baseline incorporated within Tariff as part of its journey towards financial sustainability. The target is in excess of the minimum expected of 1.6% (1.1% national efficiency factor plus 0.5% additional requirement for Trust's in deficit).	Long term Financial plan continues to be developed in conjunction with regulators and department of health with a Strategic Outline Case for reconfiguration due for submission in April. 19/20 Financial plan has been submitted to NHS Improvement and the Trust has submitted a plan that accepted the Trust's allocated control total of £37.99m. This will allow the organisation to access non-recurrent MRET funding of £6.13m, Provider Sustainability Funding (PSF) of £7.33m and Financial Recovery Funding (FRF) of £14.81m reducing the overall planned deficit to £9.71m.	May-2019	Mar-2020		FPC	Gary Boothby	Philippa Russell
Very High	6345	Corporate	Organisational	Resourcing / Recruitment	Jul-2015	Active	Keeping the base	Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077) Risk of not being able to deliver safe, effective and high quality care with a	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse	Low number of applications	16 4 x 4	20 4 x 5	9 3 x 3	• Recruitment including international recruitment of Nurses • Nursing associate role development • Developing nursing retention strategy	**April 2019** Applicants from the Philippines continue to progress (119 offers were made in country, since March 2017, with on-going	May-2019	Jun-2019		WF	Jackie Murphy,	Rachael Pierce

								positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	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					• Use of flexible workforce	training and tests underway), 15 Nurses have started with the Trust, 4 are currently going through the visa process and 61 still engaged in the recruitment process. From the nursing associate role is adverted in January, 4 offers are being progressed by recruitment with 1 starting in April.						
Very High	2827	Medical	Emergency Care	Accident & Emergency CRH/HRI	Apr-2011	Active	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.	20 4 x 5	20 5 x 4	12 4 x 3	1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	**April 2019** In light of increased trainee numbers, a full review of junior and Middle Grade doctor rotas is being undertaken to ensure best use of available resources and ensure minimal utilisation of locum staff while maintaining as safe and effective a service as possible.	May-2019	Aug-2019		WEB	David Birkenhead	Dr Mark Davies

								2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risk 6131should be read in conjunction with this risk.	programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM								
Very High	7078	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Oct-2017	Active	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient	Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Lack of: - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	• Monitored by Medical Workforce Group • Active recruitment including international	**April 2019** Over 60 nominations have been made for the Doctors in Training Awards. Judging is underway and the awards ceremony has been booked to be held at Cedar Court Hotel on the 9 May 2019. Consultant Job Plans are now all held centrally in the Allocate system along with over 70% of Job Plans for SAS Doctors. A consistency panel, led by the Deputy Medical Director will be created to commence looking at areas of discrepancy within the Trust. Having the information available on the Allocate system will enable reporting which has been problematic and resource intensive previously. A number of Consultant appointments have been made recently. Substantive appointments have been made in Ophthalmology, Anaesthesia and Radiology. Fixed Term Locum Consultants on NHS Contracts have also been made in	May-2019	Sept-2019		WF	David Birkenhead	Pauline North

								Record) "							Haematology, Histopathology and Breast Radiology. There have also been a number of Trust doctors appointed in Medicine at ST3 Level who will support the General Medicine rotas and reduce the requirement for agency locums. There were a small number of new doctors in training that commenced in post at the beginning of April without any delays. It is anticipated that the names of the new trainees for August 2019 will start to arrive in May. There will be over 200 new doctors in training that are allocated to CHFT by Health Education England, and will require full employment clearances and work schedules at least 8 weeks prior to commencing in post.						
Very High	5806	Calderdale and Huddersfield Solutions	Estates	Estates Department	May-2015	Active	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm	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	Significant gap in maintenance funding to maintain regulatory requirements at the HIR site. Also the time it takes to deliver some of the repairs required. 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.	16 4 x 4	20 5 x 4	12 3 x 4	Results of 6 facet survey to be reviewed once final report received.	**April 2019** Asbestos removal in Block 3 plant room now complete. 6 facet condition survey now complete and figures being sense checked. Emergency cladding repairs continuing, badly corroded mulling found during repair further investigation been carried out.	May-2019	Mar-2020		RC	Gary Boothby	Paul Gilling / Chris Davies

							from structural failure. The main risks identified within the Estates Risk Register being: • 7220 Flooring: cracked, torn, blown flooring screed and vinyl resulting in possible slips, trips, falls • 6734 Pipework: Potential of water borne diseases due to the corrosion of services pipe work • 6735 Structural: if more openings are made through the structure it will make the building unstable. • 6736 Air Handling Units: non-compliance, & increased infection risk to both patients and staff • 6737 Windows: all elevations of the Hospital require replacing, prone to leeks and very drafty • 6739 Roofs: water ingress through roofs resulting in decanting services, wards and departments. • 6761 Ward Upgrade Programmes: Compliance with regulatory standards - Health & Social Care Act • 6762 Day Surgery: Non-compliance with relevant HTM standards • 6763 Environmental Condition: failure to bring areas of the Hospital to a condition B level • 6766 Road Surfaces: South Drive and Tennis Court car park in need of repairs potential for injury to public • 6767 Staff Residences: Properties not statutory compliant for accommodation in regard to fire and utilities.	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.														

								• 6769 Electrics: Statutory compliance to reduce the risk of electric shock and damage to equipment • 6770 Plantroom: Statutory and physical condition of the plant room to H & S regulations • 6332 Asbestos: risk of industrial disease to staff, patients and general public • 6771 Emergency Lighting: Statutory compliance in order to provide adequate emergency lighting • 5963 Equality Act: non-compliance with the Equality Act 2010 due to a inadequate physical access • 6764 Fire Detection: aged fire detection could lead to inadequate fire detection. • 6860 Electrical 3rd substation HV supply only 1 meter apart • 5511 Fire Compartmentation: inadequate fire compartmentation in ceilings; risers and ducts. • 6897 BMS heating controls failure will result no control over heating or air condition throughout the hospital • 6997 Structural Cladding - Loose Portland Stone creating a hazard • 5630 Poor condition of the WCs in HRI's public areas • 6848 Water Safety: non-compliance to statutory law across HRI due to the ageing infrastructure														
High	7345	Communit	y Nursing Communit	Nursing /	Oct-2018	Active	Transform	Patient Safety Risk - There is a risk of patients with a nursing need not being referred on	Wards have been advised to contact the DN teams via telephone to make referrals on discharge. Community	System requires testing.	16 4 x 4	16 4 x 4	2 1 x 2	Directory of Community services circulated to wards and departments Ward staff encouraged	April 2019 Update from Digital Board. E Referral is now with the	May-2019	Jun-2019		PSC	Liz Morley	Caroline

								discharge to the District Nursing service. Due to lack of referral facility on EPR and the discontinuation of the PASWEB referral pathway prior to the implementation of EPR. Resulting in patients not receiving district nursing care deteriorating at home and being re admitted to hospital.	Division to work with the other division to test out if this process is being followed and understood. Community Division are reporting incidents of non referral on to Datix to enable monitoring					to refer to District nurse via telephone E referral option being scoped Wards and discharge coordinators encouraged to invite District nurse to MDT	IT build team. Proposed go live date is end of June/July 2019						
High	7132	Medical	Emergency Care	Accident & Emergency CRH/HRI	Nov-2017	Active	Keeping the base safe	The Trust EPR system whilst having the facility to record NEWS and PAWS assessments, it does not have the facility to calculate the score unless all fields are filled. This is not always clinically appropriate. There is a risk to patient safety due to EPR system not automatically calculating and recording the score. This provides the potential for non recording, miscalculation and non detection of deterioration of patients. A number of clinical incidents have identified failure to detect deterioration as a contributing factor	All staff informed to document PAWS and NEWS as a clinical note with PAWS and NEWS in the title and laminated charts put up in the cubicles in the department. All staff have been made aware of the change. SOP and training has been provided. Above audited as part of monthly documentation audit.	Clinical staff not routinely looking at PAWS and NEWS and relying on individual judgement of vital signs recorded.	16 4 x 4	16 4 x 4	2 1 x 2	Regular documentation spot checks by lead nurses. Medical staff to evidence use of early warning scores in their clinical decision making. Issue escalated to A Morris and J Murphy to establish if PAWS and NEWS can be on the front page of the ED clinical summary.	**April 2019** Continue to monitor incidents and documentation audits. If no issues from April audits then risk can be downgraded or closed.	May-2019	Jul-2019		PSQB	David Birkenhead	Louise Croxall
High	7223	Corporate	THIS	THIS -Operational	Mar-2018	Active	Keeping the base safe	Risk of inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to failure of CHFTs digital infrastructure, failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit	16 4 x 4	16 4 x 4	8 4 x 2	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018	**April 19** Awaiting Divisional/Trust testing of BCPs. Conversations underway with OPs colleagues.	May-2019	Oct-2019		RC	Mandy Griffin	Rob Birkett

								through whatever cause (Cyber, Configuration, Component failure). Resulting in the inability to effectively treat patients and deliver compassionate care, not achieving regulatory targets, loss of income	- Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data and Cyber Security					- IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete).							
High	7248	Corporate	Workforce & Organisational Development	Workforce Development	Apr-2018	Active	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated essential safety training within the rolling 12 month period. A proposal to reduce the compliance target to 90% has been put to Board, to be more in-line with WYAAT Trusts. The proposal has been agreed for 2019/2020. Impact: - Colleagues	All electronic e-learning training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and	None	16 x 4 = 4	16 x 4 = 4	4 x 1 = 4	Targeted emails to departments with an average compliance below 85% Weekly drop in sessions at CRH and HRI for staff to access ESR support. Additional training dates have been added for safeguarding and MCA/DoLS level 3. There are sufficient places to train ALL staff	**April 2019** The target for EST has been amended for 2019/20 - A stretch target of 95%, 90% green, 85 - 90% amber and <85% red. All 9/9 EST subjects for all are above 90%. A meeting with the SME for Blood Collection has taken place to look at the target audience and review the learning. A meeting is	May-2019	Mar-2020		WF	Suzanne Dunkley	Claire Wilson

								practice without a basic, or higher depending on role/service, understanding of our essential safety training subjects. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised. UPDATE: Training now falls under the title 'Essential Safety Training' and includes our 9 essential safety training subjects alongside the 29 role specific essential skills training. This approach strengthens the importance of completing the essential skills designated to specific roles and by combining the two areas into one enhances the Trust's requirement to reach 95% across all the competency offerings. Risk:- There have been issues with ESR and the consequences of not being able to undertake e-learning. ESR was down for 15 days from 31 December 2018 - 14 January 2019. Impact:- Employees have been unable to access ESR to undertake e-learning and in turn affects our ability to reach and maintain 95% compliance.	compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.						who are currently non-compliant. Plans are in place to ensure that the right staff are booked on and that the courses are full. Role Specific EST - SMEs of subjects with compliance below 90% will be contacted w/c 28.01.19 and asked to submit a plan of action for Q4 2018/19 and Q1 2019/20 to improve compliance. Registers will be marked 'live ' in ESR at the point of training which will show compliance in a much more timely manner.	planned with the SME for Resuscitation to do the same.						
High	3793	Surgery &	Head and Neck	Ophthalmology	May-2017	Active	Keeping the base	Risk of delays for patients on the pending list requiring follow up appointments due to clinic capacity and consultant vacancies. This may result in clinical delays, possible	- Substantive consultants (Con A, Con B, Con C, Con D...) and a bank consultant (NA) are undertaking WLIs and Validations - Have 2 long term locum Consultants (Con E & Con F) in place (as of Nov 2018)	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum staff (potential loss of capacity with 2 weeks notice) - Need to optimise clinic templates to help prioritise patients based on their clinical needs and therefore reduce	6 3 x 2	16 4 x 4	3 1 x 3	- Corneal consultant advert out (shortlisting complete, interview date set April 2019) - Glaucoma consultant advert due out (job description being re-written as of Nov 2018,	**April 2019** - Corneal Consultant appointed - prioritisation of holding list patients over New referrals - triaging of all referrals to	May-2019	Jun-2019		DB	Will Ainslie	Pnt Laloe

								deterioration of patient's condition, reputational damage and poor patient experience.	- Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in Ophthalmology (happened in summer 2018)	risk				VCF already approved by execs) - Release medical ophthalmic staff from MR/RVO intravitreal injection clinics by training non-medical injectors e.g. nurses and orthoptists (Mar 2019)	minimise incorrect opd appts						
High	6829	Family & Specialist Services	Pharmacy	Pharmacy	Aug-2016	Active	Keeping the base safe	The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispensing Service to provide the required number of aseptically prepared parenteral medicines. This is due to the CRH unit being temporarily closed for a refit and the HRI ADU having quality issues as highlighted in the May 2018 EL (97) 52 external audit which reported 4 major deficiencies limiting its capacity to make parenteral products, resulting in the unavailability of chemotherapy / parenteral treatments in a timely manner (i.e. delays in treatment for patients), increase in cost of buying in ready to use products and increase in staff time	A business case has been approved 2017/18 to provide update facilities on the CRH site. It is planned that the new unit will open ~ Feb 2020 and the HRI unit will close. An action plan has been produced (and agreed by the auditor) to remedy the major deficiencies at HRI unit which includes a capacity plan to limit products made on site. The action plan is monitored by the Pharmacy Board at monthly team meetings and FSS Divisional Board and PSQB with monitoring of non-compliance. Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products.	Until the strategies outlined above to improve capacity have been implemented we will not know that this workload is safe to deliver. other options to consider will be working hours of the unit - currently operational Mon-Fri 8.30-5pm and Sat am 8.30-12 Require ward staff engagement regarding potential impact on staff from making products on wards	15 3 x 5	16 4 x 4	3 3 x 1	Action Plan October 18 in place - key points relate to process measures in department (being addressed) and the need to progress consolidation of the units leading to closure of the HRI unit.	**April 2019** HRI EL audit plan produced and submitted to auditor for review. Capacity tool now in use to review products made at HRI and monitor capacity. Capacity report submitted monthly for review at Pharmacy Board. Syringe drivers no longer made by unit. TPN outsourcing- Go See to Chesterfield March 26th. FS liaising with dieticians and nursing staff and must ensure any increase in nursing time is clearly highlighted (require understanding if extra lines required for additional electrolyte administration) Ready to use chemo- procurement plan agreed - to introduce more ready to use batch chemo over next 3 months .	May-2019	Feb-2020		DB	Jackie Murphy	Elisabeth Street

								(and error risk) from nursing staff preparing parenteral products including syringe drivers on the wards.	HRI ADU currently being re-audited every 6 months - re audit Jan 19 In order to provide assurance regarding capacity during the interim period there are a number of strategies to be developed before July 2019, including: buying in ready to administer injectable medicines (mainly chemo), reviewing products which are prepared in the units on both sites to reduce activity (to include: syringe drivers, adult parenteral nutrition, product catalogue, and from Feb 2020 -outsourcing radiopharmacy)										Carol Gregson/Graham Walsh
High	6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Active	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation This can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group.- lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment	20 4 x 5	15 3 x 5	6 3 x 2	Establish clinical documentation group	**April 2019** Work ongoing to in relation to Clinical Record Group with two main areas of interest - Digital Champions and devising an audit tool. Direct link now with a new project - Voice Recognition which requires streamlined EPR clinical documentation.	May-2019	Jul-2019		WEB	Jackie Murphy	Carol Gregson/Graham Walsh
High	7315	Family & Specialist Services	Appointment and Records	Appointments Service	Aug-2018	Active	Keeping the base safe	Risk of delay to patient care, diagnosis and treatment caused insufficient outpatient appointment capacity to meet current demands resulting in poor patient experience, damage to organizational reputation and increased concerns/complaints and	Monitoring of appointment backlog at Performance Meetings Validation of Holding List (follow up backlog) and Appointment Slot Issues List (new patient backlog) Clinical Assessment of follow up backlog (where exceeded 10 weeks beyond appointment due	Insufficient appointments to meet current demands at specialty level. Consultant vacancy factor Non compliance of Clinical Assessment process Loss of functionality (EPR) for GPs to refer to named clinician and patients to use self check in on arrival at appointment.	15 3 x 5	15 3 x 5	6 2 x 3	Monitoring of appointment backlog at Performance Meetings Validation of Holding List and Appointment Slot Issues List SOPs and Data Collection Workbooks for management of backlogs Review of templates at	**April 2019** New patient ASI has reduced slightly but still significantly higher than previous years. All specialties have been instructed to clear all patients >3m by the end of April.	May-2019	Jun-2019		PSQB	Gill Harries	Katharine Fletcher

								possible claims. Currently there are in excess of 11,000 patients awaiting appointments. circa 3500 new referrals awaiting appointments (large proportion seen within maximum waiting time for specialty) and and 8,000 follow up patients that have all exceeded the appointment due date. Please refer to following individual risks: 4050 6078 6079 7199 7202	date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT..					consultant/specialty level	Follow Ups - Backlog reduced significantly. Partial booking invite letter has been switched off enabling the appointments team to book in chronological order. >12 weeks past see by date is down to 653 with total number exceeded appointment date down to 5336						
High	7338	Corporate	Corporate Nursing	Workforce and Clinical Development	Oct-2018	Active	Keeping the base safe	The risk of an incomplete Electronic Patient Record due to clinicians failing to commit a clinical entry to the electronic system in a timely manner. This is due to the fact there is an ability to 'save' an entry on to the system which is not submitted to the patient record until the 'signed' option is selected. The system at no point advises the clinician that their entry is still in a 'saved' state. The result of this is that the 'saved' entry is only viewable to the clinician who has entered the data, rendering the record incomplete. There are currently 65,000 entries on the system that have not been signed potentially since the start of EPR which equates to 0.5% of records.	Training of all staff prior to implementation and EPR training as part of induction. Standard Operating Procedure available on the Trust Intranet for staff to access. Clinicians with 10 or more 'saved' entries have been directly targeted via email highlighting the number of unsigned entries with appropriate instruction as to how to address. EPR banner viewable to clinicians launching the EPR system with appropriate advice on 'saved' and 'signed' entries. Ward Managers Forum informed - issue on their action log. Nursing and Midwifery Committee informed, appropriate teaching given and user guide supplied. Escalated to Data Quality Team Escalated to EPR Operation Group	This risk highlights that all staff do not understand the difference between a 'signed' and a 'saved' entry. That staff do not use Message Centre regularly to review any 'saved' entries. There are reports that clinicians use the 'save' functionality without due diligence. Potential training re-evaluation required. Greater emphasis required to routinely report, monitor and cascade the status of these records. Not clear in the system as to the difference between 'save' and 'sign'. No automatic prompt advising that the entry only viewable to the author.	15 3 x 5	15 3 x 5	8 2 x 4	1. Inform Divisional Leads as to current status. 2. Form a Task and Finish Group to evaluate available options to resolve this issue in the short and long term. 3. Monitor and report back none compliance until situation improves - to be determined as part of the Task and Finish Group. 4. Propose potential changes to the EPR system such as automate signing an entry after a designated time having a prompt to 'sign' an entry remove 'save' option 5. Review training for all cohorts.	**April 2019** 1. Awaiting computer tags - order has been placed. 2. Figures remain at 39,000. 3. Work ongoing to commit historical entries to the system.	May-2019	Jun-2019		NA	Jackie Murphy	Carol Gregson/Graham Walsh

High	5747	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Mar-2013	Active	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant posts at consultant interventional radiologist level resulting in an inability to deliver hot week interventinonalist cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	- 1wte substantive consultant in post - Ad-hoc locums supporting the service - Continue to try to recruit to vacant posts	- Failure to secure long term locum support. - Lack of clarity on regional commissioning arrangements relating to vascular services	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post; 2. Progressing a regional approach to attract candidates to work regionally; 3. Progressing approach to contingency arrangements as a regional-wide response	**April 2019** -substantive consultant in post -ad-hoc locums supporting the service as no cover agreed with Leeds or Bradford - NHS locum for 12 months due to start in June 2019 - regional reconfiguration project will establish longer term solution although no definite timescales to date	May-2019	Jun-2019		DB	Gill Harries	Sarah Clenton
High	7253	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Apr-2018	Active	Keeping the base safe	Quality and Safety and Service Delivery Risk - (re-worded to fully reflect risk) There is a risk that due to 5 WTE gaps in the 11 person Tier 2 medical staffing rota, that over the next 6 months delivery of safe care for the Paediatric and Neonatal unit may be compromised. This shortfall is likely to result in inadequate service provision for local children, young people and their families, reliance on bank and agency staff and individual's resilience both at tier 2 and Consultant level. This shortfall will impact on the Consultant workforce who may be required to cover service critical tier 2 gaps which will in turn impact on OPD activity, financial stability and individual's resilience.	Escalate and update Divisional Board and PSQB Re-worded and increased risk score Feb 2019 Actively manage roster Discussed at weekly Divisional workforce meeting out to advert for trust grade doctors Utilise ANNP workforce Out to advert for bank posts Manage sickness and maternity leave as per policy and guidance	Insufficient workforce to cover gaps	9 3 x 3	15 3 x 5	4 2 x 2	Recruitment of Trust grade doctor secure bank doctors utilise speciality doctor review rota - *removing the twilight shift from the rota following consultation with the trainees	**April 2019** I doctor to start in April 2019 continue to work with the consultant body for ongoing solutions	May-2019	Oct-2019		PSQB	Gill Harries	Gill harries /Eilean Crosbie

High	7396	Trustwide	All Divisions	All Departments/Wards	Jan-2019	Active	Keeping the base safe	For patients prescribed oxygen, there is a risk of staff connecting the tubing to an air flowmeter which has been inserted into the air outlet in the wall rather than the oxygen flowmeter in the oxygen outlet. This is because the outlets are adjacent throughout CRH, and the tubing fits both flowmeters. The impact results in reduced oxygen saturations for a patient which could potentially lead to a deterioration in clinical condition and potential harm. There is also a reputational impact as connecting oxygen tubing to the air is a Never Event and reportable as a serious incident.	All terminal air ports to be capped off Trust purchased 100 electric nebulisers Training in relevant areas in the use of the use of the new devices Daily spot checks until all terminal air ports are permanently capped off Check of air outlets added to the must do checklist for ward staff. Medical Gas Pipeline Policy Medicine Code (section on Medical Gases) HTM Medical Gas Technical Memorandum on national standards NIV and Oxygen Group leading on Medical Gases Outlets are marked oxygen and air - and colour coded. Flowmeters state 'oxygen' or 'air', are different colours and only fit the relevant outlet (eg. air to air) Flaps were attached to air flowmeters Staff training Removal of air flowmeters is part of the Environmental Check linked to the Ward Assurance Tool Quality Walkrounds have been periodically checking on the removal of air flowmeters	• The flaps on the air flowmeters can be easily knocked off - no alternate device with a more secure flap is available • Medical Device - Oxygen / Air training has been revised (Sept 2018) to cover the alert, but numbers trained so far on the new training is small. • Staff may leave flowmeters in the air outlet after giving nebulisers. • The Trust is not currently compliant with HTM Medical Gas Technical Memorandum on staff training • Lack of clinical staff awareness about the Never Event and risks of connecting patients to air. • The failure of the air flowmeters on the Environmental check does not flag up on the front of the Ward Assurance Tool • Patients often remove nebulisers, leaving flowmeters in place • NIV and Oxygen Group - previously separate now being combined for oversight with meeting for the first time in February 2019	15 3 x 5	15 3 x 5	3 3 x 1	Actions below for NIV / Oxygen Group: 1. Action plan for assurance on compliance with the training as per the HTM Medical Gas Technical Memorandum to be developed at the NIV and Oxygen Group 2. Review of the assurance provided via the Ward Assurance Tool at the NIV and Oxygen Group 3. Monitoring of attendance at the NIV and Oxygen Group to ensure appropriate attendance. Assess if a new risk needs to be identified re: prescription and administration of oxygen FSS division to be asked to consider an addition to their risk register relating to Paediatrics having semi-permanent caps.	**April 2019** Assurance air flowmeters were being removed completely from clinical areas other than the one required for paeds transfer Clinical areas have been invited to return their stock of air flowmeters to medical engineering All areas are permanently capped now other than paeds and some areas that require air for treatments- those areas have semi- permanent caps and additional barrier of a stop sign Removable plugs being fitted to wall air outlets in all ward based areas Risk assessment in Paediatrics has led to semi-permanent caps being added due to the requirement for Vapotherm. We have stopped the ordering process for air flow meters . Delivered Medical Device Air / Oxygen training to all registered nursing staff via cascade training. Assurance from the Medical Device Training Database, monitored by the Medication Safety and Compliance Group. Achieved training trajectory An audit was undertaken which showed full compliance ISR review has been completed	May-2019	May-2019		QC	Jackie Murphy	Nick Scriven

														compliance with prescribing of oxygen via administration						
High	7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	HRI There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher	Number of Areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 x 3	15 x 3	1 x 1	Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard.	**April 2019** paper presented to Board via CHS MD (L Hill). Funding approved for additional sockets on wards for computers on wheels, new design of toasters approved and discussions taking place to agree staff who will take on the role of Fire Wardens. This is still to be agreed.	May-2019	Dec-2019		FC	Gary bBothby	Alison Wilson
High	7414	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 x 3	15 x 3	1 x 1	Feb 2019 - Structural Engineers requested to provide costings based on high risk, medium risk and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. Costs	**April 2019** Remedial works taken place on very high risk areas. Feasibility study being carried out on remaining panels (1515) on all elevations to agree a way forward. Option appraisal expected with	May-2019	Dec-2019		FC	Gary Boothby	Alison Wilson

								significant incident and harm to patients, visitors and staff.	Structural Engineers to repair the areas observed along the west side elevation of the building and carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis.					expected March 2019. Progress managed at monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 are escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan	CHS by end April 19/beginning May 19 which will be presented to CHFT.						

12. Director of Infection Prevention Control Quarterly Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2nd May 2019
Meeting:	Board of Directors
Title:	Director of Infection Prevention Control Quarterly Report
Author:	Shelley Adrian, PA to Medical Director
Previous Forums:	None.

Action requested:

To approve

Purpose of the report

To provide the Board of Directors with the Trusts Q4 position on healthcare associated infections.

Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)

- C.difficile objectives met
- 2 MRSA bacteraemia during 2018/19
- Flu CQUIN achieved.

EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)

-

Recommendation

The Board is asked to receive and approve the Q4 position of healthcare associated infections.

Calderdale and Huddersfield NHS Foundation Trust

Report from the Director of Infection Prevention and Control Q4 to the Board of Directors
1st December 2018 to 31st March 2019

1. Introduction

This report covers the period from 1st December 2018 – 31st March 2019 (Q4) and aims to provide assurance of effective infection prevention. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated
Infections (HCAI). Assurance against key performance and quality indicators is provided in the report.

2. Performance targets

Indicator	End of year ceiling 18/19	Year-end performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**2**	2 post case
C.difficile (trust assigned)	20	**18**	13 Non-Preventable 5 Preventable
MSSA bacteraemia (post admission)	9 (Internal)	**16**	14 cases within the medical division 2 cases within the surgical division
E. coli bacteraemia (post admission)	39	**52**	41 cases within the medical division 11 cases within the surgical division
MRSA screening (electives)	95%	96.57%	
Central line associated blood stream infections (Rate per 1000 cvc days)	1	0.44	Rolling 12 months
ANTT Competency assessments (doctors)	90%	84.7%	Divisions have been tasked with improving compliance by the end of 2018/19.
ANTT Competency assessments (nursing and AHP)	90%	95.83%	
Hand hygiene	95%	99.2%	

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	93.8%	Divisions are working to improve this.
Isolation breaches	**Non-set**	398	An Increase from 354 compared to 2017/18.
Cleanliness	Non-set	97%	

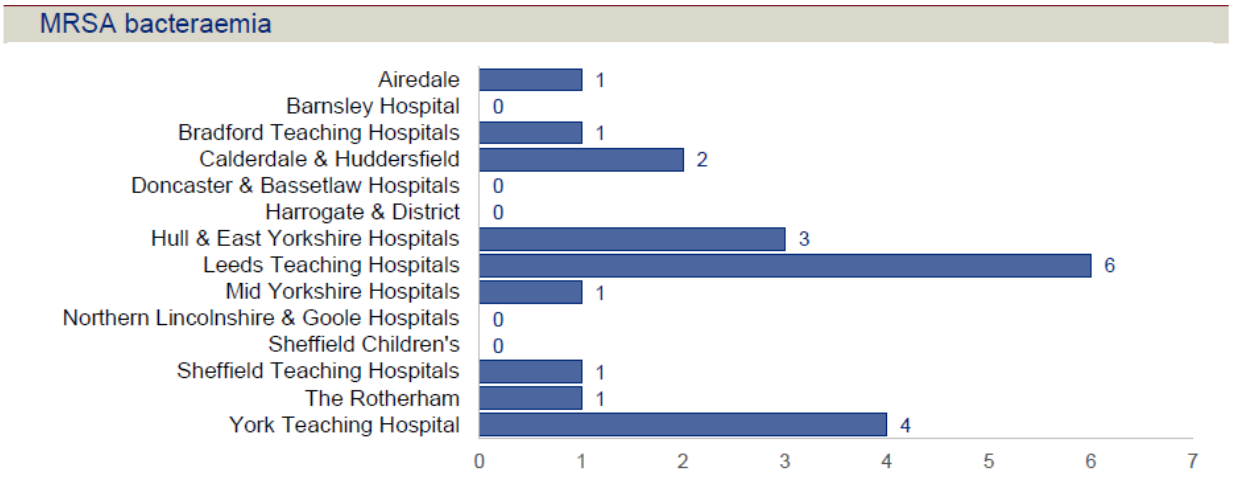
4. MRSA bacteraemia:

There have been 2 MRSA cases attributed to the organisation: -

- A patient on ward 8 who had previously had 2 pre-MRSA bacteraemia since the 1st April. Repeat blood cultures where taken on numerous times during this hospital admission, it is classified as an ongoing infection but will appear on CHFT figures.

- A patient who was admitted onto ward 17 via MAU, had been discharged less than 48 hours before this admission with MRSA suppression treatment, this was not complete. There was a delay in finding out if the treatment had been completed. The patient was having leg ulcers dressed regularly by District Nurses from Locala and performed intermittent self-catheterisation.

The chart below compares total numbers of attributed MRSA bloodstream infections to each organisation in Yorkshire & The Humber.



5. MSSA bacteraemia:

There have been 16 post-admission MSSA bacteraemia cases at the end of March 2019, against the internal objective of 9. A review of cases has been presented at the Infection Prevention and Performance Board. There are no common themes, ongoing cases will be reviewed on a monthly basis.

6. Clostridium difficile:

The ceiling for 2018/19 is for no more than 20 post-admission cases. At the end of March there have been 18 which is a great achievement and over a 50% reduction on cases from 2017/18 when we had 40 cases.

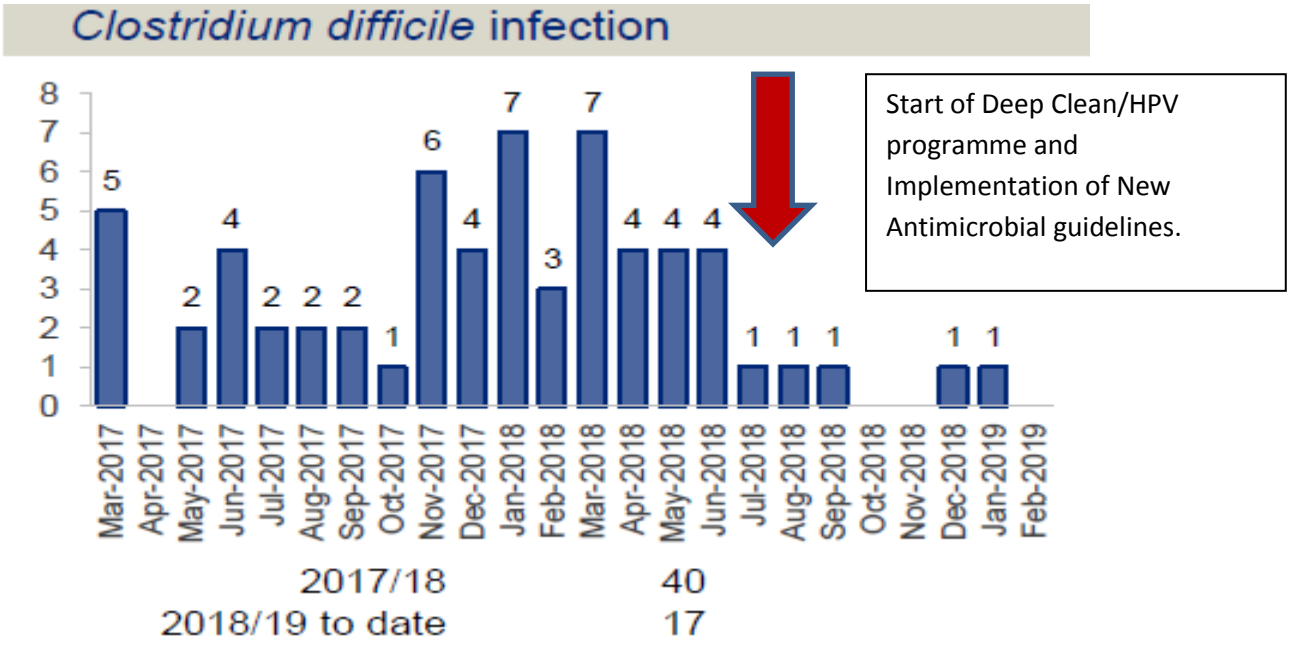
Two key initiatives contributed to this reduction: -

- Antimicrobial guidelines for over 65yrs has been updated to improve prescribing.
- Deep clean and HPV of high risk wards. This has been approved again for the forthcoming year and a plan is currently being developed to support its implementation.

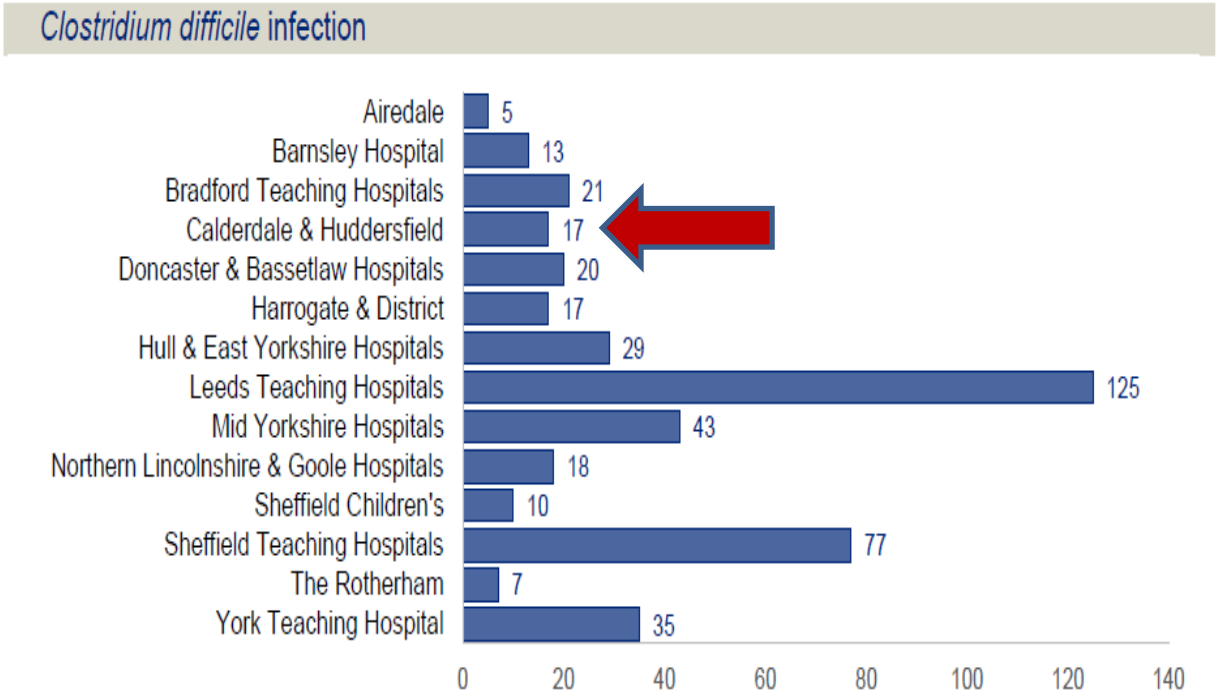
New criteria for C-difficile cases commenced on the 1st April 2019 as follows: -

a) Healthcare onset healthcare associated: cases detected in the hospital ≥2 days after admission,
b) Community onset healthcare associated: cases that occur in the community (or ≥2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks,

The chart below shows CHFT cases 2017/18 and 2018 - Feb 2019



The chart below compares total numbers of attributed C. difficile infections to each organisation in Yorkshire & The Humber March 2018-Feb 2019.



7. **E. coli bacteraemia:**

There have been 52 post-admission E-coli bacteraemia cases against the internal objective of 43. New guidance is due to be published within the next couple of months to aid organisations on how to achieve reductions and delivering a 25% reduction by 2021-22 with a full 50% by 2023/24, these aspirations are for the CCG's.

8. **Outbreaks & Incidents:** Only one ward has been affected with Norovirus during the last quarter that required outbreak management.

WARDS CLOSED & BED DAYS LOST FIGURES 2018/19					
MONTH	**HOSPITAL SITE**	**WARD**	**DAYS CLOSED**	**BAY/S CLOSED**	**BED DAYS LOST**
January 19	HRI	20A	12	0	15

9. **Influenza:**

The Flu campaign commenced on the 3rd October with over 1000 staff having the vaccine in the first week. Over 76% of frontline staff have been vaccinated, frontline vaccinators were vital in achieving this and supported the ongoing Flu campaign programme and we acknowledge the contribution of colleagues in this achievement.

10. Central Vascular Access Device related bacteraemia

The internally set target for CVAD related bacteraemia is 1 per 1000 CVAD line days, the current rate is 0.44%

11. Isolation Breaches

There have been 398 isolation breaches since 1st April 2018 compared to 354 breaches for the previous year. The majority of breaches are patients with a previous history of MRSA or ESBL at the time of admission to MAU, or patients being transferred, and their infection status not being handed over, although this information is all clearly visible within the EPR.

The IPCT will continue to monitor isolation breaches and manage the risk on an individual basis; actions to reduce breaches have been included in the HCAI annual action plan, this includes ongoing work with the medical division where the majority of breaches occur. This is recorded on the Risk Register as 7237.

12. Quality Improvement Audits:

65 Quality improvement environmental audits have been carried out since the beginning 1st April 2018 to 31st March 2019.

Compliance scores: <75% = red rating; 76% - 90% = amber rating; 91%+ = green rating.

- 33 of the areas achieved a green rating.
- 30 of the areas achieved an amber rating; actions plans are produced by the ward/department following the audit in order to address any issues or concerns identified.
- 2 areas were deemed as a Red rating;
  One in September which was re-audited in November with improvements being made and achieved an amber scoring.
  One in January which is a Leeds service hosted by CHFT: the IPCT in Leeds have been contacted re concerns and they are following this up.
  Actions plans are produced and completed and will be re-audited within the next month, general themes included;
  1. Clutter
  2. Dirty equipment
  3. Cleaning issues

13. ANTT: -

As of the 1st September 2019, all staff who undertakes ANTT will require re-assessment every three years. This will have an initial impact on the ANTT performance matrix as staff ESR records will automatically lapse to RED if their previous assessment was more than 3 years ago (before 1st September 2016). To counteract this all staff that have not been assessed during the last 3 years are advised to undertake an ANTT re-assessment as soon as possible.

14. IPC Team:

Portfolio's within the Trust team have been reviewed;

Dr Anu Rajgopal is now the Infection Control Doctor and Dr Nicola Hardman is the Antimicrobial Lead.

The Trust is currently recruiting into an antimicrobial pharmacy post.

The team wish to acknowledge the leadership provided by Dr Gavin Boyd in the role of the ICD for the Trust over the last 5 years.

The IPC Team continue to work both proactively and reactively.

13. Medical Revalidation and Appraisal Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2 May 2019
Meeting:	Board of Directors
Title:	Revalidation and Appraisal of Non Training Grade Medical Staff
Author:	Sue Burton, Medical Education Manager
Previous Forums:	N/A

Action requested:

To approve

Purpose of the report

The paper updates the Board on the position regarding revalidation and appraisal of non-training grade medical staff as at the end of the revalidation and appraisal year (31st March 2019).

Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)

Summary of key points:

- As at 31st March 2019, 373 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 338 on 31st March 2018)

- In the 2018/19 revalidation year (1st April 2018 – 31st March 2019) 86 non-training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC), as compared to 49 non-training grade medical staff in 2017/2018.

- Based on headcount, 93.0% of non-training grade appraisals were completed and submitted in the appraisal year (94.7% 2017/2018). It is important to note that 6.9% of non-training grade medical staff were not required to complete an appraisal for a verified reason (due to recently joining the Trust, long term ill health, maternity leave, recent return from secondment etc). This compares to 5.2% in 2017/2018. The completion rate for all appraisals required to be completed was 99.7%.

EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)

Complete and no issues.

Recommendation

The Board of Directors is asked to approve the report.

BOARD OF DIRECTORS - THURSDAY 2nd MAY 2019

REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF

1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation. The report will also cover the 2018/19 appraisal and revalidation year (1st April 2018 – 31st March 2019).

Summary of key points:

- As at 31st March 2019, 373 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 338 on 31st March 2018)
- In the 2018/19 revalidation year (1st April 2018 – 31st March 2019) 86 non-training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC), as compared to 49 non-training grade medical staff in 2017/2018.
- Based on headcount, 93.0% of non-training grade appraisals were completed and submitted in the appraisal year (94.7% 2017/2018). It is important to note that 6.9% of non-training grade medical staff were not required to complete an appraisal for a verified reason (due to recently joining the Trust, long term ill health, maternity leave, recent return from secondment etc). This compares to 5.2% in 2017/2018. **The completion rate for all appraisals required to be completed was 99.7%.**

2. Background

2.1 Medical revalidation was launched in December 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of care provided to patients. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

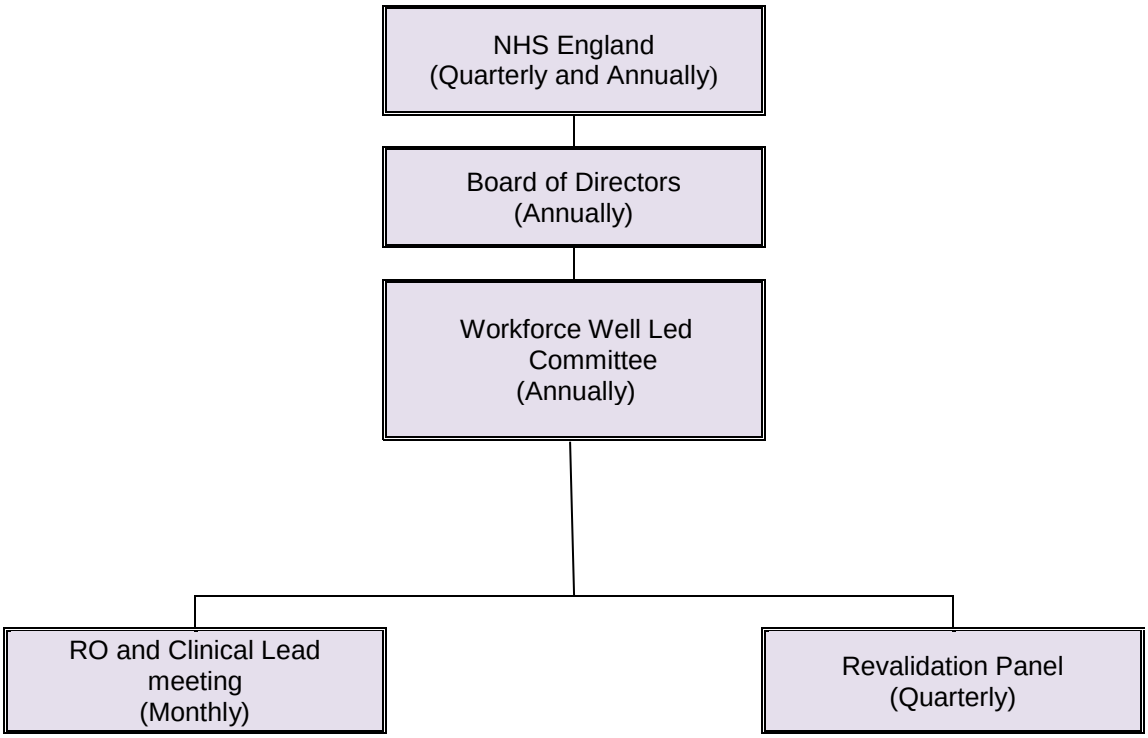
2.2 The Trust has a statutory duty to support the Responsible Officer (Executive Medical Director) in discharging their duties under Responsible Officer Regulations and is expected that the board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems on place for monitoring the performance and conduct of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process;
- ensure that appropriate pre-employment checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

3. Governance Arrangements

3.1 The Trust's governance reporting structure for medical appraisal and revalidation is shown below:



3.2 **GMC Connect**

GMC Connect is the General Medical Councils database used by Designated Bodies (ie Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

GMC is managed by the Revalidation Office on behalf of the Responsible Officer. The Trust's Electronic Staff Record (ESR) is used as the main source in relation to starters and leavers.

4. Medical Appraisal and Revalidation Performance Data

Revalidation Cycles

4.1 The first revalidation cycle started in January 2013. The majority of doctors (with the exception of new starters and those whose revalidation has been put on hold by the GMC) completed their first revalidation cycle by 31st March 2018 and will have had a recommendation made about their fitness to practise by a Responsible Officer (for this Trust this is the Medical Director).

4.2 In the 2018/2019 revalidation year (Year 6) the Responsible Officer has made recommendations for doctors as follows: (see also Appendix A **-** Audit of Revalidation Recommendations)

Revalidation Cycle (Year 6)	Positive Recommendations	Recommendation Deferred **
Year 6, Quarter 1 (April 2018 – June 2018)	23	4
Year 6, Quarter 2 (July 2018 – September 2018)	20	1
Year 6, Quarter 3 (October 2018 – December 2018)	14	0
Year 6, Quarter 4 (January 2019 – March 2019)	23	1
Total:	**80**	**6**

** The reasons for the deferrals were insufficient evidence being presented for a revalidation recommendation to be made. This was usually due to the fact the doctors were relatively new to the organisation and did not provide sufficient or relevant evidence from previous employers for a recommendation to be made.

Medical Appraisal

4.3. Medical Appraisal underpins the revalidation process. Doctors are expected to complete five appraisals within the revalidation cycle.

4.4 The appraisal year runs from 1st April – 31st March. The table below shows the compliance rate at the end of the 2018/2019 appraisal year on 31st March 2019 (see also Appendix B – Audit of all missed or incomplete appraisals).

Grade	Number of doctors with prescribed connection to CHFT	Completed Appraisals (by 31/03/19)	Approved incomplete or missed appraisal	Unapproved incomplete or missed appraisal
Consultants (permanent)	248	242	6	0
Staff Grade, Associate Specialist, Specialty Doctor (permanent)	71	70	1	0
Temporary or short term contract holders (all grades)	54	34	19	1
Total	**373**	**346**	**26**	**1**

(Doctors with a GMC prescribed connection to CHFT as at 31st March 2019)

5. Allocation of Appraisers

5.1 The Revalidation Office (part of Medical Education) allocates appraisers to appraisees and also allocates the month the appraisal should take place.

6. Quality Assurance of the Process

6.1 The process used to monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal;
- The appraiser;
- The appraisal discussion

All appraisals submitted as part of the revalidation process are reviewed thoroughly by the Revalidation Panel Quality Assurance Group. This involves a comprehensive review of the appraisal form (appraisal inputs and supporting information). (see Appendix C - Quality assurance audit of appraisal inputs and outputs (1st April 2018 - 31st March 2019)

6.2 The Clinical Appraisal and Revalidation lead also routinely quality assures sample of appraisals submitted (see Appendix C which shows the framework for quality assurance used)

6.3 Access, security and confidentiality

Historical appraisal folders, supporting information and all correspondence relating to the revalidation processes are stored on the Trust network drive. Access to the drive is restricted to the Responsible Officer, the Clinical Lead for Appraisal and Revalidation, the Revalidation Panel clinical members and the Revalidation Office administrative support. All appraisals and supporting information are stored on the PReP system which is ISO27001 accredited, GDPR compliant, 100% IG Toolkit compliant. Access to appraisals is in line with the Appraisal Policy for non-training grade medical staff.

6.5 Clinical Governance

Data is provided annually by the Trust to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to CHFT activity data, benchmarking data and attendance at audit.

7. Update

a) PReP – Appraisal and Revalidation E-Portfolio

The PReP appraisal and revalidation e-portfolio is now used by all non-training grade doctors when completing their appraisals. There have been some updates to the system:

a) The number and frequency of automatic reminders has been increased in order to improve compliance rates for the month the appraisal is due to take place.
b) We are looking to incorporate the Trust Pillars into the appraisal documentation.
c) For the first time appraisers will receive anonymised feedback from the appraisees.

b) Month of Appraisal

In addition to allocating appraisers to appraisees the Revalidation Office also allocate the month the appraisal needs to be completed (with no appraisals being allocated in March). There is still work to do in ensuring that appraisals are completed in the correct month. There is a tendency for there to be a rush in February and March to ensure appraisals are completed by the NHSE deadline of 31st March.

In 2018/2019 14.4% of all appraisals (54 appraisals) were completed in March 2019. This is far from ideal since:

a) It puts unnecessary pressure on appraisers to undertake the appraisal;
b) It leaves little time for appraisal meeting to be reflected upon prior to the appraise and appraiser having to sign off the paperwork;
c) It does not give sufficient time if an appraisal meeting needs to be postponed for any reason

The Revalidation Office is stressing the need to complete appraisals the month they are due with the month the appraisal is due.

8 Action Required of the Board

The Board of Directors is asked to:

(i) approve this report.

Dr David Birkenhead
Medical Director/Responsible Officer
May 2019

Appendix A

Audit of Revalidation Recommendations (1st April 2018 - 31st March 2019)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Revalidation Recommendations made between 1st April 2018 and 31st March 2019

	Number
Recommendations completed on time (within the GMC recommendation window)	86
Late recommendations (completed but after GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	**86**
Primary reason for late/missed recommendations For late or missed recommendations only one primary reason may be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctors revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for responsible officer role	0
Other	0
TOTAL SUM OF LATE AND MISSED RECOMMENDATIONS	**0**

Appendix B

Audit of all missed or incomplete appraisals audit (1st April 2018 - 31st March 2019)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Doctors Factors (Total)	Number
Maternity leave during the majority of the 'appraisal due window'	2
Sickness absence during the majority of the 'appraisal due' window'	4
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 months of appraisal due date	17
New starter more than 3 months from the appraisal due date	0
Postponed due to incomplete portfolio/insufficient reporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	1
Other doctors factors (describe)	0
	26
Appraiser Factors (Total)	
Unplanned absence of appraiser	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational Factors (Total)	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Appendix C

Quality assurance audit of appraisal inputs and outputs (1st April 2018 - 31st March 2019)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Below is a breakdown of the appraisals audited via the Revalidation process. In addition 10% of all appraisals are audited by the Clinical Lead for Appraisal and revalidation.

Total number of appraisals completed		
346	Number of appraisal portfolios sampled	Number of the sampled appraisal portfolios deemed acceptable against standards
Appraisal Inputs	**Number audited**	**Number acceptable**
Scope of work: Has a full scope of practice been described?	86	86
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	86	82
Quality Improvement Activity: Is quality improvement activity compliant with GMC requirements?	86	84
Patient feedback exercise: Has a patient feedback exercise been completed?	86	85
Colleague feedback exercise: Has a colleague feedback exercise been completed?	86	85
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	86	86
Is there sufficient supporting information from all the doctors roles and places of work?	86	85
Is the portfolio sufficiently complete for the stage of the revalidation cycle	86	80
Appraisal Outputs		
Appraisal Summary	86	86
Appraiser statements	86	86
Personal Development Plan	86	86

14. Learning from Deaths Thematic Review

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2 May 2019
Meeting:	Board of Directors
Title:	Learning from Deaths – Thematic Analysis
Author:	Sal Uka, Associate Medical Director
Previous Forums:	Learning from Deaths Panel, Mortality Surveillance Group
Action requested: To approve	
Purpose of the report	
The paper updates the Board on the position regarding the thematic analysis from Structured Judgement Reviews over a 12 month period.	
Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)	
• Themes include areas of good practice and for improvement • Many themes overlap with existing groups such as End of Life and the Deteriorating Patient Group • Proposed that reporting of improvement to the new Clinical Outcomes Group planned for Q1 2018/19 most likely to be called the Clinical Improvement Group	
EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)	
Completed and there are no issues.	
Recommendation	
The Board is asked to support and approve improvement themes identified from these reviews.	

Thematic analysis of learning from Structure Judgement Reviews

A thematic review of SJRs completed between Aug 17 and July 18 has been completed. Themes of good practice and areas for improvement have been identified as follows:

The top 5 areas of **good** practice identified were:

- Overall good quality of care in approximately 85% of cases reviewed
- Excellent junior doctor initial management
- Good pre and post procedural care
- Excellent Specialist Palliative Care Team in-reach
- Timely and appropriate in-reach into the Emergency Department

The 5 main areas for **improvement** are:

- Communication between healthcare professionals, patients and their families and carers
- Documentation especially of communication, diagnoses (primary and secondary) and cause of death
- Timely senior review
- Timely escalation or decision not to escalate
- Recognition of the dying phase and full implementation of the Individualised Care of the Dying document (ICODD)

Theme	Detail	Opportunity	Core Group
Communication	Comments regarding lack of or poor communication between professionals, patients and the families or carers and/or lack of documentation of what was said	Redelivery of improved communication skills in house training. How we embed enhanced communication skills should fit into EoL Strategy EoL Strategy being refreshed	End of Life Steering Group

Gemma Pickup & Dr Sal Uka, April 2019

Documentation	Quality of documentation is often reported as poor. Actions not always recorded. Important information regarding diagnoses and Cause of Death not easily found	Voice Recognition technology EPR optimisation CoD recording should improve through new ME role	EPR Documentation Group
Senior review	Frequently reported delay in senior review	Implementation of NEWS2 and renewed escalation policy NEWs2 evaluation as Quality Priority	Deterioration Group
Escalation/Non Escalation		Roll out of 'PLAN' which includes decision making about escalation and is part of weekend medical care planning	Drs R Karadi & Sal Uka
Advanced Care Planning	Not being utilised effectively	End of Life Strategy being refreshed	End of Life Steering Group
ICODD	ICODD not being completed	ICODD put on to EPR	End of Life Steering Group

In addition to the above these themes will be shared with the clinical divisions through their Patient Safety & Quality Boards. The Quality Improvement from the Learning from Deaths agenda will need monitoring and it is proposed that this reports to the new 'COG' which will primarily focus on clinical improvement. This new forum is nearly agreed, and the new Clinical Improvement Group will form within Q1 of 2019/20.

15. Fire Safety Annual Report 2018-19

To Approve

Presented by Lesley Hill

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2nd May 2019
Meeting:	Board of Directors
Title:	Annual Fire Report 2019-20
Author:	Carole Gorman, PA to Director of Planning, Performance, Estates & Facilities
Previous Forums:	Health & Safety Committee
Action requested: To approve	
Purpose of the report	
To update the Board on the position regarding fire safety.	
Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)	
EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)	
N/A	
Recommendation	
The Board is asked to receive and note the contents of the annual report and approve the draft work plan for 2019 / 2020.	

Integrated Facilities Management

Working in partnership with Calderdale and Huddersfield NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust

CHFT Annual Fire Safety Report
1st April 2018 – 31st March 2019

1. INTRODUCTION

The Fire Safety annual report has been prepared by Calderdale & Huddersfield Solutions (CHS) on behalf of Calderdale and Huddersfield NHS Foundation Trust (CHFT). CHS was formed in 2018 and is working in partnership with CHFT. The report provides a retrospective review of the past 12 months and an update on the Fire Safety Annual Action Plan. This report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2018/2019 (1st April 2018 to 31st March 2019) in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

The Trust has made progress over the last 12 months in terms of fire safety, however there is further work to complete to ensure full compliance.

2. EXECUTIVE SUMMARY

The RRO provides the legal framework for the implementation of fire safety in organisation's and the HTM provides guidance on how to manage fire safety in healthcare premises detailing the responsibilities placed on the Trust and its employees.

Fire safety advice, support and training is provided by the Fire Officer who resides within the Estates and Facilities Department of CHS. The Trust is provided with independent advice from the formally appointed authorising fire engineer AE(Fire) as required by HTM 05.

The achievements during 18/19 have been done against a background of reduced capital available, and have required prioritisation. Work has been completed on sub-basement areas and penthouses, which were the highest risk areas, and will now continue to ensure 60 minute compartmentation is in place across HRI. This will be followed by a plan to restore 30 minute compartmentation to wards, and other clinical areas. Compartmentation concerns at HRI and in other buildings across the UK have shown how vulnerable buildings are if compartmentation issues are not managed appropriately and, once installed, must be maintained. Compartmentation at Calderdale Royal Hospital does not fall within the poor state some PFI hospital buildings find themselves in as all changes to the building are fire stopped on completion of work. Whenever an area has a change of use, the implications for fire safety should be assessed, and any safety issues addressed prior to the change. This includes the movement of wards, so that different types of patients are treated in different areas, as well as areas that were once clinical being changed to office based accommodation.

The HRI fire detection upgrade programme has resulted in an improved detection system, and this is making good progress. Once the agreed work has been completed during 19/20 this will be fully compliant. Over the last 5 years approximately 1400 additional devices (mainly smoke detectors) have been installed across HRI.

The CRH fire alarm system is being upgraded via the life cycle programme and a floor per year is being achieved. Work commenced at the top of the building and has now reached the lower ground floor.

Fire training this year was face to face training sessions which involved all staff who work within the CHFT estate, be they Trust or others such as ISS and Leeds Teaching Hospitals staff (Renal). This coming year will involve staff reading an updated version of the booklet through their Electronic Staff Record (ESR). There will be other training to support this, such as evacuation training, and face to face training is available for specialist areas such as Theatres and ICU, etc.

Space utilisation continues to be a challenge with the requirements to move departments rapidly resulting in missed opportunities to check adequate fire precautions / compartmentation / fire alarms are in place for the change of use. Often fire risk assessments are not considered before the move has taken place.

The Trust must also ensure departments change their working practices and refrain from placing combustible materials (i.e. beds and chairs) in corridors which is dangerous due to the impact this can have on evacuation and the increase in the fire loading; unfortunately, this continues to be common practice which has increased due to the use of the new mobile work stations (Electronic Patient Record).

Work is underway to increase awareness of fire risks from the charging of personal devices, be that either staff or patients. Another fire risk has been identified with the use of Emollients, creams or gels (Paraffin based creams) for skin conditions. Unless clothing or bedding is wasked at very high temperatures the paraffin residue is not removed. This is not an issue within the hospitals, as linen is washed by specialist contractors at high temperatures, but will be one in the community where washing at lower temperatures will be the norm.

3. REPORT

3.1 Fire Risk Assessments

Fire Risk Assessments are a legal requirement and have been carried out for CHFT premises; a new round of assessments is being carried out. It is important that the review is actioned at Quality and Safety Boards and the responsibility of implementing action plans resides with local areas and it is challenging to provide assurance that all actions have been implemented and completed. To address this, an audit of the Fire Risk Assessments is to be carried out to ensure we have a clear view of the current position.

The main areas for improvement are fire compartmentation (HRI) and fire door maintenance (HRI). Other common findings include poor housekeeping and storage with particular storage issues across both sites resulting in beds and other equipment being located on corridors.

The continual movement of departments and staff to different locations does not always necessitate the need for a review of the fire risk assessment. More thought and planning is needed in the use of space so it is appropriate both in terms of location and appropriate from a fire safety perspective.

3.2 Fires and Fire Alarms

Fires

There has been a fire during the last 12 months at HRI (a light fitting on ward 15), at CRH there has not been a fire however there have been in the Dales which is operated by SWYMHT.

False Alarms

The Trust is required to monitor fire alarm activations to ensure they are kept to a reasonable level and determine the reason for the activation and actions to prevent a reoccurrence.

There remains a high number of false alarms activations, particularly at HRI. These have significantly

increased over the last two years, mainly due to the misuse of toasters as better detection was introduced within the premises. Efforts are being made to reduce these False Alarms through adjustments to the sensitivity of the new fire detectors and the introduction of new switches for the toasters which have to be pressed down for the toaster to work (to prevent the toast burning and activating the alarm). Life cycle upgrades on the fire alarm system at CRH is helping to reduce the activations.

We have been having numerous false alarms in the old nurses home at HRI as the condition of that building is deteriorating. To combat this we have reduced the coverage of detectors by approximately 80%. This provides enough coverage to detect a fire should one occur, and ensures the Learning Centre is still safe.

The figures quoted below present a clearer picture as to what is happening in each hospital. Activations in the Dales have been removed and activations at HRI are only shown for the main hospital building and not other buildings on the curtilage.

Table 1 – Fire Alarm Statistics HRI

Year	Location	Actuations	Fires	False Alarms	Unwanted Fire Signals
2018/19	HRI	46	1	38	1
2017/18	HRI	76	0	76	0
2016/17	HRI	35	0	35	0
2015/16	HRI	36	2	34	0
2014/15	HRI	53	4	49	4
2013/14	HRI	67	5	40	6

Table 2 Fire Alarm Statistics CRH

Year	Location	Actuations	Fires	False Alarms	Unwanted Fire Signals
2018/19	CRH	21	0	21	1
2017/18	CRH	37	0	37	1
2016/17	CRH	33	2	31	1
2015/16	CRH	62	2	60	3
2014/15	CRH	100	0	100	5
2013/14	CRH	95	2	93	6

An unwanted fire signal (UFS) is a fire alarm where the fire service attend site and there is no fire. West Yorkshire Fire and Rescue Authority charge organisation's £450 for each UFS. Their objective is to reduce the number of UFS thus ensuring fire tenders are available for actual fire calls. CHFT's Fire Officer and AE continue to work closely with the Fire Authority, Estates and Facilities, Engie and ISS to ensure, where possible, we manage UFS internally and are not charged.

3.3 Fire Safety Training

Fire training for 2018/19 has been delivered through face to face classroom sessions. These are known to be the best way to ensure staff understand their responsibilities. It also gives staff the opportunity to question and clarify anything they are unsure of in relation to fire. There has been a slight drop in % compliance against the 95% target, but it should be noted that in 18/19 5799 people were trained. This is more than the previous 4 years. The requirement for staff to have their training up to date for their appraisals has had a major positive influence in helping to improve training achievement throughout the Trust. Table 3 illustrates fire safety training statistics.

Table 3 Fire Training Statistics

Year	Fire Safety Training	Fire Warden Training
2018/19	5465	334
2017/18	5630	270
2016/17	4452	151
2015/16	4171	1089
2014/15	4976	1042
2013/14	2460	826

The numbers above account for just Trust staff, there will probably be somewhere around another 800 staff trained in Fire Safety, from areas such as ISS, Engie, Renal, Locala, Social Services, League of Friends, etc.

This coming year's fire training will revert back to reading the booklet on-line with face to face training planned for the year after so that the Trust remains compliant with the RRO requirements. When there is a rise in the number of capital schemes being implemented, especially with reconfiguration, then additional training capacity will be required, and the Fire Officer will need to assist with the capital schemes.

In addition to the above training, evacuation training is carried out using the evacuation aids, for stairs evacuation. Fire extinguisher training is carried out for fire wardens, the fire response team and areas where evacuation is not easy, such as Theatres and ICU. Further training may be identified when the fire training plan is developed or other circumstances indicate a weakness that needs improving.

Fire Warden Training

There has been a marked drop in numbers of staff being trained as fire wardens. A plan to rectify this risk is contained within the Fire Safety Action Plan as a Fire Warden should be available on every shift in 24/7 patient areas, and for those hours when the service or department is open in others.

Fire Response Team Training

Additional training, including using fire extinguishers, has been provided to CHFT's fire response teams which include Site Coordinators/Night Matrons, Porters, Estates and Security. This response is provided 24/7 and is co-ordinated by Switchboard on both HRI and CRH sites following the activation of a fire alarm. All of these staff have had the opportunity of additional training to help them fulfil this role.

Trust Induction Training

The reintroduction of face to face Induction training is a big step forward; this allows new staff to get to know key support staff and lets them know that they are OK to ask for support and advice.

Fire Evacuation Training

Due to the risk to patients there are limited options to undertake live fire evacuation training on wards. However, in numerous areas some evacuations with staff actually practicing "hands on" training has

occurred. Further evacuation training is planned for 2019 but these exercises depend on the availability of suitable facilities and staff being available. The health Centre's where we have control have all completed an evacuation drill, (e.g. Allan House, Brighouse).

4. GOVERNANCE

4.1 Audits

CHFT's AE (Fire) commenced an audit of the CHFT's premises in the spring of 2019 to measure compliance against the Fire Safety (Regulatory Reform) Order (RRO and HTM 05 (Fire Safety). An in depth compliance report will be produced by the AE (Fire) detailing both strengths and areas for improvement.

4.2 Health & Safety Committee

Monthly or bi-monthly performance fire safety, and fire training reports are provided to the Health and Safety Committee with quarterly updates detailing progress against the annual action plan.

4.3 Fire Safety Meetings

Regular meetings take place which involve the Fire Manager, Fire Safety Officer, AE (Fire) and other key stakeholders ensuring any new and emerging risks are captured and managed accordingly.

4.4 A Fire Safety Committee

A specific committee has been established to look at CRH fire issues and help resolve and monitor issues. This was previously covered by the JSLT (joint safety leadership team) meeting, but became too onerous.

4.5 Director for Fire Safety

A CHFT Director will be identified, who takes responsibility for fire safety across the Trust.

5. CAPITAL WORKS

5.1 Fire Compartmentation

The Trusts buildings are made up of a number of fire resisting compartments to reduce the spread of fire from one location to another. This fire compartmentation allows the Trust to use progressive horizontal evacuation as its primary evacuation method.

The fire compartmentation at HRI has deteriorated over a large number of years due to intrusive work carried out by contractors when installing new services. A compartmentation survey has been commissioned to identify areas where remediation is necessary to reinstate the compartmentation back to its original design. This work will initially be to rectify holes in the 60 minute compartmentation around wards, other clinical departments, and internal risers, and then a plan will be developed for the 30 minute sub compartmentation.

CRH does not have or need major fire prevention capital works as it is newer, and has an annual life cycle programme which keeps the areas to a good standard.

5.2 Fire Alarm

We are now nearing completion of the HRI fire detection programme, which has seen upgrades to fire detection, some new panels, new interfaces, and has taken nearly 6 years to complete. In 18/19 we finished fitting the 1400 new detectors, some of which were 30 years old and didn't work. The work on interfaces is underway and will be completed in 19/20.

Once this and the relabeling of the detection is complete, a new graphics package will be ready to become operational. In simple terms this means that on activation of a fire alarm, a screen with a floor plan will be visible in Switchboard at HRI so the location of the actual device activated will be known. The better detection should see a reduction in fire alarm calls, despite there being more detectors installed.

CRH fire detection is also being upgraded with the lifecycle programme that is in place and so a further reduction of calls is anticipated.

5.3 Emergency Lighting

Work is underway to bring the emergency lighting up to the required British Standard BS5266; as there are major weaknesses in large parts of HRI.

5.4 Fire Door Maintenance

A new workshop has been built so that fire doors can be maintained at HRI.

External qualified contractors have been brought in to maintain the fire doors, but another fire safety issue has been identified. The gap between the wall and the door frame has not been sealed appropriately and a fire would bypass the fire door by travelling through the architrave to the other side. Work to rectify this issue is now underway. The doors and doorframes associated with the 60 minute compartmentation will be the first to be repaired, and this will take place during the 2019/20 financial year.

6. WEST YORKSHIRE FIRE AND RESCUE

There is a sustained open dialogue between West Yorkshire Fire & Rescue Service, the Trust Fire Officer and the Fire AE. This happens when fires occur and whenever upgrade work is planned through building control. The regular contact also gives them reassurance the Trust is progressing and hence they have not made a formal visit during the last 5 years.

6.1 Operational Visits

There have been a steady number of both operational and familiarisation visits by local Fire Crews. These ensure that the fire crews have a better understanding of the problems they will face in the event of a fire or evacuation which will enable them to manage and deal with the situation more efficiently.

Some of the unoccupied buildings are being used to facilitate fire service training. Both Acre House Avenue and the old nurses' accommodation block are being used to do this, mainly in an evening and at weekends.

7. FIRE SAFETY WORK PLAN 2018/19

Although a work plan is submitted each year the majority of the items are a continual and ongoing. These include progression with capital works, such as compartmentation, fire alarm systems and fire training.

Additional work is created either by a Fire Risk Assessment that identifies an issue which we were not aware of such as gaps behind architraves, or actual fires and external events, e.g. Grenfell Towers.

The next year will see progression towards finishing of the Fire Risk Assessment work in each department/ward and completion of the delayed annual audit.

The Fire Safety Work Plan below, details the rest of the work that will be completed during 19/20.

7.1 FIRE SAFETY WORKPLAN FOR 2019/2020

	WHAT	WHO	WHEN
1.	Provide fire safety data Trust and DoH following Grenfell fire incident	Fire Officer / Head of Estates	As and when required
2.	**Fire Risk Assessments** Embed fire risk assessments as part of Divisions local governance structure (e.g.: Div. Quality & Safety Boards). These should be cascaded upon review	Fire Officer / Director of Estates, Facilities Planning & Performance	On going
2.1	**Audit** Complete HRI / CRH audit of fire safety Vs HTM (including Fire Risk Assessments)	Authorising Engineer AE (Fire)	On going
3.	**Training** Fire warden training (Refresher & New)	Fire Officer	On-going
3.1	**Training** Monitor staff to ensure understanding of Fire safety awareness training	Fire Officer	31.3.20
3.2	**Training** Fire extinguishers training for key staff (practical)	Fire Officer	31.3.20
3.3	**Training** Develop training for 2020/21	Fire Officer	31.12.19
3.4	**Training** Plan and deliver practical evacuation training including off site office areas	Fire Officer	31.3.20
4.	**Fire Alarm Activations** Continue to reduce the number of fire alarm activations across CHFT	Fire Officer / CHFT Colleagues / Engie	31.3.20
5.	**Estates Maintenance** Ensure any works carried out comply with Fire Regulations	Fire Officer / Head of Estates / Head of Engie Estates	31.3.20
5.1	**Capital Works** Progress and complete upgrade of the fire alarm system at HRI	Fire Officer / Head of Estates	31.3.20
5.2	**Capital Works** Continue to provide overview of CRH new fire detection system	Fire Officer / Head of Engie Estates	31.3.20
5.3	**Capital Works** Implement and complete the 60 min compartmentation strategy for HRI	Fire Officer / Head of Estates / Capital Estates Officer	31.3.20

5.4	**Estates Maintenance** Continue to survey and repair fire doors	Fire Officer / Head of Estates / Estates Officer	On-going
5.5	**Estates New Works / Small Works** Install electrical sockets decluttering equipment across HRI and CRH	Fire Officer / Head of Estates / Head of Engie Estates	31.08.19

8. RECOMMENDATION

The Board of Directors is requested to receive and note the contents of the annual report and agree the draft work plan for 2019 / 2020.

2nd May 2019 Keith Rawnsley, Fire Officer

16. Integrated Performance Report – March 2019

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2 May 2019
Meeting:	Board of Directors
Title:	Integrated Performance Report - March 2019
Author:	Peter Keogh, Assistant Director of Performance
Previous Forums:	Executive Board, Finance & Performance Committee, Quality Committee

Action requested:

To note

Purpose of the report

To provide the Executive Board with the performance position for the month of March 2019.

Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)

March's Performance Score has peaked again at just over 73%. The SAFE domain is still green and has improved further with no RIDDOR or Cat 4 pressure ulcer. The CARING domain has improved to green with FFT A%E would recommend moving to amber. EFFECTIVE domain is green for the fifth consecutive month although #NoF missed target this month. The RESPONSIVE domain has deteriorated slightly to 67% with % patients spending 90% on a stroke unit falling below target and the 6 weeks Diagnostics target missed again however we achieved all key cancer targets for the fifth consecutive month. WORKFORCE has improved by 10 percentage points to 67% with better performance in all 9 EST areas (3 greens, 6 ambers) and also appraisals for medical staff. In month in FINANCE there was a deterioration in I&E surplus and CIP although for the full year all key indicators were green, EFFICIENCY maintained its green performance.

EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)

N/A

Recommendation

The Board of Directors is asked to note the contents of the report and the overall performance score for March.

Appendix

Integrated Performance Report (summary version) - March 2019.pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

March 2019

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

To Note

Sometimes the previous month's % in the Performance Summary is different in the next month's report. This usually happens when there are late changes to indicator values due to validation.

The following indicator has now been excluded due to the closure of HRI SPU 4th February:
Theatre Utilisation (TT) - HRI SPU.

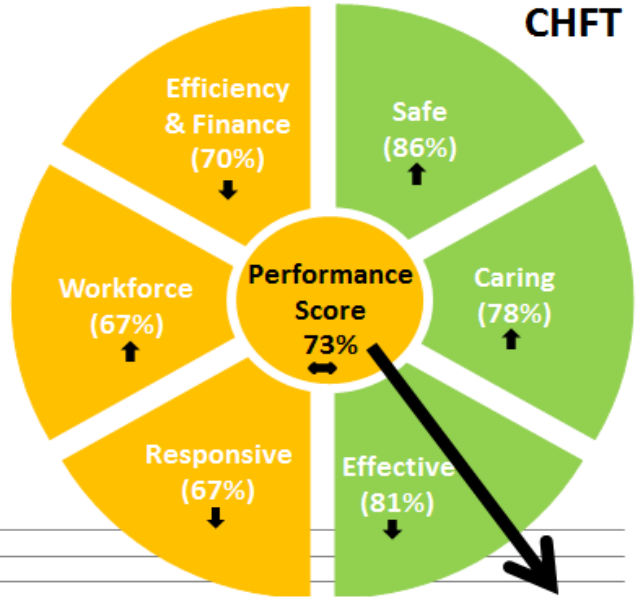
This has had a very minor impact on monthly Performance Scores.

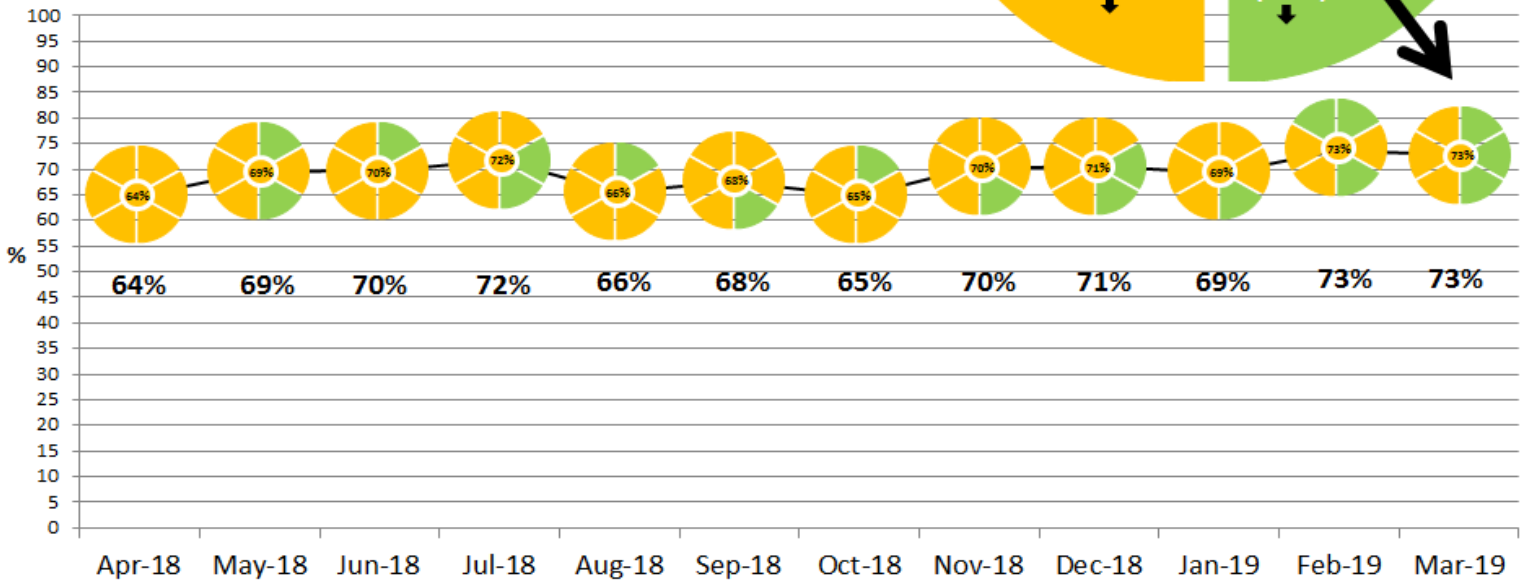
Performance Summary

March

RAG Movement

March's Performance Score has peaked again at just over 73%. The SAFE domain is still green and has improved further with no RIDDOR or Cat 4 pressure ulcer. The CARING domain has improved to green with FFT A%E would recommend moving to amber. EFFECTIVE domain is green for the fifth consecutive month although #NoF missed target this month. The RESPONSIVE domain has deteriorated slightly to 67% with % patients spending 90% on a stroke unit falling below target and the 6 weeks Diagnostics target missed again however we achieved all key cancer targets for the fifth consecutive month. WORKFORCE has improved by 10 percentage points to 67% with better performance in all 9 EST areas (3 greens, 6 ambers) and also appraisals for medical staff. In month in FINANCE there was a deterioration in I&E surplus and CIP although for the full year all key indicators were green, EFFICIENCY maintained its green performance.





SINGLE OVERSIGHT FRAMEWORK

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

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

Key Indicators

	17/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD	Annual Target	Monthly Target
SAFE																
Never Events	1	0	0	0	0	0	1	0	1	0	2	0	0	4	0	0
CARING																
% Complaints closed within target timeframe	48.70%	37.00%	44.00%	30.00%	31.00%	33.0%	53.0%	45.0%	49.0%	67.0%	50.0%	33.0%	49.0%	42.0%	95%	95%
Friends & Family Test (IP Survey) - Response Rate	31.40%	39.97%	39.75%	38.83%	36.47%	37.83%	34.93%	35.53%	30.65%	32.99%	35.53%	36.27%	34.82%	36.39%	>=25.9% /24.5% from June 18	
Friends & Family Test (IP Survey) - % would recommend the Service	96.90%	96.78%	97.98%	97.38%	97.42%	97.65%	97.70%	97.35%	97.81%	96.77%	97.42%	97.38%	97.92%	97.46%	>=96.3% / 96.7% from June 18	
Friends and Family Test Outpatient - Response Rate	10.10%	11.30%	10.45%	11.43%	11.40%	11.32%	11.61%	10.21%	11.01%	8.92%	10.71%	10.32%	10.19%	10.75%	>=5.3% / 4.7% from June 18	
Friends and Family Test Outpatients Survey - % would recommend the Service	89.70%	90.66%	90.99%	90.40%	90.79%	90.82%	90.96%	90.79%	91.54%	91.19%	91.47%	90.70%	90.76%	90.92%	>=95.7% / 96.2% from June 18	
Friends and Family Test A & E Survey - Response Rate	10.20%	10.74%	9.55%	12.85%	15.25%	14.53%	13.10%	13.71%	13.73%	12.66%	14.18%	13.50%	12.49%	13.03%	>=13.3% / 11.7% from June 18	
Friends and Family Test A & E Survey - % would recommend the Service	85.00%	84.65%	86.35%	84.28%	84.30%	82.15%	84.75%	82.56%	83.62%	84.14%	82.53%	82.21%	84.99%	83.80%	>=86.5% / 87.2% from June 18	
Friends & Family Test (Maternity Survey) - Response Rate	41.00%	33.20%	34.80%	34.80%	33.70%	35.60%	36.30%	35.10%	36.10%	31.00%	35.60%	45.50%	44.83%	36.51%	>=22.0% / >=20.8% from June 18	
Friends & Family Test (Maternity) - % would recommend the Service	97.60%	98.00%	98.90%	98.20%	98.40%	98.10%	99.00%	99.70%	98.30%	98.26%	98.25%	99.20%	99.10%	98.64%	>=97% / 97.3% from June 18	
Friends and Family Test Community - Response Rate	6.50%	3.60%	6.30%	4.20%	4.40%	4.66%	6.98%	5.22%	6.67%	3.36%	2.30%	5.74%	4.45%	4.91%	>=1.5% / >=3.2% from June 18	
Friends and Family Test Community Survey - % would recommend the Service	90.00%	93.94%	92.59%	92.02%	97.42%	94.06%	93.18%	91.72%	95.87%	98.42%	98.07%	97.04%	96.81%	94.64%	>=94.2% / >=96.7% from June 18	
EFFECTIVE																
Number of MRSA Bacteraemias – Trust assigned	5	0	0	1	0	0	0	1	0	0	0	0	0	2	0	0
Preventable number of Clostridium Difficile Cases	8	3	1	1	0	0	0	0	0	0	0	0	0	5	<=20	< = 2
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.98													100.25	<=100	100
Hospital Standardised Mortality Rate (1 yr Rolling Data)	82.47													84.51	<=100	100
RESPONSIVE																
Emergency Care Standard 4 hours	90.61%	91.52%	93.23%	94.78%	92.37%	91.15%	89.63%	90.31%	90.74%	89.19%	87.96%	89.56%	94.46%	91.29%	>=95%	95%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	60.36%	58.00%	53.49%	68.63%	54.00%	59.02%	70.21%	68.33%	70.90%	69.70%	61.54%	75.51%	58.46%	64.00%	>=90%	90%
% Incomplete Pathways <18 Weeks	93.75%	93.77%	93.32%	94.05%	93.99%	93.18%	93.00%	93.15%	93.12%	92.19%	92.11%	92.02%	92.05%	92.05%	>=92%	92%
Two Week Wait From Referral to Date First Seen	94.09%	95.63%	98.78%	98.61%	98.82%	97.67%	98.79%	99.05%	99.39%	98.85%	99.17%	98.75%	97.76%	98.46%	>=93%	93%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.88%	95.48%	95.28%	98.94%	95.24%	100.00%	100.00%	99.50%	98.92%	97.22%	96.74%	96.98%	97.38%	97.56%	>=93%	93%
31 Days From Diagnosis to First Treatment	99.83%	100.00%	99.37%	99.41%	100.00%	100.00%	100.00%	100.00%	99.36%	99.38%	98.86%	99.35%	100.00%	99.63%	>=96%	96%
31 Day Subsequent Surgery Treatment	99.26%	100.00%	100.00%	100.00%	97.22%	100.00%	100.00%	95.45%	100.00%	100.00%	100.00%	96.55%	100.00%	99.04%	>=94%	94%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	>=98%	98%
38 Day Referral to Tertiary	45.49%	47.62%	40.00%	50.00%	50.00%	42.86%	52.00%	73.33%	47.06%	70.59%	52.17%	66.67%	64.29%	52.42%	>=85%	85%
62 Day GP Referral to Treatment	88.67%	90.66%	92.35%	83.98%	87.72%	83.51%	88.83%	85.97%	89.27%	92.22%	90.77%	88.70%	88.13%	88.37%	>=85%	85%
62 Day Referral From Screening to Treatment	94.87%	81.82%	91.67%	100.00%	100.00%	100.00%	88.89%	84.62%	96.00%	100.00%	95.83%	93.75%	100.00%	94.42%	>=90%	90%
WORKFORCE																
Sickness Absence rate (%) - Rolling 12m	4.10%	4.10%	4.07%	4.04%	4.01%	3.97%	3.92%	3.90%	3.84%	3.83%	3.76%	3.74%	*	-	4%	4%
Long Term Sickness Absence rate (%) -Rolling 12m	2.55%	2.54%	2.53%	2.51%	2.48%	2.45%	2.42%	2.41%	2.38%	2.37%	2.35%	2.41%	*	-	2.7%	2.7%
Short Term Sickness Absence rate (%) -Rolling 12m	1.55%	1.56%	1.53%	1.53%	1.53%	1.52%	1.50%	1.49%	1.47%	1.45%	1.41%	1.33%	*	-	1.3%	1.3%
Overall Essential Safety Compliance		95.00%	94.40%	93.96%	93.84%	91.56%	90.12%	91.02%	91.47%	91.45%	91.84%	92.79%	94.45%	-	95%	95%
Appraisal (1 Year Refresher) - Non-Medical Staff - Rolling 12m	93.50%	15.43%	62.67%	96.65%	96.74%	95.74%	95.76%	94.33%	93.81%	92.57%	91.50%	90.79%	90.03%	-	95%	95%
Appraisal (1 Year Refresher) - Medical Staff - Rolling 12m	69.88%	99.75%	99.70%	98.65%	96.59%	97.21%	97.42%	92.50%	89.24%	83.50%	63.00%	85.22%	92.85%	-	95%	95%
FINANCE																
I&E: Surplus / (Deficit) Var £m	-7.97	0.01	0.00	0.00	0.01	0.26	-0.02	-0.20	-0.03	0.00	0.01	0.00	-0.02	0.01		

Most Improved/Deteriorated

MOST IMPROVED	MOST DETERIORATED	ACTIONS
% Dementia patients screened following emergency admission aged 75 and over - improved to 60%.	% Harm Free Care - At 91.62% worst performance in 12 month. % of Harm Free Care (new) has just missed target this month at 97.66%.	Colleagues across all Divisions actively contribute to CHFT Pressure Ulcer Collaborative aimed at reducing both the numbers of pressure ulcers and deterioration of ulcers. Further work is being undertaken in monitoring ward assurance standards in documentation to provide evidence of care interventions.
Emergency Care Standard 4 hours - improved to 94.46% in March, (95.22% all types).	% Diagnostic Waiting List Within 6 Weeks - target missed in 4 out of last 5 months due to staffing issues and capacity within Echocardiography. In addition a cohort of non-registered requests were identified which have subsequently breached the 6 week target.	We are working with the EPR team to produce a build for all referrals to be added to a waiting list on EPR, allowing visibility of the backlog of patients waiting and the timeframe they occupy. Until then we have built a spreadsheet to track the referrals and a manual report will be sent to the information team every Monday to build this into the weekly performance report. An outsourcing company have been commissioned to clear the backlog and provide ongoing support to meet the current demand. A price has been negotiated and contracts are being exchanged. This service is due to start in June with the company providing staff to scan and report outpatients. The company will carry out up to 800 scans per month and are expected to clear the backlog in 3 months and then provide a further 100 scans per month. Recruitment for bank/substantive staff is ongoing with a rolling advert out every month. HR are supporting the department looking at the recruitment and training strategy. One extra full time bank recruit is in the pipeline and will be able to provide up to 50 scans per week. Neurophysiology - We plan to achieve this recovery within forecast by: Increasing the scope of our CESR doctors to perform EMG's and increasing the PA's of our experienced specialty doctors to cover maternity leave.
All key cancer targets achieved for 5th month running.	Stroke targets - The decrease in 90% stay is due to the increased number of strokes which have needed admission to the unit. This means the unit has been full and we have had to outlie stroke patients into other specialties. 8 beds were closed across the Stroke Unit by 29th March.	To support this a task and finish group has been set up to look at ways we can standardise pathways and processes across all the band 7's to aid timely and appropriate discharges. Weekly MADE events are being held and will have at least one member of the management team present and the discharge team.

Executive Summary

The report covers the period from March 2018 to allow comparison with historic performance. However the key messages and targets relate to March 2019 for the financial year 2018/19.

Domain	Area
Safe (86%)	• **% Harm Free Care** - At 91.62% worst performance in 12 month. % of Harm Free Care (new) has just missed target this month at 97.66%. Colleagues across all Divisions actively contribute to CHFT Pressure Ulcer Collaborative aimed at reducing both the numbers of pressure ulcers and deterioration of ulcers. Further work is being undertaken in monitoring ward assurance standards in documentation to provide evidence of care interventions.
Caring (78%)	• **Complaints closed within timeframe** - Of the complaints closed in March, 49% (13/39) were closed within target timeframe. Chief Executive continues to meet with colleagues involved in complaint management to identify areas for improvement. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance is < 91% against the 95.7% target. Outpatients as a whole continues to undergo a transformational programme of work, the FFT metrics are being monitored throughout the period to assess changes in patient satisfaction levels. The action plan is being worked through and an improved performance is expected by Q3.
	• **Friends and Family Test A & E Survey - % would recommend the service**. Performance has improved to 85% which is best since last May against the 87.2% target. A paper was presented to WEB regarding patient experience and all the improvement work that is taking place in the department. This has also been included in the directorate's objectives to focus on over the next 12 months.
	• **% Dementia patients screened following emergency admission aged 75 and over** - performance has improved further to 60% but is still below the 90% target. Multi-disciplinary, dementia screening quality improvement programme continues to work across all clinical areas to improve the quality of the screen and reporting of the screen. Improvement team includes EPR and Informatics support to ensure recording processes are improved.
Effective (81%)	• **% Non-elective #NoF Patients With Admission to Procedure of < 36 Hours** - performance at 69% in March well below the 85% target. There was a deterioration in the ability to get patients to theatre during the month of February. These patients have been discharged and reported in March. Higher than usual volumes of complex upper limb trauma created challenges for the trauma team and competing priorities. Resources have been reviewed with escalation processes recirculated. Plans have been put in place to ensure suitable Total Hip Replacement capacity is in place over the forthcoming BH weekends and also additional trauma lists both before and after the weekend to facilitate prompt time to theatre.

Background Context

Focused work has been carried out throughout March on several key performance metrics with emphasis on ensuring compliance with agreed protocols. Dedicated coordination capacity at a senior level implemented and daily huddles to assess impact in place.

The Frailty Service is now working across ED, CDU, SAU and the Acute Floor. The team aim to complete a Comprehensive Geriatric Assessment (CGA) on all frail patients seen.

Physiotherapy and Occupational Therapy - to support with 'bed before 10am' and PJ Paralysis have restructured their day and now carry out caseload planning meeting during the patients' protected lunchtime so that they are present on the wards earlier in the morning.

Within Surgery vacancies plus long and short term sickness continue to impact upon activity and patient experience with list cancellations and on day cancellations. This is then creating an additional challenge to ensure delivery of the 28 day promise.

Maternity services invited HSIB for a review of Maternity care. The themes that came out of the review were in line with other Trusts' Radiology.

Executive Summary

The report covers the period from March 2018 to allow comparison with historic performance. However the key messages and targets relate to March 2019 for the financial year 2018/19.

Domain	Area
Responsive (67%)	• **Emergency Care Standard 4 hours** - improved to 94.46% in March, (95.22% all types) - We are looking at having dedicated transport overnight from the ED, allowing faster discharge for patients. We are also looking at introducing a senior ED nurse daily to reduce the time to triage, to turn patients round from triage and to stream to alternate services (pharmacy/GP/ambulatory care). We are aiming to triage 100% of walk-in patients within 15 minutes, the current performance remains a risk. We have put a proposal through the Urgent Care Board to increase the number of nurses on triage to reduce this time. A task and finish group will be set up to review the assessment process on both sites and how this can be improved. 8 to 10 hour waits in the department - This has been included on the directorate's objectives for the next 12 months and work will be ongoing to reduce the number of over 8 hour waits in the department.
	• **Stroke targets** - The decrease in 90% stay is due to the increased number of strokes which have needed admission to the unit. This means the unit has been full and we have had to outlie stroke patients into other specialties. 8 beds were closed across the Stroke Unit by 29th March. To support this a task and finish group has been set up to look at ways we can standardise pathways and processes across all the band 7's to aid timely and appropriate discharges. Weekly MADE events are being held and will have at least one member of the management team present and the discharge team.
	• **% Diagnostic Waiting List Within 6 Weeks** - target missed in 3 out of last 4 months due to staffing issues and capacity within Echocardiography. In addition a cohort of non-registered requests were identified which have subsequently breached the 6 week target. We are working with the EPR team to produce a build for all referrals to be added to a waiting list on EPR, allowing visibility of the backlog of patients waiting and the timeframe they occupy. Until then we have built a spreadsheet to track the referrals and a manual report will be sent to the information team every Monday to build this into the weekly performance report. An outsourcing company have been commissioned to clear the backlog and provide ongoing support to meet the current demand. A price has been negotiated and contracts are being exchanged. This service is due to start in June with the company providing staff to scan and report outpatients. The company will carry out up to 800 scans per month and are expected to clear the backlog in 3 months and then provide a further 100 scans per month. Recruitment for bank/substantive staff is ongoing with a rolling advert out every month. HR are supporting the department looking at the recruitment and training strategy. One extra full time bank recruit is in the pipeline and will be able to provide up to 50 scans per week. Neurophysiology - We plan to achieve this recovery within forecast by: Increasing the scope of our CESR doctors to perform EMG's and increasing the PA's of our experienced specialty doctors to cover maternity leave.
	• **38 Day Referral to Tertiary** - performance was 64% in March. Discussions are ongoing with Leeds and CHFT Radiology department around capacity issues. Minor improvements are being seen but the waits are being monitored and escalated through the weekly fast-track meetings. Capacity for Endoscopy has recently been increased by three lists per week due to new consultant. Second Gastro locum starting 6th May providing three extra lists per week.
	• **Appointment Slot Issues on Choose & Book** - performance has deteriorated to 49%. Action plans in place including additional clinics, template review and the extension of polling ranges for specialties with largest numbers.
Workforce (67%)	• **Overall Sickness absence/Return to Work Interviews** - Sickness rolling 12 month total is at its lowest position although the last 3 months have been above 4%. RTWI performance continues to improve and is now at 76.15%. • **Essential Safety Training - All** 9 EST areas improved in month with 3 greens and 6 ambers.
Finance (70%)	• **Finance**: **Year to Date Summary** The year to date deficit is £43.04m, a £0.01m favourable variance from plan. • Compared to the Month 11 forecast position there have been some additional cost pressures in month including a stock adjustment and other year-end technical adjustments. • These pressures have been offset in the reported position by a reduction in depreciation charges based on recent asset valuations and changes to asset lives. • Clinical contract income performance is below plan by £3.41m. The Aligned Incentive Contract (AIC) protects the income position by £3.05m in the year to date leaving a residual pressure of £0.36m. However, this income protection (£3.45m) is as a result of CIP plans and management decisions where there is a corresponding reduction in cost. • CIP achieved for the year is £18.00m as planned. • Agency expenditure for the year was £12.49m, £2.14m below the agency trajectory set by NHSI. **Key Variances** • Medical staffing expenditure continued above plan, with pressure on non-contracted pay costs due to vacancy pressures particularly in Obs & Gynae, ENT, Dermatology, Urology and General Surgery. • There have been significant pressures on non-pay expenditure including a significant cost increase relating to the new clinical waste contract with Mitie (hosted by LTHT), where invoices have exceeded the expected impact of the price uplift, increased utilities costs following a price uplift of 23% on electricity, pressure relating to Radiology and Pathology sendaway tests charged from other providers and additional professional fees. There were also non-recurrent costs incurred in month relating to the year end stock adjustment and an increase in general provisions. • Nursing pay expenditure remains under control despite continued bank usage for one to ones and additional Agency costs linked to the opening of some additional capacity over the last two months. **Technical Movements/Non-Operating Expenditure** • The revaluation of assets has resulted in the Trust reporting an impairment taken to I &E of £26.51m. Whilst this charge increases the total reported deficit to £69.61m, the impairment is excluded for Control Total purposes on the basis that is it both exceptional and non cash impacting. • The revaluation has also impacted on the depreciation charge reported for the year, reducing the total cost for the year from a planned £11.93m to an actual cost of £8.86m, a £3.07m favourable variance.

Background Context

Issues continue with inaccurate coding of RTT activity leading to pressures on total incomplete waiting list number and RTT compliance of 92%. Additional validation capacity in place in March through to April and 2 Divisions on escalation. In addition several long waiting Bariatric patients have been transferred in from out of region impacting on over 18 week waiters.

Community Division is undertaking a review of all Community RTT pathways with significant validation required.

A change process was implemented in the Booking Centre that has released capacity for validation and booking of the follow-up waiting list and is then moving to support the ASI patients once the validation for RTT has been completed.

8 beds were closed across the Stroke Unit by 29th March. To support this a task and finish group has been set up to look at ways we can standardise pathways and processes across all the band 7's to aid timely and appropriate discharges. Weekly MADE events are being held and will have at least one member of the management team present and the discharge team.

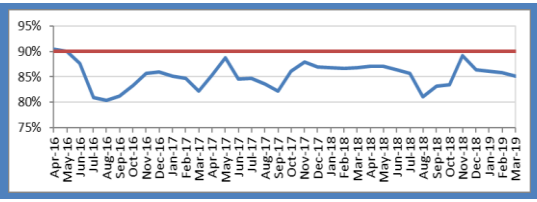
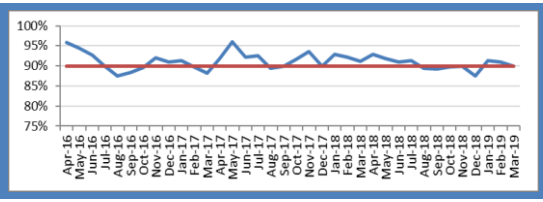
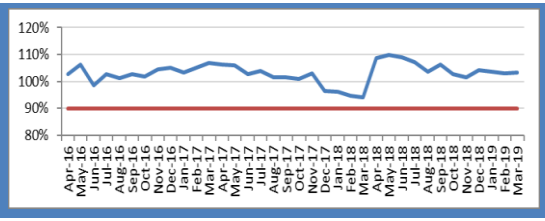
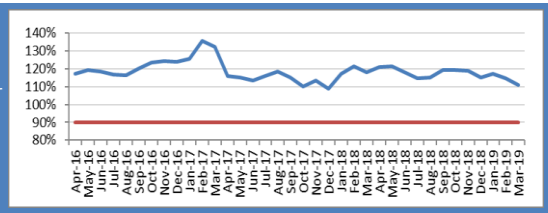
Radiologist capacity reduced in March impacting on 3 tumour sites with ongoing impact for Q1. Working with other Trusts to secure additional capacity. In addition the PET CT capacity at Leeds has been impacted by a supply issue restricting numbers and impacting on diagnosis time.

The Paediatric service continued to manage activity levels within planned resources in month, despite an escalation of pressures within the medical workforce due to a significantly reduced allocation of deanery registrar doctors. The Directorate team with the Senior Divisional team are continuing to work with the Paediatric medical workforce to respond to this position whilst supporting wellbeing.

Theatre has a cohort of staff on long term sick which as planned absence for elective procedures scheduled to coincide with the theatre upgrade programme. The programme was subsequently deferred at the request of the provider which has impacted on Theatre availability.

Director approval for vacancies and change forms continues alongside authorisation of all requisitions.
Buddy sessions continue with key budget holders and Directors.

Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation	Result
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	85.14% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 6 72.6% - Ward 17 72% - Ward 8a 65.9%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed and monitored within the divisions by the matron and senior nursing team. The low fill rates are attributed to a level of vacancy. CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	89.85% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - Ward 5b/c 74.7% - Ward 10 66.7%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates are due to a level of vacancy. CHPPD has been maintained by using skill mix opportunities and supported by acuity data on safe care live.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	103.41% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - LDRP 56.8% - NICU 63.9%	The low HCA fill rates in March are attributed to a level of HCA sickness within the FSS division. This is managed on a daily basis against the acuity of the work load. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; and support of reduced RN fill.
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	110.99% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% - NICU 57.2%	The low HCA fill rates in March are attributed to a level of HCA sickness within the FSS division. This is managed on a daily basis against the acuity of the workload. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; and support of reduced RN fill.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT						Care Hours Per Patient Day		MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies	Ward Assurance
		Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD						
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual										
CRH ACUTE FLOOR	ACUTE	2,946.83	2,809.42	2,332.33	2,228.67	95.3%	95.6%	2,505.50	2,366.00	2,046.00	2,072.67	94.4%	101.3%	9.8	9.4	0	1	18	8.33	-0.07	63.8%
HRI ACUTE FLOOR	ACUTE	3,192.00	2,876.10	2,709.27	2,558.83	90.1%	94.4%	2,728.00	2,509.08	2,046.00	2,044.00	92.0%	99.9%	12.5	11.7	0	6	26	-4.51	-12.53	70.0%
WARD 4	ACUTE	896.87	799.60	1,163.92	1,119.58	89.2%	96.2%	682.00	693.00	682.00	682.00	101.6%	100.0%	5.9	5.7	0	1	3	4.47	-0.03	55.7%
WARD 5	ACUTE	1,663.83	1,314.17	1,192.00	1,469.33	79.0%	123.3%	1,023.00	1,012.00	1,023.00	1,233.00	98.9%	120.5%	5.7	5.8	0	0	13	2.15	-1.32	72.8%
WARD 15	ACUTE	1,840.00	1,407.92	1,574.67	1,900.33	76.5%	120.7%	1,364.00	1,265.00	1,364.00	1,484.50	92.7%	108.8%	6.9	6.8	0	2	3	3.94	-2.41	72.5%
WARD 5BC	MED SPECS	2,555.35	1,994.83	1,593.67	1,623.42	78.1%	101.9%	2,057.00	1,535.75	682.00	1,265.00	74.7%	185.5%	7.7	7.2	0	1	6	10.47	-1.00	50.3%
WARD 6	ACUTE	1,687.75	1,225.42	1,210.33	1,818.33	72.6%	150.2%	1,016.00	993.17	1,023.00	1,336.75	97.8%	130.7%	6.1	6.6	0	0	0	5.27	-0.77	69.8%
WARD 6C	MED SPECS	1,121.13	844.55	783.83	750.83	75.3%	95.8%	682.00	682.00	341.00	341.00	100.0%	100.0%	5.0	4.5	0	3	2	11.77	7.43	66.8%
WARD 6AB	ACUTE	1,404.83	1,182.63	1,116.00	1,133.20	84.2%	101.5%	1,023.00	1,056.00	1,023.00	1,177.00	103.2%	115.1%	5.2	5.1	0	0	5	1.40	-4.30	47.8%
WARD CCU	MED SPECS	1,474.17	1,380.75	372.00	324.00	93.7%	87.1%	1,023.00	968.00	0.00	33.00	94.6%	-	9.4	8.9	0	0	2	3.81	0.13	75.1%
WARD 7AD	IMS	1,719.17	1,374.17	1,585.33	1,809.62	79.9%	114.1%	1,023.00	1,012.00	1,023.00	1,012.00	98.9%	98.9%	7.0	6.8	0	0	3	1.74	2.50	65.8%
WARD 7BC	IMS	2,582.00	2,041.03	1,652.33	1,574.83	79.0%	95.3%	2,046.00	1,648.80	682.00	1,012.00	80.6%	148.4%	9.2	8.3	0	0	1	2.26	-4.44	72.2%
WARD 12	IMS	1,649.00	1,286.50	789.00	1,132.50	78.0%	143.5%	1,023.00	891.00	341.00	440.00	87.1%	129.0%	7.0	6.9	0	2	5	3.65	1.16	65.3%
WARD 17	MED SPECS	2,201.00	1,585.33	1,122.00	1,098.50	72.0%	97.9%	1,023.00	990.00	682.00	693.00	96.8%	101.6%	5.9	5.1	0	0	3	6.30	-2.38	53.0%
WARD 5D	MED SPECS	1,089.33	957.83	816.00	952.50	87.9%	116.7%	682.00	627.00	341.00	451.00	91.9%	132.3%	5.8	5.9	0	0	5	0.73	-2.70	52.2%
WARD 20	ACUTE	1,846.00	1,620.08	1,767.33	1,928.83	87.8%	109.1%	1,364.00	1,100.00	1,364.00	1,672.50	80.6%	122.6%	6.5	6.5	0	3	3	7.14	0.35	62.7%
WARD 21	TRAUMA & ORTHOPAEDICS	1,596.50	1,221.25	1,532.17	1,482.33	76.5%	96.7%	1,069.50	931.00	1,069.50	1,115.50	87.1%	104.3%	8.3	7.5	0	1	3	5.38	1.14	67.5%
ICU	OPERATING SERVICES, ANAESTHETICS AND CRITICAL CARE	4,248.75	3,988.25	776.00	813.00	93.9%	104.8%	4,278.00	3,811.25	0.00	0.00	89.1%	-	35.6	33.0	0	5	2	11.97	1.74	74.5%
WARD 3	GENERAL SURGERY	1,046.08	974.58	589.00	571.25	93.2%	97.0%	713.00	690.00	514.00	490.00	96.8%	95.3%	6.1	5.8	0	1	5	0.00	0.37	52.3%
WARD 8A	TRAUMA & ORTHOPAEDICS	994.37	655.53	708.83	734.02	65.9%	103.6%	701.50	577.00	356.50	356.50	82.3%	100.0%	10.4	8.8	0	1	2	1.21	-0.75	60.6%
WARD 8D	ENT	977.25	914.50	794.00	747.42	93.6%	94.1%	713.00	701.50	0.00	23.00	98.4%	-	7.2	6.9	0	0	0	1.76	0.03	47.1%
WARD 10	GENERAL SURGERY	1,430.00	1,193.00	818.50	1,005.50	83.4%	122.8%	1,069.50	713.00	713.00	1,161.50	66.7%	162.9%	6.8	6.9	0	0	3	6.67	1.90	55.3%
WARD 11	GENERAL SURGERY	1,640.40	1,501.92	1,113.30	1,101.22	91.6%	98.9%	1,231.83	1,133.33	724.50	831.00	92.0%	114.7%	6.0	5.8	0	1	1	5.40	-1.31	59.4%
WARD 19	TRAUMA & ORTHOPAEDICS	1,722.00	1,332.33	1,168.17	1,257.33	77.4%	107.6%	1,069.50	1,024.58	1,069.50	1,104.00	95.8%	103.2%	7.7	7.2	0	5	3	3.66	-1.72	76.1%
WARD 22	UROLOGY	1,226.67	1,173.50	1,137.00	1,109.50	95.7%	97.6%	713.00	712.33	713.00	701.50	99.9%	98.4%	5.9	5.8	0	1	1	2.21	0.72	45.9%
SAU HRI	GENERAL SURGERY	1,943.67	1,737.67	863.00	958.50	89.4%	111.1%	1,426.00	1,350.50	454.00	444.00	94.7%	97.8%	12.9	12.3	0	0	1	-1.63	-1.80	67.6%
WARD LDRP	OBSTETRICS	4,443.32	3,700.67	945.50	537.50	83.3%	56.8%	4,222.75	3,468.75	708.25	690.00	82.1%	97.4%	22.5	18.3	0	0	0	0.00	0.00	28.2%
WARD NICU	PAEDIATRICS	2,359.50	1,776.08	797.00	509.00	75.3%	63.9%	2,116.00	1,633.32	713.00	408.00	77.2%	57.2%	15.1	10.9	0	0	0	3.01	2.52	45.4%
WARD 3ABCD	PAEDIATRICS	3,648.20	3,570.25	739.50	721.50	97.9%	97.6%	3,637.00	3,465.50	356.50	333.50	95.3%	93.5%	9.9	9.5	0	0	0	-1.63	0.82	17.5%
WARD 4ABD	OBSTETRICS	2,014.50	1,913.00	713.00	691.00	95.0%	96.9%	1,426.00	1,394.00	708.25	708.25	97.8%	100.0%	4.4	4.3	0	1	0	-14.83	-4.56	14.6%
WARD 4C	GYNAECOLOGY	1,335.00	1,154.58	340.25	340.25	86.5%	100.0%	713.00	703.25	356.50	345.00	98.6%	96.8%	8.4	7.8	0	0	0	1.77	0.52	70.5%
TRUST		########	51507.45	34815.2	36002.6	85.14%	103.41%	46364.08	41658.1	23119.5	25661.2	89.85%	110.99%	8.2	7.7						

Hard Truths: Safe Staffing Levels (3)

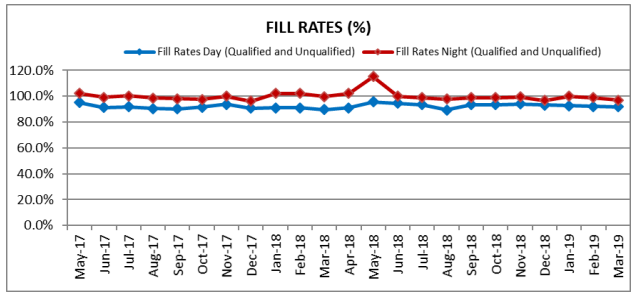
Care Hours per Patient Day

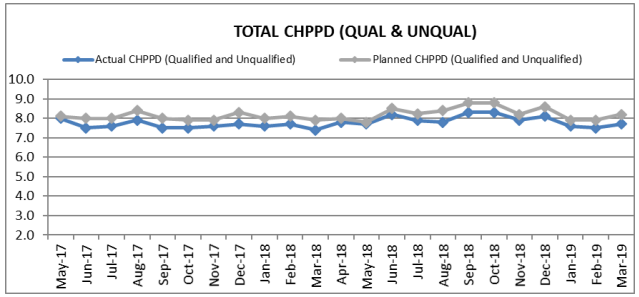
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Jan-19	Feb-19	Mar-19
Fill Rates Day (Qualified and Unqualified)	92.5%	92.0%	91.8%
Fill Rates Night (Qualified and Unqualified)	99.9%	98.9%	96.9%

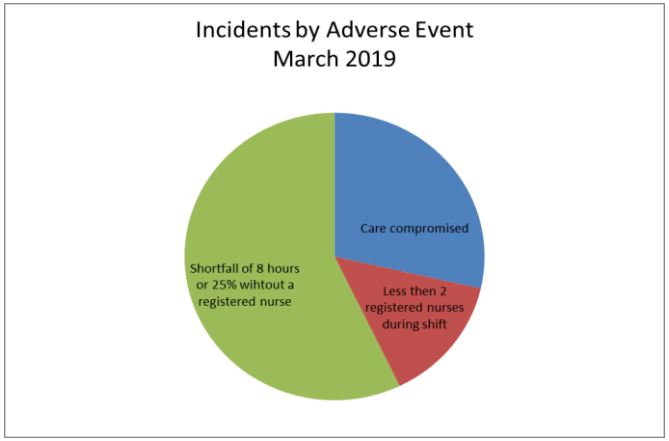
Planned CHPPD (Qualified and Unqualified)	7.9	7.9	8.2
Actual CHPPD (Qualified and Unqualified)	7.6	7.5	7.7

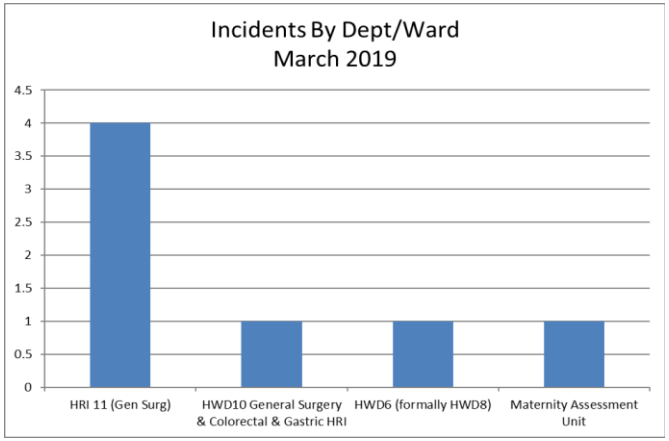
A review of March CHPPD data indicates that the combined (RN and carer staff) metric resulted in 26 clinical areas of the 30 reviewed having CHPPD less than planned. 3 areas reported CHPPD slightly in excess of those planned and 1 area having CHPPD as planned. Areas with CHPPD more than planned were due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correc t but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix. These are monitored daily by the divisions and reviewed monthly through the Nursing workforce strategy group.
There were 7 **Trust Wide Red shifts** declared in **March.**
As illustrated above the most frequently recorded red flagged incident is related to a shortfall in RN hrs.
No datex's reported in March have resulted in patient harm.

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse staffing establishments.

On-going activity:

1. The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continues for this specific area.
2. Further recruitment event planned for April.
3. Applications from international recruitment projects are progressing well and the first 20 nurses have arrived in Trust.
4. CHFT is a fast follower pilot for the Nursing Associate (NA). We have 5 TNA who are due to graduate in April and a further 43 in training. The Trust are currently recruiting a further 20 trainees to commence study in June 2019.
5. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment and retention of the graduate workforce
6. A new module of E roster called safe care has been introduced across the clinical divisions. Benefits will include, better reporting of red flag event and, real-time data of staffing position against acuity

CQUINS - Key messages

Area	Reality	Response	Result
Overall		The CQUIN scheme for 2018/19 is, in the main, a continuation of the 2017/18 scheme. However, there are some key changes which include: - Suspension of CQUIN 8A - Reduction in AWaRe antibiotics rather than piperacillin - Higher target for Flu Vaccinations @75% - **ACHIEVED**	
Risky Behaviours	The required improvements to the separate elements of the risky behaviour CQUINs are not being realised. It is recognised that the targets for this CQUIN are challenging to achieve.	Work is on-going through the joint task and finish group. Key focus areas: Data Capture- Change on EPR that has been requested through Digital Prioritisation Board is due to be completed in July 2019 Training and engagement-Plan on a page developed with screenshots on how to complete the required fields on EPR.	Improvements are expected by the end of Q4 but not likely to reach the ambitious target of 100% in all elements. Accountable: Director of Ops (Community)

CQUIN - Key measures

Goal Reference	Provider Type	Financial Value of Indicator	Indicator Name	Description	Baseline	Targets				ACTUAL PERFORMANCE													
						Q1	Q2	Q3	Q4	Q1			Q1 Position	Q2			Q2 Position	Q3			Q3	Q4			Q4
										Apr-18	May-18	Jun-18		Jul-18	Aug-18	Sep-18		Oct-18	Nov-18	Dec-18		Jan-19	Feb-19	Mar-19	
1. Improving staff health and wellbeing																									
1a.1	Acute & Community	£213,082	Improvement of health and wellbeing of NHS staff	% Definitely takes positive action on health and well-being	25	N/A	N/A	N/A	30	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			TBC
1a.2				% Experienced MSK in the last 12 months as a result of work activities	25	N/A	N/A	N/A	20	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			TBC
1a.3				% Felt unwell in the last 12 months as a result of work related stress	37	N/A	N/A	N/A	32	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			Data available at year end	Data available at year end			TBC
1b.1	Acute & Community	£213,082	Healthy food for NHS staff, visitors and patients	Maintain 16-17 changes	-	N/A	Written report for evidence	N/A	Written report for evidence	Written report due at the end of Q2			Written report due at the end of Q2	Written report due at the end of Q2			Written report due at the end of Q2	Written report due at the end of Q4			Written report due at the end of Q4	Written report due at the end of Q4			TBC
1b.2				Improve the changes made in 2017-18	-	N/A	Written report for evidence	N/A	Written report for evidence																
1c	Acute & Community	£213,082	Improving the uptake of flu vaccinations for frontline clinical staff	% Front line staff vacinated	71%	N/A	N/A	75%	75%	Data available from October 2018			Data available from	Data available from October 2018			Data available from October 2018	65.6%	65.6%	71.9%	71.9%	75.5%			75.5%
2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)																									
2a.1	Acute	£95,887	Timely identification (screening) of patients with sepsis in emergency departments and acute inpatient settings	% Eligible patients screened for Sepsis in Emergency Admissions	100.0%	90%	90%	90%	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2a.2				% Eligible patients screened for Sepsis in Inpatients (LOS >0)	100.0%	90%	90%	90%	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2b.1		£95,887	Timely treatment of sepsis in emergency departments and acute inpatient settings	% Patients with severe red flag/ septic shock that received Iv antibiotics < 1hr in Emergency Admissions	92.9%	90%	90%	90%	90%	91.0%	97.0%	100.0%	96.0%	100.0%	97.0%	93.5%	96.7%	93.0%	86.0%	93.0%	90.0%	87.0%	94.0%	93.0%	91.0%
2b.2				% Patients with severe red flag/ septic shock that received Iv antibiotics < 1hr in Inpatients (LOS >0)	78.7%	90%	90%	90%	90%	77.3%	82.6%	78.9%	79.7%	85.7%	96.0%	87.0%	90.6%	92.0%	88.0%	91.0%	91.0%	84.0%	89.0%	96.0%	91.0%
2c	Acute	£95,887	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	% of antibiotic presciptions documented and reviewed within 72 hours	-	25%	50%	75%	90%	90% (April and May Only)			95.6%	Data available at quarter end			63.3%	Data available at quarter end			85.3%	Data available at quarter end			TBC
2d.1	Acute	£95,887	Reduction in antibiotic consumption per 1,000 admissions	% of antibiotic presciptions documented and reviewed within 72 hours	TBC	Submit to PHE	Submit to PHE	Submit to PHE	TBC	Data available at quarter end			42.2%	Data available at quarter end			43.9%	Data available at quarter end			45.0%	Data available at quarter end			TBC
2d.2				1% reduction (from 16/17 position) in Carbapenem	TBC	Submit to PHE	Submit to PHE	Submit to PHE	TBC	Data available at quarter end				Data available at quarter end				Data available at quarter end				Data available at quarter end			TBC
2d.3				1% reduction (from 16/17 position) in Piperacillin-Taxobactam	TBC	Submit to PHE	Submit to PHE	Submit to PHE	TBC	Data available at quarter end				Data available at quarter end				Data available at quarter end				Data available at quarter end			TBC
4. Improving services for people with mental health needs who present to A&E																									
4a	Acute	£255,698	Improving services for people with mental health needs who present to A&E	Number of ED attendances - Maintain attendance level of cohort 1 patients	245	61	61	61	61	24	20	14	58	20	14	12	46	9	12	9	30	9	9	13	31
4b				Number of ED attendances - Reduce the number of attendances by 20% of cohort 2 patients	397	79	79	80	80	26	25	32	83	22	21	14	57	23	20	16	59	14	23	24	61
4c				To improve the level of data quality for the fields:																					
				- Chief Complaint	N/A	N/A	75%	N/A	85%	N/A			N/A	Quarter Position Only			93.9%	Quarter Position Only			92.0%	Quarter Position Only			92.0%
				- Diagnosis	N/A	N/A	30%	N/A	50%								32.1%				37.5%				52.0%
				- Injury Intent	N/A	N/A	75%	N/A	85%								98.6%				98.4%				98.0%
6. Offering advice and guidance																									
6	Acute	£319,623	Advice & Guidance	% A&G responses within 2 days	-	50% (Internal Target)	60% (Internal Target)	70% (Internal Target)	80% (CQUIN Target)	67.9%	74.0%	69.9%	70.7%	69.8%	75.4%	74.2%	72.5%	68.1%	78.3%	78.9%	75.1%	83.2%	83.7%	86.9%	84.4%
9. Preventing ill health by risky behaviours – alcohol and tobacco																									
9a	Acute	£7,991	Preventing ill health by risky behaviours - alcohol and tobacco	% Patients screened for Tobacco usage	-	Create Training Plan	100%			Presentation completed			Yes	67.8%	68.9%	69.5%	68.7%	68.1%	68.8%	67.3%	68.1%	66.6%	67.2%	69.0%	67.6%
9b		£31,962		% Smokers given brief advice										15.0%	16.2%	15.4%	15.5%	14.2%	15.9%	15.3%	15.1%	15.6%	16.1%	15.6%	15.7%
9c		£39,953		% Smokers referred and/or offered medication										15.9%	12.4%	16.0%	14.7%	15.9%	13.0%	12.5%	13.8%	14.5%	11.5%	15.4%	13.9%
9d		£39,953		% Patients screened for Alcohol usage										64.7%	66.0%	66.1%	65.6%	64.5%	66.4%	64.0%	65.0%	64.1%	64.7%	67.0%	65.2%
9e		£39,953		% Alcohol users given brief advice										17.4%	16.0%	15.9%	16.5%	14.8%	17.2%	17.3%	16.5%	15.5%	12.3%	14.6%	14.2%
9a	Community	£15,981	Preventing ill health by risky behaviours - alcohol and tobacco	% Patients screened for Tobacco usage	73.0%	100%				Quarter End Position			74.0%	Quarter End Position			76.5%	Quarter End Position			77.2%	Quarter End Position			78.60%
9b		£63,925		% Smokers given brief advice	100.0%					Quarter End Position			56.0%	Quarter End Position			91.9%	Quarter End Position			85.9%	Quarter End Position			91.60%
9c		£79,906		% Smokers referred and/or offered medication	0.0%					Quarter End Position			5.4%	Quarter End Position			7.3%	Quarter End Position			0.5%	Quarter End Position			0.50%
9d		£79,906		% Patients screened for Alcohol usage	4.0%					Quarter End Position			1.4%	Quarter End Position			14.8%	Quarter End Position			16.1%	Quarter End Position			16.40%
9e		£79,906		% Alcohol users given brief advice or medication	0.0%					Quarter End Position			0.0%	Quarter End Position			7.7%	Quarter End Position			6.3%	Quarter End Position			0.00%
10. Improving the assessment of wounds																									
10	Community	£383,547	Improving the assessment of wounds	% Patients with a chronic wound who have received a full wound assessment	50.0%	50% (Internal Target)	60%	70% (Internal Target)	80%	Quarter End Position			55.3%	Quarter End Position			61.6%	Quarter End Position			55.7%	Quarter End Position			90.20%
11. Personalised care and support planning																									
11a	Community	£319,623	Personalised care and support planning	Cohort 1 patients having evidence of care and support planning	-	N/A	N/A	N/A	75%	Data available at year end			N/A	Data available at year end			N/A	Data available at year end			N/A	Data available at year end			100%
11b				Cohort 2 patients improvements in patient activation assessments	-	N/A	N/A	N/A	50%	Data available at year end			N/A	Data available at year end			N/A	Data available at year end			N/A	Data available at year end			82%

17. Governance Report

a) Scheme of Delegation Review

b) Board of Directors Attendance Register 2018-19

c) Board Committees and Revised Governance Structure

d) Sub-Committees Self-Effectiveness

e) Updated Quality Committee Terms of Reference

f) Constitutional Changes - Proposal to appoint an additional Partnership Governor

g) Compliance with Code of Governance

h) Compliance with NHS Improvement (Monitor) License Conditions

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2 May 2019
Meeting:	Board of Directors
Title:	Governance Report – May 2019
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee (a, c, g, h) Quality Committee (e) Council of Governors (f)

Actions Requested:

- To approve

Purpose of the Report

To ensure effective corporate governance, and in line with the Trust Code of Governance, this report provides updates to the Board on current governance issues and presents key documents that form part of the Trust's governance framework for review and approval.

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

a. Scheme of Delegation Review
b. Board of Directors Attendance Register 2018-19
c. Board Committees and Revised Governance Structure
d. Sub-Committees Self Effectiveness
e. Quality Committee Terms of Reference
f. Constitutional Changes - Proposal to appoint an additional Partnership Governor
g. Compliance with Code of Governance
h. Compliance with NHS Improvement (Monitor) Licence Conditions

Key Points to Note

a. Scheme of Delegation Review

The purpose of the Scheme of Reservation and Delegation is to set out the powers reserved to the Board of Directors and those that the Board has delegated.

It forms part of the Trust's corporate governance framework which is the regulatory framework for the business conduct of the Trust within which all Trust Directors and officers are expected to comply. The scheme shows only the most senior level of delegation within the Trust and should be used in conjunction with the system of budgetary control and other established procedures within the Trust.

The Trust scheme of delegation with standing orders, standing financial instructions and scheme of delegation has been reviewed and updated and is enclosed at Appendix K1. Updates include alignment with the Trust Standing Financial Instructions, lead changes and addition of a scheme of delegation relating to the Mental Health Act 1983 which formalises a service level agreement in place with South West Yorkshire Partnership Foundation Trust.

The Scheme of Delegation was reviewed at the Audit and Risk Committee meeting on 17 April 2019 and is recommended for **APPROVAL** to the Board of Directors.

b. Board of Directors Attendance Register 2018-19
The Board is asked to review and confirm the Board of Directors attendance register for the period 1 April 2018 to 31 March 2019. The Board are asked to **APPROVE** the Board of Directors Attendance Register at Appendix K2.

c. Board Committees and Revised Governance Structure
Following a review of the Board Sub-Committees, a revised governance structure has been discussed with both Executive Directors and Non-Executive Directors. The proposed revisions to the governance structure is attached at Appendix K3 and has been discussed by the Audit and Risk Committee on 17 April 2019 and is recommended to the Board for approval. The main changes include:

• Estates Sustainability Committee will cease and a Transformation Programme Board will be established

• Health and Safety Group to report to the Audit and Risk Committee

• The Health Informatics Service (THIS) Board, Huddersfield Pharmacy Specials (HPS) Board and the Joint Liaison Committee for Calderdale Huddersfield Solutions to report to Finance and Performance Committee

• Further work will be undertaken involving the Chief Nurse and Chief Operating Officer on the sub-group reporting structure to the Quality Committee during Q1 2019/20.

It is proposed that a review of the terms of reference of all Board committees is undertaken to ensure consistency of terms of reference.

The Board are asked to **APPROVE** the revised Board Committee governance structure.

d. Sub-Committee Self Effectiveness
In line with best practice during January to April 2019, all Board sub-committees have been assessing themselves against their terms of reference and how well the committee operates across a number of categories using a structured checklist. The outcome of the assessment is shared with each Committee. A meeting of Board Committee Chairs is planned, and the outcomes of the self-effectiveness report will be discussed at this meeting.

e. Quality Committee Terms of Reference
The terms of reference of the Quality Committee have been reviewed in January 2019 and are presented to the Board for **APPROVAL** at Appendix K4. The main changes are to receive internal audit reports (with a quality element) and seek assurance on recommendations, changes to the membership including the requirement for two Non-Executives to attend rather than three.

It is acknowledged that once the work reviewing the Quality Committee sub-group reporting structure is complete the terms of reference may need further review and approval.

f. Constitutional Changes - Proposal to appoint an additional Partnership Governor
The Council of Governors currently comprises 16 elected public governors, up to six elected staff governors and six appointed stakeholder or partnership governors, excluding the two local councils, one from each of the following as identified in the Trust's Constitution.

• Locala;
• South West Yorkshire Partnership Foundation Trust;
• Huddersfield University;
• Healthwatch

Stakeholder or partnership governors are not elected as local representatives but are invited and appointed by the Trust on the recommendation of their organisations. The tenure period is normally three years commencing from the date of the appointment.

As noted above there are currently four partnership governors and an option of up to six partnership governors.

The Trust established Calderdale and Huddersfield Solutions Limited (CHS) as a wholly owned subsidiary in September 2018 and it is proposed that the Constitution be amended to include Calderdale and Huddersfield Solutions Ltd as an additional stakeholder / partnership governor.

Subject to Board approval of CHS as a partnership governor the next steps would be as follows:

• to liaise with CHS about the appointment of a partnership governor
• to confirm this appointment to the Council of Governors
• to announce this appointment at the Annual General Meeting on 18 July 2019
• to amend Annexe 6, section 1.4 of the Constitution to confirm CHS as a partnership governor.

This proposal was presented to the Council of Governors on 17 April which supported the addition of CHS as a partnership governor. The Board is therefore asked to **APPROVE** the appointment of CHS as an additional partnership governor.

g. Compliance with Code of Governance
As part of our annual reporting process we are required to provide a report stating compliance against the Code of Governance on a comply or explain basis. An assessment of compliance was reviewed and approved by the Audit and Risk Committee at its meeting on 17 April 2019. Specific disclosures within this document will be included in the Annual Report for 2018/19 in line with national guidance.

h. Compliance with NHS Improvement (Monitor) Licence Conditions
The NHS Provider licence requires the Board to submit an annual self-certification that the Trust has:

• effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the NHS constitution, Condition G (6) 3 – deadline 31 May 2019
• complied with governance arrangements (condition FT4) – deadline 30 June 2019
• the required resources are available to deliver designated services for the 12 months from the date of the statement, Condition COS 7(3) – deadline 31 May 2019.

The Board is asked to **NOTE** that self -certification with licence conditions will be completed by the deadlines above. As in 2017 and 2018, due to the financial deficit position and breach of licence the Trust will not be able to certify compliance with the third condition, CoS7(3).

EQIA – Equality Impact Assessment
There are no significant equality issues.
Recommendation
The Board is asked to **APPROVE** the following: • Scheme of Delegation (Appendix K1) • Board of Directors Attendance Register 2018-19 (Appendix K2) • Board Committee Governance Structure (Appendix K3) • Terms of Reference of the Quality Committee (Appendix K4) • Proposal to appoint Calderdale Huddersfield Solutions (CHS) Limited as a partnership governor and amend the Trust Constitution accordingly The Board is asked to **NOTE** the following: • Declarations regarding the Code of Governance have been approved by the Audit and Risk Committee • The Trust will submit the required annual self-certification under the NHS provider licence in line with the deadlines and national guidance.

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: April 2020
Review Lead: Finance Director

Calderdale and Huddersfield NHS Foundation Trust

SCHEME OF DELEGATION
AND
RESERVATION OF POWERS TO THE BOARD

FOR

Calderdale and Huddersfield NHS Foundation Trust

(Reviewed April 2019)

Document Summary Table			
Unique Identifier Number	G-3-2010		
Status			
Version			
Implementation Date	April 2010		
Current/Last Review Dates	April 2019		
Next Formal Review	April 2020		
Sponsor	Director of Finance		
Author	Company Secretary		
Where available	Intranet		
Target audience	All staff		
Ratifying Committee			
Executive Board			
Consultation Committees			
Committee Name		**Committee Chair**	**Date**
Audit and Risk Committee		Richard Hopkin	17 April 2019
Other Stakeholders Consulted			
Deputy Director of Finance			
Head of Safeguarding			

Does this document map to other Regulator requirements?	
Monitor / NHS Improvement	*NHS Foundation Trust Code of Governance*

Document Version Control	
Version no	*Details of review/alterations, rational for document etc*
2	Update to align with revised Standing Financial Instructions and Director lead changes Addition of scheme of delegation for Mental Health Act 1983

CONTENTS

1.0 INTRODUCTION

This Scheme of Delegation (SoD) details administrative practice and procedure and records the delegations and reservations of powers and functions adopted by the Calderdale and Huddersfield NHS Foundation Trust (referred to as the "Trust"). They should be used in conjunction with the *Constitution* and the *Standing Financial Instructions* which have been adopted by the Trust. The Trust's *Constitution* and the *Foundation Trust Code of Governance* from NHS Improvement (formerly Monitor) requires such a formal document recording the exercise of delegated powers.

The Trust is a Public Benefit Corporation following approval by the Independent Regulator of NHS Foundation Trusts (known as Monitor or NHS Improvement) pursuant to the National Health Service Act 2006 (the "2006 Act"). The Trust is governed by the 2006 Act, as amended by the Health and Social Care Act 2012 (or subsequent statute, its Constitution and the NHS Licence Conditions granted by NHS improvement. The functions of the Trust are conferred by the Regulatory Framework and the Trust is required to comply with the guidance issued by NHS Improvement. This SoD and their content and approval are the sole responsibility of the Board of Directors and are not required to be submitted for approval to any group or organisation including NHS Improvement or the Council of Governors.

The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee or by the CHAIR or a director or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit". The NHS Code of Accountability for NHS Boards also requires that there should be a formal schedule of matters specifically reserved to the Trust.

The purpose of this document is to detail how those powers may be reserved to the Board - generally matters for which it is held accountable to NHS Improvement, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions, even those delegated to the CHAIR, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.1 The Purpose of the Board

The Board of Directors is a strategic unitary board that has regard to robust arrangements being in place that will deliver strong and high quality patient care and strong financial management. The appropriate role of the Board is to ensure that the governance mechanisms to meet these objectives are in place. This means that the Board takes the view that the experts it employs in each functional field should have the authority to present policies and procedural documents to the operational Executive Board who will give approval. The Board of Directors will be notified of policy and procedural changes for them to scrutinize if they wish, but will not do this as part of the normal function of the Board of Directors Meetings.

1.2 Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions

he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain on accountability to the Board.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer the Chief Executive is accountable to NHS Improvement for the funds entrusted to the Trust.

1.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a matter, which, in their judgement was likely to be a cause for public concern.

1.4 Directors' Ability to Delegate their own Delegated Powers

The SoD shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

1.5 Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, their delegated powers may be exercised by the designated Deputy Chief Executive. If both the Chief Executive and the Deputy Chief Executive are absent, the Chief Executive's delegated powers may be exercised by a nominated Executive Director acting in the Chief Executive's absence.

2.0 RESERVATION OF POWERS TO THE BOARD

The NHS Code of Accountability which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto itself. These reserved matters are set out below:

2.1 General Enabling Provision

The Board may determine any matter it wishes in full session within its statutory powers.

2.2 Regulation and Control

2.2.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

2.2.2 Approval of a scheme of delegation of powers from the Board to officers.

2.2.3 Receiving declarations of directors' interests and also the requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.

2.2.4 Requiring and receiving the declaration of interests from officers which may conflict with those of the Trust.

2.2.5 Disciplining directors who are in breach of statutory requirements or SOs.

2.2.6 Approval of the disciplinary procedure for officers of the Trust.

2.2.7 Approval of arrangements for dealing with complaints.

2.2.8 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to.

2.2.9 To receive reports from committees including those which the Trust is required by Monitor or other regulation to establish and to take appropriate action thereon.

2.2.10 To confirm the recommendations of the Trust's committees where the committees do not have executive powers. To establish terms of reference and reporting arrangements of all sub-committees (and other committees if required).

2.2.11 Notification of any urgent decisions taken by the Chief Executive in accordance with SO 4.2.

2.2.12 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

2.3 Appointments

2.3.1 The appointment and dismissal of committees.

2.3.2 The appointment, appraisal, disciplining and dismissal of executive directors (subject to SO2.6).

2.3.3 The appointment of members of any committee/sub committee of the Trust or the appointment of representatives on outside bodies.

2.4 Policy Determination

2.4.1 Having regard to the strategic context that the Board has set for itself and the way it conducts the business of the Trust, it will only deal in determining strategic business. Therefore policies will be approved by the Executive Board and reported to the next Board of Directors Meeting.

2.5 Strategy and Business Plans and Budgets

2.5.1 Definition of the strategic aims and objectives of the Trust.

2.5.2 Approval of annual business plans

2.5.3 Approval of annual budgets for the Trust.

2.6 Direct Operational Decisions

2.6.1 Acquisition, disposal or change of use of land and/or buildings of a significant nature (above £300,000.

,

2.6.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £1m.

2.7 Financial and Performance Reporting Arrangements

2.7.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees, associate directors and officers of the Trust as set out in management policy statements. All monitoring returns required by Monitor, Care Quality Commission and the Charity Commission shall be reported, at least in summary, to the Trust.

2.7.2 Approval of the opening or closing of any bank or investment account.

2.7.3 Approval of any working capital facility arrangement entered into.

2.7.4 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

2.7.5 Consideration and approval of the Trust's Annual Report including the annual accounts.

2.7.6 Receipt and approval of the Annual Report(s) for funds held on trust.

2.8 Audit Arrangements

2.8.1 To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit Committee meetings and take appropriate action.

2.8.2 The receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit Committee.

2.8.3 To receive a report/minutes from the Audit Committee relating to the annual report received from the internal auditors and the agreement of action on any recommendations.

3.0 DELEGATION OF POWERS

3.1 Delegation to Committees

The Board may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of Monitor and or the Charity Commissioners (including the need to appoint an Audit Committee, and a Remuneration and Terms of Service Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 5.5 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

4.0 SCHEME OF DELEGATION TO OFFICERS

4.1 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Director of Finance (DoF) and other directors. These responsibilities are summarised below.

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
General Data Protection Regulation Requirements	Managing Director, Digital Health
Health and Safety Arrangements	Chief Executive

There are two schemes of delegation. The “top level” scheme covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs (Appendix A).

A more detailed scheme of delegation including financial limits is attached as Appendix B.

APPENDIX A

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of SOs.
3.5	CHAIR	Calling meetings.
3.13	CHAIR	Chair all board meetings and associated responsibilities.
6.8	CE	Register(s) of interests.
9.19	CE	Best value for money is demonstrated for all services provided under contract or in-house.
9.20	CE	Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.
9.22	CE	Ensure that procedures are in place to manage each contract on behalf of the Trust.
9.23	CE	Ensure that procedures are in place to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts.
9.24	CE	Nominate officers with power to negotiate commissioning contracts with providers of healthcare and other authorities.
10(a)	CE/NOMINATED OFFICER	Determining any items to be sold by sale or negotiation.
12.1	CE	Responsible for ensuring seal is kept in a safe place and a register of sealing is maintained.
12.2	CHAIR/CE OR DEPUTIES	Board delegated powers to seal documents and initial any amendments thereto.
12.3a.	CHAIR/CE/DEPUTIES DOF AND/OR NOMINATED OFFICERS	Board delegated powers to approve the signing and sealing all building, engineering, property or capital documents and initial any amendments thereto.
12.3b	DOF	Board delegated powers to approve building, engineering, property or capital documents and any amendments thereto.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
13.1	CE	Approve and sign all documents which will be necessary in legal proceedings
13.2	CE OR NOMINATED OFFICERS	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
14.1	CE	Existing Directors and employees and all new appointees are notified of and understand their responsibilities within Standing Orders SFIs.
Annex s2	CE	Designate an officer responsible for receipt and custody of tenders before opening.
Annex s3	TWO SENIOR OFFICERS	Open tenders. (paper based only)
Annex s4	CE OR NOMINATED OFFICER	Decide whether any late tenders should be considered.
Annex s5	DOF	Keep lists of approved firms for tenders.

APPENDIX B

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.6	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	DIRECTOR OF FINANCE (DOF)	Responsible for: Implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.8	ALL DIRECTORS AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.10	DOF	Form and adequacy of financial records of all departments.
2.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
2.2	DOF	Carry out all work to counter fraud and corruption in accordance with Directions on Fraud and Corruption and Bribery Act 2010
2.3.1	DOF	Monitor effectiveness of internal financial control, internal audit function and Investigate any suspected cases of irregularity not related to fraud or corruption and not covered by work to counter fraud and corruption.
2.4	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.5	AUDIT COMMITTEE	Ensure cost-effective external audit.
3.1.2	DOF	Submit budgets.
3.1.3	DOF	Monitor performance against budget, submit to Board financial estimates and forecasts.
3.2	CE	Delegate budget to budget holders and submit monitoring returns.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
3.3	DOF	Devise and maintain systems of budgetary control.
4	DOF	Annual accounts and reports.
5	DOF	Banking arrangements.
6	DOF	Income systems.
8 7.3	CE DOF	Ensure adequate and appropriate business arrangements for the provision of patient services. Regular reports of actual and forecast contract expenditure.
9.1 – 9.2 9.4	BOARD REMUN COMMITTEE DIRECTOR/EMPLOYEE	Remuneration & Terms of Service Committee Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees. Staff, including agency staff, appointments.
9.5	DIRECTOR OF WORKFORCE AND OD	Payroll
10.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
10.2.3	DOF	Prompt payment of accounts.
10.2.5	CE	Authorise who may use and be issued with official orders.
10.2.7	DOF	Ensure that Standing Orders are compatible with requirements of NHS Improvement re building and engineering contracts.
11	DOF	Advise Board on borrowing and investment needs and prepare procedural instructions.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
12.1	CE	Capital investment programme
12.1.5	DOF	Monitoring the capital programme.
12.3	CE	Maintenance of asset registers.
12	CE	Overall responsibility for fixed assets.
12.4.4	ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
13	DOF	Responsible for systems of control over stores and receipt of goods.
13.8	CE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
14	DOF	Prepare procedures for recording and accounting for losses and special payments and informing NHSI of all frauds and informing police in cases of suspected arson or theft.
15	DOF	Responsible for accuracy and security of computerised financial data.
16	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17	DOF	Shall ensure each fund held on trust is managed appropriately.
18	CE	Retention of document procedures
19	CE	Risk management programme
19.3	CE	Insurance arrangements

APPENDIX C

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST - DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated.** Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1.	**Management of Budgets** Responsibility of keeping expenditure within budgets		
a)	At individual budget level (Pay and Non Pay and non-contracted income)	Budget Manager	SFIs Section 3
b)	For the totality of services covered in a division.	Divisional Director	
2.	**Maintenance / Operation of Bank Accounts**	Director of Finance	SFIS Section 5
3. **a)**	**Non Pay Revenue and Capital Expenditure/Requisitioning/Ordering/Payment of Goods & Services** Non-Pay expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified in the Authorisation Limits in Appendix I of the SFIs		SFIs Section 10 and Appendix 1, Standing Orders section 9
4.	**Capital Schemes**		
a)	Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations and the Trust tender process	Chief Executive or Director of Finance	SFIs Section 12 and Appendix 1
b)	Financial monitoring and reporting on all capital scheme expenditure	Director of Finance or	
c)	Granting, extension and termination of leases for equipment	Director of Finance	

d)	Granting, extension and termination of leases for land and buildings	Director of Finance and Chief Executive	
e)	Approval of business case ▪ £2,500,000and over ▪ Between £2,000,000 and £2,500,000 ▪ Between 50,000 and £2,500,000 ▪ Less than £50,000	Board of Directors Trust Executive Board Chief Executive and Director of Finance Capital Investment Group	
5. **a)**	**Quotation, Tendering and Contract Procedures for Goods and Services** **Competitive Tenders** **Authorisation limits**	Chief Executive	Refer to the Authorisation Limits in Appendix 1 of the SFIs
b)	**Opening Tenders**	Nominated representative by the Director of Finance	
i.	Receipt and custody of tenders prior to opening (where e-tendering portal being used)	Nominated representative by the Director of Finance	
ii.	Receipt and custody of tenders prior to opening (where the paper-based system used)	Two Trust HQ officers designated by the Chief Executive	
d)	**Waiving of Quotations and Tenders**		
. i.	Tenders – refer to paragraph 7.6 of the Standing Financial Instructions subject to the completion of the relevant Application to Waive Competitive Tenders Procedure form. Quotes – refer to paragraph 7.6 of the Standing Financial Instructions subject to the completion of the relevant Application to Waive Competitive Tenders Procedure form.	Director of Finance (or a nominated representative) (reported to the Audit Committee) Director of Finance (or a nominated representative)	
6.	**Setting of Fees and Charges**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	Appropriate Director	SFIs Section 6.2

b)	Price of NHS Contracts Charges for all NHS Contracts	Chief Executive or Director of Finance	SFIs Section [8]
7. a) b) c) c) d) e) i. ii iii	**Engagement of Management/Specialist Consultancy (non-medical)** Management or Specialist Consultancy Where total commitment is less than £20,000 Where total commitment is between £20,000 and £100,000. Where total commitment is above £100,000 In accordance with NHS Improvement mandatory guidance the engagement, appointment or commissioning of any consultancy over £50,000 Engagement of Trust's Solicitors • Employment law matters • All other legal matters Booking of Bank or Agency Staff • Nursing Off framework Above 50% wage Bank and Tier 1 Agency cap • Medical	Appropriate Director Two Executive Directors (one of whom must be the Chief Executive, Deputy Chief Executive or Director of Finance Chief Executive and Director of Finance NHS Improvement Director of Workforce and OD Company Secretary Appropriate Director Executive Director Executive Director Deputy Director of Nursing (via Nursing Daily staffing meeting)	SFIs Section 9

8.	**Expenditure on Charitable Funds** For authorisation limits please refer to Appendix 1 of the Standing Financial Instructions and to paragraph 17 for further guidance.		SFIs Section 17
a)	Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	Director of Finance	
b)	Letting of premises to non NHS organisations.	Chief Executive/ Director of Finance	
c)	Letting of premises to other NHS Organisations	Chief Executive and Director of Finance	
d)	Approval of rent based on professional assessment	Director of Finance	
e)	Sales and purchase of land not exceeding £100	Chief Executive and Director of Finance of Director of Finance	
10.	**Condemning & Disposal**		
a)	Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively (to be recorded in the appropriate Losses Register		SFIs Section 14.1 and SFIs Appendix 2,
	i) all IT equipment with new price <£5,000	Director of Health Informatics	
	ii) all medical equipment with new price <£5,000	Divisional Director	
	iii) all mechanical and engineering plant <5,000	Chief Executive or Director of Finance (as Chair of Capital Investment Group	
	iv) all general equipment with new price <£5,000		
	v) all equipment with new price >£5,000		
11.	**Losses, Write-off & Compensation**		
a)	Losses and Cash due to theft, fraud, overpayment & others Up to £50,000	Chief Executive and Director of Finance	SFIs Section 14.2 and SFIs Appendix 2
b)	Fruitless Payments (including abandoned Capital Schemes) Up to £250,000	Chief Executive and Director of Finance	

c)	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other Up to £1,000 –Over £1,000	Chief Executive or Director of Finance Audit Committee	
d)	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other Up to £50,000	Chief Executive or Director of Finance	
e)	Extra Contractual payments to contractors Up to £50,000	Chief Executive or Director of Finance	
f)	Ex-gratia Payments Patients and staff for loss of personal effects Up to £2,500 £2,500 to £100,000	~~Head of Governance and Risk~~ Assistant Director for Quality and Safety, Chief Executive or Director of Finance AND Medical Director or Director of Nursing	
g)	Payments or admissions of liability for personal injury claims involving negligence where legal advice has been obtained and guidance applied Up to £10,000 for employers liability and Up to £3,000 for public liability (to reflect the excess payment)	Assistant Director for Quality and Safety	
h)	Other, except cases of maladministration where there was no financial loss by claimant up to £50,000 **The following safeguards must have been made before payment can be made:** **a. For clinical negligence claims, the claim has been agreed with the NHS Resolution with the appropriate legal advice.** **b. For employee liability and public liability cases, that the claim has been agreed with the insurers with the appropriate legal advice.** **c. Where the level of expenditure is below that which requires either NHS Resolution or our insurers' approval, that legal advice supports the amount and payment of the claim.**	Chief Executive and Director of Finance	

12. a) b)	Reporting of Incidents to the Police Where a criminal offence is suspected i) criminal offence of a violent nature ii) other than fraud Where a fraud in involved	 Duty Manager Appropriate Director Director of Finance	 SFIs Section 2 & 14 Fraud Policy & Response Plan
13. a)	**Petty Cash Disbursements** Expenditure up to £40 per item	 Manager / Authorised Signatory	 SFIs Section10
14. **a)** **b)**	**Receiving Hospitality, Gifts and Individual Corporate Sponsorship** Declaring the receipt of gifts and hospitality and/or individual sponsorships for inclusion in the Trust register. (Applies to both individual and collective hospitality / gifts / sponsorship received in In excess of £20.00 per item received. Approving the retention of gifts and receipt of hospitality/sponsorship • For Non-Executive Directors • For all employees	 Individual Staff Member Declaration required in Trust's Hospitality Register maintained by Company Secretary CHAIR Chief Executive	 Refer to Standards of Business Policy and [Conflicts of Interests Policy]
15.	**Implementation of Internal and External Audit Recommendations**	Director of Finance	SFIs Section 2
17.	**Investment of Funds (including Charitable & Endowment Funds)**	Director of Finance	SFIs Section 11 and 17
18. a) b)	**Personnel, Pay and Expenses** Authority to fill funded post on the establishment with permanent staff. Authority to appoint staff to post not on the formal establishment.	 Director/Assistant Divisional Director Director/Assistant Divisional Director	

d)	Regrading All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure.	Director of Workforce and OD/Assistant Divisional Director	
e)	Establishments		
	i. Additional staff to the agreed establishment with specifically allocated finance.	Director/Assistant Divisional Director	
	ii. Additional staff to the agreed establishment without specifically allocated finance.	Director/Assistant Divisional Director	
f)	Pay		
	i. Authority to complete standing data forms effecting pay, new starters, variations and leavers.	Director of Workforce & OD /Assistant Divisional Director	
	ii. Authority to complete and authorise positive reporting forms.	Line Manager	
	iii. Authority to authorise overtime.	Line Manager	
	iv. Authority to complete and authorise positive reporting forms.	Line Manager	
	v. Authority to authorise travel & subsistence expenses.	Line Manager	
g)	Leave		
	i. Approval of annual leave	Line Manager	See appropriate Trust Policy
	ii. Annual Leave – approval of carry forward f 5 days.	Line Manager	
	iii. Annual Leave – approval of carry over 5 days (to occur in exceptional circumstances only	Line Manager	
	iv.		
	v. Compassionate Leave up to 6 days.	Line Manager	
	vi. Special Leave arrangements	Line Manager	

	• paternity leave • carers leave • adoption leave (to be applied in accordance with Trust Policy	Line Manager
	vii. Leave without pay	
	viii. Medical Staff Leave of Absence • paid and unpaid	Clinical Director/General Manager/Line Manager
	ix. Time off in lieu	Line Manager
	x. Maternity Leave – paid and unpaid	Line Manager
h)	<u>Sick Leave</u> i. Extension of sick pay	Director of Workforce & OD /Assistant Divisional Director
i)	<u>Study Leave</u> i. Study leave outside the UK	Divisional Director
	ii. Medical staff study leave (UK)	Clinical Director/General Manager/Line Manager
	iii. All other study leave (UK)	Line Manager
j)	<u>Removal Expenses</u> Authorisation of payment of removal expenses	Director/Assistant Divisional Director
k)	<u>Authorised Car & Mobile Phone Users</u>	
	Requests for new posts to be authorised as car users.	Line Manager
	Requests for new posts to be authorised as mobile telephone users.	Line Manager

l)	Renewal of Fixed Term Contract	Line Manager	
m)	Redundancy	Director of Workforce & OD and Director of Finance	
n)	Dismissal inc. Ill Health	Director/Assistant Divisional Director	
19.	**Authorisation of New Drugs**	Drugs and Therapeutics Committee	
20.	**Authorisation of Sponsorship Deals**	Chief Executive, Medical Director	
21.	**Authorisation of Research Projects**	Chief Executive, Medical Director	
22.	**Authorisation of Clinical Trials**	Chief Executive, Medical Director & Deputy and Director of Operations	
23.	**Insurance Policies** **Risk management arrangements** Risk Management Strategy	Director of Finance Director of Nursing	SFIs Section 19
24.	**Patients & Relatives Complaints** a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico – Legal Complaints Co-ordination of their management	 Director of Nursing Director of Nursing Director of Nursing	
25.	**Relationships with Press** a) Non-Emergency General Enquiries • Within Hours • Outside Hours	 ~~Company Secretary~~ / Communications Manager ~~Company Secretary~~ / Communications Manager	

	b) Emergency • Within Hours • Outside Hours	Chief Executive or Executive Director Communications Manager or On Call Director	
26.	**Infectious Diseases & Notifiable Outbreaks**	On Call Infection Control Team	
27.	**Extended Role Activities** Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.	Director of Nursing	Nurse/Midwives Health Visitors Act Midwives Rules/Code of Professional Conduct
28.	**Patient Services** a) Variation of operating and clinic sessions within existing numbers • Outpatients • Theatres • Other b) All proposed changes in bed allocation and use • Temporary Change • Permanent Change	General Manager General Manager General Manager Associate Divisional Director Chief Operating Officer and Divisional Director	
29.	**Facilities for staff not employed by the Trust to gain practical experience** Professional Recognition, Honorary Contracts, and Insurance of Medical Staff. Work experience students.	Clinical Directors or Medical Staffing Manager or PGME Director as appropriate Departmental Managers / Personnel Officer	
30.	**Review of fire precautions**	~~Director of Estates~~ Director of Finance , Director of	Fire Safety Policy

		Workforce and Organisational Development	
31.	**Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations**	Director of Nursing in conjunction with Director of Estates as appropriate	Health & Safety at Work
32.	**Review of Medicines Inspectorate Regulations**	Clinical Director of Pharmacy	
33.	**Review of compliance with environmental regulations, for example those relating to clean air and waste disposal**	~~[Director of Estates]~~ Director of Workforce and Organisational Development Director of Finance	
34.	**Review of Trust's compliance with the Data Protection Act**	Director of Health Informatics	
35.	**Monitor proposals for contractual arrangements between the Trust and outside bodies**	Director of Transformation and Partnerships	
36.	**Review the Trust's compliance with the Access to Records Act**	Medical Records Manager	
37.	**Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" practices.**	Managing Director Digital Health ole ?	
38.	**The keeping of a Declaration of Interests Register**	Chief Executive/Company Secretary	SOs Section 6
39.	**Attestation of sealings in accordance with Standing Orders**	Company Secretary	SOs Section 12
40.	**The keeping of a register of Sealings**	Company Secretary or PA to Chief Executive	SOs Section 12
41.	**The keeping of the Hospitality Register**	Company Secretary	
42.	**Retention of Records**	Medical Records Manager	SFIs Section 18

43. **Mental Health Act 1983: Scheme of Delegation by the Hospital Managers and Training**

Director with responsibility: Chief Nurse **Operational lead: Chief Operating Officer**

FUNCTIONS WHICH CANNOT BE DELEGATED TO OFFICERS OF THE TRUST

Function	Legislative Reference	Code of Practice Reference	Authorised Person / Committee
Review the Trust's operation of the Act, governance arrangements & varying this scheme of delegation		Chapter 37	Board of Directors

FUNCTIONS DELEGATED TO OTHER ORGANISATIONS

The Trust has a Service Level Agreement with South West Yorkshire Partnership Foundation Trust to act as hospital manager for the purpose of detaining an individual under the Mental Health Act	MHA sections 5(2)		South West Yorkshire Partnership Foundation Trust

FUNCTIONS DELEGATED TO OFFICERS

Recording admission For section 5(2) – Form H1	MHA sections 5(2) Regulation 4(1)(g)	Chapter 18: holding powers	H1 Part 1: Medical Practitioner in Charge of Patient or nominated deputy H1 Part 2: the designated authorised hospital manger which is the senior nurse in and out of hours who has received appropriate Mental Health Act receipt and scrutiny training
Formal Receipt and Scrutiny of statutory forms	MHA sections 5(2)	Chapter 18: holding powers	Head of Safeguarding
Provision of information on section 5(2) to patients and their nearest relative	MHA sections 5(2)	Chapter 2	Senior hospital nurse in and out of hours will provide relative letter 5(2) and the rights leaflet S5 (2).
Patient discharged from section 5(2) detention before the expiry of the 72	MHA sections 5(2)	Chapter 18: 18.19, 18.20 & 18.35	Medical Practitioner in Charge of Patient or nominated deputy or Approved

hours holding period (with clarity over start and finish times of the detention period)			Mental Health Practitioner (AMHP).

TRAINING PROVISION

Programme	Frequency	Course Length	Delivery Method	Trainer(s)	Recording Attendance	Strategic & Operational Responsibility
MCA Level 3	Every three years	31/2 hours	Face to face	Safeguarding team	Training team	Deputy Director of Nursing

*To be reviewed - Medical Staff also receive specific training in the use of the MHA at induction sessions, foundation year programme training and department specific sessions including Emergency Department.

Attendance	✓	Apologies	×

ATTENDANCE REGISTER – PUBLIC BOARD OF DIRECTORS
1 APRIL 2018 – 31 MARCH 2019

DIRECTOR	5.4.18	3.5.18	7.6.18	5.7.18	19.7.18 AGM	23.8.18	6.9.18	1.11.18	3.1.19	7.3.19	TOTAL
Philip Lewer (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Alastair Graham	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	**09/10**
Andy Nelson	✓	✓	✓	✓	✓	×	×	✓	✓	✓	**08/10**
Brendan Brown	✓	✓									**02/02**
David Anderson	✓	✓	✓	✓	✓	✓	✓				**07/07**
David Birkenhead	✓	✓	✓	× Rep	✓	✓	✓	✓	✓	✓	**09/10**
Gary Boothby	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Helen Barker	✓	✓	✓	✓	✓	✓	× Rep	✓	✓	× Rep	**08/10**
Jackie Murphy			✓	✓	× Rep	✓	✓	✓	✓	✓	**07/08**
Karen Heaton	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	**09/10**
Lesley Hill	✓	✓	✓	✓	✓	✓	✓	**App'd to CHS Limited 1.9.2018**			**06/06**
Linda Patterson	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	**09/10**
Owen Williams	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	**09/10**
Phil Oldfield	×	✓	✓	✓	×	✓	✓	✓	✓	✓	**08/10**
Richard Hopkin	✓	✓	✓	✓	×	✓	✓	✓	x	✓	**08/10**
Suzanne Dunkley	✓	✓	✓	× Rep	✓	× Rep	✓	✓	× Rep	✓	**07/10**

DRAFT GOVERNANCE STRUCTURE
APRIL 2019

A&E Board (System Resilience Group)

Partnership Transformation Board

WYAAT Committee in Common

BOARD OF DIRECTORS

Charitable Trustees

Charitable Funds Committee
Chair: Philip Lewer
Frequency: Quarterly

Council of Governors
Chair: Philip Lewer
Frequency: Quarterly

Nominations & Remuneration Committee
Chair: Philip Lewer
Frequency: Ad hoc but at least once annually

Audit and Risk Committee
Chair: Richard Hopkin
Frequency: Quarterly

Transformation Programme Board
Chair:
Frequency: Bi-Monthly
(Estates Sustainability Committee ceases June 2019)

Finance & Performance Committee
Chair: Phil Oldfield
Frequency: Monthly

Nominations & Remuneration Committee
Chair: Philip Lewer
Frequency: Ad hoc at least once annually

Workforce Committee
Chair: Karen Heaton
Frequency: Bi-Monthly

Quality Committee
Chair: Linda Patterson
Frequency: Monthly

Risk & Compliance Group
Chair: Chief Nurse
Frequency: Monthly

Information Governance & Risk Strategy Committee
Chair: CIO
Frequency: Quarterly

Clinical Records Group

Data Quality Board
Chair: COO
Frequency: Monthly

Health & Safety Group
Chair: ED Workforce & OD / Chief Nurse
Frequency: Monthly

Security & Resilience Group

Capital Planning Group

Commercial Investment & Strategy Committee

The Health Informatics Service Board

Huddersfield Pharmacy Specials Board

CHS & CHFT Joint Liaison Committee

Medical Devices & Procurement Group

Divisional and Corporate Performance Reviews Executive Lead &
Chair: **COO**
Frequency: Monthly

Trust Executive Board
Frequency: Weekly

Chair: CEO
Frequency: Weekly
One meeting per month focused on performance

Turnaround Executive
Chair: **CEO**
Frequency: Weekly

Performance Management

Strategic Development

Risk Management

Divisional Management, Patient Safety, Quality and Digital Boards
Chair: **DD**
Frequency: Monthly

Directorates (Speciality)

Research and Innovation Group
Chair: Deputy Medical Director
Frequency: Quarterly

Medication Safety and Compliance
Chair: CD Pharmacy
Frequency: Monthly

Infection Control Prevention Committee
Chair: IPC Doctor
Frequency: Quarterly

Infection Control Prevention Board
Chair: Medical Director
Frequency: Monthly

Hospital Transfusion Committee

Falls Improvement Collaborative

Resuscitation Group

Thrombosis / VTE Group

Pressure Ulcers Collaborative

IV Strategy Group ~~**Point of Care**~~

Radiation Protection Board

Safeguarding Committee
Chair: Deputy Chief Nurse
Frequency: Monthly

Patient Safety Group
Chair: AD Quality & Safety
Frequency: Monthly

Cancer Board
Chair: COO
Frequency: Monthly

Serious Incident Panel
Chair: **CEO**
Frequency: Bi-monthly

CQC Response Group (Task & Finish)
Chair: DofN
Frequency: Fortnightly

Dementia Operational Group

Family and Friends Group

Patient Experience and Caring Group
Chair: AD Quality
Frequency: Six Weekly

Deteriorating Patient Collaborative

End of Life Care Group

Clinical Effectiveness and Audit Group

Nutrition Steering Group

Mortality Surveillance Group

Sepsis Improvement Collaborative

Organ Donation Committee
Chair: Philip Lewer
Frequency: Quarterly

Clinical Outcomes Group
Chair: Medical Director
Frequency: Monthly

V12 January 2019

QUALITY COMMITTEE TERMS OF REFERENCE

1. Constitution

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

2. Authority

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

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

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

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

3. Purpose

3.1. The purpose of the Quality Committee is:

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

3.2. The Quality Committee is responsible for:

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

4. Duties

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

Quality improvement

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

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

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

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

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

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

Governance and risk

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

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

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

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

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

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

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

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

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

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

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

Quality and safety reporting

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

Audit and assurance

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

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

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

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

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

4.24. To receive internal audit reports (with a quality element) and seek assurance on recommendations

5. Membership and attendance

5.1. The Committee shall consist of the following members:

- Two Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee.
- Executive Director of Nursing
- Medical Director
- Executive Director of Workforce and Organisational Development

5.2. The following shall be required to attend all meetings of the Committee:

- Assistant Director of Quality and Safety
- Deputy Director of Nursing
- Head of Governance and Risk
- Governance administrator (notes)

5.3. The Chair of the Board of Directors will appoint a representative of the Council of Governors to attend each meeting as an observer. The appointment will be reviewed each year.

5.4. The following shall be required to attend the meetings focused on divisional performance (one meeting per quarter):

- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Surgery & Anaesthetics
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Medicine Division
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Families and Specialist Services
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Community Division

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

5.6. A quorum will be four members of the Committee and must include at least three board members of which one must be a Non-Executive and one an Executive Director.

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

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

6. Administration

6.1. The Committee shall be supported by the Administrator, whose duties in this respect will include:

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation
- Maintaining a record of attendance.

7. Frequency of meetings

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

8. Reporting

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

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

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

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

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

9. Review

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

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

10. Monitoring effectiveness

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

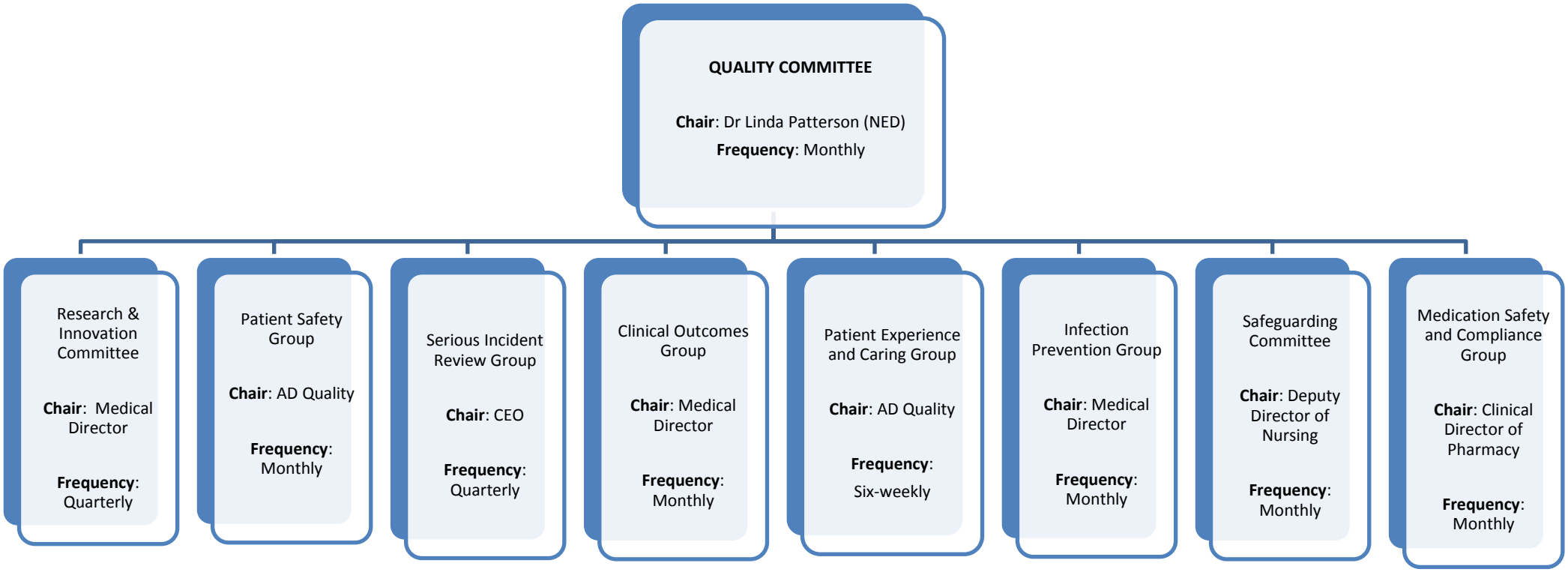
- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 5 working days prior to the meetings;
- The action point from each meeting are circulated within two working days, on 80% of occasions

Appendix 1
Members and required attendees of the Committee

Title	Required at
Non-Executive Director ***(Chair)***	All meetings
Non-Executive Director ***(Vice Chair)***	All meetings
Executive Director of Nursing	All meetings
Medical Director	All meetings
Executive Director of Workforce & Organisational Development	All meetings
Assistant Director of Quality and Safety	All meetings
Deputy Director of Nursing - Corporate	All meetings
Head of Governance and Risk	All meetings
Council of Governors	All meetings
Governance Administrator ***(Minutes)***	All meetings

Quarterly Representation	Required at
Surgical Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
FSS Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
Medical Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
Community Division Director of Operations / Associate Director of Nursing	Quarterly meetings

Appendix 2
Sub-groups



Appendix 3
Reports aligned to CQC domains

CQC domain	Reporting to Quality Committee via
Safe	▪ Safeguarding (Six monthly and annual reports) ▪ Patient Safety Group (Two reports per quarter) ▪ Board Assurance Framework (Quarterly) ▪ Corporate risk register (Two reports per quarter) ▪ Medication Safety and Compliance Group (Monthly) ▪ Falls Collaborative (Six monthly) <u>As required</u>: ▪ Prevention of future death reports, ▪ Incident reports / action plans.
Effective	▪ Organ donation (Annual reports) ▪ NICE guidance compliance (Six monthly) ▪ Clinical audit plan (Six monthly report) ▪ Clinical Outcomes Group (Two reports per quarter) ▪ Mortality Surveillance Group (Two reports per quarter) <u>As required:</u> ▪ Service specific reports / invited service reviews as required – detailed in workplan
Experience	▪ Patient Experience and Caring Group (Two reports per quarter)
Responsive	▪ Quarterly report (Quarterly) ▪ Quality Account ▪ Quality Annual report
Well-Led	▪ CQC report (Monthly) ▪ Research and Innovation (Six monthly report) ▪ Quality Impact Assessment process (Annual) ▪ Divisional Patient Safety and Quality Board Reports (Quarterly) ▪ Serious Incident Review Group (Quarterly) ▪ Infection Control Committee minutes (Quarterly)
Overall	▪ Quality Performance Report (Monthly)

Versions:	**1.1** first draft circulated for review to Chair / Director of Nursing **1.2** Amendments prior to Trust Board **1.3** Amendments after submission to Quality Committee **1.4** Further amendments **1.5** Further amendments **2** Amendments made: ▪ Director of Workforce and Organisational Development added to section 5.1; ▪ Section 5.2 added ▪ Divisional attendance amended in section 5.4 ▪ Quorum amended at section 5.6 ▪ Medication and Safety Compliance Group and Cancer Board added to sub-groups at appendix 2 ▪ Medication and Safety Compliance Group and Cancer Board added to reports at appendix 3 **3** Amendments made: ▪ Chief Operating Officer removed from membership ▪ Executive Director of Planning, Estates and Facilities removed from membership ▪ Two non-executive directors instead of three ▪ Purpose added in relation to internal audits
Appendices	**1.** List of members **2.** Sub groups **3.** Reports aligned to CQC domains
Date issued by Quality Committee:	January 2019
Date approved by Board of Directors:	<date>
Review date:	January 2020

18. Month 12 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS
NHS Foundation Trust

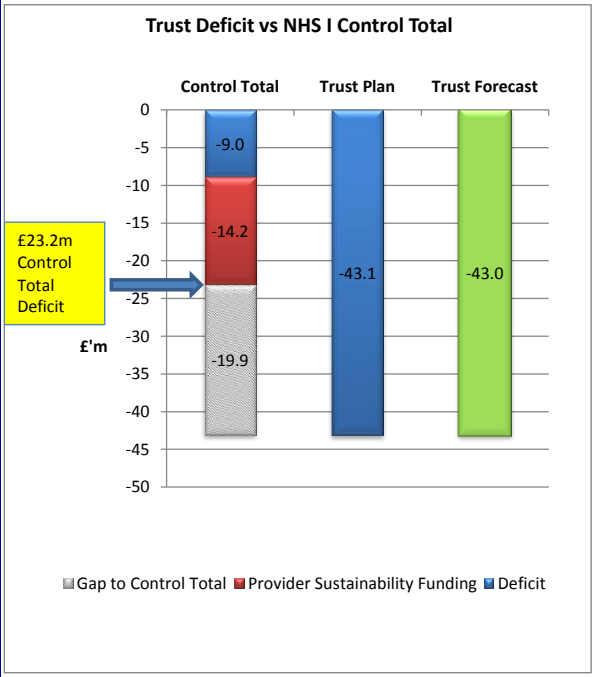
Cover Sheet

Date of Meeting:	Thursday 2nd May 2019
Meeting:	Board of Directors
Title:	Month 12 Total Group Financial Overview
Author:	Betty Sewell, PA to Director of Finance
Previous Forums:	Weekly Executive Meeting - Quality & Performance
Action requested: To note	
Purpose of the report	
Reported Financial Position at Year-Ended 2018/19	
Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)	
N/A	
EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)	
N/A	
Recommendation	
The Board to note the contents of the month 12 financial overview.	

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Mar 2019 - Month 12

KEY METRICS

	M12				YTD (MAR 2019)				Forecast 18/19			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£2.00)	(£2.02)	(£0.02)		(£43.05)	(£43.04)	£0.01		(£43.05)	(£43.04)	£0.01	
Agency Expenditure	(£1.21)	(£0.84)	£0.38		(£14.63)	(£12.49)	£2.14		(£14.63)	(£12.49)	£2.14	
Capital	£0.97	£1.91	(£0.94)		£9.14	£8.25	£0.89		£9.14	£8.25	£0.89	
Cash	£1.91	£2.04	£0.13		£1.91	£2.04	£0.13		£1.91	£2.04	£0.13	
Borrowing (Cumulative)	£144.83	£144.90	£0.07		£144.83	£144.90	£0.07		£144.83	£144.90	£0.07	
CIP	£2.56	£1.96	(£0.60)		£18.00	£18.00	£0.00		£18.00	£18.00	£0.00	
Use of Resource Metric	3	3			3	3			3	3		



Year to Date Summary

The year to date deficit is £43.04m, a £0.01m favourable variance from plan.

- Compared to the Month 11 forecast position there have been some additional cost pressures in month including a stock adjustment and other year end technical adjustments.
- These pressures have been offset in the reported position by a reduction in depreciation charges based on recent asset valuations and changes to asset lives.
- Clinical contract income performance is below plan by £3.41m. The Aligned Incentive Contract (AIC) protects the income position by £3.05m in the year to date leaving a residual pressure of £0.36m. However, this income protection (£3.45m) is as a result of CIP plans and management decisions where there is a corresponding reduction in cost.
- CIP achieved for the year is £18.00m as planned.
- Agency expenditure for the year was £12.49m, £2.14m below the agency trajectory set by NHSI.

Key Variances

- Medical staffing expenditure continued above plan, with pressure on non-contracted pay costs due to vacancy pressures particularly in Obs & Gynae, ENT, Dermatology, Urology and General Surgery.
- There have been significant pressures on non pay expenditure including a significant cost increase relating to the new clinical waste contract with Mitie (hosted by LTHT), where invoices have exceeded the expected impact of the price uplift, increased utilities costs following a price uplift of 23% on electricity, pressure relating to Radiology and Pathology send away tests charged from other providers and additional professional fees. There were also non recurrent costs incurred in month relating to the year end stock adjustment and an increase in general provisions.
- Nursing pay expenditure remains under control despite continued bank usage for one to ones and additional Agency costs linked to the opening of some additional capacity over the last two months.

Technical Movements / Non Operating Expenditure

- The revaluation of assets has resulted in the Trust reporting an impairment taken to I &E of £26.51m. Whilst this charge increases the total reported deficit to £69.61m, the impairment is excluded for Control Total purposes on the basis that is it both exceptional and non cash impacting.
- The revaluation has also impacted on the depreciation charge reported for the year, reducing the total cost for the year from a planned £11.93m to an actual cost of £8.86m, a £3.07m favourable variance.

Note: The reported position is representative of the Trust's draft annual accounts for 2018/19 which remain subject to external audit review and ratification.

19. Gender Pay Gap Reporting

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS
NHS Foundation Trust

Cover Sheet

Date of Meeting:	Thursday 2 May 2019
Meeting:	Board of Directors
Title:	GENDER PAY GAP REPORTING
Author:	Tracy Rushworth, PA to Director of Workforce and OD
Previous Forums:	EXECUTIVE BOARD 21 MARCH 2019

Action requested:

To note

Purpose of the report

The paper updates the Board of Directors on the position regarding the Trust data on the gender pay gap for the year ending 31 March 2018. The Trust is required to publish its data through the Government online reporting service, and on its own website, by 30 March 2019. This data was published on 21 March 2019. The paper compares the position with the year ending 31 March 2017 and identifies actions that the Trust is pursuing to reduce the gender pay gap.

Key Points to Note (Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)

Work to close the gender pay gap will form part of our approach to equality, diversity and inclusion which is an identified theme in our people strategy.

EQIA – Equality Impact Assessment (confirmation this has been completed and summary if any significant issues from this)

None

Recommendation

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

Appendix

Gender Pay Gap Reporting - BoD 2.5.19.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

2 MAY 2019

GENDER PAY GAP REPORTING

1. PURPOSE

This paper describes the gender pay gap for the Trust for the year ending **31 March 2018**. The data is now on our own website and has been submitted through the Government online reporting service as part of its mandatory publication scheme.

2. BACKGROUND

It became mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap. The Trust is registered with the Government Equalities Office enabling it to submit data on to the website. The Trust published its first gender pay gap data on 8 March 2018. This is the second year of the reporting scheme and the Trust was required to report its gender pay gap data by 30 March 2019.

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings.

The gender pay gap differs from equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The Equality and Human Rights Commission (EHRC) is responsible for monitoring how public bodies are complying with the gender pay gap reporting requirements and can take enforcement action.

3. WHAT IS TO BE REPORTED?

Employers within the scope of the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 (the Regulations) must carry out calculations using 'ordinary pay' in respect of the gender pay gap and 'bonus pay' in respect of the bonus pay gap.

Ordinary pay is defined as:-

- basic pay
- paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave)
- area and other allowances
- shift premium pay, defined as the difference between basic pay and any higher rate paid for work during different times of the day or night
- pay for piecework.

It does not include:-

- overtime payments
- redundancy or termination of employment payments
- payments in lieu of leave
- salary sacrifice
- remuneration provided otherwise than in money

Bonus pay is defined as:-

Any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission.

Bonus pay includes:-

- Doctors' clinical distinction/excellence awards as well as any other payments above the level of ordinary for performance or expertise such as performance related pay for very senior managers and others.
- Long Service Awards, where a monetary payment is made.

For each employee who receives a bonus, organisations need to add together all bonus pay received by employees in the 12 month period ending on 31 March each year.

It is essential, therefore, for organisations to consider very carefully the variety of payments made to employees throughout the year in order to categorise them as ordinary pay or bonus pay or to exclude from the calculations altogether.

There are two changes in the way gender pay gap data was reported by the Trust for the period ending 31 March 2018 when compared to its reporting for the period ending 31 March 2017. For 2018, payments in respect of Clinical Excellence Awards (CEAs) was reported in 'bonus pay' only rather than both 'ordinary pay' and 'bonus pay' as was the case for 2017, and Long Service Awards are now included in 'bonus pay' even if issued in the form of vouchers. This was consistent with guidance provided by NHS Employers.

4. GENDER PAY GAP DATA FOR PUBLICATION

The Trust's March 2018 gender pay gap data submission to the Government on line reporting service is at Appendix 1. It includes pay data in respect of the 431 colleagues that are now employed by Calderdale and Huddersfield Solutions Ltd, as these colleagues were employed by the Trust as at 31 March 2018.

The pay data analysed to produce this submission was obtained from the Electronic Staff Record (ESR) Business Intelligence reporting suite using gender pay gap dashboards constructed nationally. Long service award monetary values are calculated outside of ESR.

5. GENDER PAY GAP DATA ANALYSIS

Appendix 2 includes a comparison between the Trust's gender pay gap submissions for 2017 and 2018.

A full analysis of the Trust's gender pay gap is provided in Appendix 3.

6. REDUCING THE GENDER PAY GAP

Work to close the gender pay gap will form part of our approach to equality, diversity and inclusion which is an identified theme in our people strategy. We will bring forward our gender pay gap reporting data for the period ending 31 March 2019 shortly and this will inform the actions necessary to close the gender pay gap. In the meantime, the following have been identified as areas for attention:-

- Take account of gender in the providing of leadership opportunities
- Commitment to a gender balance at Board level
- Design and establish a Women's Network in the Trust with an Executive Director and /Non-Executive Director sponsorship
- Support female Consultants to apply for Clinical Excellence Awards

The Equality, Diversity and Inclusion Manager commenced in post on 25 March 2019 and will lead on taking the above actions and consider further activity to reduce the gender pay gap within the Trust taking into account data for the period ending 31 March 2019.

A paper with 31 March 2019 data will be taken to Executive Board on 9 May 2019, so that the Trust can review the data ahead of the submission date in March 2020.

The Workforce Committee will provide oversight of the action plan.

7. CONCLUSION

The Board of Directors is asked to note the content of the paper.

Claire Wilson
Assistant Director of Human Resources

May 2019

GOV.UK
Gender pay gap service

Sign out

Reporting as Calderdale & Huddersfield N H S

Enter your gender pay gap data for snapshot date 31 March 2018

Please enter your data to 1 decimal point.

For differences in rates of pay and bonuses, a positive % indicates that men in your organisation receive a higher rate than women in your organisation.

A negative % indicates that men in your organisation receive a lower rate than women in your organisation.

Gender pay gap guidance

Gender pay gap reporting: data you must gather

Gender pay gap reporting: make your calculations

Difference in hourly rate of pay – mean

Enter the difference in mean hourly rate

26.3 %

Difference in hourly rate of pay – median

Enter the difference in median hourly rate

8.4 %

Difference in bonus pay – mean

Enter the difference in mean bonus pay, calculated from the mean

60.4 %

Difference in bonus pay – median

Enter the difference in median bonus pay, calculated from the median

97.5 %

Percentage of employees who received bonus pay

Males who received bonus pay

6.3 %

Females who received bonus pay

1.5 %

Employees by pay quartile

Upper quartile

Male

29.4 %

Female

70.6 %

Upper middle quartile

Male

12.1 %

Female

87.9 %

Lower middle quartile

Male

15.8 %

Female

84.2 %

Lower quartile

Male

16.9 %

Female

83.4 %

Continue

Cancel

APPENDIX 2

Due to the different way that the Trust has calculated the gender pay gap from last year (following NHS Employers guidance on Clinical Excellence Awards and Long Service Awards), the two tables below enable comparison of data to understand the difference from last year's submission.

Table 1

Table 1 shows the comparison with last year's submission if we used the same guidance as this year (Clinical Excellence Awards not included in 'ordinary' pay and Long Term Service Awards included in 'bonus' pay).

	As at 31 March 2017	As at 31 March 2018	Difference
1. Difference in hourly rate of pay - mean	25.5%	26.3%	0.8%
2. Difference in hourly rate of pay - median	7.6%	8.4%	0.8%
3. Difference in bonus pay - mean	59.1%	60.4%	1.3%
4. Difference in bonus pay - median	96.6%	97.5%	0.9%
5. Percentage of employees receiving a bonus	-	-	-
Male	6.2%	6.3%	0.1%
Female	1.3%	1.5%	0.2%
6. Employees by quartile	-	-	-
Upper Quartile - Male	28.3%	29.4%	1.1%
Upper Quartile - Female	71.7%	70.6%	-1.1%
Upper Middle Quartile - Male	12.8%	12.1%	-0.7%
Upper Middle Quartile - Female	87.2%	87.9%	0.7%
Lower Middle Quartile - Male	15.5%	15.8%	0.3%
Lower Middle Quartile - Female	84.5%	84.2%	-0.3%
Lower Quartile - Male	18.1%	16.9%	-1.2%
Lower Quartile - Female	81.9%	83.4%	1.5%

The highlighted cells indicate data which was submitted on 21 March 2019.

Table 2

Table 2 shows the comparison with last year's submission if we used the same guidance as last year (Clinical Excellence Awards included in 'ordinary' pay and Long Term Service Awards not included in "bonus" pay).

	As at 31 March 2017	As at 31 March 2018	Difference
1. Difference in hourly rate of pay - mean	26.6%	27.4%	0.8%
2. Difference in hourly rate of pay - median	7.8%	8.4%	0.6%
3. Difference in bonus pay - mean	18.4%	12.4%	-6.0%
4. Difference in bonus pay - median	0.0%	0.0%	0.0%
5. Percentage of employees receiving a bonus	-	-	-
Male	6.1%	5.9%	-0.2%
Female	0.6%	0.6%	0.0%
6. Employees by quartile	-	-	-
Upper Quartile - Male	28.3%	29.4%	1.1%
Upper Quartile - Female	71.7%	70.6%	-1.1%
Upper Middle Quartile - Male	12.8%	12.1%	-0.7%
Upper Middle Quartile - Female	87.2%	87.9%	0.7%
Lower Middle Quartile - Male	15.5%	15.8%	0.3%
Lower Middle Quartile - Female	84.5%	84.2%	-0.3%
Lower Quartile - Male	18.1%	16.9%	-1.2%
Lower Quartile - Female	81.9%	83.4%	1.5%

The highlighted cells indicate submitted data on 8 March 2018.

APPENDIX 3

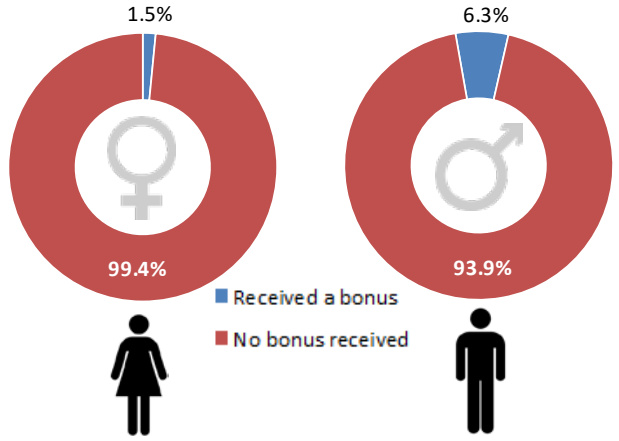
Calderdale and Huddersfield NHS Foundation Trust - Gender pay gap analysis

As at 31 March 2018

Gender pay & bonus gap

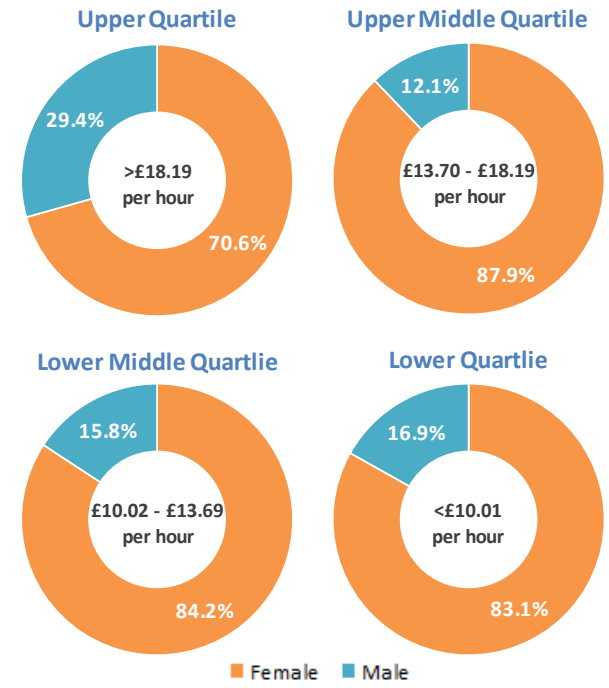
Difference between Men and Women	Mean (Average)	Median (Middle)
Gender Pay Gap	26.3%	8.4%
Gender Bonus Pay	60.4%	97.5%

Proportion of staff receiving a bonus



Bonus pay relates to payments made in the period 1st April 17 - 31st March 18

Pay quartiles

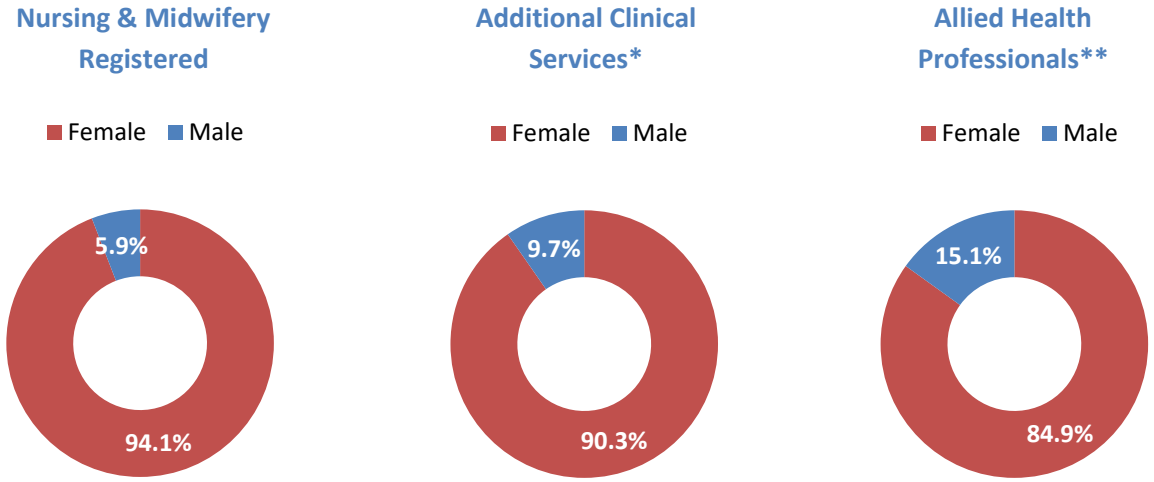


All data provided in this report was obtained through the national Gender Pay Gap dashboards via the Electronic Staff Record (ESR) Business Intelligence (BI) reporting suite.

The overall mean gender pay gap for Calderdale and Huddersfield NHS Foundation Trust is 26.3%, while the median gender pay gap is 8.4%.

This indicates that a higher proportion of women are in lower grade roles, and men are in higher grade roles.

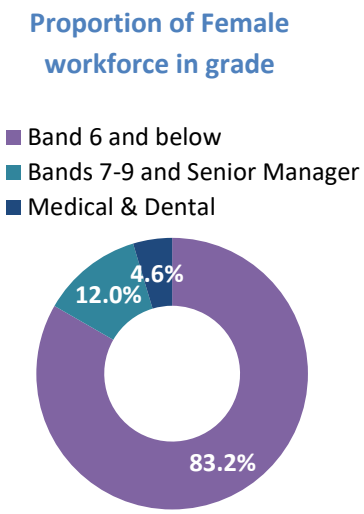
As at 31 March 2018, the workforce at Calderdale and Huddersfield NHS Foundation Trust comprises of 81.6% female employees. Women are generally more likely to work within the public sector, and more so within the NHS (77.1% of the NHS workforce is female), this in turn introduces strong occupation segregation.

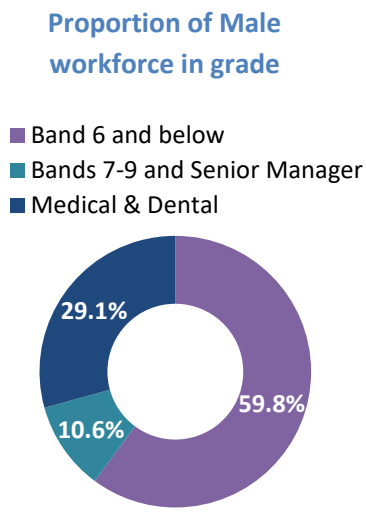


APPENDIX 3

Staff Group	Female % (headcount)	Male % (headcount)
Professional Scientific & Technical	76.0% (158)	24.0% (50)
Additional Clinical Services	90.3% (1119)	9.7% (120)
Administrative and Clerical	77.8% (965)	22.2% (276)
Allied Health Professionals	84.9% (366)	15.1% (65)
Estates and Ancillary	64.1% (243)	35.9% (136)
Healthcare Scientists	73.8% (90)	26.2% (32)
Medical and Dental	41.5% (228)	58.5% (322)
Nursing and Midwifery Registered	94.1% (1747)	5.9% (109)
Total	**81.6% (4917)**	**18.4% (1109)**

The Medical and Dental staff group is the only group that has more males than females. All other staff groups are heavily skewed towards women.

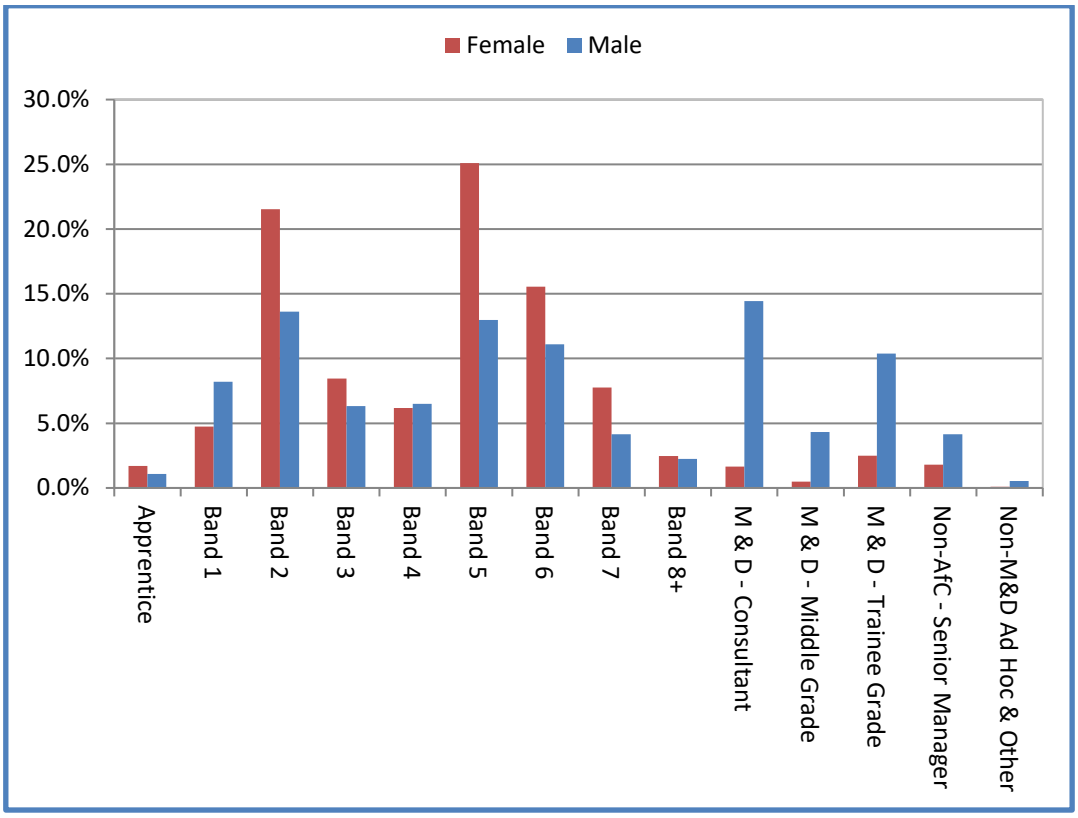




The data shows that 83.2% of women work at Band 6 or below; compared to 59.8% of men, with the majority of women working at Band 2, 5, and 6. This correlates to additional clinical services support roles and staff nursing grades.

Women are proportionally under-represented in medical and dental grades, with only 4.6% of the female workforce in medical and dental roles, compared to 29.1% of all males employed by the Trust. Additionally, 1.6% of the female workforce is employed at medical consultant grade compared to 14.4% of the male workforce.

APPENDIX 3



Pay Grade	Female	Male
Apprentice	1.7% (83)	1.1% (12)
Band 1	4.7% (233)	8.2% (91)
Band 2	21.5% (1059)	13.6% (151)
Band 3	8.4% (415)	6.3% (70)
Band 4	6.2% (304)	6.5% (72)
Band 5	25.1% (1234)	13.0% (144)
Band 6	15.5% (764)	11.1% (123)
Band 7	7.8% (382)	4.1% (46)
Band 8+	2.5% (121)	2.3% (25)
M & D - Consultant	1.6% (81)	14.4% (160)
M & D - Middle Grade	0.5% (24)	4.3% (48)
M & D - Trainee Grade	2.5% (123)	10.4% (115)
Non-AfC - Senior Manager	1.8% (89)	4.1% (46)
Non-M&D Ad Hoc & Other	0.1% (5)	0.5% (6)
Grand Total	**100.0% (4917)**	**100.0% (1109)**

This greater proportion of men in higher paid medical and dental roles, combined with the greater proportion of women in lower grades can be clearly seen in the pay quartiles and impacts on the mean and median pay gap.

APPENDIX 3

Staff Group	Mean	Median
Professional Science & Technical	12.2%	14.5%
Additional Clinical Services	-2.4%	-1.5%
Administrative and Clerical	17.8%	12.2%
Allied Health Professionals	-9.2%	-11.6%
Estates and Ancillary	1.2%	4.8%
Healthcare Scientists	-8.1%	-5.5%
Medical and Dental	13.6%	23.6%
Nursing and Midwifery Registered	5.6%	3.6%
All Staff Groups - Excluding M&D	**0.8%**	**-10.3%**
All Staff Groups	**26.3%**	**8.4%**

The medical and dental staff group has an impact on the gender pay gap. Excluding medical and dental staff from the calculation significantly decreases the pay gap, to the extent that the overall mean pay gap changes from 26.3% in favour of men to 0.8%.

The mean bonus pay gap between men and women is 60.3%, and the median is 97.5%. 6.3% of males compared to 1.5% of females received a bonus payment. Unlike last year, Long Service Awards have been included in bonus payments, which has increased significantly the gap between male and female bonus payments. Other bonus payments included are Clinical Excellence Awards (CEA), discretionary points, and Performance Related Pay payments (PRP). 86.7% of Long Service Awards went to female colleagues in 2017/2018 but only 30.6% of the higher value CEA payments went to females.

Long Service Awards 2017/2018

	25 Years	40 Years
Male	6	2
Female	44	8

Clinical Excellence Awards

Clinical Excellence Awards are limited to consultant employees within the medical and dental staff group. The payment for the 2016/2017 CEA round was made in August 2018 and the payment for the 2017/2018 CEA round will be made in March 2019 so these are not included in this submission. The payments given during the 2015/2016 awards round will be included. The table below shows the payment date for each CEA awards round and the year in which they will be included in the Gender Pay Gap submission.

Award Round	Date Paid	Gender Pay Gap submission
2015/2016	May-17	2019 (Data as at 31 March 2018)
2016/2017	Aug-18	2020 (Data as at 31 March 2019)
2017/2018	Mar-19	2021 (Data as at 31 March 2020)

APPENDIX 3

The gender split for the last 3 rounds of CEAs is highlighted below:-

Number of eligible Consultants

	2015/16	2016/17	2017/18
Male	113	110	128
Female	55	63	69

Number of applicants

	2015/16	2016/17	2017/18
Male	32	37	43
Female	13	13	17

Percentage of eligible Consultants applied

	2015/16	2016/17	2017/18
Male	28.3%	33.6%	33.6%
Female	23.6%	20.6%	24.6%

The larger proportion of males within the medical consultant grade makes it is more likely that bonuses are awarded to male employees. In addition, male consultants are more likely to apply for a CEA with 33.6% eligible male consultants applying for the 2017/2018 CEA round as opposed to 24.6% Females.

Number of successful applicants

	2015/16	2016/17	2017/18
Male	18	21	22
Female	8	5	10

Percentage of applicants that were successful

	2015/16	2016/17	2017/18
Male	56.3%	56.8%	51.2%
Female	61.5%	38.5%	58.8%

However, when applying for a CEA, female consultants are generally more successful that male consultants with 58.8% of Female applicants in 2017/18 being awarded a CEA. This is a 20.3% increase from 2016/17. 51.2% of male applicants were successful in being awarded a CEA in 2017/18.

Gender split of successful applicants

	2015/16	2016/17	2017/18
Male	69.2%	80.8%	68.8%
Female	30.8%	19.2%	31.3%

APPENDIX 3

Example Roles	
***Additional Clinical Services**	****Allied Health Professionals**
Assistant/Associate Practitioner	Advanced Practitioner
Assistant/Associate Practitioner Nursing	Chiropodist/Podiatrist
Cytoscreener	Chiropodist/Podiatrist Manager
Dental Surgery Assistant	Dietitian
Health Care Support Worker	Occupational Therapist
Healthcare Assistant	Orthoptist
Healthcare Science Assistant	Orthoptist Manager
Healthcare Science Associate	Physiotherapist
Helper/Assistant	Physiotherapist Manager
Nursery Nurse	Physiotherapist Specialist Practitioner
Phlebotomist	Radiographer - Diagnostic
Pre-reg Pharmacist	Radiographer - Diagnostic, Manager
Technical Instructor	Radiographer - Diagnostic, Specialist Practitioner
Technician	Speech and Language Therapist
Trainee Healthcare Science Practitioner	Speech and Language Therapist Specialist Practitioner
Trainee Healthcare Scientist	
Trainee Practitioner	

Adam Matthews
Workforce Business Intelligence Manager
14 March 2019

Appendix 4

West Yorkshire Association of Acute Trusts (WYAAT) Gender Pay Gap Benchmarking

A comparison of the Trust's reported pay gap submission and that of other WYAAT Trusts is provided. In addition, clarification on the inclusion of bonus payments for WYAAT Trusts is set out.

	Calderdale & Huddersfield	Airedale	Bradford	Harrogate	Leeds Teaching	Mid Yorkshire
1. Difference in hourly rate of pay - mean	26.3%	37.1%	31.3%	31.8%	27.3%	30.2%
2. Difference in hourly rate of pay - median	8.4%	22.8%	10.1%	15.2%	9.1%	16.3%
3. Difference in bonus pay - mean	60.4%	32.0%	40.4%	19.1%	34.6%	37.8%
4. Difference in bonus pay - median	97.5%	33.3%	33.3%	8.4%	35.0%	33.2%
5. Percentage of employees receiving a bonus	-	-	-	-	-	-
Male	6.3%	6.8%	7.3%	10.4%	59.0%	8.2%
Female	1.5%	0.8%	0.9%	3.5%	50.0%	0.6%
6. Employees by quartile	-	-	-	-	-	-
Upper Quartile - Male	29.4%	31.6%	33.0%	27.5%	36.2%	30.4%
Upper Quartile - Female	70.6%	68.4%	67.0%	72.5%	63.8%	69.6%
Upper Middle Quartile - Male	12.1%	12.8%	17.2%	10.8%	17.3%	13.8%
Upper Middle Quartile - Female	87.9%	87.2%	82.8%	89.2%	82.7%	86.2%
Lower Middle Quartile - Male	15.8%	12.4%	18.9%	12.2%	20.8%	15.8%
Lower Middle Quartile - Female	84.2%	87.6%	81.1%	87.8%	79.2%	84.2%
Lower Quartile - Male	16.9%	11.3%	23.0%	12.2%	23.0%	14.5%
Lower Quartile - Female	83.4%	88.7%	77.0%	87.8%	77.0%	85.5%

Airedale	No report on Trust's website.
Bradford	Report suggests only some doctors received a bonus payment (presumably CEAs).
Harrogate	Only included CEAs despite saying in the report that they pay long service awards of £40 for 25, 35 and 40 years service.
Leeds Teaching	Report showed only CEAs were included in bonus pay. Discussions with Payroll confirmed LTH do not have long service awards. Percentage of employees receiving a bonus has only shown the % of consultants receiving a CEA.
Mid Yorkshire	Only CEAs contributing to bonus pay.

20. Update from sub-committees and receipt of minutes & papers

• Finance and Performance Committee – minutes from meeting held 29.3.19

• Quality Committee – minutes from meeting held 4.3.19

• Council of Governors – minutes from meeting held 11.4.19

• Workforce Committee - minutes from meeting held 8.4.19

• Charitable Funds Committee – minutes from meeting held 22.5.19

• A&E Delivery Board Minutes – 12.3.19

To Note

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Friday 29 March 2019, 9.30am – 12.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

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

IN ATTENDANCE

Betty Sewell	PA (Minutes)
Kimberly Scholes	Business Manager, Outpatient Services (In part)
Kirsty Archer	Deputy Director of Finance
Philip Lewer	Chair of Trust
Rob Aitchison	Director of Operations (FSS) (In part)
Sian Grbin	Governor (In part)

ITEM

049/19 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

050/19 APOLOGIES FOR ABSENCE

There were no apologies to note.

051/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

052/19 MINUTES OF THE MEETING HELD 1 MARCH 2019

The following post-meeting changes were received from Richard Hopkin and have been reflected in the Minutes of the meeting held 1 March 2019:-

Page 2 (2019/20 Financial Plan)
First bullet – suggest adding after **'£38m'....** 'before central funding'
Third bullet – should be 'Strategic **Outline** Case'
Tenth bullet – should be '**site revaluation'**

At the end suggest...'The Committee APPROVED the 2019/20 Plan **for recommendation** to the Board'

Page 3 (IPR)
Last sentence under 'Safe' – suggest refer to 'separate failings **against** target within month'

Last sentence under 'Complaints' – suggest adding the words '**in this respect**' after 'A dramatic turnaround was required.'

053/19 ACTION LOG AND MATTERS ARISING

Matters Arising

026/19 – Finance & Procurement System Update: The Director of Finance confirmed discussions had taken place with WYAAT DoFs who are of the same view that to have a conclusion rather than receiving a credit this year would be beneficial- **action closed**.

199/18 – What Makes Us Fiscally Unique: Following the presentation to the Board on the 26/3/19 a number of questions and queries were raised which will be followed up. The Chief Executive commented that the presentation was well received by colleagues which helped simplify a difficult topic.

ACTION: The Chair of the Committee would still like to see how we justify what is not financially unique to our regulators in terms of Use of Resources – **GB/KA, 28 June 2019**

023/19: The Chief Operating Officer confirmed that Anne-Marie Henshaw would be issuing a briefing note to Richard Hopkins to close this action – **action closed.**

In terms of Complaints, the Chief Executive confirmed that he would be making a presentation at the next Deep Dive in April.

055/19 INCOME & EXPENDITURE AND BALANCE SHEET

The Deputy Director of Finance presented a summary of the financial statements representing the 2019/20 Financial Plan which was signed-off by the Board and will form the basis of the 2019/20 Operational Plan submission to NHSI on 4 April 2109.

Any further adjustments prior to submission will be minor category adjustments based on the finalisation of divisional budgets and triangulation with workforce information.

The full final Budget Book will be presented to the Committee in April 2019.

It was noted that in terms of the Balance Sheet the revaluation of assets will affect these figures.

The Committee **NOTED** the contents of the Financial Statements.

058/19 TERMS OF REFERENCE

The Committee reviewed the Terms of Reference (ToR) and the following amends were noted:-

Section 4.3 – the first bullet point should read: *Ensure compliance is in line with Treasury Management Guidance.*
It was suggested that a review of PMU should also be added to this section.
Section 5.1 – The Committee shall consist of two Non-Executive Directors, the Chair and Vice-Chair.
Section 8 – The timing of the meeting was discussed to enable papers to be issued in a timely manner and dates for the rest of the year will be reviewed.

ACTION: To review the dates of the Committee for the remainder of 2019 - **BS**
ACTION: To pick up regarding Governance for all Committees should be picked up within the imminent Board/Governor Workshops - **PL**

The Chief Executive commented that NHSI are updating their website which states that we are still in breach of licence. Discussions took place and it was agreed that the management of our long-term financial sustainability risk does sit with this Committee and it should be referenced within our ToR. The following wording will be added to **Section 4.1** within the ToR *"Work is progressing and the Committee have set a target to review on completion of the FBC".*

The Committee **APPROVED** the ToR, however, it was recognised that they may have to be reviewed again once the meeting for the Chair of Committees takes place.

053/19 OUTPATIENT SERVICES

The Director of Operations for FSS presented an update following a previous presentation to the Committee.

The presentations covered:

1. Access to Services – focus on how patients access Trust services.
2. Utilisation of resources – focused on the efficiency of processes supporting outpatients,
3. Clinic Efficiency – focus on the efficiency of outpatient clinics

The following headlines were noted: -

1. **Access to Services**
   - Issues with ASIs were acknowledged and actions to address were noted.
   - The average queue time is rated as acceptable, but the aim is to be less than 4 mins.
2. **Utilisation of Resources**
   - DNA rates are positive and we continue to perform in the top quartile nationally.
   - There is work to do for patient experience in relation to Cancellations.
   - Slot utilisation is in a good position at 94%
3. **Clinic Efficiency**
   - Clinic start/finish times need to be evidence based for Clinicians.
   - Patient Satisfaction – CHFT are a significant outlier when compared to national and regional Trusts.
   - Template variation – this information is now routinely available on the Knowledge Portal.
   - Discharge Rates – choice is being debated and work is progressing through the Outpatient Transformation group.

The Chief Executive raised his concern regarding Outpatient Benchmarking and the correlation of information. The Chief Operating Officer described a couple of issues, namely the follow up backlog and the change to inpatients who are admitted non-electively and then need to be seen in outpatients which is now a new slot, both issues have reduced available capacity. The lack of assurance/re-assurance was recognised, and we need to be clear what our recovery actions area.

It was noted that regarding ASIs the areas correlate to specialties who have come forward with outpatient transformations such as Cardiology, Gastroenterology, General Surgery and Ophthalmology all have recognised issues and are self-generating front end capacity. In terms of the Outpatient Transformation the plans this year is to deliver outpatients in a different way for 26,000 attendances, appointments may not be needed or would be delivered either digitally or through a nurse led service, this should start to have an impact into capacity.

In summary, it was noted that there are positives coming out the presentation, it was noted that there are issues around understanding ASIs and there will be a deep-dive. Work is ongoing in terms of Outpatient Transformation which will start to review the way we deliver activity and the benefits of that activity. Regarding CIP plans for next year there should be caution around cost out and reinvestment. In terms of activity levels pre EPR, this needs evidencing specialty by specialty.

The Committee **NOTED** the presentation.

057/19 CIP 2019/20

The Director of Transformation & Partnerships presented the 2019/20 Dashboard which identified an £11m CIP target. The inclusion of Project Echo is an enabler to report a full plan at this stage to NHS I, however plans to identify additional schemes continues. Through Turnaround Executive plans are being developed and worked through and £8m is at GW2, £2m at GW1 and the remainder is at scoping.

The Theatre Productivity scheme was highlighted, it was confirmed that £100k of the £569k CIP value was at GW2 and plans for the remaining value are at GW1. The good clinical engagement was acknowledged however, it is reliant on individual buy-in from colleagues and would be classified as high-risk.

It was noted that this is the first time that we have submitted plans to NHSI which have been fully identified at this time. It was also noted that at TE conversations are taking place to identify additional schemes assuming some schemes may not come to fruition.

The Committee **NOTED** the 2019/20 Dashboard.

053/19 RESULT OF THE INVESTMENT EVALUATIONS

The Director of Finance reported that at the Commercial Investment & Strategy Committee held 21 March 2019 several Investment Schemes had been reviewed, this followed a comment by the CQC that we were unable to evidence the benefit of historical investments. The Minutes of the CI&SC will be available at the next F&P Committee but the schedule provided the Committee with a summary of the findings which highlighted a varied level of financial success. Most of the business cases demonstrated delivery of the qualitive benefits but when it came to financial benefits some demonstrated that they had contributed to financial savings but equally there were others that from a financial point of view did not deliver but it was the right thing to do.

It was noted that this was a positive exercise and several schemes will contribute to CIP savings this year. It was also evident that KPIs for future Business Cases need to be realistic and measurable in what they can deliver which may not be financial.

The Director of Finance acknowledged that the learnings from the exercise was that we cannot suggest a financial benefit just to get the Business Case approved and cash releasing benefits should be clearly identified against other non-cash releasing benefits.

The Committee **NOTED** the paper.

054/19 MONTH 11 FINANCE REPORT

The Director of Finance reported that at Month 11 we are on Plan to deliver a £41m deficit. The Agency expenditure is below the trajectory set by NHSI and is forecast to remain below the trajectory for the rest of the year. The pressures in month have been offset by improved CIP delivery due to timing. We currently have a Capital under-spend but the forecast is to spend all we have generated internally. Our Regulators have been informed that due to the revaluation exercise we will breach our Capital Department Expenditure Level (CDEL).

The Financial Risks were discussed, and the following was agreed: -

- Risk of not achieving the 2019/20 Financial Plan – the risk score to be reviewed before the next Board meeting with a proposed score of 12.
- Risk that the Trust will overspend on its Capital Programme to be reduced from 12 to 6.
- Risk that the Trust will not be able to pay suppliers etc., to stay at 12.

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

056/19 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported that February's performance had seen the best performance this financial year at 73% with the 'Effective' domain the only deterioration this month.

The key headlines were noted as follows:

- **Diagnostics** – a cohort of paper referrals have been identified as not being on the system and have waited over 6 weeks, these are now on the system. A clinical validation has taken place and there has been no risk to patient safety.
- **Still Births** – there is a robust internal process and all cases are discussed at Multi-Disciplinary Team (MDT) weekly governance meeting but nationally there is more external focus and is to come under the jurisdiction of the Coroner's Office.
- **SHMI** – has moved from Green to Amber, need to keep in focus.
- **C-diff** – no cases since July, therefore, it has been agreed to repeat the deep-clean process next winter.
- **E.coli** – there are concerns regarding our position and conversations will take place with David Birkenhead to agree interventions.
- **Coding** – a deep-dive has taken place through the Digital Health forum, some areas need further improvement, however, this would require significant clinical capacity. A decision has been made to concentrate on improvement work to get the 'Safety' element right.

- **Emergency Re-admissions** – showing as 'RED' on the report, a deep-dive audit has taken place, there are coding issues on some planned pathways which are showing as an emergency re-admission, this will be reviewed.
- **Emergency Care** – this is a key element with a slight improvement in February from January. There is a push for a March NHSI trajectory of 95%. If we continue for the next few days we could potentially achieve 95.08%.
- **Patient Experience** – there has been a deep-dive into patient and staff experience to better understand those using the ED pathway. The main issue of over-night resilience remains. There has been a Performance Masterclass to review the learning over the last month and to review 19/20 plans. It was agreed that a report relating to 'Marvellous March' will be presented to the Committee in May.
- **Stroke** – a SSNAP 'A' score has been achieved.
- **Cancer** – standards have been achieved in February and the position looks positive for March, however, Day 38 needs more focus. Our risk with cancer is our Radiologist capacity.
- **RTT** – is a concern, validation taking place. In terms of RTT, Medicine and Surgery have been put into an escalation process.
- **Falls/Surgery** – this has been discussed at PRM, the spike arose with the change in location and layout. Nursing staff have been observing patients and there has been a significant improvement in month.

ACTION: To present a report capturing staff thoughts relating to 'Marvellous March' to come to the Committee – **HB, 31 May 2019**.

The Chair observed that looking back over previous years there is a lot of positives which usually gets lost within the detail both financially and operationally.

The Committee **NOTED** the contents of the report.

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059/19 DRAFT MINUTES FROM SUB-COMMITTEES

- Draft Capital Management Group held 13 March 2019.

The Minutes were **RECEIVED** and **NOTED** by the Committee.

060/19 WORK PLAN

The following items were noted for inclusion to the Work Plan:-

- Marvellous March Report – **HB, May 2019**
- Fiscally Unique Update – **GB/KA, June 2019**

The Committee **NOTED** the Work Plan.

061/19 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following for cascading to the Board:

- Fiscally Unique – further work is required but the work which has been done has been well received.
- Terms of Reference reviewed.

- Detailed presentation on Outpatient Services well received, better information available but there is still ASIs issues and a deep-dive will take place. Further opportunities for transformation.
- CIP
- Capital Investment – feed-back through Minutes from the CI&SC
- Finance – secure year-end position
- Risks for 19/20 discussed – agreed Capital 6 / I&E 12
- Performance – solid performance across a range of indicators, however, RTT was highlighted as a key area.

062/19 REVIEW OF MEETING

It was felt that the meeting had a balanced view.

063/19 ANY OTHER BUSINESS

There were no further items raised.

DATE AND TIME OF NEXT MEETING:

FRIDAY 26 April 2019, 9.30am – 12.30pm, Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 4 March 2019
Acre Mill Room 3, Huddersfield Royal Infirmary

038/19 WELCOME AND INTRODUCTIONS

Present

Dr Linda Patterson **(LP)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce and Development
Anne-Marie Henshaw **(AMH)**	Assistant Director for Quality and Safety
Karen Heaton **(KH)**	Non-Executive Director
Christine Mills **(CM)**	Public Governor
Jackie Murphy **(JMy)**	Chief Nurse
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

In Attendance

Mr Neeraj Bhasin **(NB)**	Associate Medical Director **(items 045/19 and 046/19)**
Fiona Kaye **(FK)**	Nurse Manager – Pre-assessment Unit **(Observing JMy)**
Caroline Lane **(CL)**	Matron – Community Health Services **(item 050/19)**
Maggie Metcalfe **(MM)**	Associate Director of Nursing – Medical Division **(item 048/19)**
Joanne Middleton **(JM)**	Associate Director of Nursing – Surgical Division **(item 049/19)**
Dr Julie O'Riordan **(JOR)**	Divisional Director – FSS Division **(item 051/19)**
Rosie Robinson **(RR)**	Risk Manager **(items 043/19 and 044/19)**
Karen Spencer **(KS)**	Associate Director of Nursing – FSS Division **(item 051/19)**
Vicky Thersby **(VT)**	Safeguarding Lead – Child Protection **(item 054/19)**

039/19 APOLOGIES

Andrea McCourt	Head of Governance and Risk
Lindsay Rudge	Deputy Director of Nursing

040/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

041/19 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 4 February 2019 were approved as a correct record, with the exception that the fifth bullet point on item 024/19 is amended to read:

- *A regulatory planning document from the CQC is expected in March 2019. The Trust submitted an action plan on our never events, which the CQC reviewed and were assured of our reporting.*

042/19 ACTION LOG AND MATTERS ARISING

The action log can be found at the end of the minutes.

Cardiology Mortality Alert Review Paper

Dr David Birkenhead (Medical Director) presented appendix C which outlines an alert received from the Doctor Foster unit at Imperial College regarding their analysis showing a *'higher than average mortality rate for cardiac pacemaker or defibrillator introduced through the vein'* at the Trust. During the period of September 2017 to August 2018, there were 13 observed deaths compared to an expected number of five. CHFT were not aware of this alert from the Trust's preferred alerting system Health Evaluation Data (HED), however a

two-stage review was commissioned nonetheless; a case note review and structured judgement reviews.

The findings of the reviews were included in the paper and show two cases where the patient's death may have been directly attributable to the procedure, however, for the remaining 10 cases, the patient's deaths were not thought to be related in any way to the procedure. One case was incorrectly identified within the alert.

There were no issues with inadequate care provided to the patient group or any significant issues to action. It is recommended that this review is shared with the cardiology team. The Quality Committee were assured of the process, which will be kept under review.

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

043/19 SERIOUS INCIDENTS OUTSTANDING ACTIONS

Rosie Robinson (Risk Manager) presented appendix D which provides an update on outstanding actions from completed serious incidents and the risks associated with actions that remain open.

The current position of the report shows the number of outstanding actions in each division; Community – 9; Estates and Facilities – 1; Family and Specialist Services – 19; Surgery and Anaesthetics – 4 and Medical – 53. The majority of serious incidents, and therefore the majority of actions, are from the Medical division; however, the division has seen an overall decrease in the percentage of overdue actions since the previous report. It was stated that more accountability has been put into the process and the appointment of a new Associate Director of Nursing into the medical division has also supported the decrease of overdue actions in the division.

Discussion ensued on the new process of including a risk rating for the overdue actions, and that despite the amount of outstanding actions, there are none which are rated as a high risk (red). It was also asked that since the last report, if there have been improvements, whether it could be isolated as to why there have been improvements and whether they could be sustained. It was also queried how CHFT complies with other Trusts of a similar size. It was stated that comparisons with other Trusts is currently realised through the review of CQC reports from Trusts of a similar size, however, this information could be sought.

It was also stated that there is a particular focus to continue and sustain to follow through with actions associated with complaints. The Quality Committee were assured on the governance of the outstanding actions and agreed that the report was very useful and would welcome a more concise update for the next report.

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

044/19 HIGH LEVEL RISK REGISTER

Rosie Robinson (Risk Manager) presented appendix E summarising the high level risk register as at 22 February 2019:

- Eight top risks scoring 20 or 25:
  - 7278 (25) *Longer term financial sustainability risk*
  - 6903 (20) *Estates / Resuscitation risk, HRI*
  - 7271 (20) *HRI ICU collective infrastructure risk*
  - 2827 (20) *Over-reliance on locum middle grade doctors in the Emergency department*
  - 5806 (20) *Urgent estates schemes not undertaken*
  - 6345 (20) *Nurse staffing risk*
  - 7078 (20) *Medical staffing risk*
  - 7240 (20) *Surgical financial risk*

- Four new risks:
  - 7345 (16) *Community referral to district nursing service*
  - 7396 (15) *Connection to piped air*
  - 7413 (15) *HRI fire compartmentation*
  - 7414 (15) *Building safety*

- Three reduced score risk:
  - 7309 (9) *Electronic Patient Record National Early Warning Score (NEWS) 2 update* **(reduced from 16 to 9)**
  - 6299 (12) *Medical devices maintenance risk* **(reduced from 16 to 12)**
  - 7251 (9) *Ophthalmology equipment risk* **(reduced from 15 to 9)**

OUTCOME: The Quality Committee received and noted the content that this is an active document which assessed when risks should increase and decrease.

045/19 NICE REPORT

Mr Neeraj Bhasin (Associate Medical Director) was in attendance to present appendix F, which provides the Trust's six-month snapshot position of NICE (National Institute for Health and Care Excellence) guidelines as at 15 February 2019.

The report demonstrates good compliance and awareness of NICE guidance, which has historically resulted in 45-50% compliance, is now at 69% compliance. Partially compliant guidelines are reviewed every six months, and those not working toward full compliance, which may include guidelines not commissioned or those which agree deviation, are reviewed on a yearly basis.

Interventional procedures have 87% compliance. There is one procedure included as outstanding since March 2018; however, since the publication of this report, the procedure has now been confirmed as not being carried out at CHFT.

Technology appraisals have 99% compliance. On the previous report, an issue was raised regarding the 42 long-term outstanding appraisals. This has now been reduced to seven, with the most outstanding being from July 2017. The drug has been approved by the Medicines Management Committee and a business case being discussed with the surgical division.

Discussion ensued on concerns with the length of time taken to obtain a decision on compliance, and whether this process could be tightened, and described in more detail. It was stated that there are now signs of progress and clear assurance with the compliance process, and also a much clearer way of reporting.

Mr Bhasin thanked the governance team for the work undertaken to produce this report.

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

046/19 CLINICAL AUDIT PROGRAMME

Mr Neeraj Bhasin (Associate Medical Director) was in attendance to present appendix G, a six-month update on the clinical audit programme. There are a total of 312 projects in the 2018/2019 clinical audit programme, a decrease from the 339 projects on the 2017/2018 programme. The reason for the reduction is that audits which have been completed are taken off the programme. Audits on the 2018/2019 programme are broken down by divisions, local and national audits, and mandatory and non-mandatory audits. There is a standard operating procedure for national and local audits which describe the plan, progress and escalation, and through clinical audit reporting at the Clinical Outcomes Group, an action was requested for any metrics to be reviewed which can show how the procedure has created an improvement. Several factors are being reviewed and will be measured

retrospectively. A standardised template has also been created to improve the audit process via the Patient Safety and Quality Board meetings, which will highlight any difficulties in engagement with audits and also highlight any positives where teams have done well.

One of the further developments with the audit programme is for audits to be allocated to a trainee in order for them to contribute and be responsible for an audit while they are with the Trust, which will become part of their learning agreement.

Some audits within the report are described as 'abandoned or on hold', and these are labelled as such due to suitable patients not being available for the audit.

The Quality Committee thanked Mr Bhasin for the very useful report and detailed update on the clinical audit programme, and suggested that comparisons with other Trusts would be worthwhile reviewing. Some examples of audits from the Healthcare Quality Improvement Partnership (HQIP) will be made available at the next meeting for information.

It was also noted that Mr Bhasin will be leaving the role of Associate Medical Director and thanks were conveyed for the work done over the past two years.

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

047/19 CARE QUALITY COMMISSION (CQC) UPDATE

Anne-Marie Henshaw (Associate Director of Quality and Safety) presented appendix H which provides an update on the delivery of the Trust's response to the CQC report.

There has been a positive shift with actions that have been signed-off from green to blue, as detailed in the report. Next month will be crucial as all actions are due to turn blue and be embedded by the end of March 2019. The task is to now test areas to provide evidence of embeddedness. The monitoring of the action plan continues with face-to-face meetings between the CQC Compliance Manager and core service teams. These meetings will identify any further concerns against the delivery of the action plan against the agreed timescales.

A Quality Summit will take place at Huddersfield Royal Infirmary on Thursday, 18 April 2019, with attendees including representatives from the Trust executive team, senior divisional management teams as well as external bodies such as CQC, NHS Improvement, Clinical Commissioning Groups, local council and NHS trusts. The aim of the summit will be to review effectiveness of current approaches to assurance processes. Teams will also be encouraged to identify opportunities and ambition which will strive to outstanding practice.

Progress is also taking place with the ongoing divisional health checks, and a CQC relationship manager will be observing various meetings at the Trust. The chairs of all meetings involved have been informed.

Discussion ensued on two actions that are not progressing; must do action 8 – medical staffing in critical care CRH and should do action 9 – medical staffing in urgent and emergency care, and it was stated that a paper will be submitted to the Weekly Executive Board regarding mitigations and risks of the actions. It was also noted that the figures on the core service current position table did not add up correctly, which was agreed to be reviewed.

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

048/19 MEDICAL DIVISION'S QUARTER 3 PATIENT SAFETY AND QUALITY BOARD REPORT

Maggie Metcalfe (Associate Director of Nursing – medical division) presented appendix I highlighting issues identified during quarter 3 (October to December 2018):

- Quality and safety issues
  - *Falls* - there was one harm fall during this quarter in the emergency department at CRH, resulting in a sub-dural haematoma. The investigation found that it was likely that the index head injury that caused the intracranial bleed occurred before the patient came to the Emergency Department and not during the fall in the cubicle.
  - *Nurse staffing* - The division has seen a significant reduction in turnover in December and continues to see a reduction in nursing vacancies.
  - *Legal issues* - There were 45 red and orange severity incidents reported during quarter 3. All had Duty of Candour letters completed within the 10 day timescale or had a justified reason for non-completion.
  - *Never events* - Two never event incidents were reported during quarter 3 where oxygen tubing was wrongly connected to an air port on wards 6c and 3abcd at CRH. Both incidents are at action planning stage.
  - *Complaints* - 64% of complaints were closed within timeframe in December 2018, an increase from 56% in the previous month. Eight complaints were closed down within the timeframe and the division received 19 complaints in the month.
  - *Sickness* - Total sickness absence rate is currently 3.36% (year to date). This is a worsening position from the same point in October (3.31%), but is currently achieving target.

- Issues for future improvement work
  - *Falls summit* – this was held on Tuesday, 26 February 2019 with a follow up workshop planned for March 2019 where ward teams can update on progress so far.
  - *Pressure ulcer action plan* – pressure ulcer prevention work to now focus on reducing moisture damage; matrons are carrying out a further walk round of wards to check how incontinent aids are being stored and that slide sheets have been placed behind each bed space. New signage to be rolled out regarding 2 - 4 hourly turns, these will be placed behind each patient's bed and will be used as a reminder when next turn due.

- Exceptions for Quality Committee
  - *Safeguarding training compliance* – level 1 (94.74%), level 2 (94.72%), level 3 (84.02%)
  - *Nasogastric tube training* – This strategy has been developed to outline and identify the effective training necessary to ensure team members develop the necessary skills for their position and to ensure the safety of the client group. The aim is to ensure 90% training compliance in high use areas which have been identified as: Critical care, Stroke unit and Rehabilitation wards, Paediatrics (inpatient and community), Gastroenterology and the HOOP (hospital out of hours) team. Training for medical staff will be once only and for registered nurses on arrival at the Trust and three yearly renewal. Going forwards, training compliance will be monitored via the Electronic Staff Record (ESR) and not the medical devices database. Divisions will report on progress against training trajectory to the Quality Committee on a quarterly basis describing mitigation and actions to address where needed.

Discussion ensued on the top 10 types of incidents and abuse of staff by patients which has increased in the last two quarters. It was reported that work is to take place with Ian Kilroy (Resilience and Security Manager) to understand why, as previously only incidents which resulted in harm were reported, but now reporting more. It was also asked whether the amount of incidents correlate to staffing issues, as the amount of incidents reported during quarter 3 for the emergency department doubled. It was stated that it would be helpful to have some deeper analysis of incidents with a comprehensive response in order to get a picture of how to manage. MM stated that a report is being run in the division, and it was asked what the scale of staff shortfalls was in relation to workforce. JMy agreed to liaise with MM to review this from a quality and safety view.

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

049/19 SURGICAL DIVISION'S QUARTER 3 PATIENT SAFETY AND QUALITY BOARD REPORT

Joanne Middleton (Associate Director of Nursing – surgical division) presented appendix J highlighting issues identified during quarter 3 (October to December 2018):

- Quality and safety issues
  - Continued focus on reducing the pending list in ophthalmology which has been caused by consultant gaps in this team. The first WTGR (Working Together to Get Results) session was held with colleagues in ophthalmology and follow up sessions to progress the response planned for quarter 4.
  - Work is ongoing on Ward 21 (orthopaedic) as part of the pressure ulcer collaborative working with NHS Improvement. Ward 21 reported four pressure ulcers in quarter 2 and eight in quarter 3, however only one avoidable category 3 was reported in each quarter.

- Exceptions for Quality Committee
  - The clinical director for orthopaedics has worked with the clinical team to improve the responsiveness when total hip replacement is needed. The performance for fractured neck of femur patients being operated on within 36 hours was 82% at the end of quarter 3.
  - Endoscopy JAG (Joint Accreditation Group) accreditation was achieved and both sites have been asked if they can be exemplar sites and accommodate external visits
  - All directorates have started the CQC health check process and continue to work through the action plan
  - There was a never event that occurred in theatres which was reported in November 2018. The investigation is complete and the action plan has been signed off and accepted by the CCG (Clinical Commissioning Group).
  - The division had 40 open complaints at the end of quarter 3. 29 were in time and 11 were breaching the target, equating to 72.5%. Six complaints were re-opened in quarter 3, an increase from four in quarter 2.
  - Nasogastric tube training - Critical care is the only high risk area in the division for nasogastric tube insertion, which is done by medical staff.
  - Safeguarding training – 93% compliance

Discussion ensued on positive feedback received following a peer review from the Association of Paediatric Anaesthetists (APA) and the potential to drive this forward. JMidd agreed to pick this up with the division.

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

050/19 COMMUNITY DIVISION'S QUARTER 3 PATIENT SAFETY AND QUALITY BOARD REPORT

Caroline Lane (Community matron) presented appendix K highlighting issues identified during quarter 3 (October to December 2018):

- Quality and safety issues
  - *Staffing* – Recruitment continues to be a challenge in District Nursing teams. For the short term the directorate are currently deploying staff differently in order to cover shortfall. The long term plan is to review the Community Nursing model to ensure patient needs continue to be met.
  - *Sickness* - There has been an increase in long term absence month on month in quarter 3. Hotspot areas have been identified and meetings held with Clinical Managers, these include an analysis of themes within service areas and action plans to respond to the themes identified.

- *Mandatory Training* – Focused work had been done to identify areas of low compliance and targeted training is now being offered within division. Compliance is due to improve for quarter 4.

- Issues for future improvement work
  - The division are starting to see an increase in issues relating to discharges. Work has begun with Central Operations colleagues to identify opportunities for improvement
  - There are improvement opportunities around falls reporting, and work ongoing to improve the understanding of reportable incidents in our Intermediate Care beds.

- Exceptions for Quality Committee
  A decision has been made to integrate Central Operations in the Community Division. This is a welcomed development which will enable further streamlining of patient pathways whilst maximising and strengthening the out of hospital offer. It also represents the beginning of a significant journey with service integration at the heart of the agenda. Members of the Senior Management Team from both areas have had two planning meetings to describe the steps required to implement the new division by the 1 April 2019.

- Complaints
  Two orange severity complaints were received in quarter 3, both from the relative of a patient. One complaint is regarding the care and equipment provided by the district nursing services and the other is regarding care provided by the Dietetic service within Community Rehabilitation. To date the complainant has been unable to provide the Trust with evidence of consent from the patient to enable the division to answer the complaint.

- Nasogastric tube training
  Some staff in the division have attended nasogastric tube training, however there remains the issue of how their competencies are assessed in the Community. The issues are being addressed through the Community nasogastric feeding meetings and overseen by the artificial nutrition steering group who are working a train the trainer strategy to train one person in each of the five community hubs (and for the out of hours service) who can then roll out training across the division and sign off competencies.

- Safeguarding training
  The committee requested sight of the divisional breakdown for Safeguarding training. The division will review Level 3 safeguarding training to ascertain who should be undertaking this training.

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

051/19 FAMILIES AND SPECIALIST SERVICES DIVISION'S QUARTER 3 PATIENT SAFETY AND QUALITY BOARD REPORT

Dr Julie O'Riordan (Divisional Director) presented appendix L highlighting issues identified during quarter 3 (October to December 2018):

- Quality and safety issues
  - *Rota gaps* - tier 2 junior doctor level is a concern for the winter period. Currently reviewing a number of potential actions to improve the staffing position.
  - *Yorkshire Fertility* - nursing workforce/resilience continues to have challenges due to specialist skills (scanning), sickness and pregnancy. Succession planning to sustain Yorkshire fertility through 2019 and beyond requires urgent planning as Ward Manager may be on maternity leave as early as April 2019
  - *Patient Transport Services* - Transport booking changes and issues have raised concerns and have resulted in poor patient experience. Work commenced to look at the processes in place.

- Issues for future improvement work
  - The Maternal and Neonatal Health Safety Collaborative is a three-year programme, launched in February 2017 and led by our Patient Safety team and covers all maternity and neonatal services across England. The maternity/neonatal work continues with good engagement from neonates. The neonatal team are presenting the neonatal project to wave 3 in London in March 2019.
  - BloodTrack, which provides the control, visibility and traceability needed to safely store, dispense and administer blood components, went live with phase 1 and 2 in August 2018, but through quarter 3, there continue to be teething problems. The system has been a success for the team; however, it has been hard work for improving safety. Once phase 3 is complete, CHFT will be one of only a handful of users in the world to achieve it.

- Two maternity cases were referred to the Healthcare Safety Investigation Branch (HSIB) in December 2018. The HSIB conduct investigations for all incidents that fit the criteria of the Each Baby Counts programme and also any maternal deaths within 42 days of birth. The investigation replaces the Trust investigation. It was agreed that once the reports are received from HSIB, that they should be circulated to the Quality Committee.

- Safeguarding training is up to 95% compliance. Two high use areas are paediatrics and the neonatal unit, which have their own trajectory, and is not part of the adult services.

Discussion ensued on improvements made with the quality of complaints responses, but there still being a delay in sending complaints out. It was stated that governor colleagues have been exercised in this, and it was asked what it would take for complaints rates to move to where they need to be, and whether it was a matter of resource. It was stated that it is about capacity and the changing of priorities. The Chief Executive has meetings scheduled with all complaints handlers, which may help with the reduction in complaint returns. There is a lot of work ongoing, and the effect of these will be monitored.

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

052/19 QUALITY AND PERFORMANCE REPORT

January's performance score has fallen by 3 percentage points to 68%. The safe domain remains at 61% with two never events having a major impact on performance. The caring domain is now amber at 69% with worsening performance in Friends and Family Test in the emergency department's would recommend rates and Friends and Family Test Community response rates. The effective domain is green for the third consecutive month. The responsive domain is at 69% having missed 6 weeks diagnostics target, but has achieved all key cancer targets for the third consecutive month. In workforce, there has been improvement in return to work interviews and a couple of Essential Safety Training areas. Within efficiency and finance, cost improvement programmes have improved to amber in month which means the Financial element of the domain is now green for the first time since June.

Most improved - % of stroke patients thrombolysed within one hour is at 100%, the best performance since July 2018. The latest Sentinel Stroke National Audit Programme (SSNAP) results for quarter 3 show that CHFT has scored an 'A' for the very first time since SSNAP came into existence approximately 8 years ago. This puts the Trust in the top 20 percent of trusts delivering excellence in stroke care. Thanks were conveyed to all who contributed to the achievement.

It was also reported that more focus on improving performance in key areas is being undertaken as part of the Marvellous March campaign.

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

053/19 QUALITY ACCOUNT TIMELINE AND PROGRESS

Anne-Marie Henshaw (Assistant Director of Quality and Safety) presented appendix N which listed the process and key dates for the production of the 2018/2019 quality accounts.

18 December 2018	Workshop with Governors held to: - Provide update on progress with 2018/19 quality account priorities - Review long list of proposed quality account priorities for 21019/20 and agree shortlist
29 January 2019	Short list of priorities sent to wider membership in Foundation News for voting
15 February 2019	Deadline for selection of quality account priorities 2019 /20 and notification to leads for information for quality accounts
22 March paper 1 April 2019	Draft quality account to Quality Committee for review (Paper required by 22 March 2019) with 11 month data
4 April 2019	Draft quality account to Council of Governors and stakeholders for comment (Council of Governors meeting 11 April 2019)
18 April 2018	Draft quality account to External Auditors
March and w/c 1 April 2019	Audit work begins on quality indicators (4 hour A&E, 62 day, SHMI)
14 May 2019 21 May 2019	Quality Account submitted to Audit & Risk Committee for approval Meeting Audit and Risk Committee 21 May 2019
18 May 2019 21 May 2019	Quality Account to Board of Directors Board meeting 21 May 2019
30 May 2019	Quality Account uploaded on to Trust website

054/19 PROCEDURE FOR JOINT WORKING BETWEEN SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST AND CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Vicky Thersby (Safeguarding Lead – Child Protection) was in attendance to present appendix O for information.

The procedure sets out joint working between South West Yorkshire NHS Foundation Trust (SWYPFT) and Calderdale and Huddersfield NHS Foundation Trust (CHFT) with regard to their responsibilities in relation to patients detained in CHFT under the Mental Health Act 1983 and treatment of their mental disorder. The document has already been submitted to and signed off by the Safeguarding Committee and also been to the Weekly Executive Board, and is at the Quality Committee to provide assurance that there is a robust process in place.

Following a brief summary, it was asked if there are any implications for training of our staff regarding this and any implications in legislation. It was stated that there is a mental health group reviewing the training implications and the legislations have been reviewed by legal services at SWYPFT.

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

055/19 INFECTION CONTROL COMMITTEE MINUTES

A copy of the infection control committee minutes from 29 January 2019 were circulated for information.

056/19 ANY OTHER BUSINESS

There was no other business.

057/19 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

- Receipt and commendation on the NICE and Clinical Audit reports

058/19 EVALUATION OF MEETING

What went well……

- Papers were focussed and learning from divisional reports were more consistent
- Agenda timings
- Highlight and exception reporting has been managed well with divisional reports
- New Patient Safety Group report has helped with the Patient Safety and Quality Board reports and will focus on issues of concern and improvement in learning.

Even better if……..

- Divisional reports could highlight some positive outcomes as well

059/19 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix Q) was accepted, and to include the Healthcare Safety Investigation Branch reports as a required report.

NEXT MEETING

Monday, 1 April 2019
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

FUTURE MEETINGS

All taking place 3:00 – 5:30 pm in Acre Mill Room 3, Third Floor, Outpatients Building, HRI

- Monday, 29 April 2019
- Monday, 3 June 2019 *(including PSQB Q4 reports)*
- Monday, 1 July 2019
- Monday, 29 July 2019
- Tuesday, 3 September 2019 *(including PSQB Q1 reports)*
- Monday, 30 September 2019
- Monday, 4 November 2019
- Monday, 2 December 2019 *(including PSQB Q2 reports)*

APPENDIX A

Calderdale and Huddersfield NHS Foundation Trust

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 3:30 PM ON THURSDAY 11 APRIL 2019 IN THE LARGE TRAINING ROOM, CALDERDALE ROYAL HOSPITAL

PRESENT:

Philip Lewer	Chair

PUBLICLY ELECTED GOVERNORS

Brian Moore	Public Elected - Lindley and the Valleys
Dianne Hughes	Public Elected - South Kirklees
Jude Goddard	Public Elected - Calder and Ryburn Valleys
Rosemary Hedges	Public Elected - Lindley and the Valleys (Reserve Register)
Stephen Baines	Public Elected - Skircoat and Lower Calder Valley
Lynn Moore	Public Elected - North and Central Halifax
Alison Schofield	Public Elected - North and Central Halifax / Lead Governor
Brian Richardson	Public Elected - Skircoat and Lower Calder Valley
Paul Butterworth	Public Elected - East Halifax and Bradford
Donald Rodgers-Walker	Public Elected - Calder and Ryburn Valleys (Partial attendance)
Veronica Maher	Public Elected - North Kirklees

STAFF GOVERNORS

Linzi Smith	Staff Elected – Management / Admin / Clerical
Dr Peter Bamber	Staff Elected – Drs / Dentists
Sian Grbin	Staff Elected – Nurses/ Midwives

STAKEHOLDER GOVERNORS

Dr Tomasina Stacey	University of Huddersfield (On behalf of Felicity Astin)

IN ATTENDANCE:

Helen Barker	Chief Operating Officer
Gary Boothby	Executive Director of Finance
Suzanne Dunkley	Executive Director of Workforce and OD
Amber Fox	Corporate Governance Manager (minutes)
Andrea McCourt	Company Secretary
Alastair Graham	Non-Executive Director
Phil Oldfield	Non-Executive Director / Deputy Chair
Mandy Griffin	Managing Director – Digital Health
David Birkenhead	Executive Medical Director
Alison Wilson	Contracts and Compliance Manager (Item 22/19)

APOLOGIES FOR ABSENCE:

Apologies for absence were received from:

Owen Williams	Chief Executive
Jackie Murphy	Chief Nurse
Anna Basford	Director of Partnerships and Transformation
Annette Bell	Public Elected - East Halifax and Bradford
John Richardson	Public Elected - South Kirklees

Felicity Astin	University of Huddersfield
Chris Reeve	Locala
Nasim Banu Esmail	Public Elected - North Kirklees
Salma Yasmeen	South West Yorkshire Partnership Foundation Trust
Christine Mills	Public Elected - Huddersfield Central
Sheila Taylor	Public Elected - Huddersfield Central
Helen Hunter	Healthwatch Kirklees and Calderdale

16/19 WELCOME & INTRODUCTIONS

The Chair thanked all the governors he has met over the last 6 months for their feedback and suggestions and informed governors that he has met with all of the Chairs in the region who have a Council of Governors to understand best practice. The Council of Governors is a public meeting and the dates will be advertised on the Trust website. The Chair confirmed stakeholder governors can send representatives to the public Council of Governors meeting to represent them.

The Chair welcomed governors, Non-Executive Directors, colleagues from the Board of Directors and staff colleagues to the meeting. Governors were invited to introduce themselves and provide a brief background.

17/19 DECLARATIONS OF INTEREST

The Chair reminded the Council of Governors and staff colleagues to declare their interest at any point on the agenda.

18/19 MINUTES OF THE LAST MEETINGS HELD 24 JANUARY 2019

The minutes of the previous minutes held 24 January 2019 were approved as a correct record.

OUTCOME: The minutes of the previous meeting held 24 January 2019 were **APPROVED** as a correct record.

Rosemary Hedges highlighted page 4 of the previous minutes where she discussed the Calderdale CCG intention to build an alliance contract with existing contractual providers and asked if this means all providers will stay as they are currently, rather than going out to tender. The Chief Operating Officer confirmed there is no intention from Calderdale CCG to go to tender. A separate decision will need to be made by Greater Huddersfield to roll forward with the Locala tender and there is no indication that Huddersfield will build an alliance.

19/19 MATTERS ARISING / ACTION LOG

The action log was reviewed and updated accordingly.

Paul Butterworth highlighted a previous action regarding the complaints process and raised concern that the Trust's complaints procedure and the Trust's complaints policy do not match. The Company Secretary agreed to investigate this.

Action: Company Secretary

20/19 DISCUSSION WITH NON-EXECUTIVE DIRECTORS

The Chair confirmed that two Non-Executive Directors are allocated to each of the Council of Governors meetings on a rotation going forward.

The Council of Governors split into two groups for the governors to have an informal opportunity to ask the two Non-Executive Directors present, Alastair Graham and Phil Oldfield questions and understand their roles.

Rosemary Hedges suggested there should be more frequent meetings with governors and Non-Executive Directors. Brian Moore suggested it would be helpful if more governors attended the Council of Governors / Non-Executive Directors Informal workshops arranged and noted that attendance at these was better from Non-Executive Directors than governors.

Donald Rodgers-Walker left the meeting at 16:10 pm.

21/19 UPDATE ON STAFF CONSULTATION (CAR PARKING)

Alison Wilson provided an update on the staff consultation engagement sessions over February and March for staff across both hospital sites and Broad Street Plaza to discuss challenges, opportunities and gather views from staff.

These engagement sessions were well attended by staff and the responses and suggestions are being compiled into a report to review the feedback and to decide on next steps. Alison confirmed the staff car parking proposal will come to a future Board meeting, likely in July 2019.

Alison Schofield confirmed an afternoon 'in my shoes' has been arranged in May 2019 as a learning experience for wheelchair users in the car park.

Alison Wilson explained the consultation focused on where the Trust is now and what the future will look like. Staff were asked for ideas on how the Trust could do things differently to be more cost effective.

Peter Bamber asked what the output of the consultation will be. The Director of Workforce and OD confirmed the decision and output of the consultation including how the decision was made will come back to the Board in July 2019.

OUTCOME: The Council of Governors **RECEIVED** the update on staff consultation.

22/19 UPDATE FROM LEAD GOVERNOR

Alison Schofield reported on the hard work from the current governors attending regular meetings and asking pertinent questions to ensure the Trust is held to account. She explained the governors are liaising with Board members to improve opportunities to make a difference in the governor role.

Alison encouraged all governors to feel confident to ask questions and make comments within the meetings they attend. She added improvements have been highlighted in how the governors work and communicate alongside the Board of Directors and Non-Executive Directors and the Trust is working towards an improved experience for governors.

Alison asked the governors to contact her if they have any issues or questions and she will acknowledge receipt of the email and will aim to respond within seven calendar days.

Alison explained it has taken her longer to understand the role of lead Governor; however, she feels she is now improving in the role and gaining more experience. She explained she would like to stand for a second year as lead Governor in July 2019 and asked if at least four governors could nominate her by email to support her to continue her role as lead Governor.

23/19 CHAIR'S APPRAISAL PROCESS

The Chair left the room for this discussion. Phil Oldfield, the Senior Independent Non-Executive Director presented the Chair's appraisal process which was approved at the Nominations and Remuneration Committee on 25 March 2019.

The Chair's appraisal evaluation form will be circulated to governors shortly for responses by 6 May 2019. The Chair and Senior Independent Non-Executive Director will meet in June 2019 and a paper will be presented at the Council of Governors on 18 July 2019.

Brian Moore highlighted the collation of the forms should be by the lead Governor only. Alison Schofield responded it has been agreed the Company Secretary and Corporate Governance Manager will work with her to support her in collating the responses.

The Corporate Governance Manager will circulate the long-version of the evaluation form as agreed at the Nominations and Remuneration Committee on 25 March and Brian Moore confirmed it has been shortened last year for the 2017-18 Chair's appraisal due to the Chair's tenure expiring.

24/19 CHAIR'S REPORT

The Chair thanked Lynn Moore for participating in the interview panel for the Executive Director of Nursing / Deputy Chief Executive post.

The Chair reported on the number of improvements that are being explored and put into place for the Council of Governors.

The Chair is meeting with the lead Governor on a monthly basis and meetings between the Chief Executive and staff governors every 6 months is being re-

introduced. Governors are asked to direct any questions to the lead Governor, copying in the Chair. Alison Schofield thanked the Chair for taking the time to visit each governor or contact them individually.

Governors invited to attend the Board, including the lead Governor, are welcome to sit at the Board of Directors table and are invited to comment at the end of the meeting.

The Chair confirmed the attendance lists for the Council of Governors meetings will be circulated every quarter.

Non-Executive Director Appraisals
The Chair confirmed the Non-Executive Directors appraisals have been completed for 2018/19 and discussed with the lead Governor.

Governor's Charter
The Chair highlighted section 3g of the Governors charter regarding the 12 month period for monitoring meeting attendance and asked for clarity. The Council of Governors agreed the wording should say 'Governors are required, under the Trust's Constitution, to attend a minimum of two Council meetings from *September to September'* rather than financial year. Brian Moore asked if the Company Secretary can make governor attendance explicit in the Constitution.
Action: Company Secretary

The Chair explained attendance from the Executive Directors at the Council of Governors is to be agreed, governors can invite Executives to attend; however, they are not all required to attend.

Sian Grbin fed back that she attended the Regional Governor workshop hosted by Mark Price from NHS Providers and will circulate the information from this workshop.
Action: Sian to circulate the information from the Regional Governor workshop

Rosemary Hedges commented that the improvements are very helpful and makes the role of a Governor clearer.

25/19 PERFORMANCE AND STRATEGY

a. Performance Report

The Chief Operating Officer reported a positive position for February 2019, the main highlights from the report were:

- Overall position of 73%, best performance this financial year
- 6 weeks Diagnostics target was missed for the third time in 4 months – issue in January where a cohort of referrals on paper (Cardiology tests) were not being tracked, these are now on the system and reported to regulators, this had an impact on performance; however, there was no harm – anticipate the backlog to be cleared by June 2019
- Infection Prevention Control – Deep clean Programme through the Summer

will take place again this year, there were no ward closures during Winter due to infection

- Emergency re-admissions – higher number of re-admitted patients, an audit took place which identified coding issues and areas in process that can be improved
- Frail patient's re-admission rate is 13%, nationally best rate is 23%
- 'Getting It Right First Time' (GIRFT) re-admissions summit will take place with clinicians for feedback at the next meeting
- Emergency Care Standard improved from January in March (type 1 – A&E Department 4 hours – achieve 94.46% - best in the year), including other pathways achieved 95.22% - over 91% for the full year (upper quartile nationally and one of the busiest A&E)
- Workshop with clinical colleagues took place on 10 April to look at innovation and improvements and will be shared at the next meeting
- Cancer delivered across all metrics in March 2019
- Risk with radiologist capacity
- Complaints – Intervention meetings with the Chief Executive and every manager with an overdue complaint to understand the blockers who is presenting the findings at a deep dive at the end of May 2019
- Community Voices (volunteers trained on patient engagement) spent a week in the A&E Department to cover the 24-hour period, interviewed 1,200 patients in the Department, gained consent from 600 to review the experience afterwards – a report will be presented at the next meeting
  Action: Chief Operating Officer to share findings from Community Voices
- Stroke achieved an A rating for the stroke services in the last audit

Paul Butterworth challenged the significant drop in complaints down by 33%. The Chief Operating Officer clarified the performance will dip whilst clearing the backlog before an improvement shows on the trajectory.

Rosemary Hedges asked why A&E attendances are very high. The Chief Operating Officer explained there is no alternative to A&E other than GPs which is unusual as there are no walk-in centres. Rosemary asked if community provision is reducing. The Chief Operating Officer clarified the 'Right care, right time, right place' will improve community provision with primary care networks as part of the 10-year plan. Mark Davies, Clinical Director for the Emergency Care Network is the clinical lead for a pilot site for the workforce re-design to front end staffing.

Rosemary Hedges highlighted the high level of incidents reported on ward 11 and asked what type of ward this was.
Action: Chief Nurse to confirm

Sian Grbin asked about the stroke SSNAP scoring an 'A' with an overall rating of 64.2%. The Chief Operating Officer confirmed the Trust doesn't need to achieve

100% or an A in all targets. The Medical Director added the Trust are on an improvement journey.

Rosemary asked about a hyper acute stroke unit at CRH, the Medical Director explained options were reviewed in terms of a hyper acute stroke unit and there will be four in the West Yorkshire region, which includes Bradford Teaching Hospitals, Mid Yorks, Leeds and Calderdale and Huddersfield will remain with a hyper acute stroke unit.

b. Financial Position and Forecast – Month 11

The Executive Director of Finance summarised the key points from the Month 11 position;

- Forecast to achieve the planned £43.1m deficit plan
- Agency expenditure is £1.74m below the agency trajectory set by NHSI and is forecast to remain below the trajectory for the rest of the year
- On track to deliver the Cost Improvement Programme (CIP)
- Capital expenditure year to date is lower than planned at £6.34m against a planned £8.17m
- Final accounts submission CDEL (capital department expenditure limit) – re-evaluation exercise took place on assets and the outcome was less depreciation – breach of £2.5m (regulators are aware)
- The Trust are planning for a £10m deficit plan for next year
- Cost pressures throughout the year including clinical waste

Peter Bamber asked how much of the deficit plan serves as debt. The Director of Finance clarified the Trust will pay £3.2m in interest next year which us up from £2.3m; therefore, a £900k increase. The interest rate will be 1.5% next year which is a decrease from 3%.

Rosemary Hedges asked if the control total has been agreed, the Director of Finance responded the control total has been agreed and the Trust is borrowing less cash next year and more money will go into the tariff to get providers back into balance.

26/19 UPDATE FROM COUNCIL OF GOVERNORS SUB-COMMITTEE

<u>Nominations and Remuneration Committee – 14.2.19</u>

Alison Schofield highlighted the key points from the Nominations and Remuneration Committee held on 14 February 2019. The Committee reviewed the terms of reference for the committee and amendments were received and considered. There was discussion on engagement, communication and involvement in the Non-Executive Director appraisal process. The re-appointment of two Non-Executives coming to an end of tenure were discussed and approved, the Committee considered their attendance, appraisals and other feedback and the Chair exercised a casting vote to support one of the re-appointments.

The Committee reviewed the Board skills and competencies required for the new Non-Executive Directors. Paul Butterworth highlighted this is the one committee where governors can vote and asked that all governors attend to avoid the need for the chair to use a casting vote.

Nominations and Remuneration Committee – 25.3.19

Stephen Baines highlighted the key points from the Nominations and Remuneration Committee held on 25 March 2019. The Committee approved the revised terms of reference. The Non-Executive Director process for recruitment was approved. All governors taking part in the NED recruitment process will have to undertake training.

27/19 COMPANY SECRETARY REPORT

1. **Process for election of Lead Governor**
   Public governors can nominate themselves as lead Governor, including stakeholder governors and expression of interest are asked for by 29 April 2019. The voting process with governors will take place at the end of May 2019 and appointment will be announced at the Annual General Meeting. Sian Grbin clarified a governor can nominate another governor.

2. **2019/20 Quality Account Priorities**
   The Council of Governors is asked to **NOTE** the selected 2019/20 Quality Account priorities following a selection process that began at a Governor Workshop in December 2018 and completed during February 2019.

3. **Council of Governors Register**
   The Council of Governors' is asked to **NOTE** and receive the Council of Governors register attached.

4. **Elections to the Council of Governors**
   The Company Secretary reported the governor elections are underway and the deadline for receipt of nominations is 20 May 2019, including those governors who wish to re-stand. Brian Moore clarified that governors who want to re-stand must live in the area they want to represent.

5. **Council of Governors Self-Appraisal Process**
   The feedback from the 2017/18 Council of Governors self-appraisal process will be shared at the Board and Council of Governors Workshop on 21 May 2019. The details of the self-appraisal process for 2018/19 will be confirmed in due course.

6. **Review Annual CoG Meetings Workplan**
   The Council of Governors is asked to review and approve the annual workplan for the Council of Governors. Comments are to be sent to the Corporate Governance Manager.

7. **Review date of Annual General Meeting 2019**
   The Council of Governors is advised that the Joint Board/Council of Governors' Annual General Meeting will be held on Wednesday 17 July 2019. The meeting will take place on the 3rd floor, Acre Mills Outpatients commencing at 6:00 pm.

8. **Council of Governors Formal Attendance Register – Annual Report and**

Accounts
Governors were asked to review the attendance register for accuracy as this will be published in the Annual Report and Accounts 2018-19.

9. **Proposal for an additional Stakeholder Governor**
The Council of Governors were asked to approve the proposal for an additional partnership Governor for CHS. The Chair has reviewed the process at other Trusts and this will be in line with other organisations. Sian Grbin asked if this post would start from July 2019. The Company Secretary clarified the partner organisation will be asked to put someone forward for the governor role and the post would commence in July 2019.

OUTCOME: The Council of Governors **APPROVED** a stakeholder governor for Calderdale and Huddersfield Solutions Limited (CHS).

10. **Proposal for a Governor Workshop**
The Trust is in discussions with NHS Providers to provide 'Holding to Account' and 'Non-Executive Director Recruitment' training for governors. The potential date for the full day training is Tuesday 14 May 2019 and a second session will be provided in house. It is proposed that a half day will focus on NED recruitment and a half day will focus on 'Holding to Account'. Governors are asked to confirm their availability for the workshop on 14 May to the Corporate Governance Manager.
Action: All Governors to confirm availability for the workshop to the Corporate Governance Manager

OUTCOME: The Council of Governors **NOTED** a workshop will be organised and were asked to confirm their availability on 14 May to the Corporate Governance Manager.

11. **Nominations and Remuneration Revised Terms of Reference**
A revised term of reference for the Nominations and Remuneration Committee for the Council of Governors was reviewed and approved at the meeting of the Nominations and Remuneration Committee on 25 March 2019.

OUTCOME: The Council of Governors **APPROVED** the revised Nominations and Remuneration terms of reference.

28/19 UPDATES FROM SUB-COMMITTEES

Quality Committee
Christine Mills provided written feedback on the Quality Committee noting it is chaired well, discussion is open and areas that require improvement are highlighted. The department leads give clear evidence of how the improvement is planned, how it is progressing and are open with all facts whether improvements are going well and when improvement is not progressing.

Charitable Funds Committee
Sheila Taylor provided written feedback on the Charitable Funds Committee, she explained it discusses how funding comes about, how it is spent and if any restrictions are in place. Whilst some legacies are received, other specifies how their legacy can

be used i.e. ‘Restricted’ or ‘Unrestricted’ use of funds. A Fundraising Manager has successfully been appointed to fund raise for the charity and raise the profile. There has been discussion around how the Todmorden Health Centre could be utilised more having had a great amount of money spent on it. The Todmorden Health Centre is under used at present and progress is ongoing in terms of how it can be better used, and a survey will be carried out to ascertain patient preferences. Sheila was heartened to hear how some of the funds are raised and how some on the money is spent within the hospitals.

Organ Donation Committee
The Chair reported on the Organ Donation Committee and the efforts to increase the number of people who can donate organs. This is proving difficult with recent law changes. There was discussion how the Trust can engage with communities via the chaplin service through the hospital.

Audit and Risk Committee
Brian Moore reported on the Audit and Risk Committee which focused on clinic outcomes data quality issues that have been raised and the Trust are re-running a self-assessment which will be reported at the next meeting. The Board Assurance Framework (BAF) has been discussed in terms of how risks are being managed for CHS. There was discussion about the Annual Report and Accounts and the risks due to the timing of the departure of the Company Secretary.

Finance and Performance Committee
Sian Grbin reported on the Finance and Performance Committee and confirmed the Managing Director for Digital Health is submitting a final report on EPR Benefits to the next meeting. A Committee Chair’s meeting has been arranged which was an output of the self-effectiveness action plan. The Committee has been reviewing financial improvements in previous years. There has been an increase in waiting times for first appointments (Outpatient transformation) and the Chief Executive has asked for a deep dive.

Project echo is discussed at this Committee which is where the Trust review the relationships under the PFI and better use of public money.

Workforce Committee
Alison Schofield reported on the Workforce Committee and is impressed by the number of creative opportunities to improve staff experiences within the Trust. Karen Heaton has been working hard on the Organisational Development Kitchen event creating a knowledge cupboard of recipes to support staff and signpost them towards policies and support resources within the workplace. This has opened opportunities for staff engagement and discussion such as staff support groups for BAME and engaging new staff group colleagues with a disability. This is enhanced with the recent recruitment of an equality manager to strengthen this important work. During 2019/20 the Trust will be improving mandatory fire training. Agency spend across the

Trust has reduced. The Trust have several support strategies in place for colleagues, such as NEYBER for finance issues.

29/19 COUNCIL OF GOVERNORS CALENDAR 2019

The updated Council of Governors calendar for 2019 was circulated for information.

DATE AND TIME OF NEXT MEETING

Council of Governors Meeting
Date: Thursday 18 July 2019
Time: 3:30 – 5:30 pm
Venue: Boardroom, Sub-Basement, HRI

Annual General Meeting
Date: Wednesday 17 July 2019
Time: Commencing at 6:00 pm
Venue: 3rd floor, Acre Mills Outpatients

The Chair thanked the governors, Non-Executive Directors and Executive Directors for attending and formally closed the meeting at 17:44 pm.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

WORKFORCE COMMITTEE

NOTES and ACTIONS of the REVIEW of the QUALITY AND PERFORMANCE REPORT – WORKFORCE (FEBRUARY 2019)

Held on Monday 8 April 2019, 11.30am – 12 noon, Learning & Development Centre, HRI

PRESENT:

Mel Addy	(MA)	Director of Operations, Surgery & Anaesthetics
David Birkenhead	(DB)	Medical Director
Gary Boothby	(GB)	Director of Finance
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Karen Heaton	(KH)	Non-Executive Director (Chair)
Ruth Mason	(RM)	Associate Director of Organisational Development
Adam Matthews	(AM)	Workforce Information Analyst
Andy Nelson	(AN)	Non-Executive Director
Alison Schofield	(AS)	Lead Governor
Sharon Senior	(SS)	Staff Side Representative
Claire Wilson	(CW)	Assistant Director of Human Resources

15/19 WELCOME AND INTRODUCTIONS

Sharon Senior was welcomed to her first Committee meeting.

16/19 QUALITY AND PERFORMANCE REPORT – WORKFORCE

The February 2019 report was circulated ahead of the meeting along with a summary document.

It was noted the Workforce domain had improved from 55.2% in January 2019 to 56.9% in February 2019. This is due to improvements in Essential Safety Training (EST), particularly Infection Control which moved above the 90% 'Amber' target.

Fire Safety training still of concern, revised matrix shows currently at 81%. AS asked if there had been a different approach to the training. SD explained alternative methods are being pursued to deliver fire training differently.

AN asked for clarification of how the 90% EST target was agreed. SD referred to the Board discussion when setting targets and to the model hospital.

GB asked if we saw 11% retention as good. AM explained difference between turnover and retention. GB noted Leeds is at 4% - is this good? All agreed that this did not sound healthy. Agreed to investigate what this included. It was agreed to refresh the unplanned turnover position data and share this with the Committee.

Medical Appraisal achievement has improved and KH thanked colleagues for this.

Absence has improved but RTW still not where we would want it to be. The last Committee meeting discussed the reason for this in relation to recording. MA confirmed the recording procedure has been clarified.

Agency Spend – AN asked if we were below the agency spend ceiling and GB confirmed we would come in £1.5m below this. There is a sense that NHSI will focus on administration and estates next year.

Recruitment - time taken to recruit this still seems high. AM confirmed all metrics had improved in February 2019. There has been sustained improvement for 2 years. SD confirmed that we had purposely put in stronger vacancy controls - adding to monthly performance review meetings can mean an added 2-3 weeks' delay. This has no front-line impact.

AN asked if there was any data collected on application numbers. SD confirmed more consultant applications are received. Time to hire performance for individual staff groups will be provided at the May Committee meeting.

Administration and clerical 61 vacancies – MA confirmed that divisions were holding admin vacancies with regard to the voice recognition project. SD confirmed THIS were also holding vacancies within the service desk team.

AS asked if disabled colleagues had rights if they met the essential criteria and SD confirmed they do. AS confirmed that she has set a date to meet with Nicola Hosty and was interested in establishing a staff disability group. RM confirmed that this is our next network to create.

KH asked about 23 Employee Relation cases. JE confirmed the majority are disciplinary cases and that this is a norm for the organisation and that at any one time cases were coming off and other cases were coming on. This also includes medical cases.

GB raised that a grievance heard in month there was some learning from this. SD confirmed that there always would be learning from cases. JE confirmed that a standard operation procedure is to be developed to supplement the existing policy. KH confirmed that only patterns of lessons learned should be discussed at the Committee meetings.

KH asked if there were any further comments from colleagues.

AN noted the planned vacancy rate was at 4.4% - had we achieved target? AM confirmed the position at 6% at year end - this was partly due to Filipino nurses exercise still progressing. AN noted that 6% felt more realistic.

AS asked if we had any contingency on Brexit. CW confirmed this is still largely unknown but letters have been sent to EU nationals employed by the Trust on where we are including information received from the Home Secretary. CW agreed to share the letter with Workforce Committee colleagues. It was noted there are 15 Spanish nationals employed as nurses who may be affected by a regulation in Spain that does not recognise service/experience in non-EU countries. This could mean they are encouraged to stay with us. JE referred to new proposed immigration laws subject to consultation that set a salary cap which will affect the ability of NHS Trust to recruit overseas. It was noted this is not supported by NHS employer organisations. KH recognised the overall good position of workforce metrics and that things are heading in the right direction.

JE referenced needing to work harder in Q1 due to the number of colleagues coming out of EST compliance.

AN agreed the story looks good and the summary page could be more positive to reflect the positions.

Summary of actions arising from today's meeting to be added to the Workforce Committee action log:-

Recruitment and Retention
AM to refresh the unplanned turnover position data and share this with the Committee.

Employee Relations
KH and JH to meet to discuss lessons learned.
AK to develop a job matching standard operation procedure to support the existing policy.

European Colleagues/Brexit
CW to share with the Committee information sent to European colleagues.

17/19 DATE AND TIME OF NEXT MEETING:

17 May 2019, Workforce Committee Deep Dive
2.00pm – 4.00pm, CE Office, CRH/Discussion Room 1, Learning Centre, HRI

Calderdale & Huddersfield NHS Foundation Trust
Charitable Funds

CHARITABLE FUNDS COMMITTEE

Minutes of meeting held on Wednesday, 27 February 2019

Present: Philip Lewer, Gary Boothby, Jackie Murphy, Phil Oldfield, David Birkenhead Linda Patterson, Sheila Taylor

In attendance: Carol Harrison, Lyn Walsh (minutes)
Apologies: None

1. Declaration of Independence
At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. Minutes of the last meeting
The minutes of the last meeting held on 29 November 2018 were agreed as a true and correct record. These have already been uploaded to the board paper site for the previous Board of Directors meeting.

3. Action Log
The action points 1-3 were discussed and it was agreed that they were all linked into the recruitment of a fundraiser and overall promotion of charitable funds going forward. An advert has now gone out for the position with an interview date TBC. A 6 month due date was agreed on these now combined actions.

Risk register & Strategy update - the updated papers were shared outside the meeting and were brought for approval it was decided that there would be further review when the fundraiser was in post. Discussion took place whether the strategy is ambitious enough but it was agreed that this is progress and that the strategy would be reviewed again once the fund holder resource was in place. Action: bring back to a future meeting. 6 Months.

Age Concern- The letter has been sent and a response received. This is linked to the following action point.

Todmorden premium costs – G Boothby there is currently work being done on developing a business case, at present there seems to be lower activity but discussions about exploring digital technology may be the answer and this could be linked to age concern using some of the building. J Murphy suggested that volunteers may be used to help patients use the new technology and we need to capture data about Todmorden and Hebden bridge with some outpatient work that

is going on at present. There needs to be better understanding on why patients are not accessing services at Todmorden D Birkenhead stated that it is about patient choice and experience. L Patterson said Hebden bridge also needs looking at. Further Action: G Boothby agreed to bring a proposal where there may be a request of use of charitable funds to support either continued activity at Todmorden which costs a premium to deliver or for digital technology investment to allow the local service to continue and expand. Linked to the review of what activity takes place at Todmorden Jackie Murphy would support discussions and survey with patients to understand their preferences for Todmorden activity. This may be included within any request for funds but the overall review of Todmorden should be addressed elsewhere.

2014 Legacy- C Harrison updated that shortly after the last meeting the legacy was received £152k, there was a further legacy £173k received in January. Action closed.

4. Risk Register update –refer to point 2 in action log. It was also suggested that Asif Ameen and the new fundraiser attend future meetings.

5. Quarter 3 SOFA and Balance Sheet 2018/19

C Harrison presented the paper and its contents were noted. P Oldfield raised a question on restricted and unrestricted funds, Carol went on to explain these to the new members of the committee, she also updated how funds currently work and explained that we have investments with CCLA. P Oldfield asked what the current balance on the general purpose fund was, this is currently £89k but monies need to be put aside to initially cover the fundraiser post. It was agreed at this point no further funds would be put aside for the fundraiser to utilise apart from the salary.

6. Quarter 3 2018/19 Expenditure Summary

C Harrison presented this paper and its contents were noted.

7. Minutes from the Staff Lottery Committee meeting held on 4 December 2018

These were noted.

8. Any other business

L Patterson asked with regards to the Charity Commission who was held responsible it was confirmed that the Trust Board is the corporate trustee.

P Oldfield discussed consolidation of funds, Jackie Murphy said we need to get the views of the people it affects and is there a better way of doing things in the future.

Action: C Harrison to provide updated fund information.

Fund holder post to bring review of options to consolidate smaller accounts alongside merits of both options – 6 months

13. Date and time of next meeting

The next meeting will be on Wednesday, 22 May 2019 at 1.30pm-3.00pm in Meeting Room 2, Acre Mills.

Action Log - 2018/19

CURRENT ACTIONS					
Agenda Topic	**Ref**	**Action**	**Lead**	**Due Date**	**Status**
Matters arising	28.08 - 4	Fundraiser recruitment - Brand launch and promotion of Charitable Funds.	**PL/GB**	Aug-19	ongoing
Risk Register & Strategy update	28.08.18	Papers are updated await further approval when fundraiser appointed.	**GB/TBC**	Aug-19	ongoing
Todmorden premium cost	29.11.18	Bring a proposal where there may be a request of use of charitable funds to support either continued activity at Todmorden which costs a premium to deliver or for digital technology investment to allow the local service to continue and expand. Linked to the review of what activity takes place at Todmorden Jackie Murphy would support discussions and survey with patients to understand their preferences for Todmorden activity. This may be included within any request for funds but the overall review of Todmorden should be addressed elsewhere.	**GB / JM**	May-19	ongoing
AOB	27.02.19	Updated fund balances & transactions	**CH**	May-19	
AOB	27.02.19	Fund holder post to bring review of options to consolidate smaller accounts alongside merits of both options	**TBC**	Aug-19	

Calderdale and Greater Huddersfield A&E Delivery Board (A&EDB) Highlight Report		
12th March 2019	**12:30 – 14.00**	**Shibden Room Dean Clough**

Chair	Matt Walsh – Calderdale CCG
Attendees **Guest**	Andrew Bottomley (AB) – CCCG Andrew Simpson (AS) – YAS Bev Walker (BW) - CHFT Carol McKenna (CMcK) – GHCCG David Hughes (DH) – GHCCG Debbie Graham (DG) - CCCG Helen Barker (HB) – CHFT Helen Carr (HC) – LCD John Kevany (JK) – Mark Davies (MD) – CHFT Matthew Bleach (MB) – CCCG Michele Day (MD) - Locala Peter Horner (PH) – Locala Richard Parry (RP) – Kirklees Council Vicky Dutchburn (VD) – GHCCG
Note Taker	Emily Addison – Calderdale CCG

1. Welcome and Apologies	
Lead	**MW**
Apologies	Members were welcomed to the meeting and a round of introductions made. The following apologies were noted: Amanda Evans, Balrajjit Leighton, Jane Close, Michele Day, Rachel Foster, Cath Bange

2. Sign off Highlight Report and Action log	
Lead	**MW**
Discussion	The Board reviewed the notes from 12th February 2019 and agreed they were an accurate record of the meeting. DG reviewed the action log with the Board: Actions: 247, 331, are ongoing Actions: 332, 338, were closed.

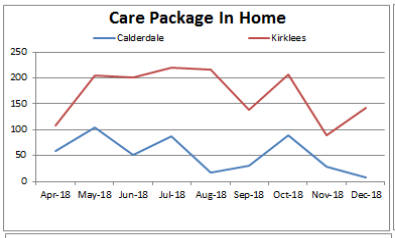
3. System Update	
Lead	**DG**
	DG provided the system update showing the narrative for the week beginning the 4th March 2019. Key elements were: **1. System Status Update:** • Evaluation of CHFTs 'Marvellous March' to be brought through to April 2019 A&EDB • Group sighted on update 11/03/2019

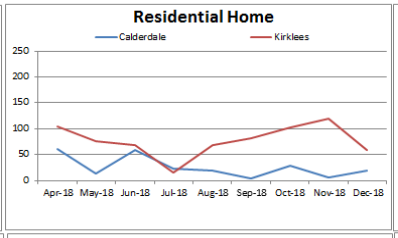
	• Looking at optimising LCD service models to avoid issues around moving up their local escalation • Winter plans working well – only one silver call this year. **2. Activities since February Board** • Easter assurance shows no major risks – The board will have a clearer view by April 2019 • A&E Engagement Report is due at the end of March 2019; the A&E DB may use these finding for a deep dive in the future. • YAS have circulated their SDIP which will come with Catherine Bange to the A&E Delivery board for a deep dive in April 2019.
4. Performance	
Lead	**All**
	MB provided the performance exception report. The full report is included with the papers for information: **1. Performance** • A&E performance ranks in top quartile nationally with significant improvement from mid Feb to date • A&E performance stronger at CRH compared to HRI • Stronger levels of performance in A&E reported midweek, particularly Thursday • Ambulance handovers within 30 mins around 50th percentile nationally • Stronger levels of performance for handovers at HRI compared to CRH **2. Activity** • Busiest days in A&E are Sundays & Mondays • Monday & Friday are the busiest days for admissions • Conversion rate from A&E highest on Fridays • Volume of discharges highest on Fridays **3. Variation** • No significant variation in volume of attendance and emergency admissions **4. Flu** • Low consultation rates for flu and flu like illness. Levels are below previous years and below rates reported across the region
5. Brexit	
Lead	**MW**
	Whilst it was agreed that the majority of Brexit preparation is not in the gift of the A&EDB, the Board did need to consider the following issues; medication, fuel and workforce. There was a regional teleconference earlier in the month, involving many members of the A&E Delivery Board. This did not identify any new areas which had not previously been discussed. • MW emphasised the identification of vulnerable service users who are being nursed at home and how easily these individuals can be identified. CHFT had also identified this need at their recent table top exercise. It was decided that this would be done as near to the time as possible as the situation was fluid. • VD emphasised a need for accurate and up to date lists of intensive service users i.e. patients on ventilators, dialysis or having chemotherapy and the need for accurate up to date lists of such individuals from both our providers and continuing health care. • In regards to workforce it is believed that there will be a low initial impact, however, there may be a greater impact in the months following due to pressure from staff

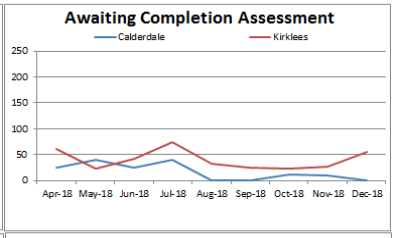
	migration and may also be an issue to consider in terms of providers. • General Practice readiness is yet to be fully understood, and has yet to identify their practices priority fuel users. • Place based emergency planning should be leading the conversation around plans in the event of civil unrest (which may lead to added pressures on A&E services). • Insulin stock and supply, assurance received by NHSE these are at a viable level.
6. West Yorkshire Emergency Care Deep Dive	
Lead	**DG**
	DG presented the 'Deep Dive' into the role of the West Yorkshire Urgent Emergency Care Network and a conversation around the Network's broader role in line with the expectations set out in the NHS plan. Also to prompt a conversation about how the A&EDB would like to be sighted on work going forward. The Network has emphasised that the Long Term Plan is a framework for system improvement, with primacy sitting in place. **Expectations on UEC Network** • The WYECN is expected to reprioritise and deprioritise where needed as not to crowd transformation with targets. • There will be a "Confirm and Challenge" process starting in May 2019 to look into the networks progress in regards to the expectations highlighted. This process will be fed through the A&E Delivery board. **Expectations CAS** • Each area is expected to be delivering and supporting the 50% of NHS 111 calls receiving a clinical assessment. • At the moment Calderdale is at 44% and Huddersfield is at 48%. Work is underway across West Yorkshire to increase to 50% • 50% is seen as a critical level for transformation to be explored. This is based on telephone assessments including HCP call backs. (Patients ringing Single Point of Contact, rather than 111, are not included in these figures.) • The board needs to consider its local offers in order to support delivery through local responses and third sector services to achieve the 50%. **Expectations UTCs** • More than 40% of people calling 111 triage are being booked onto face to face appointments. • In Calderdale 4 practices are live with extended access, work continues looking at how extended access hubs will go online in the near future. • In Greater Huddersfield direct booking is in the extended access scheme, HRI and 6 practices are live. • By March 2020 there should be a reduction in the default to A&E from our Directory of Services, DOS, the baseline for this has to go to 1% which impacts locally. • Currently far too many DOS disposals go to A&E; the more of the DOS populated with local service models the less that will happen. • Vicky Dutchburn, Sarah Antemes and Alex Jevins have had a conversation with Martin Pursey, Head of Contracting and Procurement, CCG, around helping to support this by updating the mental health side so it is more robust. • Urgent Treatment Centres models have been consulted on and by Autumn 2020 there should be some consistency around options and the deliver services in localities. • The majority of UTCs in West Yorkshire will be designated by December 2019 and any exception will have to go through the Regional Director at NHSE. • Calderdale and Kirklees will not be in a position to implement this by December 2019.

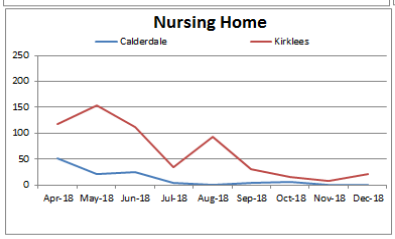
	• It is necessary to have a clear view of the future plans, along with a clear and coherent view of the current processes being implemented. • How this model is developed locally needs to be well investigated before implementation due to the risk of 'double demand' which is having an impact on A&E in other areas currently. **Expectations – Same Day Emergency Care** • National targets will be reduced from 1/5 to 1/3. • As a system we are quite far along in the process. **Expectations – Transfers of Care** • There is a further 15% reduction in DTOC expected from January 2020 to March 2020. **Expectations – Mental Health** • Mental Health 111 Universal offers 24/7 support in the community. • Some national standards will be coming out in the near future specifically for emergency services in regards to mental health. The UECN are seeking views from A&EDBs about the Network's role in delivering the above, and anything else associated with delivery of the NHS Plan. The Board agreed that much of the work is already in the strategies for Calderdale and Greater Huddersfield and place and that we needed to evolve our performance reporting arrangements as clarity emerges
7. A&E Delivery Board Priorities	
Lead	**AB/MB**
	AB presented the Home First update. Our mini winter review document has been shared with NSHE and the Board will receive the full WY document once it is published by NHSE. The Academic Health Science Networks, AHSN, is looking at building a relationship with the Home First Group in terms of responses to DTOC solutions especially in respect of the groups TOC list reporting, data solutions and knowledge portal. The MADE principles have been applied to Mental Health patients, this has been seen as achieving positive outcomes and has accelerated some discharges, this is ongoing. Some key points were highlighted in relation to the DTOC webinar: - Good representation from our system - Good learning from the conversations around consistency of approaches - An inter-organisational group has been developed to move the work forward through shared leaning from the webinar to implement changes across WY Super Stranded Patient performance targets are increasing by 15%. We are under the 104 target now. However we need to consider the step-changes need to deliver the additional ambition. MB presented the performance in key areas.

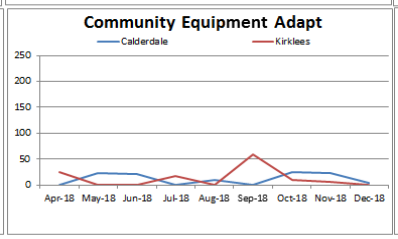
CHFT Reportable Delays – Reasons for Delay

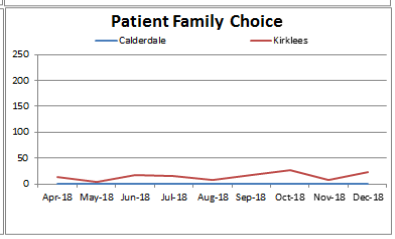


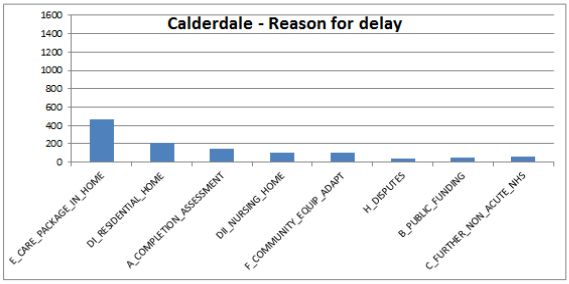


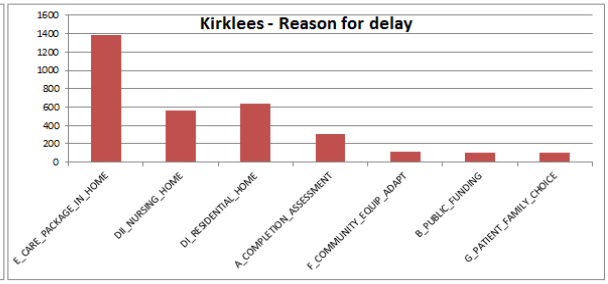




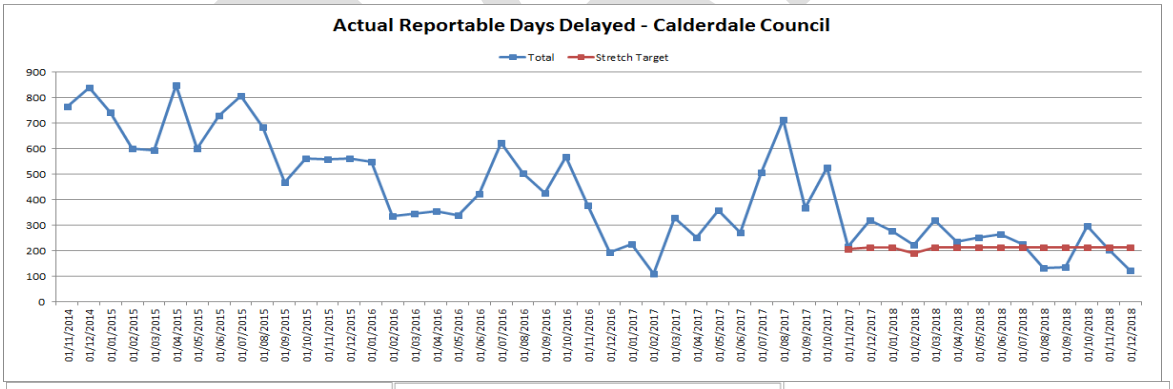


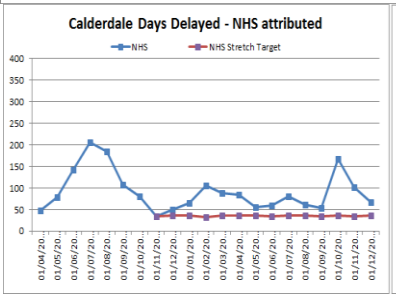


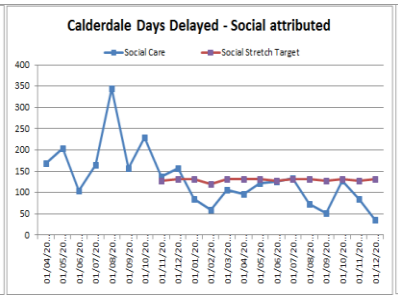


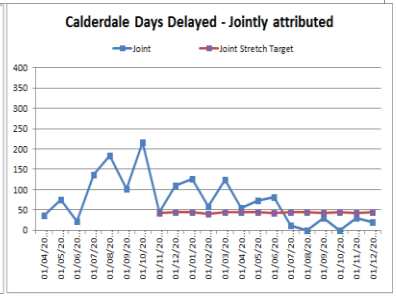


Reportable Days Delayed – Calderdale

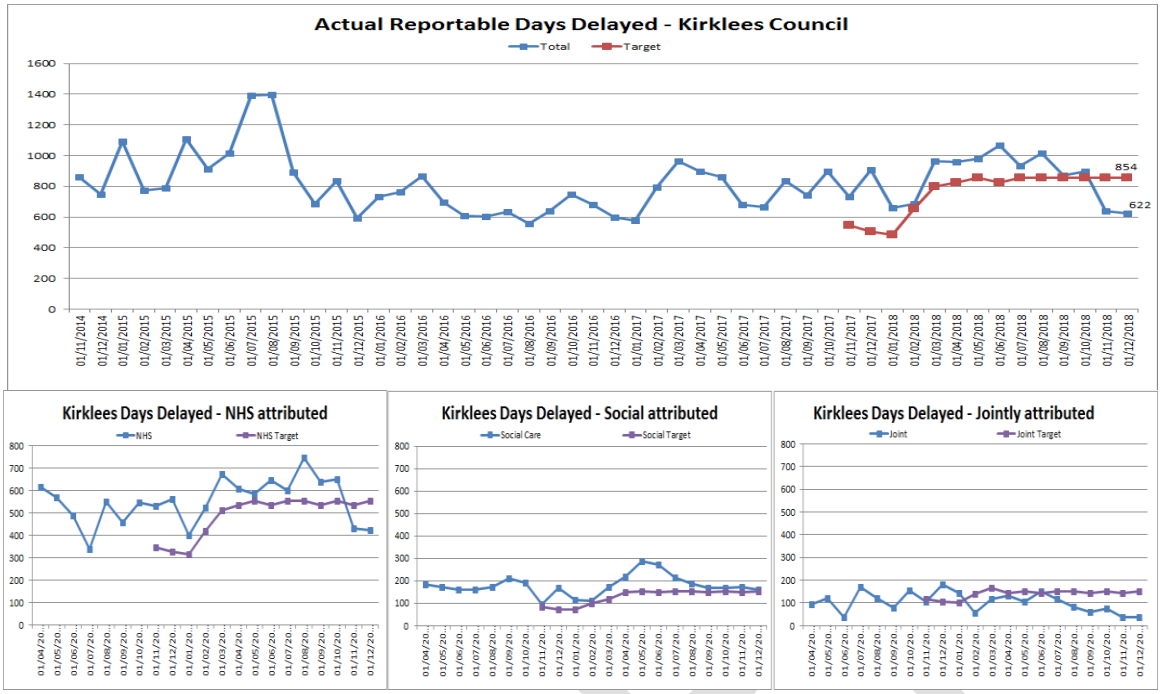




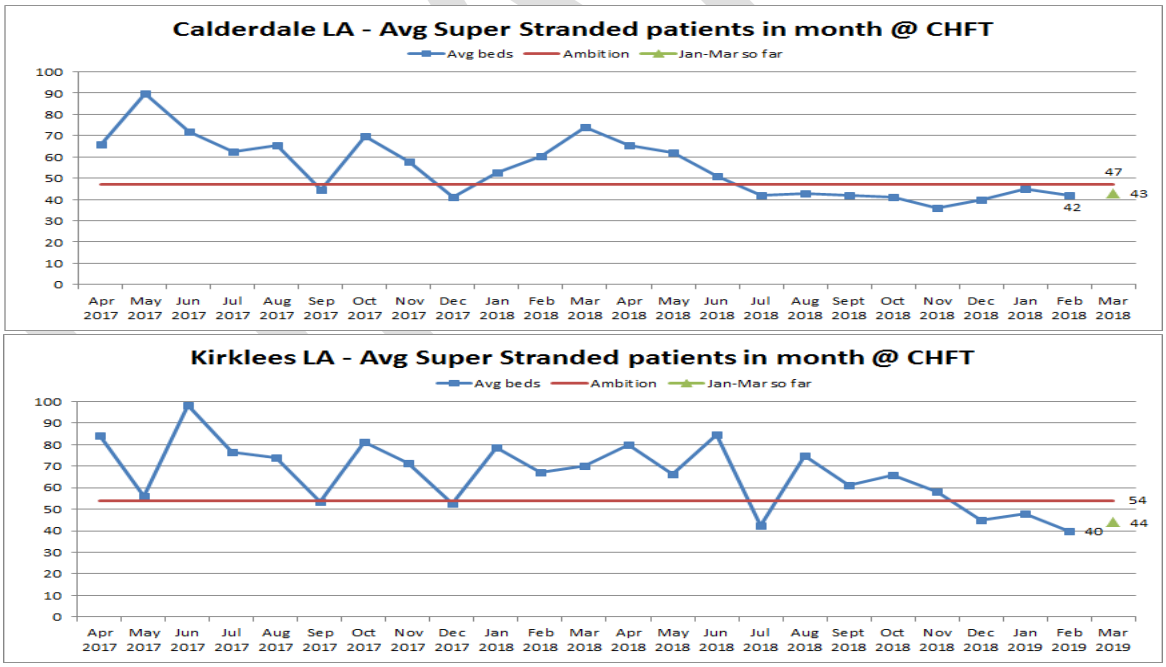




Reportable Days Delayed – Kirklees



Average Super Stranded Patients at CHFT by Local Authority



7. West Yorkshire Emergency Care Notes to Review

Lead	DG
	The Board's was that there was strong representation from our system From the conversation at the last A&EDB, and the discussion today, the future the agenda of the Network looks to be broadening and this was supported by the A&EDB.

6. AOB	
Lead	**All**
	• David Hughes informed the Board that he will be retiring in June 2019, but will be attending the May meeting. • A&E May meeting will be a development session and be extended till 15.00.
Next Meeting	14th May 2019, Shibden Room, Dean Clough, 12.30-15.00 11th June 2019, Shibden Room, Dean Clough, 12.30-14.00 9th July 2019, Shibden Room, Dean Clough, 12.30-14.00 13th August 2019, Shibden Room, Dean Clough, 12.30-14.00 10th September 2019, Shibden Room, Dean Clough, 12.30-14.00 8th October 2019, Shibden Room, Dean Clough, 12.30-14.00 12th November 2019, Shibden Room, Dean Clough, 12.30-14.00 10th December 2019, Shibden Room, Dean Clough, 12.30-14.00 14th January 2020, Shibden Room, Dean Clough, 12.30-14.00 11th February 2020, Shibden Room, Dean Clough, 12.30-14.00 11th March 2020, Shibden Room Dean Clough, 12.30-14.00

Enclosure A

Calderdale & Greater Huddersfield Health Economy
A&E Delivery Board (A&EDB)

Action log

No	Minute Ref	Action	Who	Date	Update	Status
247	Planning	To bring the content of the developing SRG urgent care programme to the Board once it had been through its first gateway on 28 February 2019	HB/DG /VD	May 19	On schedule/on forward plan	Open
331	Leadership	Feedback on the meeting between MW, CMcK, IB, RP and HB at the February meeting	MW	March 2019	Meeting taking place on 16/05/2019	Outstanding
332	Surge & Escalation	VD to share written details on mental health winter funding when available	VD	Feb 2019	Now circulated, but need to pick up any issues at April meeting. To be included on agenda.	Open
336	System	Organisations agreed that they would work to identify vulnerable services users and a view on how key workers would be identified in the event of a fuel shortage – responding to both S&E plan and Brexit	All	March 2019	Work not yet concluded – update to be provided at April meeting	Open
341	System update November 2018	Rob Gibson to share information on the Cloud Nine Exercise	RG	March 2019	Completed	Closed
342	System update November 2018	Overview of delivery of YAS/999 performance expectations to feature on A&EDB work plan	CB/DG	April 2019	Completed on agenda	Closed
343	Brexit Readiness	March A&EDB to continue to pick up an further risks and mitigating actions related to Brexit	All	Ongoing	`On agenda	Open
344	Readmission Audit	A&EDB to continue to consider re-admission performance as part of its standing TOC update	TS/MB	Ongoing	Closed, logged for TOC performance updates once data flow in place	Closed
345	Readmission Audit	HB to bring back an update to the Board on the readmissions work in 3-4 months (May/June	HB	June 2019	Closed, AE placed on forward plan for June	Closed

No	Minute Ref	Action	Who	Date	Update	Status
		2019)			meeting	
346	Proposal for Changing our Performance Update	Members to consider areas for future Performance deep dives and share them back with DG in order to inform agenda setting	All	March 2019	Board identified items for forward plan (EA) • New GP Contract • UTC – Workforce. To remain standing item.	Closed
347	WY Emergency Care Update	DG and HB to feed the view of the Board into a future Network Meeting	DG/HB	March 2019	Item covered in March	Closed
348	Brexit Readiness	Individual organisations to ensure there are fully engaged in Local Health Resilience Partnership and Gold Partnership	All	Ongoing	On Agenda	Open
349	Super Stranded	TOC Group to continue work to prep for delivery of new target and feedback on progress.	HW/JP	March 2019	Closed	Closed
350	WY Footprint	MW to consider a conversation at WY AOs about representation from at the UEC Network across the WY footprint.	MW	Ongoing		Open
351	AOB	VD to confirm GP input from GH going forward (After David leaving – 111/DOS)	VD	Ongoing	Completed	Open
352	Brexit Readiness	For the board to clearly define what the criteria for a high risk or vulnerable patient is.	All	Ongoing	On Agenda	Open
353	Brexit Readiness	A conversation with both continuing health care teams in relation to them being able to identify high risk vulnerable patients.	JS(cald) /JP	Ongoing	On Agenda	Open

Key
Closed Shaded Grey
Open Due at later date Shaded Green
Outstanding due at later date, Shaded Red

21. Date and time of next meeting

Thursday 4 July 2019, 9:00 am

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

To Note

Presented by Philip Lewer