Board of Directors Public Meeting - 3.5.18

Schedule	Thursday 03 May 2018, 09:00 AM — 11:00 AM BST
Venue	Large Training Room, Learning & Development Centre, Calderdale Royal Hospital
Organiser	Kathy Bray

Agenda

9:00 AM	1. Welcome and introductions: Annette Bell, Public Elected Governor Brian Moore, Lead Governor Presented by Philip Lewer	
9:01 AM	2. Apologies for absence: Presented by Philip Lewer	
9:02 AM	3. Declaration of interests Presented by Philip Lewer	
STANDING ITEMS		
9:03 AM	4. Minutes of the previous meeting held on 5 April 2018 To Approve - Presented by Philip Lewer	
	APP A1 - PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 5.4.18.pdf	1
	APP A2 - PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 5.4.18 - Appendix - DRAFT - PUBLIC BOD MINS - 5.4.18(2) (1).pdf	3
9:08 AM	5. Action log and matters arising: To Approve - Presented by Philip Lewer	
	APP B1 - ACTION LOG - PUBLIC BOARD OF DIRECTORS.pdf	12
	APP B2 - ACTION LOG - PUBLIC BOARD OF DIRECTORS - Appendix - DRAFT ACTION LOG - BOD - PUBLIC - As at 24 APRIL 2017.pdf	14

9:13 AM	6. Chairman's Report To Note - Presented by Philip Lewer	
9:18 AM	7. Chief Executive's Report To Note - Presented by Owen Williams	
KEEPING THE BASE SAFE		
9:23 AM	8. Patient/Staff Story & Quality Report deep-dive: Kate Bell experience of LGBT patients To Note - Presented by Brendan Brown	
9:43 AM	9. High Level Risk Register To Approve - Presented by Brendan Brown	
	APP C1 - HIgh Level Risk Register.pdf	20
	APP C2 - HIgh Level Risk Register - Appendix - COMBINED HIGH LEVEL RISK for 3 may 18 board.pdf	23
9:48 AM	10. Strategy on A Page – End of Year Update To Approve - Presented by Victoria Pickles	
	APP D1 - STRATEGY ON A PAGE - END OF YEAR UPDATE.pdf	42
	APP D2 - STRATEGY ON A PAGE - END OF YEAR UPDATE - Appendix - Progress against strategy report - end of year report April 2018.pdf	44
9:53 AM	11. Hospital Pharmacy Specials (HPS) Annual Report Presented by Gary Boothby	
	APP E1 - Huddersfield Pharmacy Specials (HPS) Annual Report 2017-2018.pdf	51
	APP E2 - Huddersfield Pharmacy Specials (HPS) Annual Report 2017-2018 - Appendix - HPS_annual_report_2017-18_042518.pdf	53
9:58 AM	12. Director of Infection, Prevention and Control Quarterly Report To Note - Presented by David Birkenhead	
	APP F1 - Quarterly DIPC report.pdf	57
	APP F2 - Quarterly DIPC report - Appendix - Quarterly DIPC Report April 18.pdf	59
10:03 AM	13. Safeguarding Annual Report	

To Approve - Presented by Brendan Brown

	APP G1 - Safeguarding Annual Report.pdf	64
	APP G2 - Safeguarding Annual Report - Appendix - Safeguarding Annual Report 2017-2018 final version.pdf	66
	APP G2 - Safeguarding Annual Report - Appendix - Safeguarding Annual Report 2017-2018 final version - amended 30.4.18.pdf	102

10:08 AM 14. Nursing and Midwifery Staffing – Hard Truths Requirement
To Approve - Presented by Brendan Brown

	APP H1 - Hard Truths safe staffing paper.pdf	138
	APP H2 - Hard Truths safe staffing paper - Appendix - COMBINED HARD TRUTHS REPORT MAY 2018.pdf	140

10:13 AM 15. Integrated Performance Report
To Approve - Presented by Helen Barker

	APP I1 - Integrated Performance Report.pdf	168
	APP I2 - Integrated Performance Report - Appendix - Integrated Performance Report Mar 2018.pdf	170

10:23 AM 16. Month 12 – 2017-2018 – Financial Narrative
Presented by Brendan Brown

	APP J1 - Financial Commentary for NHS Improvement - Month 12.pdf	182
	APP J2 - Financial Commentary for NHS Improvement - Month 12 - Appendix - NHSI Financial Commentary Month 12 Final.pdf	184

10:38 AM 17. Annual Business Plan and 2018/19 Budgets
To Approve - Presented by Gary Boothby

	APP K1 - budget book - front sheet summary.docx	187
	APP K2 - Budget Book 1819 final.pdf	188

TRANSFORMING AND IMPROVING PATIENT CARE – no items

A WORKFORCE FOR THE FUTURE – no items

10:48 AM 18. Update from sub-committees and receipt of minutes & papers
- Quality Committee – verbal update from meeting 30.4.18
- Finance and Performance Committee – minutes of 3.4.18 and

verbal update from meeting 27.4.18
- Audit and Risk Committee – verbal update from meeting 18.4.18
Presented by Philip Lewer

19. Date and time of next meeting
Thursday 7 June 2018 commencing at 9.00 am
Venue: Large Training Room, Learning Centre, CRH
Presented by Philip Lewer

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 5.4.18 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 5 April 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 5 April 2018

Main Body

Purpose:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 5 April 2018

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 5 April 2018

Appendix

Attachment:

DRAFT - PUBLIC BOD MINS - 5.4.18(2).pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 5 April 2018 at 9am in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Philip Lewer	Chairman
Owen Williams	Chief Executive
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Dr David Birkenhead	Medical Director
Gary Boothby	Executive Director of Finance and Procurement
Brendan Brown	Executive Director of Nursing
Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates and Facilities
Andy Nelson	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Richard Hopkin	Non-Executive Director
Suzanne Dunkley	Executive Director of Workforce and Organisational Development

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary (minute taker)
Mandy Griffin	Managing Director Digital Health
Victoria Pickles	Company Secretary
Anne-Marie Henshaw	Associate Director of Nursing/Head of Midwifery (for item 8)
Mark Butterfield	Information Manager (for item 8)
Carol Gregson	Midwife (for item 8)

OBSERVERS

Dianne Hughes	Public Elected Governor
Kate Wileman	Public Elected Governor
Brian Moore	Lead Governor

49/18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to his first meeting as Chair. The Chief Executive advised that due to interviews with the CQC taking place it would be necessary for individual Board members to take leave of absence throughout the meeting.

50/18 APOLOGIES FOR ABSENCE

Apologies were received from:
Phil Oldfield, Non-Executive Director

51/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

52/18 MINUTES OF THE MEETING HELD 1 MARCH 2018

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

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

53/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG

There were no matters arising which had not been included on the agenda.

54/18 CHAIR'S REPORT

The Chair advised that a meeting of the Council of Governors had taken place on the 4 April 2018. The key areas of discussion included:

- Wholly Owned Subsidiary – it was agreed that an extra-ordinary private meeting of the Governors would be arranged to discuss this in more detail.
- Attendance at formal Council of Governors' Meetings – the attendance record had been circulated. Concern was expressed that this item had been on the Governors' agenda on a number of occasions. It was agreed by those present that two Governors should be asked to stand down due to non-attendance, in line with the Constitution (clause 17).

OUTCOME: The Board **NOTED** the Chair's report.

55/18 CHIEF EXECUTIVE'S REPORT

The Chief Executive formally welcomed Philip following his appointment to the position of Chair with effect from 1 April 2018. It was noted that Andrew Haigh had been thanked at the Council of Governors meeting the previous evening for the 7 years' work undertaken at the Trust and best wishes for the future had been extended to him.

The Chief Executive wished to formally thank staff for ensuring that patient safety was not affected during the recent adverse weather conditions.

It was noted that during the last month the Care Quality Commission had carried out their unannounced inspection and were currently concluding their well-led inspection. The Community Place had been highlighted as requiring particular attention. The Chief Operating Officer updated the Board on the work being undertaken with the Local Authority and Commissioners around rehabilitation at home models and care closer to home. It was agreed to share feedback across the organisation as soon as possible.

ACTION: Chief Executive

OUTCOME: The Board **NOTED** the Chief Executive's report

56/18 PATIENT/STAFF STORY – DIGITAL AWARD

Anne Marie Henshaw, Associate Director of Nursing/Head of Midwifery, Carol Gregson, Midwife and Mark Butterfield, Information Manager attended the meeting to update the Board on the recent success in the bid for a national Digital NHS Award. The Board heard how this would transfer the way we use the Maternity EPR system. The project outcomes of the bid 'Putting the Patient First' Maternity ePR Transformation project were:

- The woman – on line access to own personal records and information data
- The healthcare professional – reduce the burden on asking the same question to patients
- Provider and NHS efficiency - Reducing the cost to organisations of capturing and sharing information whilst improving data quality. Supporting new models of care to generate efficiencies and service improvement.

A link was shared with Board members enabling them to see a demonstration of the system on mobile technology showing the ease by which patients will be able to access their data. To date staff in other Trusts using the system had received good feedback from patients. The pilot would go live in May 2018 once further work has been undertaken and a training programme completed. It was noted that if the patient requested this system, it could replace the 'red folders' routinely issued to patients on booking in.

The Board noted that this would improve patient experience and reduce administrative burden but until it is rolled out the reduced costs could not be evaluated. The response from other Trusts who had used similar systems were positive.

The Chief Executive thanked the team for their presentation and asked how EPR might help

staff, particularly clinicians, realise the benefits to patient care, recruitment and retention. It was felt that this new Midwifery system could be an advocate of an electronic system moving forward in the future and the learning from this would be helpful for the EPR.

All present thanked the team for their informative and thought provoking presentation.

OUTCOME: The Board **NOTED** the presentation of a Digital Award**.**

57/18 HIGH LEVEL RISK REGISTER

The Company Secretary reported the risks scoring 15 or above within the organisation. These had been discussed in detail at the Executive Board, Finance and Performance Committee, Quality Committee and Risk and Compliance Group.

These were:-
6967 (25): Non-delivery of 2017/18 financial plan
7169 (25): Trust Financial Control 2018/19
7049 (20): EPR financial risk
7062 (20): Capital programme
7078 (20): Medical staffing risk
6903 (20): Estates/ ICU risk, HRI
6658 (20): Patient flow
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk
6441 (20): Divisional income Surgery and Anaesthetics

Risks with increased score
There were no risks with an increased score.

Risks with reduced scores
7147 - EPR financial risk within the medical division had reduced from a score of 20 to 16.

New risks
New risks agreed at the Risk and Compliance Group on 12 March were:

- 7194 Family and Specialist Services: Laboratory systems and re-use of numbers which could lead to results being reported back on the wrong patient, scored at 15. A solution is expected to be in place by May 2018.

- 7132 Medical division: Risk of not identifying deteriorating patient scores within the Emergency Department due to these not being calculated accurately within EPR, risk score of 15.

New risk agreed via Chair's action:
• 7223 THIS, Corporate Division, digital IT risk regarding inability to access clinical and corporate digital systems due to infrastructure failure, including cyber failure, risk score of 16.

Closed risks
There were no closed risks during the month.

The Board requested greater assurance around business continuity should a power outage or cyber attack occur. It was agreed that although processes were in place these needed to be tested. It was agreed that once this piece of work had been finalised the Audit and Risk Committee would monitor this risk and gain assurance.

ACTION: Managing Director Digital Health plus Audit and Risk Committee Work plan.

Andy Nelson and Alastair Graham commented that there were a number of risks appearing to remain static on the register for example CQC, training and capital requirement. It was noted that capital requirement would be discussed within the Annual Plan item later in the meeting.

The Chief Operating Officer assured the Board that through the Performance Review Meeting process a number of elements associated with EPR on the risk register were being addressed and that an extra 10 middle grade doctors had been allocated to the Trust by the Deanery.

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

58/18 GOVERNANCE REPORT

The Company Secretary advised that the Governance report brought together a number of governance items for review and approval by the Board:

a. Board of Directors attendance register

The Trust's Standing Orders state that 'the names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors'. The attendance register from April 2017 to March 2018 was attached and noted.

OUTCOME: The Board **NOTED** the attendance register.

b. Declaration of Interests Register - Board of Directors

The Declaration of Interests Register for the Board of Directors was attached at appendix 2.

OUTCOME: The Board **APPROVED** the register and agreed to advise the Board Secretary of any amendments.

c. Compliance with Licence Conditions

The NHS Provider licence requires the Board to make three declarations:
1 - Condition G6(3) - Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - Deadline 31.5.18
2 - Condition FT4(8) - Providers must certify compliance with required governance standards and objectives. Deadline 30.6.18
3 - Condition CoS7(3) - Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service.

The following narrative was considered:
In January 2015 Monitor (the Regulator of Foundation Trusts at that time) declared the Trust to be in breach of licence as a result of an unplanned year-end deficit position of £4.3m which Monitor believed to be a breach of financial and board governance. Monitor wrote to the Trust setting out the undertakings it expected the Trust to deliver. The certificate of compliance with two of the three undertakings relating to Board governance and effectiveness and general actions was presented to the Board last year. The remaining undertaking requires the Trust to 'ensure the Licensee's clinical and financial stability is maintained from the end of the financial year 2016/2017'. Clearly due to the Trust's deficit position, this undertaking is still in place. It is recognised that while the Trust has financial controls, governance and actions in place to manage its deficit position, the long term plan for getting back to a sustainable financial position across the local health economy includes the proposals for the reconfiguration of hospital services. The Full Business Case for the reconfiguration is currently going through NHS Improvement's process of review and approval. In the meantime the Trust remains in a deficit position and therefore NHS Improvement has not certified compliance with this final undertaking.

OUTCOME: The Board **APPROVED** the wording to be used on the certificate of compliance to be uploaded once the template had been issued by NHS Improvement.

59/18 FIT AND PROPER PERSON SELF DECLARATION REGISTER

The Company Secretary presented the Fit and Proper Person Test Register.
It was noted that the CQC introduced new requirements regarding the 'Fit and Proper Person Tests' (FPP) for Directors in November 2014, which became law from 1 April 2015. This approach is to ensure that providers meet Government regulations about the quality and safety of care, to ensure an open, honest and transparent culture within the NHS to ensure accountability of Directors to NHS Bodies. The process had been reviewed to learn from good practice, implement an annual declaration and broaden the scope of those required to make a declaration to senior staff that may have a deputising role.

The Board and senior staff had confirmed their self-declaration of compliance against the regulations for the Fit and Proper Persons Test and these had been collated onto the Register included with the papers. It was requested that any amendments should be notified to the Company Secretary as they arise.

The Register will be updated on an annual basis and reported to the Board along with including this information in the Annual Report.

OUTCOME: The Board **RECEIVED** and **APPROVED** the Fit and Proper Person Self-Declaration Register.

60/18 TRAVEL AND TRANSPORT REVIEW

The Company Secretary reported that following the public consultation on the proposed reconfiguration of hospital services, the two local Clinical Commissioning Groups had agreed to set up an independent working group to consider and develop plans to address the implications in relation to access, travel, parking and public transport.

It was noted that this report had been considered by the Partnership Transformation Board (which has members from the Trust) and by the Estates Sustainability Committee.
The Report was attached and appendices were available at
https://www.calderdaleccg.nhs.uk/download/tandt_appendices/

Discussion took place regarding the actions recommended within the report which were relevant to the Trust. These included:

- Parking at CRH – provision of a multi-storey car park
- Improved Bus Shelter facilities at HRI and CRH
- Improved Shuttle bus – Commissioner discussions required

It was noted that the report had been sent to the Joint Overview and Scrutiny Committee however they had not yet considered it at a formal meeting.

Dr Linda Patterson suggested that provision of electric cars and the implications should be considered in the future.

The Chief Executive highlighted the equality impact assessment of the report and confirmed that this had been fully considered by the Board.

OUTCOME: The Board **RECEIVED** the Travel and Transport Review and **NOTED** the equality considerations of the report.

61/18 ANNUAL PLAN 2018-2019

The Executive Director of Finance presented the Annual Plan 2018-2019 which had been received, discussed and agreed at the Finance and Performance Committee held on Tuesday 3 April 2018. The key issues discussed arising from within the presentation were:

- Financial Challenge 2018-19 – planned deficit of £43.1m
- Contract Position – Discussions had taken place with Commissioners to adopt an 'Aligned Incentive Contract' rather than 'Payment by Results' with a number of caveats

around protection for additional activity.
- Summary Bridge 2017/18 to 2018/19
- Additional Pressures – discussed
- Workforce – further reduction on agency spend to bring it in line with the ceiling
- CIP – further work in progress with Divisions
- Capital Plan – exceeded funds by £2.5m. Proposed schemes noted. Discussions on going with NHSI on national capital support for essential investments.
- Cash and Borrowing – The borrowing requirement for 2018/19 is planned at £43.1m in line with the deficit position.

The next steps were agreed as:
- Seasonal profiling of operational plans and final bed plans to be undertaken to allow full triangulation with workforce and finance
- Conclude contract terms with commissioners
- Finalise CIP plans and allocation to close gap to £18m
- Agree agency trajectory at divisional level
- NHS Improvement on site review of operational and financial plan 25 April 2018
- Progress discussions with NHSI on national capital support for essential investments
- Submit final 2018/19 plans to NHSI for 30 April deadline

Richard Heaton, on behalf of Phil Oldfield, Chair of Finance and Performance Committee confirmed that the Committee had reviewed and understood the forecast for 2018/19 and are clear about the deteriorating position. Further work was required on the activity and monitoring however the move to the new contract would give some assurance around this income level.

OUTCOME: The Board **NOTED** and **RECEIVED** the Annual Plan.

62/18 DATA QUALITY UPDATE

The Chief Operating Officer reminded the Board that since the deployment of the Cerner Millennium EPR system at the end of April 2017 the Trust had faced a number of data quality issues. Despite these, the Trust had managed to maintain its ability to report both internally and externally.

The Board received and noted the Data Quality report and the work of the Data Quality Group which had addressed the quality errors. It was noted that the data issues were being appropriately managed and that the focus was on correcting issues at source. The Data Quality Board had been established from 5th April 2018, with a clear remit around clinical risk. The Board were assured that it should soon see a steady return to a business as usual day-to-day approach to data quality.

The Chief Executive asked that the trajectory of achievements be circulated. The Board agreed to note the recommendation within the report (below), subject to circulation of additional information before the next BOD Meeting.

The Board agreed the following:
- The establishment of a Data Quality Board reporting into F&P Committee.
- Review all datasets used for the safe and effective management of patients and services and incorporate into a single data quality process
- Targets to be set at specialty level within divisions for each of the indicators measured in the Data Quality report.
- Agree timeline for clearance of RTT incomplete and associated investment required to facilitate

- Receive the outcome of the NHSI Data Quality Assessment and associated recommendations

ACTION: Chief Operating Officer

OUTCOME: The Board **RECEIVED** the Data Quality Update.

63/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the key points of operational performance. It was noted that this report had been discussed in detail at the Executive Board, Quality Committee and Finance and Performance Committee.

The key highlights from the report were:

- February's Performance Score had deteriorated by 3 percentage points to 57%.
- All domains had deteriorated with the exception of RESPONSIVE and WORKFORCE, which had seen improvements in 3 of the 5 Mandatory Training focus areas counterbalancing deterioration in short-term sickness.
- Within the RESPONSIVE domain, Stroke and Cancer maintained good performance.
- The CARING domain had worsened due to Family and Friends test performance.
- The EFFECTIVE domain had returned to AMBER due to two MRSAs in month.
- EFFICIENCY & FINANCE had deteriorated with a couple of efficiency targets being missed in-month.

The Chief Operating Officer reported that staffing had been challenging due to increased bed capacity and patient flow. It was noted that an event was scheduled to be held to look at discharge processes with internal and external partners.

Andy Nelson suggested that pressures in the system could be having an effect on overall performance i.e. deterioration in infection control. It was agreed that data from the IPR would be correlated to triangulate trends/money/staffing/sickness etc. to attempt to highlight the factors impacting the system.

OUTCOME: The Board **RECEIVED** and **APPROVED** the Integrated Performance Report

64/18 MONTH 11 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance presented the Month 11 Financial Narrative. It was noted that this had been discussed in detail at the Finance and Performance Committee held on Tuesday 3 April 2018.

The Month 11 position is a year to date deficit of £35.27m. On a control total basis this is an adverse variance from plan of £10.38m; excluding the impact of loss of Sustainability and Transformation funding (STF) of £6.22m that has been lost based on Q1 and 2 A&E performance and financial performance in Months 7-11. When loss of STF funding is included, the total adverse variance is £16.60m compared with a control total of £18.60m.
Since appealing the 17/18 £15.9m control total deficit in January 2017, the Trust's Board has continued to express concerns regarding the scale of this challenge. For 2017/18, the impact associated with the abnormal risk of EPR implementation was estimated at £5m, whilst only £17m of the required £20m CIP was believed to be achievable, leaving the Trust with a total risk which was assessed at the start of the year to be £8m plus any subsequent loss of STF funding.

The underlying operational performance would drive a greater adverse financial variance due to a number of a number non-recurrent income and expenditure benefits supporting the forecast position. This included a £4.2m negotiated settlement with the PFI facilities management provider ; non-recurrent income; release of prior year accruals; and £1.9m associated with the setup of the wholly owned subsidiary. This is in addition to the release in

the year to date of the full £2m contingency reserve available for this financial year, central winter funding and capital support.

Since Month 7 the Trust has been unable to deliver the financial plan reporting a year to date adverse variance of £10.38m of which £1.68m related to Month 11. The implementation of EPR continues to have a significant impact on both productivity and the capture of activity data and is significantly contributing to a material clinical contract income variance of £12.0m year to date.

As reported since Month 9 and previously discussed with colleagues in NHS Improvement, the Trust does not expect to achieve the 17/18 control total due to a combination of: slower than expected recovery of clinical activity levels and therefore income following EPR implementation; reduced operational capacity whilst resolving implementation issues and associated cost pressures; income values being lower than planned for the actual activity delivered and assumed within the HRG4+ test grouper; cost pressures linked to the requirement to open additional beds, winter and remaining unidentified CIP of £2.0m. The Trust has undertaken a detailed forecast review of both activity and income which indicates that activity levels are unlikely to recover to planned levels during this financial year.
Whilst every effort continues to be made to improve the financial out turn, including pursuing innovative technical accounting benefits, the current forecast indicates that the Trust will end the year with a gap to control total of £8m, (excluding loss of STF funding). Delivery of the financial plan remains the highest risk on the Trust risk register scoring the maximum of 25.

OUTCOME: The Board APPROVED the Financial Narrative for Month 11

65/18 GUARDIAN OF SAFE WORKING QUARTERLY REPORT

Dr Anu Rajgopal attended the meeting to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the junior doctors contract 2016 and in accordance with junior doctor's terms and conditions of service (TCS). The report set out the position relating to the period 15.12.17 to 15.3.18.

In summary there were a number of rota gaps which were in the main being filled by either Trust doctors or out of hours Trust locums. The exception reports received had produced no patient safety concerns, indicating the current staffing levels and working arrangements for the junior doctors are safe. However maintaining this continued to be a challenge to all involved with operational and educational delivery.

Dr Rajgopal reported that there had been no fines imposed during the period. However, the lack of administrative support may prevent us being able to effectively monitor breaches, particularly of the 48 hour condition. Dr Birkenhead reported that negotiations were still taking place to provide administrative support. The Executive Director of Workforce and OD agreed to take this forward outside the meeting.

ACTION: Executive Director of Workforce and OD

OUTCOME: The Board APPROVED the Guardian of Safe Working Quarterly Report.

66/18 UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES

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

a. Quality Committee

Dr Linda Patterson, Chair of the Quality Committee presented that minutes from the Quality Committee meeting held on 26 February which had been verbally reported at the March Board meeting. It was noted that the meeting scheduled for 3 April had been postponed due to the CQC Inspection.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 26 February

2018

b. Finance and Performance Committee

On behalf of Phil Oldfield, Chair of the Finance and Performance Committee, Richard Hopkin reported that the main areas discussed by the Finance and Performance Committee on the 3 April had been covered in the Board agenda discussed that morning.

OUTCOME: The Board RECEIVED the minutes from the meetings held on 23 February 2018 and 19 March 2018 and verbal update from 3 April 2018 meeting.

c. Workforce Well Led Committee

Karen Heaton, Chair of the Workforce Well-Led Committee presented the minutes from the meeting held on the 16 March 2018 and the contents were noted.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 16 March 2018.

d. Charitable Funds Committee Minutes

The minutes from the Charitable Funds Committee held on the 21 February were received and noted.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 21 February 2018.

DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 3 May 2018 commencing at 9.00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair thanked everyone for their contribution and closed the public meeting at 11:25 am.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 24 April 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 24 April 2018

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 24 April 2018

Appendix

Attachment:

DRAFT ACTION LOG - BOD - PUBLIC - As at 24 APRIL 2017.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 24 April 2018/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
7.12.17 183/17	**PATIENT STORY** It was agreed to discuss how EPR can support the serious incident investigation and information capture.	OW / JC	**1.2.18** **Agreed that EPR/Serious Incident Investigation would be presented at a future meeting.** **WINTER PRESSURES** **The COO advised that at the end of the quarter she would bring a paper to Board updating on winter planning arrangements and conversations with partners**	TBC		
7.12.17 187/17	**CHIEF EXECUTIVE'S REPORT** The Quality Committee will undertake a review of the impact of the recent interim medical services reconfiguration and report back to the Board	Chair of Quality Committee / HB		May 2018		
7.12.17 188/17	**QUARTERLY QUALITY REPORT** The Quality Committee will undertake a deep dive on sepsis and will report back to the Board	Chair of Quality Committee / DB		May 2018		
7.12.17 197/17	**UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES** The Chief Executive advised that a piece of work was underway looking at staff experience of appraisals would be brought to a future BOD meeting	SD		TBC		
4.1.18 9/18	**PREPARATION FOR THE GENERAL DATA PROTECTION REGULATIONS (GDPR)** Presentation received. It was agreed that	MG		May 2018		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	progress against plan would be monitored by the Executive Board and Audit and Risk Committee. It was agreed that clear governance arrangements would be provided through this route and an update brought to the Board in May 2018.					
1.1.18 13/18 and 5.4.18 65/18	**GUARDIAN OF SAFE WORKING** Update received. Concern was expressed regarding the lack of administrative support for the Guardian. It was agreed that the Executive Medical Director would speak to colleagues in the Trust to ascertain whether there was any dedicated support which could be provided from within the organisation to assist the Guardian of Safe Working.	DB	**1.2.18** **Requirements were clarified with Guardian, the Trust are in support and will hopefully be resolved very shortly. It was agreed that this would remain on the Action Log until the matter had been fully resolved.**	June 2018		
4.1.18 11/17	**IPR – ACTION CARDS** Discussion took place regarding Action Cards and it was agreed that the COO would be asked to circulate a briefing to the NEDs to explain the process around the use of these cards.	HB	1.2.18 The COO agreed to circulate a briefing to the NEDs to explain the process around the use of these cards. **1.3.18** **It was confirmed that this had not yet been actioned. The Chief Operating Officer was asked to circulate a briefing to the Non-Executive Directors to explain the process around the use of these cards.**	April 2018		
1.2.18 26/18	**FREEDOM TO SPEAK-UP/WHISTLEBLOWING ANNUAL REPORT**	DA		TBC		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	Karen Heaton asked if other Trusts had used alternative routes and Dr Anderson agreed that he would investigate this further.					
1.2.18 28/18	**EQUALITY AND INCLUSION ANNUAL REPORT** Karen Heaton recommended that the Trust set itself targets in relation to diversity of the workforce. The Chief Executive recommended that this could be discussed as part of a Board workshop. Action A: It was agreed that the Company Secretary would include on the agenda for a future Board workshop. Action B: Suzanne Dunkley / Karen Heaton to explore the workforce element timeline.	SD/KH	**Agreed to consider at a Workforce Well Led Committee 'hot spot' workshop**	June 2018		
1.3.18 37/18	**INTEGRATED PERFORMANCE REPORT – WEIGHTINGS REVIEW** Andy Nelson asked that an action be recorded for the item "weighting of mandatory training set against other targets should be reviewed". The Board agreed that this should be actioned by the Chief Operating Officer as this could affect the scorecard going forward.	HB		TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 24 April 2018/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
1.3.18 41/18	**QUALITY IMPROVEMENT STRATEGY** Discussion took place regarding the wider view and how other quality improvement initiatives (non-clinical) are recorded within the Trust. It was agreed that the Chief Operating Officer and Executive Director of Workforce and OD would discuss this outside the meeting and report back to the Board in May 2018. It was noted that the five year plan would shortly be revised and this would be included.	HB/SD		3.5.18		
1.3.18 42/18	**HIGH LEVEL RISK REGISTER – BOARD RISK APPETITE** It was noted that the Board Workshop on Risk Appetite had been deferred but this would be picked up by the new Chair when he came into post.	PL/SD/VP		25 May 2018		
1.3.18 43/18	**CARE OF THE ACUTE ILL PATIENT REPORT** The Chief Executive commended the Medical Director and Associate Medical Directors for their leadership and ability to identify where improvements are required and communicate this to staff, recognising the good achievements and how this is translated to the workforce. The	OW/PL		TBC		

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	Chief Executive agreed that he, along with the newly appointed Chair would ensure that lines of communication with staff continued and wider communications put in place.					
1.3.18 44/19	**BOARD SKILLS AND COMPETENCIES** Arrangements were being made to prepare a Board Development Programme and utilise some of the intelligence from this exercise, along with strategic issues in its development and would be brought back to the Board in the near future.	OW/PL/SD/ VP		July 2018		
1.3.18 44/19	**GOVERNANCE REPORT – BOARD TOR** Subject to amendments to the reference to CoG instead of MC, the Board APPROVED the Terms of Reference and noted that the information from all the sub-committees would be presented to the BOD in May.	VP		3.5.18		
1.3.18	**BOARD WORKPLAN** Karen Heaton questioned whether the Workforce Strategy going to the Board in February 2019 was too late and should be brought forward. It was agreed that she would discuss this outside the meeting with the Executive Director of Workforce and go back to the Company Secretary to amend if required.	KH/SD		TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 24 April 2018/ APP

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
5.4.18 57/18	**HIGH LEVEL RISK REGISTER** It was agreed Audit and Risk Committee would monitor the risk to business continuity should a power outage or cyber attack occur.	MG / RH		July 2018		
5.4.18 62/18	**DATA QUALITY ASSURANCE** Receive the outcome of the NHSI Data Quality Assessment and associated recommendations	HB		July 2018		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: HIgh Level Risk Register - To present the high level risks on the Trust Risk Register as at 23 April 2018	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The draft high level risk register has been reviewed by members of the Risk and Compliance Group at it's meeting on 16 April 2018.	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

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

Background/Overview:

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

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

Divisional risk registers are also discussed within divisional patient safety quality boards, with divisions identifying risks for consideration for escalation to the high level risk register for review at the Risk and Compliance Group.

The Issue:

The attached paper includes:

i. Identification of the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks. This paper refers to a summary of the Trust risk profile as at 23 April 018.

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

iii. Two new risks which have been added to the high level risk register during April 2018. These are:

- Risk 7169 regarding the 2018/19 Trust financial control for 2018/19 at a score of 25.

- Risk 7248 regarding mandatory training scored at 16.

iv. Two risks have a reduced score and eight risks have been closed as detailed in the summary sheet, six of these are related to EPR following decisions made at a meeting of the EPR risk panel on 6 April 2018 which were ratified by the Risk and Compliance Group in line with the process for closure of risks on the high level risk register.

Next Steps:

Work will continue to take place to look at the movement of risk scores to ensure the risk register remains dynamic, as discussed at the Audit and Risk Committee on 18 April 2018.

It has recently been confirmed that internal audit will be undertaking a benchmarking review of risk registers and this will feed into development work on the risk register. .

Recommendations:

Board members are requested to:

I. Consider, challenge and confirm that potential significant risks within the high level risk register are being

ii. Approve the current risks on the risk register.
iii. Advise on any further risk treatment required.

Appendix

Attachment:

COMBINED HIGH LEVEL RISK for 3 may 18 board.pdf

HIGH LEVEL RISK REGISTER SUMMARY OF CHANGES

Risks as at 23 April 2018

TOP RISKS

The following risks scored at 25 or 20 on the high level risk register are:

7169 (25): Non delivery of 2018/19 financial plan
6903 (20): ICU/Estates joint risk
7062 (20): 2018/19 Capital Programme
7078 (20): Medical staffing risk
6658 (20): Patient flow
2827 (20): Over-reliance on locum middle grade doctors in A&E
5806 (20): Urgent estates schemes not undertaken
6345 (20): Nurse staffing risk

The Trust risk appetite is included below.

RISKS WITH INCREASED SCORE

None

RISKS WITH REDUCED SCORE

7194 Family and Specialist Services: Laboratory systems and re-use of numbers which could lead to results being reported back on the wrong patient, scored at 15. During April this risk has reduced to a score of 12 as – it had been expected that a solution be in place by May 2018. If this reduced score is approved this will remove the risk from the high level risk register.

6829 Insufficient capacity for the Pharmacy Dispensing Service – this risk has reduced from 15 to 12 as progress has been made with the interim solution.

6598 – Essential skills training risk has been reduced from a score of 16 to 9 during April 2018 due to a significant increase in the compliance rates across all essential skills by 2017/18 year end. There are now 15 subjects with compliance above 90%; 11 with compliance between 80 and 90%; 5 with compliance between 70 & 80%; 3 with compliance between 50 and 70% and only 5 with compliance below 50%. Plans are now being made to ensure that the upward trend continues and that training is undertaken throughout the year and not end-loaded in Q4 in the future.

NEW RISKS

New risk agreed following the Risk and Compliance Group were :

- 7169 (25): Trust Financial Control 2018/19 (update of 2017/18 risk)
- 7248 (16): Mandatory training – refreshed risk following closure of 6977

RISKS CLOSED

The following risks have been closed as they have reached their target date.

The EPR Risk Panel met on 6 April 2018 and was assured that processes were in place within divisions and specific EPR risks are being identified through divisional governance processes. These decisions were reviewed and ratified at the Risk and Compliance Group on 16 April 2018.

7049 Trustwide EPR financial risk for 2017/18
7046 Trustwide EPR clinical risk for 2017/18
7148 Medical division clinical EPR risk
7047 Trustwide EPR performance risk
6441 Surgical and Anaesthetics division income risk 2017/18
7147 Medical division income risk 2017/18

Sepsis risk 6990 has been closed and replaced by sepsis risk 7134 – there were two sepsis risks, one Trust wide and one in the division and the leads for this have been re-confirmed.

The 2017/18 risk, 6977, regarding mandatory training has been closed – the risk had reached its target date and it was confirmed that target audiences are now clearly identified, subject matter experts are in place and compliance is improving. A new risk regarding mandatory training has been added, risk 7248 – see new risks above.

SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 23.4.18

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
012	2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20
007	7134	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/19	Medical Director (DB)	=16	=16	=16	=16	=16	=16
007	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	=16	=16	=16	=16	=16	=16
011	5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
011	6903	Keeping the base safe	ICU/Estates joint risk	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20
007	6924	Keeping the base safe	Misplaced naso gastric tube for feeding	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
007	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15
007	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
007	6011	Keeping the base safe	Blood transfusion process	Divisional Director of FSS (JO'R)	=15	=15	=15	=15	=15	=15
007	6949	Keeping the base safe	Blood transfusion service	Divisional Director of FSS (JO'R)			!15	=15	=15	=15
007	7132	Keeping the base safe	Miscalculation of deteriorating patient scores in Emergency Department	Divisional Director of Medical Division (AV)					!16	**=16**
	7233	Keeping the base safe	Digital IT systems risk	Managing Director – Digital Health					!16	**=16**
007	**7248**	**Keeping the base safe**	**Mandatory Training**	**Director of Workforce and OD (SD)**						**!16**

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
021	**7169**	**2018/19 income**	**Income and expenditure**	**Director of Finance (GB)**						**!25**
022	7062	Financial sustainability	Capital programme 2018/19	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
Performance and Regulation Risks										
007	6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (BB)	=20	=20	=20	=20	=20	=20
007	6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16
012	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 (BB), Director of Workforce	=20	=20	=20	=20	=20	=20
012	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 (BB), 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

Bold indicates for discussion as new risk for new financial year 2018/19.

Where there is no risk score given in the April column these are risks for discussion for removal or reduction in score -

TRUST RISK PROFILE AS AT 23/4/2018

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	= 6345 Nurse Staffing = 6658 Inefficient patient flow = 7078 Medical Staffing	! 7169 Not delivering 2018/19 financial plan
Likely (4)				= 6300 CQC improvement actions = 6596 Serious Incident investigations ! 7248 Mandatory Training = 5862 Falls risk = 7134 CQUIN sepsis = 7223 IT Digital systems =7132 Miscalculation of deterioration scores in ED	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6903 ICU/ resus estates risk = 7062 Capital programme 2018/19
Possible (3)					= 6924 Misplaced naso gastric tube = 6011 Blood transfusion process = 5747 Vascular /interventional radiology service = 6949 Blood transfusion service
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE NOVEMBER 2016

Risk Category	This means	Risk Level Appetite	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 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 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**

Risk No	Div	Dir	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	Tolerate	RC	Exec Dir	Lead
7169 (BAF ref 021)	Trustwide	All Divisions	Jan-2018	Financial sustainability	The Trust financial control total for 2018/19 has now been confirmed by NHS Improvement as an £8.4m deficit. There is a extremely high risk that the Trust fails to achieve this control total for 2018/19 due to: - large planning gap carried forward from 17/18 due to: non-recurrent / unidentified Cost Improvement Plans (CIP), loss of productivity and recurrent cost pressures. - CIP challenge likely to be in excess of 17/18 values - inability to reduce costs should commissioner QIPP plans deliver - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - non receipt of £14.2m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels	Financial recovery plan shared with Board in February Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Controls around use of agency staffing have been strengthened.	Lack of direct consequence to budget holders for poor budgetary management. Capacity planning challenges Difficulty in identifying EPR benefits to offset additional committed resource. Nursing Agency spend above planned level. Volume of agency breaches remain comparatively high and a higher value for each breach.	25 5 x 5	25 5 x 5	15 5 x 3	Draft financial plan submitted in March 18 indicated a gap to control total of £24m. Final plan submission is due on the 30th of April 18.	May-18	Mar-2019		FPC	Gary Boothby	Philippa Russell

7062 (BAF ref 022)	Trustwide	All Divisions	Sep-2017	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2018/19 due to having insufficient cash to meet ongoing commitments resulting in a failure to maintain infrastructure for the organisation. Based on the two year plan submitted to NHS Improvement in March 2017, the Trust will only have access to internally generated capital funds of £7.1m in 2018/19 to cover all capital requirements Whilst the capital risk for 2017/18 has been reduced to a current assessment of 9, the risk in 2018/19 is likely to be much higher as internal generated funds will only support Capital expenditure of £7.1m, less than half the amount committed for 2017/18. This value is constrained by the fact that the remainder (£8m) of the Trust's pre-approved capital loan of £30m is to be spent in 2017/18. Therefore, the Trust can only call on internally generated capital funding to the level of annual depreciation charges, against which PFI charges and capital loan repayments are pre-committed, leaving the £7.1m balance. In the context of the Trust's ageing and ailing HRI estate; medical equipment requirements including MRI investment; and with a number of schemes being pushed back from 2017/18, the risk in 2018/19 is heightened.	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances.	Limited Contingency available. Potential for slippage of 17/18 schemes in next financial year. Uncertainty regarding long term capital planning while FBC is awaiting approval.	20 5 x 4	20 5 x 4	12 4 x 3	Whilst the capital risk for 2017/18 has been reduced to a current assessment of 9, the risk in 2018/19 is likely to be much higher as internal generated funds will only support Capital expenditure of £7.1m, less than half the amount committed for 2017/18. This value is constrained by the fact that the remainder (£8m) of the Trust's pre-approved capital loan of £30m is to be spent in 2017/18. Therefore, the Trust can only call on internally generated capital funding to the level of annual depreciation charges, against which PFI charges and capital loan repayments are pre-committed, leaving the £7.1m balance. In the context of the Trust's ageing and ailing HRI estate; medical equipment requirements including MRI investment; and with a number of schemes being pushed back from 2017/18, the risk in 2018/19 is heightened.	May-18	Jun-2018		FPC	Gary Bunby	Philippa Russell

7078 (BAF ref 012)	Corpo g	Workf e & Organisational Development	Oct-20	Keepi 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 Record) "	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	**April 2018** A number of CVs have been received from the agreed agencies that we work with on permanent recruitment. Once the department have shortlisted it is hoped that there may be some suitable candidates to interview for middle grade posts. It is intended that E Rostering in A&E will be launched at the end of April.	Jun-2018	Jan-2019		WF	David E enhead	Pauline rth
6903 (BAF ref 011)	Estates & Facilities	Estates	Dec-2016	Keeping the base safe	Collective ICU & Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to inadequate access granted to estates maintenance and capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.This incluides: ICU - Air Handling Unit (AHU) RESUS - Ventilation RESUS – Electrical Resilience ICU & RESUS - Flooring ICU & RESUS - Electrical Infrastructure RESUS - Plumbing infrastructure ICU & RESUS - Life Support Beams/Pendant ICU - Building Fabric ICU - Nurse Call System RESUS - Medical Engineering Risk - 4 Dameca Anaesthetic Machines RESUS - Operational Safety f RESUS – Compliance / Statute Law All of the above does not meet the minimum requirement as stipulated in the Health Technical Memorandums (HTM) and Health Building Notes (HBN)and principal statue law whicdh could result in prosecution	Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime.	Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU & RESUS, currently this is not achievable due to inadequate access and budget constraints.	20 5 x 4	20 5 x 4	0 0 x 0	losure, this includes partial and full refurbishment of Resus. February 18 Update - Estates are continuing to look at all options to mitigate any future risk of closure, this includes partial and full refurbishment of Resus. March 18 Update - Estates are continuing to look at all options to mitigate any future risk of closure, this includes partial and full refurbishment of Resus. **April 18 Update** RECAP - The Trust has been advised by their external independent Authorising Engineer via letter to install mechanical ventilation to the RESUS area to mitigate the risk of harm to staff and patients. Having now received formal confirmation of the dangers posed to staff and patients in RESUS, CHFT now run the risk that a CQC or HSE inspector will pick up on these non-conformities and condemn the unit with possible penalties. Estates have now completed the paper looking at all possible mitigating actions and awaiting funding for the concluding mitigation. (full refurbishment)	May-2018	Dec-2018		RC	Lesley Hill	Chris Davies

2827 (BAF ref 012)	Medic	Emerg cy Care	Apr-20	Devel(ng our workforce	The inability to recruit sufficient middle grade and consultant 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 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 risks 4783 and 6131should be read in conjunction with this risk.	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 Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Development of CESR programme ACP development Continued recruitment drive for Consultant and Middle Grade doctors Weekly meeting attended by flexible workforce department, finance, CD for ED and GM	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level CESR training will extended time to reach Consultant level with no guarantee of retention	20 4 x 5	20 5 x 4	12 4 x 3	No significant change from last month Feb 2018 MTI doctor in post. Currently working in a supernumerary capacity getting used to NHS systems. Plan to get onto Junior rota in the next 2 weeks with a view to Middle Grade level by the end of April March 2018 MTI not likely to be suitable for MG rota for some time. Programme of support being developed **April 2018** MTI now on programme of support CESR rotation arranged for Anaethetics/ICU in August 2018 New ACP started this month and rota in development	May-2018	Aug-2018		WEB	David E enhead	Dr Mar avies/Mrs Caroline Smith
5806 (BAF ref 011)	Estates & Facilities	Estates	May-2015	Keeping the base safe	There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure. Details of specific risks listed in full on risk register.	Each of the risks above has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	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. In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.	16 4 x 4	20 5 x 4	6 3 x 2	February 18 Update - The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The Capital Plan for 18/19 is now at the final stages of planning, due to funding this will not include any major refurbishment but will cover statutory compliance action plans for HRI. March 18 Update - The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The Capital Plan for 18/19 is now at the final stages of planning. **April 18 Update** The 2017/18 Capital plan has concluded within budget, the Risks embedded within this overarching risk still remain active. The 18/19 plan will progress the work already started on fire safety, water safety, infrastructure replacement etc. to ensure the HRI estate remains safe and resilient.	May-2018	Feb-2019		RC	Lesley Hill	Paul Gilling / Chris Davies

6345 (DoF ref 012)	Corpo g	Workf e & Organisational Development	Jul-20	Keepi the base safe	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 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)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment		16 4 x 4	20 4 x 5	9 3 x 3	**April 2018** Applicants from the International recruitment trip to the Philippines are progressing (119 offers were made in country, since March 2017, with on-going training and tests underway). Interviews have taken place for 20 Trainee Nurse Associate roles, a new training role which will support divisions with their nurse staffing supply in the future, all posts were filled and offers are to be made late April. The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has continued and is progressing with interviews during April 2018. Also recruiting to band 5 student nurse posts, advertised to encourage final year university students to apply and provides additional information around the support offered to newly qualified nurses at CHFT (interviews in April 2018). Interest in these posts has been low. Divisions are advertising for two Physician Associates (PAs) vacancies within Medicine for 2 additional PAs, following withdrawals by two candidates.	May-2018	Dec-2018		WF	Brenda rown, Suzanne Dunkerley	Paul C on

6658 (BAF ref 007)	Corpo	Centra	Mar-2(	Keepi	There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and [illegible] This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2 . Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20 4 x 5	20 4 x 5	9 3 x 3	February 2018 Tactical Command in place for all of q4 2017/18. Health and social care system tactical command with partners now in place for full q4 2017/18. Interventions outside of winter plan implemented during January due to pressures, learning from these and continuing some initiatives during q4 due to continued pressures. Learning event for March 2018 planned. March 2018 Risk reached target date. New risk being developed regarding patient flow for review at Risk and Compliance Group on 16 April 2018, therefore proposing to close this risk and agree at April meeting. **April 2018** Discussions with Chief Operating Officer ongoing and risk to be discussed at Risk and Compliance Group on 21 May 2018 with a view to closure of this risk.	May-2018	May-2018		BOD	COO H[illegible]n Barker	Bev W[illegible]r

6596 (BAF ref 007)	Corpo a	Corpo a Quality	Jan-20	Keepi the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Scheduling of SI reports into orange divisional incident panels to ensure timely divisional review of actions. - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Risk Team support to investigators with timely and robust Serious Incident Investigations reports	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation, particularly doctors.	16 4 x 4	16 4 x 4	8 4 x 2	February 2018 Investigators pack being finalised by end of February 2018. Positive feedback from commissioners on reports using new style template. improving position on number of extensions requested. March 2018 Learning page (Sharing Learning - Improving Care) transferred to new intranet and promoted via screen saver. Learning newsletter issues - Focus in Infection Prevention including learning from serious incident (safe storage of food) and post infection reviews. Investigation pack awaiting sign off. Winter pressures impacting on timeliness of investigation reports. **April 2018** Investigation pack now signed off and being used for new investigations. Paper presented to CCG detailing completed and ongoing actions in response to analysis paper on delayed diagnosis incidents. Investigators training session held in March 2018.	May-18	May-2018		QC	Directo Nursing, Brendan Brown	Juliette sgrove
5862 (BAF ref 007)	Medical	All Directorates Medical	Aug-2013	Keeping the base safe	We have a in-patient falls risk due to a number of care planning issues that could be enhanced: patient risk assessments not being completed to support clinical judgements made, failure to use preventative equipment appropriately, low levels of staff training, failure to implement preventative care, limited amount of falls prevention equipment, ward environmental factors, on occasion staffing levels below workforce model exacerbated by increased acuity and dependency of patients. These issues are resulting in a high number of falls incidents, falls with harm, poor patient experience and increased length of hospital stay.	Safety Huddles Falls bundles Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls. Butterfly scheme. Delirium assessment	Insufficient uptake of education and training of nursing staff, particularly in equipment. On occasion staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12 4 x 3	16 4 x 4	9 3 x 3	March 2018 Challenges as additional wards open to manage demand on both sites. Ward assurance tool to be used consistently to audit falls assessment and interventions for centralised compliance and actions for individual ward. Increase in number of falls in month n=182. Harm falls n=3 **April 2018** Work on falls improvement continues as per Action Plan. Some extra capacity wards being closed during April. Results of National Audit of Inpatient Falls audit report 2017is now available,with CHFT practice below 50% compliance in the target interventions of visual screening, lying and standing blood pressure, access to mobility aids and medication review. These will influence further improvement work through the Collaborative work.	May-2018	Jul-2018		PSQB	Brendan Brown	Janette Cockroft

7132 (BAF ref 007)	Medic	Emerg cy Care	Nov-2 7	Keepi 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. This has therefore become a manual process and is prone to human error and can be missed. The previous IT system automatically calculated and recorded the score. 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.	PAWS and NEWS assessments are able to be recorded in EPR, however, it is not easily identifiable where on the EPR front screen and calculation is manual. All staff have been made aware of the change and a SOP and training has been provided to mitigate/reduce the risk	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	Immediate mitigation: 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. 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. March 2018 Update Still awaiting update from digital board. Mitigations still in place as above **April 2018 Update:** Still awaiting update from digital board and also awaiting to see how Bradford are mitigating risk. Mitigation still in place as above.	May-2018	Jul-2018		PSQB	David F enhead	Louise xall
7134 (BAF ref 007)	Corporate	Corporate Quality	Nov-2017	Transforming and improving patient care	CQUIN target at risk of not being met for 2018/19 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non - compliance with NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also financial penalties.	Awareness and new controls for ward areas Sepsis nurse in post Divisional plan, leads identified -improvement action plan in place -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign was launched introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards -sepsis prompt in EPR	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of communication and joined up working between nursing and medical colleagues Information on patients not receiving the sepsis bundle in a timely manner. Clarity on use of EPR prompts required	16 4 x 4	16 4 x 4	4 4 x 1	Assess impact of EPR sepsis prompt Improve safety huddles to include sespis Coordinate activity with the Deteriorating Patient Group NB. See high level risk register 6990 operational lead Juliette Cosgrove August update Detailed analysis work underway including a focus group with staff to understand barriers Areas for improvement identified Planning underway within each of those areas throughout August and September September update Analysis work continues focused on admission areas at both acute sites Weekly performance data shared with directorate teams Continued engament with staff as to barriers to detecting and	May-2018	Jun-2018		DB	David Birkenhead	Rob Moisey

7223	Corpo a	THIS	Mar-2(3	Keepir 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 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	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 - 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.	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 - 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). **April Update:** Trend rollout (AV & Encryption) still due to complete at the end of April 18 for CHFT. No further update.	May-2018	Sep-2018		RC	Mandy ffin	Rob Bi t
7248 (BAF ref 007)	Corporate	Workforce & Organisational Development	Apr-2018	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory 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. Impact: - Colleagues practice without a basic, or higher depending on role/service, understanding of our 9 mandatory training subjects. Due to: - Competing operational demands on colleagues time available means that time for completing training might not be prioritised.	All electronic mandatory 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 compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	None	16 4 x 4	16 4 x 4	4 4 x 1	**April 2018:** To assist compliance with Moving and Handling Level 2 additional resources are being sought as the Trusts' current capacity is unable to deliver compliance. A Line Manager Bulletin is being issued this month with information for managers about mandatory training. Compliance rates are being monitored and shared with HRBPs. WEB has confirmed the mandatory training compliance should remain at 95% and that Infection Control training should remain annual rather than be amended to every 2 years. A rebranding of 'mandatory training' to 'essential safety training' is proposed o reposition the message about the value of this training.	Jul-2018	Mar-2019		WF	Suzanne Dunkley	Ruth Mason

6300 (BAF ref 007)	Corpo a	Corpo a Quality	May-25	Keepi the base safe	As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services. Additionally the CQC has announced a programme of Well Led Inspections which the Trust will be subjected to prior to Autumn 2018 ,there is a risk that we may not meet the required standard resulting in a judgement of "requires improvement".	Follow Up Inspection Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection Action plans progressed for all must and should do actions Separate action plans in place for each core service Reports to the Trust Board on those core services requiring improvement CQC compliance reported in Divisional Board reports to the Quality Committee Mock inspections for core services System for regular assessment of Divisional and Corporate compliance Routine policies and procedures Quality Governance Assurance structure The Risk and Compliance Group has oversight of areas outstanding actions not completed Well Led Inspection A mock PIR for the Well Led domain is taking place to identify further areas for improvement Each division is restarting CQC groups to oversee pre inspection activity A Trust wide CQC Group started meeting in September 2017	The March 16 inspection report placed us in the has shown us to be in the "requires improvement" category.	16 4 x 4	16 4 x 4	8 4 x 2	February 2018 CQC senior steering group now meeting weekly focused on sharing intelligence, monitoring the well-led plan including key risk areas, receiving updates from core services, briefing on communication and engagement activity and sharing good news and emerging issues; Workshop for Divisions and core service leads delivered by Capsticks; Board good governance leadership event scheduled with NHSI; Providing supporting information for colleagues including –learning from the CQC (review of actions from March 16 inspection), updated staff handbook. The Trust has received formal notification of the Use of resources assessment which is scheduled for 28th March 2018 - working with NHSI to provide information required ahead of the assessment. Unannounced inspections in Maternity, Paediatrics, Critical Care and Emergency Department early March as expected ahead of the planned well led inspection 3rd – 5th April. Further unannounced inspections may take place ahead of this. **April 2018** The on site inspection has concluded, data is still being requested by the CQC and we are concluding the last set of data submissions. Actions have been taken in response to some concerns raised at the time and these are being overseen by the CQC Response Group and the Quality Committee. We are expecting the report in June/July. We continue to be in correspondence with the CQC both in concluding the inspection and as part of our usual relationship contacts.	May-2018	Jul-2018		WEB	Brenda rown	Juliette sgrove
6924 (BAF ref 007)	Trustwide	All Divisions	Feb-2017	Keeping the base safe	Risk of mis-placed nasogastric tube for feeding due to lack of of knowledge and training in insertion and ongoing care and management of NG feeding tubes from nursing and medical staff resulting in patients fed into the respiratory tract or pleura and possible death or severe harm	Risk overseen by Nutritional Steering Group Task and finish group established by director of nursing to address elements of NPSA alert 22.7.16 on nasogastric tube misplacement Training package available Nursing staff have been encouraged to undertake self assessment and declaration of competency Check X rays are performed where aspirate is not obtained, or greater than pH5.5 Radiology team flag when sighted if tube is in the lung following xray Training and competency package in place for nursing staff identified from high use areas	Initial X Rays are reviewed by medical staff - currently have no record of training or competency assessment for medical staff working at CHFT Daily process for checking is dependent on individuals competency to be performed accurately Training data base is only available through medical device data base and is not monitored for compliance No assurance that all medical and nursing staff who are inserting and managing NG tubes have the competency required to do this No policy in place at CHFT to support guidelines	15 5 x 3	15 5 x 3	8 4 x 2	**April 2018** Policy has been signed off at WEB and is now on repository - same highlighted to staff. Still awaiting feedback from CSN re an alternative e-learning package. Nutritional Steering Group needs re-establishing to drive this work forward. Awaiting feedback from Dr Uka re NGT placement documentation	May-2018	May-2018		QC	Brendan Brown,	Maggie Metcalfe

6949 (BAF ref 007)	Family & Specialist Services	Pathology	Mar-2017	Keeping the base safe	The inability to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain sufficient numbers of HCP's Biomedical Scientists to maintain two 24/7 rotas, resulting in a potential inability to provide a full Blood Transfusion / Haematology service on both sites	1. Substantive Biomedical Scientists are working additional shifts to cover gaps in the rotas. 2. Staff rotas changed to a block pattern for night shifts. 3. All substantive vacancies are being advertised and gaps backfilled with locum staffing. 4. Staff development plan in place for training Biomedical Scientists 5. Existing business continuity plan in place	1 & 2. Substantive Biomedical Scientists are working additional shifts on a voluntary basis with no obligation to provide cover and over a sustained period of time with no imminent resolution. 3. Delay in recruiting locums due to impact of Flexible workforce procedures. 4. Staff development plan for trainees is compromised and time scale lengthened, due to reduced levels of trainers present during core hours as a result of additional shift commitments.	10	5 x 2	15	5 x 3	5	5 x 1	Update-February 2018: Department organising dates for root cause into contributory factors. Test of BCP - dates last week of february being investigated. Planning meeting took place Jan 2015 02/03/18 BCP exercise booked for the end of March 15/03/2018 Root cause session held 9/March/2018. Action plan being developed **April 2018** Bench top exercise undertaken on 23rd March to test Business Continuity Plan struggling to cover two 24/7 rotas due to the number of trainees and high sickness	May-2018	Jul-2018		DB	Rob Aitchison	Hayley Baker
6011 (BAF ref 007)	Family & Specialist Services	Pathology	May-2014	Keeping the base safe	Potential risk of compromising patient safety, caused by failure to correct procedures for Blood Transfusion sample collection and labelling (WBIT) and administration of blood could result in patient harm in the event that the patient receives the wrong blood type (Never Events List 2015/16 NHS England).	- Evidence based procedures, which comply with SHOT guidance. - Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected. - Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust).	Lack of electronic systems Lack of duplicate sampling Training compliance not at 100%	15	5 x 3	15	5 x 3	3	3 x 1	February 2018 Work continues towards implementation of the Haemonetics equipment, however no progress will be made with this risk until implementation of stage 2 (HLB) Apex upgrade has been delayed until next spring as this isn't required until stage 3 (HLB) March 2018 Work continues towards implementation of the Haemonetics equipment, however no progress will be made with this risk until implementation of stage 2 (HLB) **April 2018** Work continues towards implementation of the Haemonetics equipment, however no progress will be made with this risk until implementation of stage 2 (HLB)	May-2018	Mar-2019		PSQB	Julie O'Riordan	Sarah Ramsden
5747 (BAF ref 007)	Family & Specialist Services	Radiology	Mar-2013	Keeping the base safe	Service Delivery Risk There is a risk of failing to provide an interventional vascular service due to challenges recruiting substantively to vacant posts at consultant interventional radiologist level resulting in our inability to meet the 6 week referral to treatment target; inability to deliver an appropriate service at CHFT and our inability to provide hot week cover on alternate in collaboration with Bradford Teaching Hospitals FT.	1wte substantive consultant Part-time short term Locums supporting the service	Failure to appoint to vacant post substantively due to limited availability. Failure to secure long term locum support.	16	4 x 4	15	5 x 3	6	2 x 3	January 2018 update: Advert for joint post with Bradford closed on Friday 12 January 2018, with no applicants. February & March 2018 update: Full time locum in place for next 6 weeks; in discussion with neighbouring Trusts to consider long term solution. April 2018 - no update	May-18	May-18		DB	Rob Aitchison	Sarah Clenton

6715 (DATIX ref 007)	Corpo	Corpo e Nursing	Apr-20	Keepir the base safe	There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication and multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs.	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy / Alistair Morris, via back office team, December 2018 Establish a joint CHFT / BTHFT clinical documentation group.- lead Jackie Murphy and Alistair Morris timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be	20 4 x 5	15 3 x 5	6 3 x 2	February 2018 JM writing to all representatives on the previous clinical records group with draft terms of reference in order to re-commence the meetings. JM followed through the actions from January update and has met with Deputy Chief Nurse and THIS colleagues to review the reporting of documentation from EPR. First reports to be available March 2018. March 2018 The clinical documentation group will re-commence following feedback from TOR. The work to establish high quality data from EPR continues, a meeting took place to understand progress, the aim is to complete this data set this month. **April 2018** The clinical documentation group will meet this month.	Aug-2018	Aug-2018		WEB	Brenda rown	Jackie rphy

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: STRATEGY ON A PAGE - END OF YEAR UPDATE - The Board is asked to receive and approve the end of year update for the Strategy on a Page.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and approve the end of year update for the Strategy on a Page.

Main Body

Purpose:

The attached report provides the Board with an assessment of the progress made against the strategic objectives of the Trust during 2017.18 and identifies the outstanding work to be incorporated into the plan for 2018.19.

Background/Overview:

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

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

The Issue:

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

This report highlights that of the 20 deliverables:

- None are rated red
- Three are rated amber
- Eight are rated green
- Nine have been fully completed

Next Steps:

The one year view for 2018/19 has been drafted building on this position. A draft will be presented to the Board and discussed with Governors at a workshop in May. This will be supported by a revised Board Assurance Framework and reviewed high level risk register to be discussed at the Board meeting in June.

Recommendations:

The Board is asked to receive and approve the end of year update for the Strategy on a Page.

Appendix

Attachment:

Progress against strategy report - end of year report April 2018.pdf

Calderdale and Huddersfield NHS Foundation Trust
Annual Plan Year ending 2018 – End of year summary

Introduction

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

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

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

These goals are underpinned by the four behaviours:

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

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

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

Purpose of Report

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

Structure of Report

The report is structured to provide an overview assessment of progress against key deliverables responses and this is rated using the following categories:
1. Completed (blue)
2. On track (green)
3. Off track – with plan (amber)
4. Off track – no plan in place (red)

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

Summary

This report highlights that of the 20 deliverables:
- None are rated red
- Three are rated amber
- Eight are rated green
- Nine have been fully completed

The one year view for 2018/19 has been drafted building on this position. A draft will be presented to the Board and discussed with Governors at a workshop in May. This will be supported by a revised Board Assurance Framework and reviewed high level risk register to be discussed at the Board meeting in June.

We will also shortly be starting the process of engagement to develop the next five year strategy through a series of workshops.

Recommendation

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

Goal: Transforming and improving patient care

Deliverable	Progress rating	Progress summary	Assurance route
Submit a full business case to NHS Improvement to secure approval of capital funding and agreement to implement.	**Complete (blue)**	The Trust has developed the draft Business Case and this has been submitted to NHS Improvement. The Commissioners agreed their support at the Governing Body meetings in October. Judicial Review hearing 12th – 14th June. Awaiting decision from Secretary of State following initial report from the Independent Reconfiguration Panel.	**Lead: AB** Hospital Services Programme Board Estates Sustainability Committee NHS I Quarterly Review Meeting Council of Governors
Delivery of 17/18 SAFER (patient flow) programme objectives	**On track (green)**	SAFER programme delivered for 17/18 and objectives for 18/19 agreed. Ambulatory Care and Frailty delivered step change in activity and Frailty team being expanded in 18/19 reflecting success. Visit from National leads very positive and team asked to speak at national events reflecting the progress made. Multi-Disciplinary Accelerated Discharge Event held on 12 April 2018 with positive outcomes and system wide agreement to run monthly alongside an enhanced GP engagement model to help shape priorities.	**Lead: HB** Weekly Executive Board Quality Committee Board
To work as an early adopter towards the implementation of selected 7 day NHS England standards (2,5,6 and 8) in agreed specialties	**On track (green)**	The Trust is now compliant with standards 2, 6 and 8. Work continues on standard 5 and in addition to the 4 core standards plans to work towards compliance with standards 3 and 4 are being developed.	**Lead: DB** Quality Committee Weekly Executive Board
Realise the benefits and transformational change opportunities from the new EPR	**Off track – with plan (amber)**	Number of outstanding issues identified and being addressed through managed process overseen by Operational Board and Weekly Executive Board. Business as usual team has been reviewed and team has been increased. A small change team has been put in place and there is a plan to consolidate the ETD and change team to enable a structured approach to transformation and re-education. . Benefits realisation work being progressed and next steps are being developed to ensure benefits can be realised as soon as possible. Data Quality issues still evident with DQ Board and associated team focussed on improvement. Weekly meetings with Cerner to work through outstanding issues and	**Lead: MG / HB** 2 weekly to Operational Board. Sponsoring Group Executive Board. DQ reported weekly to Executive Board. Report to Board and Finance and Performance Committee by exception.

		optimisation plan.	

Goal: Keeping the base safe			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Maintain a Single Oversight Framework (SOF) rating of 3 or better	**Complete (blue)**	The Trust is currently achieving a SOF rating of 3.	**Lead: VP** Progress Review Meeting Integrated Board Report Audit and Risk Committee
Strengthen patient engagement particularly in learning from incidents, complaints and in listening events	**On track (green)**	We are introducing patient readers into the complaints process and have patients working with maternity colleagues looking at serious incidents. Following feedback with clinical colleagues have introduced comprehensive learning from incidents approach using a number of communication routes. SI Review Panel in place led by CEO. HealthWatch colleagues have been talking to about range of health services health services. Listening event held with LGBT colleagues; attended Blind and Low Vision Kirklees Group. PPI plan due to come to Patient Experience Group in May.	**Lead: BB** Patient Experience and Caring Group Quality Committee Council of Governors
Implement the actions resulting from the findings from the CQC inspection in readiness for the new-style inspection	**Complete (blue)**	CQC inspection completed 3-5 April 2018. Use of Resources inspection completed 28 March 2018. Awaiting report. Test site for NHS Improvement Board development for continuous improvement programmes - linked to the policy framework *'Developing People – Improving Care'*	**Lead: BB** Board Quality Committee Weekly Executive Board Council of Governors
Develop the Quality Strategy and implement the local quality priorities	**Complete (blue)**	A Quality Improvement Strategy has been drafted and discussed at the Board following workshop with NHS Improvement	**Lead: BB** Quality Committee Board

Implement year 3 of the health and safety action plan; develop and deliver robust emergency planning and business continuity arrangements	**Complete (blue)**	Progress has been made on delivery of year three of the health and safety action plan. Business continuity plans were refreshed in preparation for EPR and were tested during go live and early live support. The learning from this is being built into the plans. Emergency planning and counter terrorism training in place. A lockdown plan has been developed.	**Lead: LH** Monitored through Health and Safety Committee to Quality Committee and reported six-monthly to the Board.

Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Implement the 5 Year workforce strategy	**On track (green)**	Implementation plan reviewed and updated March 2018. Priority setting for 2018/2019 to be completed in April 2018 with supporting OD plan to be designed and approved in May 2018.	**Lead: SD** Well Led Workforce Committee
Develop and deliver an organisational development plan	**Off track – with plan (amber)**	Four cohorts of Compassionate Leadership In Practice (CLIP) programme established. Black, Asian and Minority Ethnic (BAME) colleague network and inclusive mentoring programme in place. Band 7 Nurses Development Programme, Matrons Development Programme, Ward Manager Development Programme, Band 6 Theatres Staff Development Programme, Preceptorship Development Programme for Newly Qualified Nurses in place. Programme for Clinical Directors commences April 2018 with programme for senior divisional teams in design phase. Apprenticeships in clinical and non-clinical roles. Formal OD plan to be finalised and agreed in May 2018.	**Lead: SD** Well Led Workforce Committee.
Create and deliver an engagement strategy that ensures colleagues have a voice	**Off track – with plan (amber)**	The proposed plan has been discussed with the Colleague Engagement Network. The Trust has been working with Wrightington, Wigan and Leigh NHS FT to adopt the 'Go Engage' programme. This has been paused pending a review of the strategic approach to colleague engagement to be completed by May 2018. Successful 2017/2018 appraisal season. Freedom to Speak Up Guardian in place with Champion and Ambassador support network being established. The BAME colleague network continues to	**Lead: SD** Well Led Workforce Committee.

		meet and is well attended. 'Ask Owen' is well regarded. Board to Ward programme in place.	
Develop workforce roles and service models that enable the Trust to deliver care within planned resources and minimise use of agency and temporary staffing	**On track (green)**	A workforce planning approach with resources including the workforce planning tool is operational. The Calderdale Framework (CF) has been adopted as a skill mix and role review tool in a structured work programme. Physician Associates in place. A formal programme to support medical colleagues obtain Consultant status has been established. Significant improvements to recruitment processes and applicant/recruiting manager experience – time to hire has reduced >50%. Good progress in recruiting skilled employees particularly to Consultant posts. Agency spend is below control target. Work on strengthening the staff bank including implementation of weekly pay arrangements actioned.	**Lead: SD** Well Led Workforce Committee.
Develop a leadership and succession planning development programme	**On track (green)**	Four cohorts of CLIP programme developed. BAME network and reverse mentoring process in place. . Band 7 Nurses Development Programme, Matrons Development Programme, Ward Manager Development Programme, Band 6 Theatres Staff Development Programme, Preceptorship Development Programme for Newly Qualified Nurses in place. Programme for Clinical Directors commences April 2018, with programme for senior divisional teams in design phase. Formal OD plan to be finalised and agreed in May 2018	**Lead: SD** Well Led Workforce Committee.
Deliver a programme of workforce information systems modernisation	**On track (green)**	Electronic Staff record (ESR) enhancements are operational with local implementation activity for manager and employee self-service progressing. Allocate systems for e-rostering, job planning and staff bank in place or at implementation stage. Strengthened system in place for e-expenses.	**Lead: SD** Well Led Workforce Committee

Goal: Financial sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver a robust financial plan including CIP for YE 2018	**Complete (blue)**	A year end deficit of £31.34m has been reported (subject to Audit) which on a control total basis is an £8m adverse	**Lead: GB** Weekly progress monitored

		variance from opening plan. This is both the revised plan that was agreed in year with regulators and also the deficit proposed to regulators before the control total was accepted	through Turnaround Executive. Reported to Finance & Performance Committee Monthly regulator discussions
Refresh the commercial strategy in light of current economic climate	**Complete (blue)**	Have refreshed the Full Business Case and this describes a plan to achieve clinical and financial sustainability.	**Lead: AB** Finance and Performance Committee
Continue to proactively contribute to WYAAT and WYSTP	**On track (green)**	The WYAAT Committee in Common governance arrangements are in place. Decision to come to Board in May in relation to vascular services. A model for pathology services has been set out. Other workstreams looking at provision of estates and facilities; single radiology imaging system and pharmacy stores business cases.	**Lead: AB** Finance & Performance Committee
Lead on the development of the IM&T and Estates schemes and progress these to full business case	**Complete (blue)**	Board approved the creation of a Wholly Owned Subsidiary at its meeting in March.	**Lead: MG / LH** Business cases to be reviewed by Board and WYAAT Committee in Common
Develop a clear plan to meet the organisation's capital requirements	**Complete (blue)**	Prioritised plan approved linked to risk register. Support for additional external bids has been received from STP and NHS Improvement.	**Lead: GB** Capital Management Group Weekly Executive Board

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Betty Sewell, PA to Director of Finance
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Huddersfield Pharmacy Specials (HPS) Annual Report 2017-2018 - The paper is the 2017/2018 Annual Report of Huddersfield Pharmacy Specials (HPS), also referred to as the Pharmacy Manufacturing Unit (PMU).	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

The Annual Report provides an update of licencing issues, workforce and organisational development performance, staffing, financial performance and business strategy.

Main Body

Purpose:

The paper is for information.

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The Board are asked to NOTE the HPS Annual Report for 2017/2018

Appendix

Attachment:

HPS_annual_report_2017-18_042518.pdf

Annual Report FY2018
Huddersfield Pharmacy Specials

1. Introduction

Huddersfield Pharmacy Specials (HPS), also referred to as the Pharmacy Manufacturing Unit (PMU), is a division of Calderdale & Huddersfield NHS Foundation Trust. HPS is a manufacturer of unlicensed sterile and non-sterile products known as Specials. Additionally, HPS provides a medicines over-labelling and pre-packing service to hospitals and private providers, both contract manufacturing and research and development and clinical trial supplies for third party organisations. Furthermore, during FY18 HPS materially commenced commercialisation of its licensed wholesaling activities. We present below key achievements and the division's operation and financial performance during the financial year FY18 (1st April 2017 to 31st March 2018).

2. Structure, Governance and Management

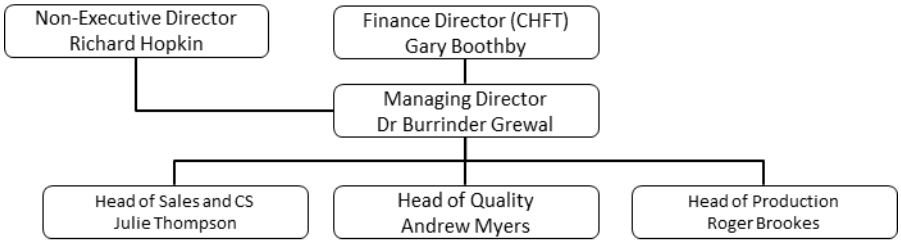
HPS trades from purpose built facilities (33,000 sq. ft. of space) located at Acre Mill (School Street West), Huddersfield. The unit operates under the authority and licences issued by The Medicines and Healthcare Products Regulatory Agency (MHRA), the UK medicines regulator. The licences the unit have which permit it to operate, manufacture and provide services are listed below:

Table 1: HPS licences and certifications

Licence/Certificate	Licence/certificate no.	Issue Date	Expiry Date
Manufacturers "Specials" Licence	MS 19055 version 15	29 November 2001	Ongoing
Wholesaler Distribution Licence WDA(H)	19055	21 July 2014	Ongoing
Investigational Medicinal Products MIA(IMP)	MIA(IMP) 19055, version 16	12 December 2005	Ongoing
United Kingdom Controlled Drug Licence	345102	14 March 2017	13 March 2019
Authorisation to receive duty free spirits	DFS/020537	23 December 2016	Ongoing
Industrial denatured alcohol (IDA)	DNA/138430	11 July 2016	Ongoing
GDP Compliance of a Wholesale Distributor	UK WDA (H) 19055 Insp GDP 19055/431097-0008	27 June 2016	Ongoing
Certificate of GMP Compliance of a Manufacturer UK MIA (IMP)	UK MIA (IMP) 19055 Insp GMP/IMP 19055/431097-0007	28 June 2016	Ongoing

On a day to day basis, HPS is run by a Senior Management team headed by a Managing Director who in turn reports into the Trust's Finance Director; the Senior Management Team meets at least once a week. The board of HPS consists of the Senior Management Team, the Trust Finance Director (also the board chair) and a Trust Non-Executive Director. Board meetings are held every two months although management and financial reports are produced on a monthly basis and the Managing Director and Trust Finance Director meet monthly. The current board governance structure is given below and the names of those in post (as at 31st March 2018).

Figure 1: HPS Governance structure



3. Workforce

During FY18, HPS completed staffing of its senior management team (SMT) by recruiting Julie Thompson as Head of Sales and Customer Services (start date 3rd July 2017). Trust representation at HPS board meetings changed at non-executive director level due to Professor Peter Roberts leaving CHFT; Peter was replaced by Richard Hopkin. The make-up of the remainder of the HPS board was unchanged.

Staff in post at the commencement and end of FY18 numbered 64 and 63 respectively. On a whole time equivalent basis, HPS employed 58.44 WTE at the beginning of FY19 (a decrease of 1.14 WTE's during FY18).

Table2: HPS staff numbers

	End of		
	FY16	FY17	FY18
No. staff in post (SIP)	56	64	63
No. WTE	51.45	59.60	58.44
Annual staff turnover rate	4.16%	5.38%	6.27%

Overall, the staffing structure (figure 2) remained largely unchanged from previous years with manufacturing and production being delivered through teams working in the distinct operational areas of Sterile, Non-Sterile and Tablet Packing; staff in these areas were supported by teams from Quality (including new product development), Customer Services, warehousing and cleaning (see table 3 below for staffing number splits by function). HPS did however recruit a clinical trials manager to ensure resourcing of a new go-to-market service offering in this area.

Figure 2: HPS staffing by band

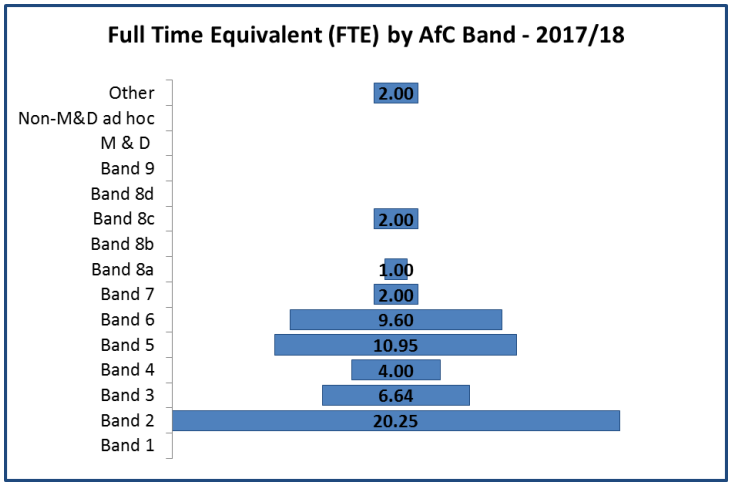


Table3: HPS staff numbers by function (March 2018)

Function	SIP	WTE
Sales, customer services, warehouse	18	17.53
Quality Control	15	14.40
Sterile production	12	10.79
Tablet packing	9	8.21
Non sterile production	9	7.51
Total	**63**	**58.44**

SIP=staff in place, WTE = whole time equivalents

Appraisals and mandatory training: At the commencement of FY19, HPS reported 100% completion of staff appraisals covering FY18. Mandatory training completion rates ranged from 98.39% to 100% across the 10 training requirements.

Sickness: At the end of FY18, HPS bore an annual sickness rate of 2.86% (long term 1.35%, short term 1.51%) versus a Trust rate of 4.10%; the estimated cost to HPS of this sickness was £40K.

4. Finance

During FY18 HPS delivered income of £9.82m and returned to the trust contribution of £2.82m. As is shown below (table 4), HPS demonstrated significant actual year on year growth; revenue increased by 26% and contribution by 23%.

Table 4: HPS financial results FY18

	FY16	FY17	FY18
Income	£7.1m	£7.8m	£9.8m
Contribution	£2.2m	£2.3m	£2.8m

The increase in contribution during FY18 was primarily derived from tablet packing activities, followed by sterile production and contract manufacturing. Furthermore, from a cost perspective all staff continue to contribute to the process of reviewing all business expenditure (for example, historic plant and equipment maintenance contracts which were identified as an area of review in-order to decrease operational cost).

Revenue wise, sales were split across our functions as set out below (table 5) during FY18.

Table 5: HPS revenue analysis FY18

Function	% of FY17 revenue	% of FY18 revenue
Tablet packing	29.8%	42.9%
Sterile production	36.9%	25.4%
Non sterile production	27.0%	20.2%
Contract manufacturing*	-	6.3%
Wholesaling	-	2.0%
Contract research	3.0%	1.0%
Clinical trials	-	0
Others**	3.3%	2.2%

* Included in sterile production figures in FY17

** Delivery charges and small order handling charges

Agency spend: There was no agency spend at close of FY18 and there is no planned agency spend for FY19.

Capital Expenditure: During FY18, HPS spent £20K on the purchase of over encapsulation and tabletting equipment (to help develop our clinical trial service offering), £20K on an oxygen analyser and polarimeter (to update and replace analytical capabilities in quality control), £32K on a hot foil press printer (to enable the manufacture of sterile medicines in plastic bags as requested by our customers) and a commitment of £381K to replace and update our existing water for injection (WFI) system. In total, actual capex spend and commitments were £453K in FY18.

Aged debt: The aged debt position for the unit deteriorated by £240K from period opening and closing values of £1.08m and £1.32m respectively, most likely due to the significant increase in trading experienced during the year. That said, the senior team monitor aged debt on a monthly basis and continue to pursue mitigation measures such as requesting card payment at the point of customer order and a formal process of debt "chasing" where customers have had accounts put on stop until monies owed have been paid.

Table 6: HPS aged debt position FY18

	FY17	FY18
Period opening value	£0.92m	£1.08m
Period closing value	£1.08m	£1.32m*
Change in period	+£160K	+£240K
Current debt (%)**	61%	52%

* subject to final verification from CHFT Finance.

** invoices issued that are less than 30 days old

5. Business activity and strategy

Historically, HPS has supplied product to every NHS Trust in the UK. During period, HPS traded with 180 NHS organisations (270 separate sites) and approximately 230 private companies (mainly corporate/independent pharmacies). Some 65% of revenue was derived from NHS organisations; revenue originating from private customers increased from 25% (FY17) to 35% in FY18. Based on our underlying strategy, we anticipate that over the coming years the share of revenue from the private sector will further increase due to HPS diversifying into contract research and manufacturing (where the customer typically will be pharmaceutical companies), clinical trials, licensing of products, wholesaling of pharmaceutical products and exporting etc.

In February 2018 HPS presented a revised strategy and investment plan geared towards significantly growing contribution over the next six year period (FY19-FY25), which after review, was endorsed by the board of CHFT. As a result of this approval, work has commenced to identify investment sources required to deliver strategic objectives.

HPS throughout FY18 pursued and delivered a business strategy that sought to enhance or develop sales in the following areas;

i) Maximise sales of existing products (across sterile, non-sterile and tablet packing)
ii) Obtain Licenses (marketing authorisations) for existing products
iii) Manufacture new products where competitors can no longer service the market (opportunity lead sales)
iv) Introduce new products where demand and a business case have been proved
v) Contract manufacturing for third parties
vi) Contract Research for third parties
vii) Clinical Trial supplies (the manufacture of investigational medicinal products and sourcing of clinical trial comparators)
viii) Wholesaling of medicinal products

Overall, the strategy is proving to be successful with the unit now having identified and developed a strong pipeline of licensable products which are being progressed through regulatory licensing/approval procedures and also, HPS signed its second contract research agreement (with a global pharmaceutical company) in August 2017.

Clinical Trials: Of particular note, through a Europe wide tender process, HPS won a significant contract to develop and manufacture oral liquids for a clinical trial being run from Sheffield Teaching hospitals; this is a major step towards HPS becoming a recognised partner and supplier of medicines for use in clinical trials. At the time of writing the pipeline of opportunities in clinical trials is becoming material and HPS is in the latter stages of winning a number of similar contracts.

Engagement with clinicians: The unit continues to increase its visibility and interactions with clinical colleagues based at CHFT and the wider region, which has resulted in a number of new products currently being developed that will be launched in FY19/20. Such activity forms a sound basis for the future growth of HPS.

Accordingly, HPS will continue business activity in the above areas and commences FY19 with a strong sales pipeline.

6. Forward plan and strategy for FY19

Looking forward HPS has embarked upon FY19 with a similar strategy as that set out above for FY18 and we expect to report significant progress against each strategic aim during the course of the coming year.

During FY19, HPS will invest through capital expenditure to update its water for injection system (approximately £700K has been committed); such capex is imperative in-order to mitigate ongoing pressures arising from lost production days that impact HPS revenue and profitability and increasing equipment maintenance costs and to ensure continuity of medicine supply is maintained to our NHS customers.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jean Robinson, Lead Infection Prevention and Control Nurse
Date: Thursday, 3rd May 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Quarterly DIPC report - The Board is asked to receive the report on the position of healthcare associated infections	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Exec Board	
Governance Requirements: keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

None

Background/Overview:

None

The Issue:

None

Next Steps:

None

Recommendations:

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

Appendix

Attachment:

Quarterly DIPC Report April 18.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Report from the Director of Infection Prevention and Control to the Board of Directors
1st April 2017 to 31st March 2018

Performance targets

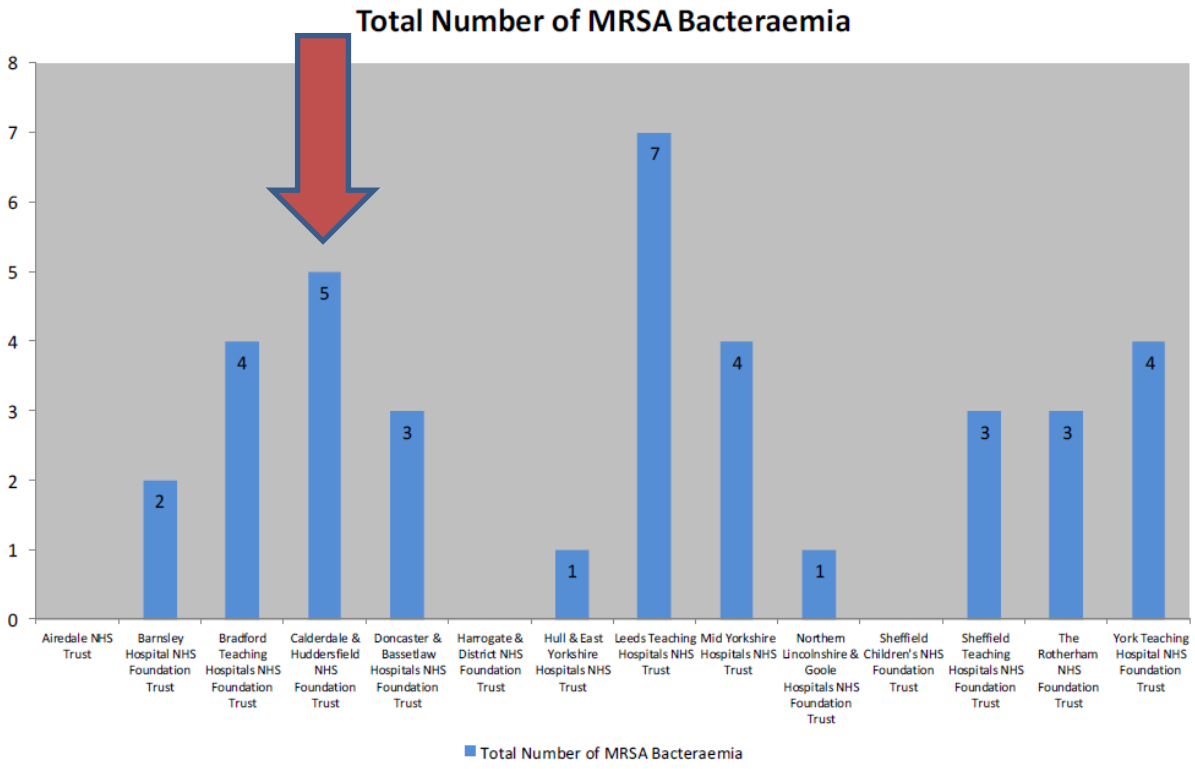
Indicator	End of year ceiling	Year-end performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**5**	3 post case 2 pre cases attributed to the organisation.
C.difficile (trust assigned)	21	**40**	27Non Preventable 13 Preventable
MSSA bacteraemia (post admission)	9	**22**	Local ceiling – 15/16 outturn 19 cases within the medical division 3 cases within the surgical division
E.coli bacteraemia (post admission)	43	**49**	Local ceiling – 15/16 outturn 35 cases within the medical division 14 cases within the surgical division
MRSA screening (electives)	95%	93.3%	
Central line associated blood stream infections (Rate per 1000 cvc days)	1	0.44	Rolling 12 months
ANTT Competency assessments (doctors)	90%	82.81%	Divisions have been tasked with improving compliance by the end of 2017/18.
ANTT Competency assessments (nursing and AHP)	90%	92.86%	Well done to our nursing colleagues
Hand hygiene	95%	98.6%	

Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	84.1%	
Isolation breaches	**Non set**	357	An Increase 75% (267) in Isolation breaches compared to 2016/17.
Cleanliness	Non set	97%	

MRSA bacteraemia:
There have been 5 MRSA cases attributed to the organisation; 3 post case and 2 pre cases. All have been subject to a post-infection review which are presented at the Infection Prevention and Control Performance Board. Action plan completion is monitored through the Infection Control Committee.

The chart below compares total numbers of attributed MRSA bloodstream infections to each organisation in Yorkshire & The Humber.



MSSA bacteraemia:
There have been 22 post-admission MSSA bacteraemia cases at the end of March 2018, against the internal objective of 9. A review of cases has been presented at the Infection Prevention and Performance Board. There is no strong common theme, although Hospital Acquired Pneumonia is an area for future focus and is incorporated in the HCAI Action Plan.

No comparative data is available with other Trusts.

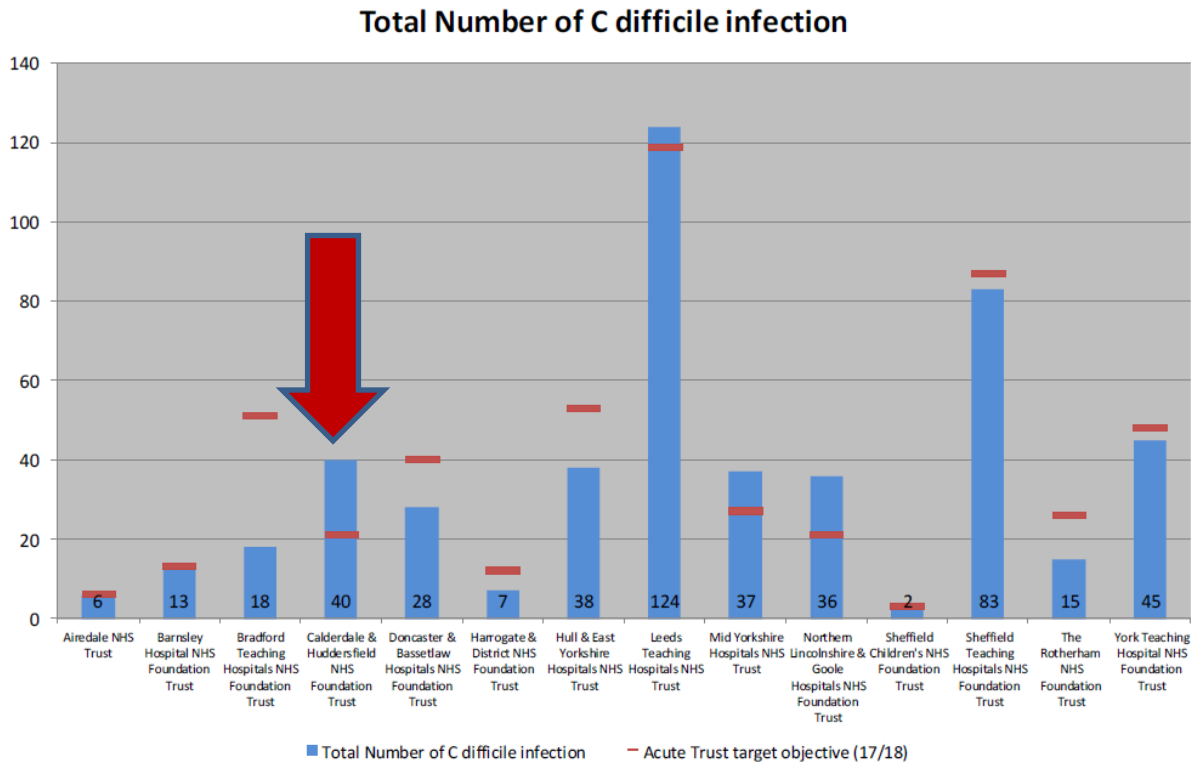
Clostridium difficile:
The ceiling for 2016/17 is for no more than 21 post-admission cases. At the end of March there have been 40 cases which is an increase on last year when we had 32 cases.

Key themes from the C. difficile cases identified at post-infection review are:

- Completion of the Bristol Stool Chart and assessing patient bowel habits. Compliance with this reduced since the introduction of EPR. Work is ongoing to improve access to, and use, of the Bristol Stool Chart within EPR.
- Delay in isolation – wards awaiting specimen results before isolation as opposed to isolating patients at the time of sampling.
- Antibiotic prescribing is generally in line with policy, although inappropriate antibiotic prescribing including extended courses of antibiotics has been highlighted in a couple of cases. Antibiotics guidelines are currently being reviewed.
- There have been 2 'outbreaks' both of which have been reported as 'Serious incidents'.

Work is ongoing to improve compliance with the above issues, and is incorporated within the HCAI Action Plan.

The chart below compares total numbers of attributed C. difficile infections to each organisation in Yorkshire & The Humber.



E. coli bacteraemia:

There have been 49 post-admission E-coli bacteraemia cases against the internal objective of 43; There is both a Trust and health economy wide reduction plan which has been developed and will be monitored through the HAI Performance Board and the HCAI Health Economy Meeting.

Outbreaks & Incidents: There have been a number of Norovirus outbreaks

WARDS CLOSED & BED DAYS LOST FIGURES					
MONTH	**HOSPITAL SITE**	**WARD**	**DAYS CLOSED**	**BAY/S CLOSED**	**BED DAYS LOST**
March	HRI	0	0	0	0
	CRH	C6B	2	-	7
April	HRI	0	0	0	0
	CRH	C5B	8	-	0
		C5C	3	-	7
		C5A	14	-	47
		C5C	2		0
		C5D	6	-	4
December	HRI	1	3	-	18
		8	6	-	15
	CRH	0	0	0	0
January	HRI	1	4	-	11
		6A	2	-	0
		6B	1	-	1
		22	10	-	27
	CRH	0	0	0	0
February	CRH	0	0	-	0
	HRI	4	2	-	0
		6A	9	-	5
		6B	13	-	16
		8	2	-	2
		12	5	-	39
		20A	28	-	28
		20B	9	-	0
		CDU	2	-	4
March	CRH	5C	5	-	9
		5D	6	-	10
	HRI	15	4	-	11
		5	11	-	57

Influenza:

There have been an unprecedented number of Flu cases identified within the organisation this year 416 in total compared to 30 the previous year.

At the beginning of January the decision was made to identify 2 Flu cohort wards (one on each site) to enable us to contain the virus and focus on supporting staff in those areas regarding the use of PPE and managing the patient pathway. This initially proved to be beneficial enabling patients with Flu to be nursed both effectively and efficiently, but due to the numbers of patients presenting with symptoms and other co-morbidities this was difficult to maintain and unfortunately we had 3 wards affected with outbreaks. Both the microbiology lab and IPCNs have supported and continue to support the organisation in

managing the situation helping to maintain patient flow safely. A planning meeting has been arranged for summer to prepare for the next Flu season.

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%

Isolation Breaches

There have been 357 isolation breaches since 1st April 2017 compared to 269 breaches for the previous year. The majority of breaches are patients with a previous history of MRSA colonisation 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; 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. Reconfiguration of services has impacted on the number of isolation breaches reported since October last year.

Audits:

46 Quality improvement environmental audits have been carried out since the beginning 1st April 2017 to 31st March.

Compliance scores: <75% = red rating; 76% - 90% = amber rating; 91%+ = green rating.

- 26 of the areas achieved a green rating.
- 15 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.
- 3 areas were deemed as a Red rating;
  One September which was re-audited and achieved an amber scoring
  One at the end of November which was re-audited in March (awaiting final report),
  One in March 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.

IPCT:

During 2017/18 the IPCT has seen a number of changes including a band 6 leaving to live in Australia and a band 7 retiring. This impacts on the team dynamics whilst training and development of new post holders is ongoing. The team have worked exceptionally and have gone over and above expectations during the last quarter of the years with regards to On-call ensuring the hospital site is kept safe with regards to increased number of flu cases within the organisation.

The IPCT continue to work both proactively and reactively, and are preparing for what is expected to be a challenging influenza season.

Thank you for your continued support.

Jean Robinson

Matron Lead IPC

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Karen Marsden, Safeguarding Administrator
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Safeguarding Annual Report - The 2017- 2018 Annual report is the 5th Annual report and provides the Trust Board with an overview of the national and local context of safeguarding and areas of practice included in safeguarding within the Trust. The report will show performance activity and inform the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks, and how these are mitigated. The Safeguarding strategy as part of this report will describe priorities for 2018-19.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: 30.04.18 Quality Committee 10.04.18 Safeguarding Committee	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

Calderdale and Huddersfield NHS Foundation Trust, is committed to ensure that safeguarding its patients, staff and the wider community is given the highest priority. All safeguarding work across the Trust is underpinned by the Trust values by demonstrating our behaviours, known as our four pillars; putting patient's first, we go see, we do the must-dos and we work together to get results.
CHFT is committed to ensuring that safeguarding is part of its core business and recognises that safeguarding children, young people and adults is a shared responsibility and is seen as everyone's business. Effective multiagency partnership working across the Districts of Kirklees and Calderdale ensures that the most vulnerable of our society are protected from harm. We work closely to protect individual human rights, treat individuals with dignity and respect and safeguard from all forms of abuse and neglect.
This is a combined children and adults report that describes all areas of safeguarding activity. The report describes how the Children and Adults team work together across the Trust and demonstrates to the Trust Board and external agencies how Calderdale and Huddersfield NHS Foundation Trust discharges its statutory duties.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Trust Board is asked to approve the annual report and the Trusts Safeguarding Strategy for 2018/19 contained within the report.

Appendix

Attachment:

Safeguarding Annual Report 2017-2018 final version.pdf

Safeguarding Annual Report

2017-2018

Foreword

Calderdale and Huddersfield NHS Foundation Trust, is committed to ensure that safeguarding its patients, staff and the wider community is given the highest priority in all that the Trust does. All safeguarding work across the Trust is underpinned by the Trust values by demonstrating our behaviours, known as our four pillars; putting patient's first, we go see, we do the must-dos and we work together to get results.

CHFT is committed to ensuring that safeguarding is part of its core business and recognises that safeguarding children, young people and adults is a shared responsibility and is seen as everyone's business. Effective multiagency partnership working across the Districts of Kirklees and Calderdale ensures that the most vulnerable of our society are protected from harm. We work closely to protect individual human rights, treat individuals with dignity and respect and safeguard from all forms of abuse and neglect.

During this challenging time for all NHS Trusts we have used our existing resources to safeguard those most vulnerable in society and are creating a culture of safeguarding as part of our core business.

Contents

INTRODUCTION

Safeguarding is a statutory responsibility of all NHS organisations as detailed under the Care Act (2014), and the Children Act (1989/2004). Legislation and guidance is built upon the principle that the welfare of the most vulnerable in our society is paramount and that all statutory services consider and promote the needs of children, families and adults at risk.

This is a combined children and adults report that describes all areas of safeguarding activity. The report describes how the Children and Adults team work together across the Trust and demonstrates to the Trust Board and external agencies how Calderdale and Huddersfield NHS Foundation Trust discharges its statutory duties in relation to:

- Registration standards, Health and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13.
- CQC national standards of quality and safety - Outcomes 7-11: Essential standards of quality and safety.
- The Children Act (1989).
- The Sexual Offences Act (2003)
- Children Act (2004) - Statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11.
- Care Act (2014)
- "Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework"
- Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document (2014).
- Working Together to Safeguard Children (2015).
- The Mental Capacity Act (2005) and Deprivation of Liberty safeguards amendment in 2007.

The 2017- 2018 Annual report is the 5th Annual report and provides the Trust Board with an overview of the national and local context of safeguarding and areas of practice included in safeguarding within the Trust. The report will show performance activity and inform the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks, and how these are mitigated. The Safeguarding strategy as part of this report will describe priorities for 2018-19.

GOVERNANCE ARRANGEMENTS

The Executive Lead for Safeguarding Children and Adults is the Chief Nurse. The Chief Nurse is responsible for ensuring that there are robust and effective arrangements for safeguarding adults and children within CHFT. This responsibility is delegated to the Deputy Chief Nurse.

The Head of Safeguarding provides strategic support and direction to the governance and safeguarding arrangements within CHFT, and for ensuring systems and processes are robust and effective. The Head of Safeguarding is responsible for key safeguarding staff and reports directly to the Deputy Chief Nurse. CHFT is represented at the Local Safeguarding Adults and Children's Boards for both Calderdale and Kirklees. CHFT has active Local Safeguarding Board membership and attendance at the Domestic Abuse Boards for both Calderdale and Kirklees Local Authorities. Designated Doctors employed by CHFT attend the Local Safeguarding Children Boards as part of their Designated role. The Trust attends the Local Child Death overview panel meetings with representation from the SUDIC Paediatrician and midwifery service.

Named and Designated Safeguarding Nurses along with the Matron for Learning Disability attend the sub-groups of the local Safeguarding Boards and contribute to multi-agency collaboration and partnership working.

The key functions of the Local Safeguarding Boards are to develop and publish a strategic plan about how members and partners contribute, publish an annual report of the effectiveness of the Board, and commission SARs for any cases that meet the criteria.

The Safeguarding Team links closely with other key departments such as Risk and Governance, Human Resources, and also Patient Safety and Quality Boards within Divisions.

The Safeguarding Committee reports directly to the Quality Committee and provides twice yearly updates. This has raised the profile and accountability of safeguarding within the Trust and ensures lines of accountability are aligned within the Trusts Governance Structure and directly with the Trust Board.

Operationally the Safeguarding Committee has in place 3 sub-groups, Learning and Audit, Training and Policy, and Incident and Review Subgroup. Safeguarding Subgroups provide a forum to bring together key senior professional and operational managers. Within the subgroups the terms of reference describe accountability for reporting, escalating and assurance. Each subgroup will communicate with the other where there are shared agendas. The individual Groups report directly to the Safeguarding Committee and support

the Chief Nurse in discharging their responsibilities in relation to safeguarding and strengthening accountability.

All statutory posts for Named Nurses for Children, Looked After children, Adults, Midwifery and the Named Doctor are in place and have been throughout the year.

CHFT hosts two Designated Doctors for Safeguarding Children, two Designated Doctors for Looked After Children and a Designated and Named Nurse for Looked After Children for Calderdale. The Designated Nurse for Kirklees is employed by Locala. These roles are directly commissioned through the Clinical Commissioning Group (CCG).

The safeguarding team play a pivotal role in supporting colleagues in carrying out their safeguarding responsibilities. Work has continued with other partner agencies across Kirklees and Calderdale to ensure CHFT is discharging its statutory responsibilities.

PREVENT

The Counter-Terrorism and Security Act 2015 places a duty on CHFT to have; 'due regard to the need to prevent people from being drawn into terrorism.'

CONTEST, is the UK national counter-terrorism strategy, and one of the elements of it is Prevent, which aims to stop people becoming terrorists or supporting terrorism. The NHS is a key strategic partner in the PREVENT work stream, as it is recognised that healthcare professionals may meet and treat people who are vulnerable to radicalisation.

The Act with relevance to PREVENT includes a duty on specified bodies, including the police, prisons, local authorities, schools, universities and health, to have due regard to preventing people being drawn into terrorism. It also makes Channel (the voluntary programme for people at risk of radicalisation) a legal requirement for public bodies so that it is delivered consistently across the country.

The Statutory guidance issued under section 29 of the Counter-Terrorism and Security Act 2015 became statute on 1 July 2015. The Counter-terrorism strategy has several strands:

- Pursue - to disrupt terrorist activity and stop attacks;
- Prevent - to stop people becoming or supporting violent extremists and build safer and stronger communities;
- Protect - strengthening the UK's infrastructure to stop or increase resilience to any possible attack;
- Prepare - should an attack occur then ensure prompt response and lessen the impact of the attack.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence. The overall principle of agencies including health providers is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation.

PREVENT has 3 national objectives:

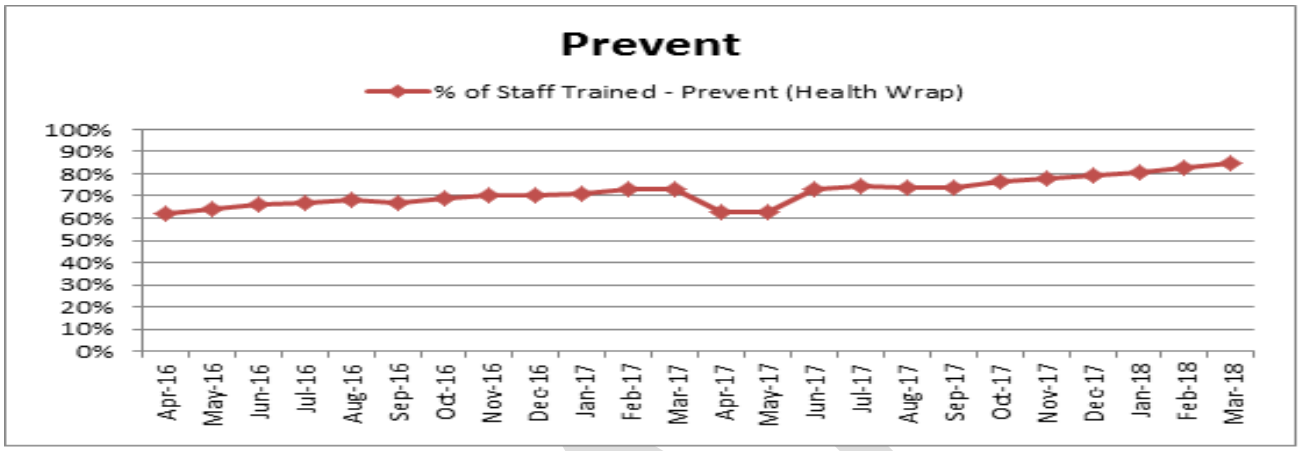
- Objective 1: respond to the ideological challenge of terrorism and the threat we face from those who promote it.
- Objective 2: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
- Objective 3: work with sectors and institutions where there are risks of radicalisation which we need to address.

This duty is incorporated into the NHS Standard Contract 2017-19, and the National Variation Agreement.

Current position of CHFT

- CHFT's Prevent Policy describes how the Prevent Strategy is implemented in CHFT.
- CHFT Prevent Lead is the Named Nurse for Safeguarding Adults, who is supported by the Head of Safeguarding. Both act as points of contact for Regional Prevent Coordinators. These two roles work in partnership to comply with the reporting requirements to NHSE. On a quarterly basis, data is requested and submitted to the Regional Prevent Coordinator (NHS England) of Prevent activities undertaken by the Trust which includes training figures.
- The Trust Safeguarding Committee receives an quarterly update regarding Prevent
- CHFT safeguarding team provides representation at Channel panels within the local Districts.
- PREVENT training compliance is monitored monthly at the safeguarding committee meeting and quarterly updates are submitted to the Regional Prevent Coordinator for Health (NHS England).
- In line with the Prevent Training Competencies Framework 2017 developed in order to meet the Prevent Duty and ensure a consistent approach to training Prevent training is delivered at level 1 and Level 3.
    - CHFT delivers Level 1 Prevent training as part of adult safeguarding level 1 mandatory eLearning training and is repeated every 3 years.
    - The Home Office Workshop to raise awareness about Prevent (WRAP) training (level 3) has been delivered as a classroom session during 2017/18. Ensuring staff complete this training has been delivered successfully over a 3 year period by Wrap facilitators registered with NHS England and the Home Office by a Trust team of facilitators.
    - The Trust has seen an increase of over 10% since last March and the overall Trust target is 95% with an NHS England target of 85% by March 2018. We have met our NHSE target of 85% by the end of March 2018. This was primarily due to a pro-active approach and continued engagement with committed trainers.
    - CHFT is considered an exemplar site in relation to the number of staff trained. This has been confirmed by the NHS Regional Prevent Coordinator.

**The graph below shows an increase year on year from August 2016 to March 2018 in achieving this 85% target. There is no comparator data available.*



Further work in 2017-18

- To review the Prevent Policy in September 2018.
- Complete an annual audit of any incidents (2017-18) relating to risks of radicalisation
- Promotion of the eLearning training package on ESR with Divisional support to meet the Trust target of 95%.

Calderdale Safeguarding Adults Board

Kirklees Safeguarding Adults Board — Partners in preventing abuse and neglect

ADULT SAFEGUARDING

Following the introduction of the Care Act (2014) adult safeguarding has been on a statutory footing since April 2015. To meet our statutory, regulatory, contractual and Safeguarding Board requirements and obligations there are robust governance arrangements, policies and procedures, and support mechanisms in place to ensure these requirements are met.

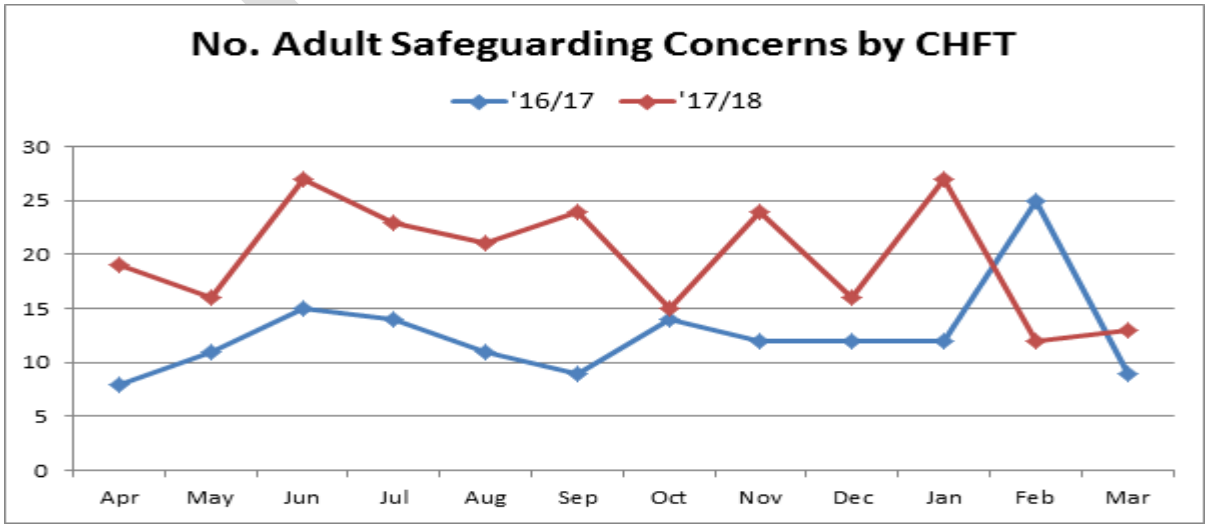
The team is the single point of contact for advice and support for all adult safeguarding concerns. A Named Lead and specialist advisor are in post and the safeguarding adults' staff continue to provide advice and practical support for a wide range of safeguarding issues relating to adults who may be at risk of abuse or neglect.

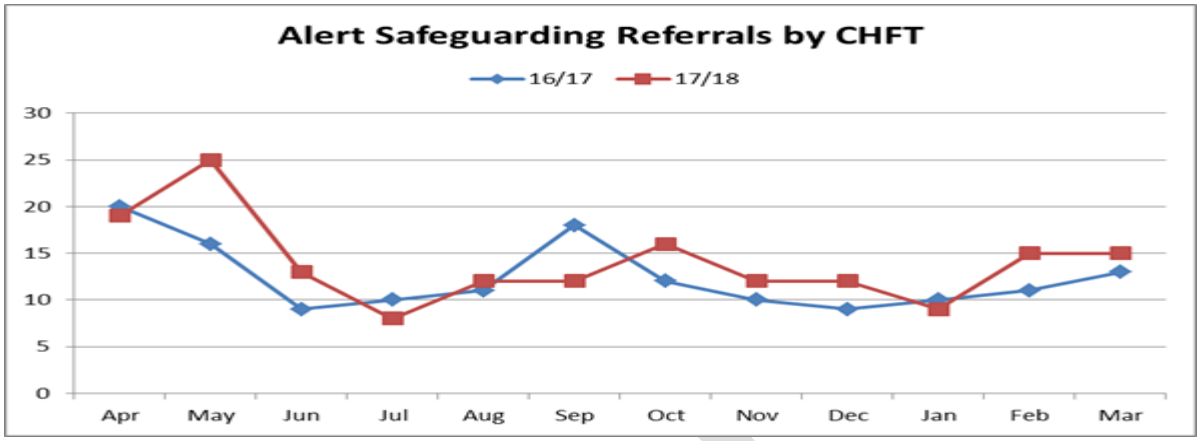
All Trust incidents are reviewed from a safeguarding perspective when initial reporting occurs to confirm or adjust the category of safeguarding concern: either level 1/ quality of care or level 2 safeguarding referral where harm has occurred and reporting into the multi-agency procedures is indicated. The Safeguarding committee has an overview of all allegations of abuse or neglect through reporting onto the safeguarding dashboard, deep dive analysis monthly for the Integrated Board Report and sharing of key messages at Divisional PSQB meetings.

The data does not include advice calls and support to wards and individual members of staff. All incident activity is recorded on Datix and there have been a total of 882 incidents recorded for 2017-18, compared to 2016-17 activity where there were a total of 574 reported incidents. This activity includes referral made by CHFT and allegations against CHFT. There is an increase in activity of 308 incidents this year which equates to a 54% increase.

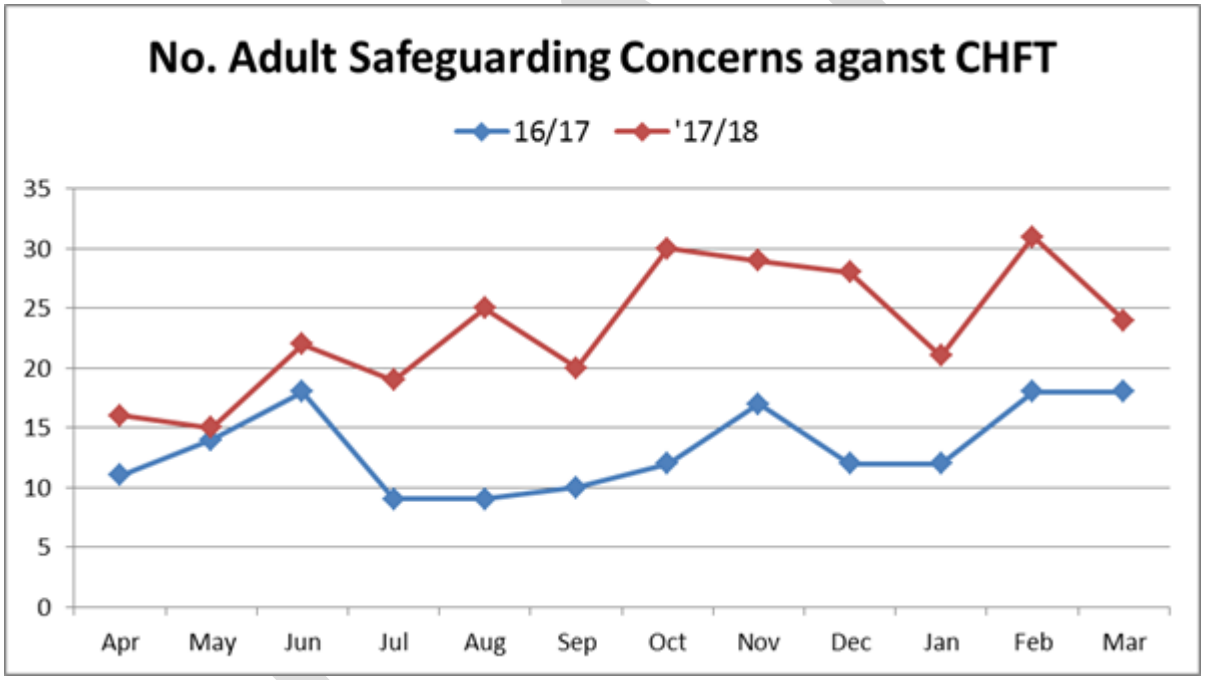
- Of these incidents 517 relate to quality of care issues. These are concerns that do not meet the threshold for referral and are reviewed by the safeguarding team and will be thematically analysed. These incidents are reviewed and investigated by the departments and divisions and learning is at department level.
- Of these incidents 365 met the section 42 Care Act Criteria for reporting into the West, North Yorkshire and York Multi-agency Safeguarding Procedures. This is an increase of 103 referrals compared to 2016-17. This includes referrals that are made by CHFT staff in relation to allegations of abuse or neglect or the risk of these on the part of other care providers and such allegations made against CHFT.
- The increased referrals assure ourselves that there are robust reporting arrangements in place and that training delivered is increasing awareness; not necessarily that more abuse is taking place.
- The largest category of abuse identified is recorded under the ‘neglect’ heading; further analysis of this category identified that discharge from hospital was involved with these equating to 85%; the remaining 15% refer to emotional, psychological, financial, physical and self-neglect.

**The following graphs illustrate the general overall increase in the numbers of concerns made by CHFT in the upward trend*

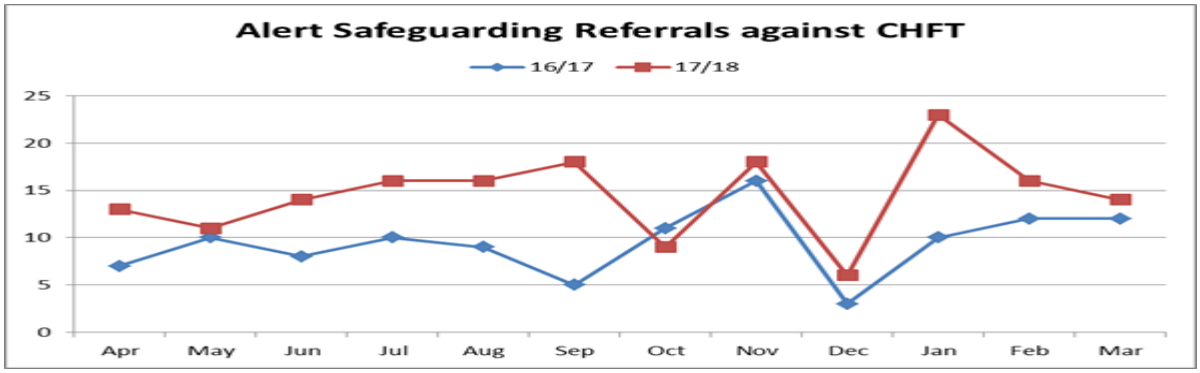




**There is an overall increase in the number of referrals made by CHFT staff into the multi-agency procedures*



**This shows us that there is an increase in concerns and referrals made against CHFT from 2016-17 to 2017-18.*



Current Position

- The Safeguarding Adults policy was updated in September 2017
- The development and implementation of the Safeguarding Committee Incident and Review Subgroup will have oversight of all incidents with a safeguarding concern that are currently being investigated through the safeguarding procedures.
- Developed a network of safeguarding Champions in wards and departments.
- Completion of the first Adult Safeguarding Policy audit awaiting analysis
- We have attended and delivered at the Nursing and Midwifery conference about 'Making Safeguarding Personal' in September 2018

.**Further work 2018-19**

- To review the Allegations Policy to include new PIPOT (Persons in a Position of Trust) Guidance issued by the Safeguarding Adults Board. The revised Care Act 2014 in 2016 removed the Designated Adult Safeguarding Manager role (DASM) and was replaces with a new section on allegations management.
- Review the Adult Safeguarding Policy in line with the updated Multi-agency Adult Safeguarding Procedures in quarter 1.
- To continue to embed 'Making Safeguarding Personal' and work with partners to put patients at the heart of what we do by embedding this culture, and to work with adult social care and gain assurance that referrers are given feedback from concerns raised and that a more consistent approach to referral thresholds is achieved.
- To ensure learning from incidents is embedded through the incident and review group
- Continue to develop systems that are lean and accessible for staff at times of high demand and impact.
- To arrange and deliver further training in relation to Missing Persons Policy with Police partner and audit against policy
- We can probably anticipate that referrals relating to pressure ulcers may increase over the next 12 months with more consistent reporting due to the new guidance. More work is needed to get the same level of consistency in relation to falls reporting.
- Further analysis and reporting will be developed over the next 12 months to aim to report on outcomes more consistently as indicated in the Making Safeguarding Personal Agenda

LEARNING DISABILITY

CHFT Learning Disability Matron champions and leads the Learning Disability (LD) service to ensure that all our vulnerable patients who use CHFT services have reasonable adjustments in place to ensure that people with a LD are treated in accordance with the Equality Act. All planned and acute admissions are overseen by our LD Matron who ensures that these reasonable adjustments are in place to ensure patients receive the right care, at the right time in the right place. Most of our patients with Learning Disabilities are offered side rooms. This has proved a challenge over the winter period pressures. One of our patients attended for multiple procedures during one anaesthetic and feedback received from mum stated 'the experience was great and staff were really good at meeting his individual needs.'

The LD Matron is pivotal in supporting the Adult Safeguarding team to deliver MCA DoLS and Adult Safeguarding training and ensuring that 'Making Safeguarding Personal' for patients with a LD is carried out and embedded, and that the outcomes that patients want in relation to safeguarding are listened to. The safeguarding committee receives quarterly reports in relation to numbers of admissions, DoLS/MHA. IMCA referrals, number of deaths and incidents. These are analysed and discussed. All deaths of patients with a LD are subject to a structured mortality review which is reported to the Trust Mortality Surveillance Group which has oversight of this. All deaths are reported to NHSE as per Learning Disability Mortality Review programme (LeDer) process.

CHFT is to be a pilot site in the first phase of the 'Treat Me Well' Campaign in association with Royal Mencap.

PRESSURE ULCERS

During 2017-18 the Safeguarding Team (adults) have worked closely with the Tissue Viability team to ensure that all category 3 / 4 and unstageable pressure ulcers are reviewed from a safeguarding perspective. The incident reporting system (Datix), is screened by the Tissue Viability team to ensure the severity grading of the incident is correct. All "orange" incidents then go to divisional panel for further investigation. The safeguarding team attend Divisional Orange panel meetings from a safeguarding perspective.

New guidance in Jan 2018 from the Department of Health and Social Care "Pressure Ulcers and the interface with a Safeguarding Enquiry: When to raise an Adults Safeguarding Concern (DH 2018), provided a framework to, identify if a pressure ulcer is primarily an issue for orange clinical investigation rather than a safeguarding enquiry led by the local authority. This requires completing a decision tool and based on the score determines if a safeguarding enquiry is raised with Gateway to Care. This has been approved by the Safeguarding Committee and is being shared with external organisations including Calderdale CCG and Calderdale Safeguarding Adults Board. Further discussion will also take place with Kirklees CCG and Kirklees Safeguarding Adults Board to promote a consistent Trust-wide approach.

Further work 2018-19

To progress and embed the use of the decision tool at orange panel meetings and evaluate its effectiveness through the safeguarding committee meeting

MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009). As such the Mental Capacity and Deprivation of Liberty Policy has been extracted from the Safeguarding Adults Policy and given separate status. This was ratified in September 2017 in conjunction with the implementation of MCA DoLS training as part of the essential skills framework approved by WEB. This strengthens current arrangements in place to support staff and vulnerable patients to ensure that their Liberty under Article 5 of the Human Rights Act is protected whilst in hospital.

Current and Historical Data

Year	Number of Urgent DoLS	Number Standard DoLS	Number Declined	Average p/month
2014	**11**	**5**	**0**	**0.9**
2015	**194**	**33**	**11**	**16**
2016 – 2017	**369**	**50**	**212**	**31**
2017-2018	**324**	**42**	**242**	**27**

**These figures suggest that there is a positive level of awareness and recognition of patients who may fall within the ACID test for DoLS. The increase in the number of declined from last year is mainly due to patients being discharged from hospital prior to assessments being undertaken.*

This year's data compared to last year's data has shown a slight decrease overall. However the figures suggest there is a positive awareness and recognition. The decrease in the number of applications was noted at the Safeguarding Committee meeting. It was noted that there was less movement of patients who were subject to a DoLS at the time and the overall complexity of the patients, and the change in approach due to the Court of Appeal in Ferreira (R (LF) v HM Senior Coroner for Inner South London & Ors [2017] EWCA Civ 31.

A number of urgent authorisations continue to lapse on a month on month basis as previously reported. This occurs when the Local Authority does not complete all its assessments within 14 days of the urgent authorisation being applied, because greater priority is given to other applications as these authorisations are likely to be for a longer time. In these cases the Safeguarding Team continues to monitor the patient to ensure that the deprivation is still valid, the patient still lacks capacity, all restrictions in place remain least restrictive whilst ensuring the patient remains safe on the ward, and that there are no objections to the DoL.

Legal Updates

The Government published their response in relation to the Law Commission report and draft Bill on 14th March 2018 which recommends that the DoLS scheme be replaced with the

Liberty Protection Safeguards (LiPS). The Government's final response to the report broadly agrees with the Liberty Protection Safeguards model, and as part of the review into the Mental Health Act, proposals that relate to the interface between the Mental Health Act and Mental Capacity Act will be considered as part of this. The Government will bring forward legislation to implement the model when parliamentary time allows ensuring that new safeguards fit with the future direction of the health and social care sector and engagement with stakeholders on implementation.

The Board will be further updated as to progress through Parliament and plans for implementation.

From the 3rd April 2017 the Policing and Crime Act has removed DOLS from being classed as state detention (as part of an amendment to Coroners and Justice Act 2009).

This removes the need for deaths (whilst a DOLS is in place) to be reported to the coroner; notwithstanding normal procedural requirements. However if someone has a DoLS which is not yet authorised, has not been applied for or it has lapsed it is still classed as a DoL.

The decision of the Court of Appeal in Ferreira (R (LF) v HM Senior Coroner for Inner South London & Ors [2017] EWCA Civ 31 has significantly changed the approach when considering a deprivation of liberty where physical healthcare needs are being met in the hospital setting. DoLS does not apply in settings and circumstances where the patient is in need of life sustaining treatment, which could include treatment in a critical care setting (e.g. ICU). It is hoped that during the review and reconsideration of authorisations in an acute setting this finding may also relate to such areas as coronary care and Acute Stroke Units.

Current Position CHFT

- Data around DoLS is captured monthly and reports are shared at the Safeguarding Committee meeting. The CQC are notified of all DoLS authorisations and outcomes. This is in line with the requirements of the legislation. All patients who are subject to an urgent or standard authorisation are monitored by the Safeguarding Team.
- The MCA DoLS policy has noted the changes to the Policing and Crime Act 2017 to reflect this change in statute
- MCA and DoLS training has been implemented in September 2017 as part of the essential skill framework for staff.
- Progress is being made with more teams attempting to complete applications, although it is noted that not all areas are completing these, and further work is being undertaken to encourage areas and give them the confidence with making their own applications
- Continued work embedding knowledge and skills in all areas regarding MCA DoLS
- A significant key achievement was that the team delivered 17 face to face sessions this year to 455 members of staff.
- Delivery of a bespoke MCA DoLS training sessions at the Surgery and Anaesthetics Audit day to over 110 medical staff in March 2018.
- We hosted Hempson's solicitors to deliver two sessions on how the MHA/MCA and DoLS interface in the Acute Trust. This was to 108 members of staff.

Further work 2018-19

- To continue to support wards in completing their own DoLS applications
- Deliver bespoke training regarding MCA/DoLS and Mental Health to maternity services

MENTAL HEALTH

We have worked in partnership with SWYPFT in the last 12month with the approval of the service level agreement, clinical working protocol. As part of partnership working it has been agreed that the safe guarding lead for CHFT will attend the MHA committee within SWYPFT and the lead for MHA will attend the safeguarding committee for CHFT. Copies of all MHA committee papers are made available to the CHFT safeguarding lead.

The “Hospital Managers” for the purpose of MHA reviews all had personal annual reviews as required by MHA code of practice. These were undertaken by a Non-Executive within SWYPFT. All were re approved for a further 12 months.

Statistical information regarding the use of the MHA has been provided to safeguarding lead on a monthly basis. No issue have been raised regarding the use of the Mental Health Act within CHFT. The implementation of the MHA is fully supported within CHFT by the mental health liaison team.

The law commission review of the MCA/Dols has been reported via the SWYPFT MHA committee. The government response has been received and the majority of which has been accepted.

The MHA is currently under Government review and the appointed chair is Sir Simon Wessley. This is being monitored and reported via the SWYPFT MHA committee.

24 October 2017 a copy of the revised regulations relating to Sections 135 and 136 MHA 1983 together with Department of Health guidance was made available. The implementation date was or 11 December 2017. This implementation is currently being monitored on a 2 weekly basis via the West Yorkshire STP.

Further work 2018-19

- The Scheme of delegation under the MHA is currently in draft and to progress this policy.
- Review the MHA protocol in line with legislative changes in the Police and Crime Police and Crime Act 2017.This Act presented implications to the Mental Health Act 1983 and changes came into effect on 11 December 2017 to sections 135 and 136 of the Mental Health Act 1983.

SAFEGUARDING CHILDREN AND YOUNG PEOPLE

CHFT is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children - 2015,' section 11 of the Children Act 2004 and to joint working with both the Calderdale and Kirklees Safeguarding Children Boards. The Trust works within the West Yorkshire Safeguarding Children Policies and Procedures for the protection of children within Calderdale and Huddersfield, and its relevant polices are aligned and refer to these documents.

There are no current vacant posts within the children's safeguarding service.

The Named Nurse for Safeguarding Children (Community) has provided additional support to the work around supervision, bespoke training for staff in the Emergency Department, the successful implementation and ongoing development of safeguarding champions to facilitate safeguarding supervision and the introduction of a new safeguarding strategy.

Current Position 2017-18

- A significant piece of work has been completed by reviewing the Safeguarding Supervision Policy and the implementation of a supervision strategy developing new ways of working to ensure that all staff who require mandatory safeguarding children's supervision have been allocated this on their ESR. The team have utilised existing resources and structures to introduce this new way of working.
- CHFT Safeguarding Team work closely with the Safeguarding Children's Boards for Kirklees and Calderdale, Children's Services and the Clinical Commissioning Groups Designated Professionals for Safeguarding Children. They achieve this by delivering multi-agency training, by attending multi-agency meetings, Safeguarding Board subgroup meetings and undertaking pro-active multi-agency work to support the safeguarding Boards in devolving statutory Trust responsibities to ensure children and young people are kept safe.
- The Team represent the Trust at internal and external meetings, training events and case reviews/lessons learned reviews.
- The introduction and development of the Virtual Notice Board to deliver key safeguarding messages monthly Trust wide
- New intranet pages have been updated and developed as a resource for staff
- CP-IS was successfully implemented within Maternity on 19th February 2018 and Paediatrics on the 29th March 2018. Kirklees Local Authority went 'live' in January 2018 with CP-IS
- Flags are added to all patient records that relate to high risk Domestic Abuse (MARAC) , CSE, Child protection plans, looked after children and FGM. A flag is a tool for staff to use when presenting with a child or young person in a healthcare setting and helps identify vulnerability
- The Children Safeguarding Policy was reviewed and updated

Further work 2018-19

- Continue to embed and provide safeguarding supervision in line with CHFT supervision strategy
- To work closely with the Risk Department regarding requests for Court statements

Performance Data Children

The way data is now captured and presented has changed. All incidents that relate to children and young people are reported onto Datix and the number of referrals made to Children's social care are recorded on the safeguarding dashboard.

Further information is collected at the request of the Safeguarding Children Boards and shared on a quarterly basis. This information provided by CHFT informs the Safeguarding Children Boards and their subgroups of activity relating to attendances of children and young people in the Emergency Department. This data supports and informs partners and contributes to multi-agency working and safeguarding of vulnerable children and young people.

The team also support staff to provide court and police statements.

This data shows an increase in reporting of incidents. Further analysis regarding themes, patterns and trends will be reported on a quarterly basis to the Safeguarding Committee Meeting.

Incidents Reported on Datix	2016 - 2017	2017-2018
Child Safeguarding Concerns	55	52
Child Safeguarding Referrals	22	17
TOTAL	77	69

Referrals made to Children's Social Care by CHFT	2017-2018
Kirklees	29
Calderdale	29
TOTAL	58

Ongoing Challenges

The team are not assured that they are aware of all referrals made to children's social care when the thresholds of early intervention and safeguarding are met. The team continue to raise awareness of ensuring that the Safeguarding Children team have overview of all referrals made to children's social care by departments and ward areas though training, supervision and .

CHILD SEXUAL EXPLOITATION

From February 2017 there was a revised statutory definition of CSE.

'CSE is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'

Current Position 2017-18

- CHFT Children's & Adults safeguarding policy & domestic abuse policy reflects guidance re CSE
- We have an identified CSE Lead
- Young people at risk of CSE are flagged on the electronic patient record system.
- Training for staff in relation to CSE which is included in detail in level 3 safeguarding children training & specific safeguarding training for A&E staff. Learning disseminated from case reviews relating to CSE via CHFT learning & audit sub group & virtual noticeboard.
- CHFT contribute to the multiagency CSE hub meetings in both Kirklees & Calderdale by providing written reports containing relevant health information to share with partners.
- CHFT contribute to KSCB & CSCB operational CSE meeting & action plan
- CHFT have developed use of an under 18 safeguarding risk assessment proforma; which includes CSE, this is used in the Integrated Sexual health Service (ISHS), Maternity & Gynaecology services.
- Any pregnant young people identified as risk of CSE referred to multiagency Supporting Women in Antenatal Services (SWANS) Kirklees/ MAPLAG Calderdale meeting for risk assessment

Further work 2018-19

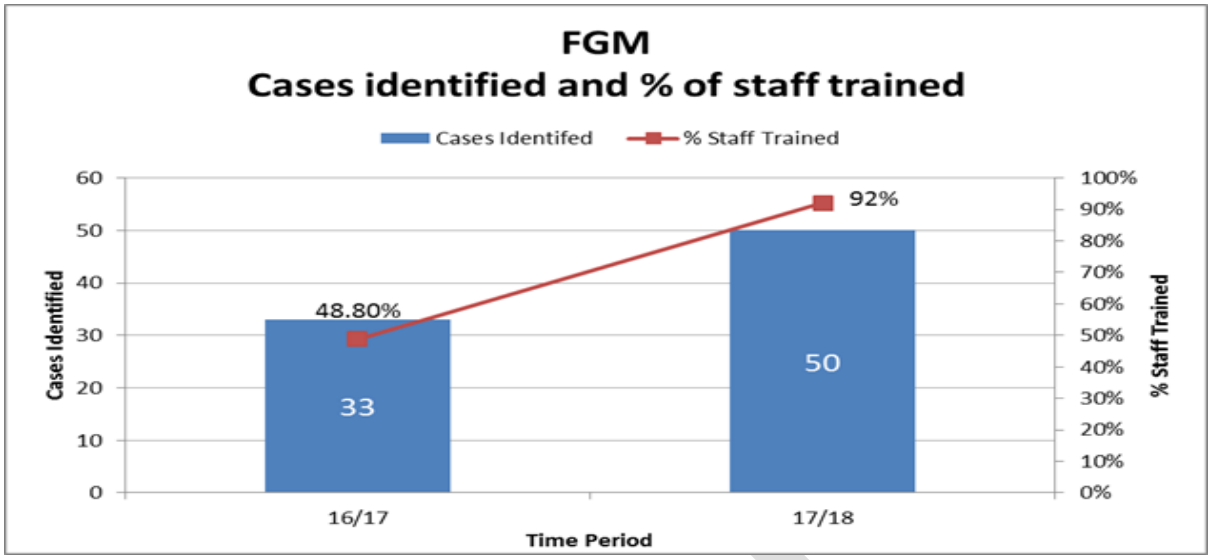
- In conjunction with National working group (NWG) to develop a national screening tool for use in healthcare, particularly the ED department
- Audit of CSE flagged records to ensure all contacts were appropriately actioned at the time of attendance

FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM) encompasses “All procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs, for non-therapeutic reasons.” FGM can have far reaching consequences for the physical, psychological and sexual health of those women and girls affected. It is a violation of their human rights, a form of child abuse and is illegal in the UK. With increasing international migration, the UK has become host to a large number of women affected by FGM. Research suggest 279,500 women and girls in the UK have undergone FGM and a further 22,000 girls are at risk of the procedure.

Current Position 2017-18

- We have an identified FGM Lead
- CHFT has an FGM guideline which includes a flow chart to support staff with enquiring and assessing the levels of risk in relation to FGM. Statutory FGM reporting is carried out and the numbers of cases are also reported internally through the Safeguarding Committee Meeting.
- FGM is routinely asked within maternity services
- Routine flagging of records if a mother identified as being a survivor of FGM
- From January 2017 FGM training became an essential skill for staff working in FSS, the Emergency Department, the Safeguarding Team, Health Visitors and the Integrated Sexual health Service. This training is also delivered in the levels of Safeguarding training for Children and Adults. Our training compliance has increased significantly this year by 43% to 92%
- The Named Midwife attends FGM task and finish groups for both Calderdale and Kirklees
- Mandatory reporting of all cases of FGM is embedded within CHFT; reported quarterly to the DoH and monthly at the safeguarding committee meeting
- We have included FGM training in safeguarding training also
- The safeguarding team have developed an under 18 safeguarding risk assessment proforma that was initially developed and used in Integrated Sexual Health Service (ISHS) which includes FGM. This has now been adapted for use in the Gynaecology assessment unit and is to be embedded into practice throughout maternity services. This was seen as good practice when CQC visited in January 2018.
- This is to assess the risk of any females under 18 that may present as a survivor or at risk of FGM. If a woman is identified as a survivor of FGM during pregnancy, the women are reviewed by the obstetric team and a data collection form is completed. Leaflets and information is provided to identify families of FGM cases. This is given to survivors of FGM and staff to raise awareness.



**This data shows the increase in awareness of staff regarding FGM due to the newly introduced eLearning training in January 2017; there is a rise in the number of referrals made compared to 2016-17.*

Further work 2018-19

- Roll out the use of the FGM risk assessment tool
- Update the FGM guideline to reflect the new risk assessment
- Development of the Maternity FGM guideline for all Trust areas

DOMESTIC ABUSE

The Domestic Abuse agenda continues to be a significant agenda for the Trust and a number of initiatives have been implemented.

CHFT has submitted a self-assessment for the Domestic Violence and Abuse Quality Mark. This standard promotes consistent and high quality service provision to women, children and men affected by domestic violence and abuse. This assessment reflects CHFT's own practice and to identify what steps we need to take to demonstrate we can achieve the standards. The West Yorkshire Domestic Violence Quality Mark, developed in 2017, has been adapted from the Safer Leeds Domestic Violence Quality Mark, created in 2005.

Our self-assessment and supporting documentation was submitted at the end of January 2018. We are currently waiting to hear the outcome of this.

CHFT hosts the Calderdale Commissioned Domestic Abuse (DA) Health Service which is located in Calderdale Domestic Abuse Hub in the Police station. Being a part of this service enables us to lead in our development and support of staff.

The DA Health Service is part of the CHFT Safeguarding team. This is a team of safeguarding adult and children named nurses who also promote and support the agenda of DA across all divisions in the trust. The safeguarding team are all highly trained professionals who all have a background/working practice of domestic abuse and working with adults/children who have experienced DA.

The Specialist Advisor for DA supports the DA Hub operationally on behalf of health services. The DA Lead role supports Occupational Health and managers of staff who are victims/perpetrators of DA e.g. safety management plans. The role leads on policy and procedures and represents the Trust at strategic and operational multi-agency meetings specific to DA. Maternity Services have a full time Specialist Midwife for domestic abuse. The role includes: case-loading highest risk pregnant women, clinical supervision with generic community midwives who have women on their caseload subject to DA, facilitation of training, awareness raising, maternity Guideline/pathway/policy development, attendance at MARAC (Kirklees only) representation for pregnant women disclosing DA.

HRI has benefitted from a hospital based Independent Domestic Violence Advocate (IDVA) working alongside the DA lead in facilitating training and embedding the IDVA role in ED and maternity services

The service provides health information from all multi-agency partners in order to manage high and medium risk incidents in cases of Domestic Abuse. The health information is on behalf of all health agencies in Calderdale and actions are then shared out to the appropriate health professionals involved in order to reduce duplication, allow a more coordinated approach and early identification of any unmet health needs.

Number of CHFT Referrals	2015 -2016	2016 - 2017	2017-18
To MARAC	27	37 (Kirklees) 60 (Calderdale)	61 (Kirklees) 59 (Calderdale)
TOTAL	27	97	120

**There has been an increase of 37 referrals this year across both Local areas. Kirklees has seen a steady increase in referrals from ED which is believed to be due to the promotion of the Domestic Abuse Pathways by the Hospital IDVA who is based at HRI.*

By Department	2015 -2016	2016 - 2017	2017-18
Emergency Department	19	48	85
Maternity		9	25
Community	8	3	10

This data is for CHFT referrals only and does not include referrals made by GP's, SWYFT or LOCALA. Huddersfield Royal Infirmary referrals data has only been collected since May 2016.

There is a dedicated worker from Pennine Domestic Violence Group who works into HRI Emergency Department providing twice weekly drop in sessions to collect referrals, support staff and raise the awareness of CHFT DA pathway and referral system.

The data evidences that as awareness is raised there is an increase in the identification of DA and referrals that are made. It is anticipated these figures will continue to increase as awareness improves across all health providers.

Number of Datix Alerts	2014-2015	2015-2016	2016-2017	2017-2018
Domestic Abuse/violence	4	6	22	28

**This is Gwen Clyde-Evans receiving her Star award from Owen at the Police Station in Halifax with members of the DA Hub for her contribution to the development of the Hub in Calderdale.*

** Gwen also received a District Chief Superintendents commendation.*

Ongoing risks/challenges

- The ongoing stability of the DA Commissioned Health Role in the DA Hub (Calderdale) remains uncertain. A report was presented to the Safeguarding Committee meeting on the 12th July 2017 which outlined the cost savings of the DA Health Role with a view to continued funding on behalf of the Health Partnership.
    - Before accessing specialist domestic abuse support each hospital victim costs an average of £4,500 per year to hospital, community and mental health services (Safe Lives 2016).
    - In 2016 there were 135 hospital victims which cost £607,500
    - By contributing to the DA Hub with a dedicated health team and using the principles of the IRIS model by establishing integrated pathways and specialist training for health professionals the principle is to engage victims in specialist support as early as possible, thereby reducing the likelihood of further incidents (and ongoing emotional, societal and financial costs)
    - In estimating savings an outcome of the work of the DA Health team specifically relates to reduction in visits to ED as a result of earlier engagement.

Since April 2016 to May 2017 the role of the DA health team in the Hub has led to:

- An additional 70 referrals from CHFT to the Hub (60 ED, Health Visiting, maternity and Surgical Ward) when compared to the previous year where a total was 19. So, the likelihood of a second visit to ED is reduced for 60 individuals. **Saving of at least £270,000 (60x £4,500).**
- 10 referrals from other health services that have previously never referred to MARAC before – Insight health care, GP's, Mental health Liaison, psychology. DA is less likely to escalate for these individuals; making a visit to ED less likely. **Saving of £45,000 (10x £4,500). This does not take into account possible savings from other health services.**

- There is a review with CCG colleagues regarding the ongoing stability of the DA hub service and how this service will continue without agreed commissioning arrangements and the risk in maintaining this service and local authority are in place to agree next steps.

Future Plans 2018-19

- Commissioning of DA Hub health service for the future 2018-19 remains uncertain. It is certain that by not having this health service there will need to be a review of how across the health partnership contributes into the Hub on a daily basis. There is a review with CCG colleagues regarding the ongoing stability of the DA Hub. We have mitigated this risk until August 2018

CHILDREN LOOKED AFTER TEAM CALDERDALE

Our Children Looked After Health Team are based at Brighouse Health Centre and are the CHFT commissioned service who work in partnership with Calderdale Metropolitan Borough Council (CMBC) to ensure that the health needs of looked after children (LAC) and young people in Calderdale are addressed. The health team provides advice and support to health and social care practitioners in order to improve health outcomes for looked after children and young people. A Looked after Child is subject to a care order (placed into care of local authorities by order of a court) and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live within foster homes, residential placements or with family members (connected carer's).

A Care Leaver is a young person who has been looked after for at least 13 weeks since the age of 14, and who was in care on their 16th birthday. This definition has been extended following the introduction of The Children and Social Work Act which received Royal Assent on 27th April 2017.The Act includes provision about: Extension of local authority support to Care Leavers to age 25, including provision of Personal Advisers, assessment of the needs of former relevant children and preparation of a Pathway Plan;

Following the CQC Children Looked After inspection in April 2016; the following recommendations were made;

- Review the staffing in the children looked-after team to ensure resources are in place to deliver the commissioned service that should be afforded to all children looked-after placed in Calderdale.
- Ensure that care leavers receive timely health passports and information to help them prepare for adulthood and are well supported in line with the service specification.

Despite recommendations being made by CQC to address the issues, progress has been limited on aspects of the CQC action plan, which resulted in entries being made to the CHFT risk register.

Progress toward CQC recommendations:

- The CLA health service specification has been rewritten and signed off by contracting and commissioning leads with an agreed reconfiguration of the service.
- Funding for the Designated Nurse CLA based in CHFT will be converted to fund 1.3 WTE specialist nurse posts with the Designated Nurse role being held by the Designated Nurse for Safeguarding Children (CCG)

- Public Health commissioner has secured agreement from Locala for initial short term and concurrent longer term secondments into the CLA health service.

Future challenges:

- Interface between operational and designated post holder to facilitate performance monitoring and service development.
- Day to day performance management of the service – Escalation process
- Supervision and line management of non CHFT workforce
- Embedding new staff members into the service in a short timeframe without disturbing the performance of the service
- Continued funding of Care Leaver passports by CMBC
- Securing larger room space at Brighouse Health Centre to accommodate new staff members

To note a separate Children Looked After report will be presented in more detail to the Board.

LOOKED AFTER CHILDREN IN KIRKLEES

The Looked After Children's Health Team covers the whole of Kirklees not just the Huddersfield area. The Designated Doctor and Medical Advisers are based at Huddersfield Royal Infirmary and the Designated Nurse and Specialist LAC nurses are employed by Locala but based within Children's Social Care at Civic Centre 1 with access to Social Care's IT system. During the last year funding was secured from the CCGs for an additional part-time nursing post.

Looked after children health services in Kirklees perform well in meeting the required timescales set out in statutory guidance.

For 2017-18 98% of initial health assessments (IHA) were undertaken within the statutory 20 day timescale against a target (given by the CCGs) of 95%, whilst 95% of review health assessments (RHA) have been undertaken within the required timescale. There are delays in RHAs for children placed out-of-area with only 71% being completed within timescales as we are reliant on other organisations giving priority to this work. Significant efforts are made to forecast any risks and track delays to out-of-area reviews taking place to help ensure children receive the levels of support they need irrespective of where they are placed and children placed within the surrounding area are seen by the Kirklees LAC nurses for their RHAs.

The Kirklees LAC Health Team had their Children Looked After and Safeguarding CQC Inspection in January 2018. A draft report has been received and an Action Plan is being developed.

Progress

In addition to carrying out more review health assessments for children placed out of area the extra nursing time for the team has allowed:-

- Dedicated weekly nurse time at the Social Care No. 11 Drop in
- Care leavers letter completed in a timely fashion
- Teenage pregnancy spreadsheet developed to collate information

- Attendance at Personal Advisors meetings to advise and build relationships
- Development of 'Coping with Crying' resource for carers

There was a pilot study of the 'We value your opinion' questionnaire with young people from the LAC and Care Leaver's service. 129 questionnaires were returned and the information received has been analysed. The young people are now completing their own SDQ forms to input their opinions of their mental health to their annual health assessment. Some positive ideas were put forward to improve communication.

Priorities for 2018-19

- These will be largely based on the CQC Action Plan

A separate Looked After Children Report for Kirklees will be presented to the Board with information about progress against priorities and new priorities for 2018-19.

TRAINING

As outlined within the safeguarding training strategy for CHFT, the Trust undertakes to support and contribute to training health professionals/ workers who come into contact with children to ensure they attain competencies appropriate to their role. The Trust also supports staff to attend the multi-agency training provided by the local safeguarding boards and external agencies.

A significant piece of work has taken place to review all staff groups within CHFT this year that require mandatory safeguarding children and adults training. This was completed in Q1 and re-reviewed in Q3. This involved ensuring that all staff groups were reviewed in line with the Intercollegiate Document for Safeguarding Children and the Draft Intercollegiate Document for Safeguarding Adults.

These new figures and compliance reflect the increased numbers of staff that are required to complete a higher level of training.

	28.03.2017			01.12.2017			05.04.2018			Compliance	Compliance
	Sum of Eligible	Sum of Compliant	% Compliance	Sum of Eligible	Sum of Compliant	% Compliance	Sum of Eligible	Sum of Compliant	% Compliance	increase in 3 months	increase in 12 months
Female Genital Mutilation	730	353	48.36%	550	403	73.27%	492	454	92.28%	19.00%	43.92%
Prevent WRAP - No Renewal	5899	4386	74.35%	4745	3724	78.48%	4527	3852	85.09%	6.61%	10.74%
Mental Capacity Act - 3 Years				455	189	41.54%	445	323	72.58%	31.05%	72.58%
Mental Capacity Act Level 2 - 3 Years				3279	2696	82.22%	3089	2911	94.24%	12.02%	94.24%
Mental Capacity Act Level 3 - 3 Years				734	343	46.73%	688	528	76.74%	30.01%	76.74%
Safeguarding Adults - Level 1 - 3 Years	1454	1257	86.45%	1560	1466	93.97%	1602	1589	99.19%	5.21%	12.74%
Safeguarding Adults Level 2 - 3 Years	3637	2702	74.29%	3635	2958	81.38%	3444	3257	94.57%	13.19%	20.28%
Safeguarding Adults Level 3 - 3 Years	529	216	40.83%	596	374	62.75%	572	437	76.40%	13.65%	35.57%
Safeguarding Children - Level 1 - 3 Years	1455	1259	86.53%	1560	1466	93.97%	1602	1589	99.19%	5.21%	12.66%
Safeguarding Children Level 2 - 3 Years	3837	2894	75.42%	3741	3108	83.08%	3547	3377	95.21%	12.13%	19.78%
Safeguarding Children Level 3 - 3 Years	603	418	69.32%	574	453	78.92%	543	483	88.95%	10.03%	19.63%

Trust targets are met for level 1 and level 2 Children's safeguarding training.

We are very close to meeting 95% compliance in FGM, adult's level 2 and Children's level 3 training.

Prevent has met NHSE target of 85% by the end of March 2018

MCA DoLS and Adult Safeguarding Level 3 have plans in place to ensure this trajectory is on track for 95 % compliance by the end of Quarter 2.

All training has shown significant growth and increase, mainly due to the commitment of trainers and successful engagement with Divisional Colleagues.

Further work 2018-19

- To deliver on the training strategy for MCA DoLS and Adult Safeguarding Level 3 to ensure this trajectory is on track for 95 % compliance by the end of Quarter 3, and deliver minimal training for quarter 4.
- To deliv
- To continue to encourage Divisions to complete training and consistently raise the profile of safeguarding training and delivery of 95% training compliance

SERIOUS CASE REVIEWS, SERIOUS ADULT REVIEWS and DOMESTIC HOMICIDE REVIEWES

Under Regulation 5 of The Children Act (2004), The Care Act (2014), and under Section 9 of the Domestic Violence and Victims Act (2004), statutory duties apply in cases of Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews.

The purposes of reviews enable Local Safeguarding Boards and Community Partnerships to fulfil their obligations under each of these Acts and for us as a partner agency to contribute to the carrying out of a review, identify any lessons to be learned and apply these lessons to future practice.

Each Act defines a slightly different obligation and review of a case in relation to adults, children and domestic homicides.

Key themes in each review enable services to look at establishing what lessons to be learned about how professionals/ agencies (individually and together), work to safeguard children and/or adults at risk; review the effectiveness of local safeguarding procedures (multi-agency and single agency) and inform and improve local inter-agency practice.

The Safeguarding Team have fulfilled partnership requests for information and contributed to a number of reviews that have been published and are ongoing.

CHFT Position

- The Trust participates fully in both the Serious Case Review process for children and the Serious Adult Review process. The Trust also works in partnership with Community Safety Partnerships in relation to the Domestic Homicide review process, which may include representation and participation by the Trust. We receive requests from both local authority areas and local authorities out of this area..
- The Trust is fully committed to identifying the learning with regards to safeguarding and review processes thus promoting the welfare of those who are vulnerable and to make changes that will improve practice, multi-agency working and outcomes.

- Any finalised overview reports and individual management reports are presented through the Trust and partner agency governance structure. The actions for the Trust are monitored through the Review and Incident Subgroup of the Safeguarding Committee meeting. Minutes of the group go to the Safeguarding committee meeting. There have been a total of 13 requests this year for information.

Cases for 2017/18

- **Serious Case Reviews**
  - There has been one new Serious Case Review's commissioned by the Local Safeguarding Children Board in Calderdale, and involvement in a Learning lessons review from out of area.
  - The Trust is currently involved in 4 cases from previous years at varying stages of progress.

- **Serious Adult Reviews**
  - There has been 2 new Serious Adult Reviews commissioned by the Local Safeguarding Adult Board in Calderdale.
  - The Trust are currently involved in 2 cases from previous years where action plans have been re-visited by the Safeguarding Board.

- **Domestic Homicide Reviews**
  - There have been no new DHR's commissioned locally.
  - The Trust is currently involved in 4 DHRs from previous years

AUDIT

A number of audits have taken place this last year. These are presented to the Safeguarding Committee for discussion and action.

- Statutory Section 11 (Children's Act 2004) audits have been undertaken and completed for both Calderdale and Kirklees Safeguarding Children's Board. The safeguarding team have contributed and been involved in the Section 11 Challenge event for Calderdale this year.
- A comprehensive audit schedule was presented at the Safeguarding Committee for approval and implementation through the Learning and Audit subgroup of the Committee .This framework and schedule will provide the group and the committee the assurance that systems and process are in place and any gaps and learning identified is implemented and reported on.

COMPLAINTS

All complaints are triaged and any complaints with a safeguarding aspect have this identified on the triage form and safeguarding staff are notified of these.
Learning this year has been the need to train the patient advice team further on recognising safeguarding issues raised through phone calls they receive and escalating immediately to a senior level.,

A monthly meeting takes place with the Governance and Risk team and Head of safeguarding. At this meeting active safeguarding cases / incidents / complaints / claims / inquests with safeguarding aspects are discussed in terms of next steps and ensuring

we all have an awareness of ongoing cases. There is discussion on individual cases with members of the team as needed through the year and the Legal Services team has helped in supporting obtaining statements for court proceedings when needed.

SERIOUS INCIDENTS

For serious incidents with a safeguarding aspect it is usual to seek a safeguarding expert view at draft report stage or as an assigned expert investigator working with the lead investigator. .

The Senior Risk Manager has reported to the Safeguarding Committee on serious incidents during the year. From February 2018 a sub group has been established to allow for more in-depth review of cases. Going forwards the Senior Risk Manager will share serious Incident reports and provide assurances on delivery of actions. Key highlights will continue to be notified on a monthly basis to the safeguarding committee which the Senior Risk manager is also a member of.

As part of a serious incident action plan; partnership training was facilitated by our Trust Solicitors Hempson's.

Further Work 2018-19

- We will continue to build on these links during 2018/19.

EXTERNAL REVIEW AND CHALLENGE EVENTS

- In January 2018 there was a review of health services for Children Looked-after and Safeguarding in Kirklees conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups. The CCG has received a draft inspection that is currently undergoing factual accuracy checks by all Health partners. This is likely to be published shortly and the Board will be updated as to progress regarding this.

- A similar review took place on 25 - 29 April 2016 for Calderdale. Progress is now being made on the Children's Looked After Action plan after securing additional resource and funding for this service which is hosted by CHFT. The outstanding action plans are now progressing. Individual action plans are monitored through the CCG arrangements with oversight from the Designated Nurse for Safeguarding Children.

Ofsted inspected Kirklees Children's Social Care in September and October 2016, focusing on local services for children in need of help and protection, looked after children and care leavers. The Independent Safeguarding Children Board was also inspected and an overall assessment of inadequate was made. Adoption performance and the experience and progress of care leavers were assessed as requiring improvement.

- The Department for Education approved the Children's Services Improvement Partnership between Kirklees Council and Leeds City Council. Senior managers from Leeds are working with Kirklees to deliver an agreed Ten Point Improvement Plan. This work is overseen by Eleanor Brazil through chairing the Children's Services Improvement Board, which includes senior

local politicians and senior managers from partner organisations within the Kirklees district.
- Kirklees Council are awaiting feedback from the latest Ofsted monitoring visit in April 2018

CHFT continues to support and attend the Safeguarding Children's Board and provide representation and membership to all of its subgroups to support in delivering the Safeguarding Children's Boards action plan.

INDEPENDENT INQUIRY INTO CHILD SEXUAL ABUSE (IICSA, FORMERLY THE GODDARD INQUIRY)

This Inquiry is the largest and most ambitious public inquiry ever established in the UK. Its purpose is to consider the extent to which all institutions in England and Wales have failed in their duty of care to protect children from sexual abuse and exploitation, and what steps they might take to stop that abuse in future. It has no cut-off date, and in this task enquiries may be made concerning events occurring many years or even decades ago. It is independent of Government and will allow victims and survivors to share their experiences privately and confidentially

Current information suggests that at least one child in every 20 has experienced sexual abuse, and there are likely to be many more instances that go unreported and uncounted. The Inquiry was set up to uncover and remedy failures that have led to this happening.

The Inquiry is headed by a Chair and supported by a three-strong Panel and a Victim and Survivors' Consultative Panel. The Inquiry is committed to delivering an outcome within a credible timeframe and expects to have made substantial progress by 2020. Interim reports will be published.
which will include tangible and achievable recommendations

The Inquiry's work is divided into three core projects:
- The Research Project: to capture the big picture and identify patterns of abuse
- The Public Hearings Project: to identify and examine case-studies of institutional failings
- The Truth Project: to enable victims and survivors to share their experience

The evidence received in all three projects will inform the overall conclusions and recommendations of the Inquiry.

There are four thematic strands that are the focus of the work and recommendations:

- Cultural: examining the attitudes, behaviours and values within institutions that prevent us from stopping child sexual abuse
- Structural: looking at the legislative, governance and organisational frameworks within and between institutions
- Financial: considering the financial, funding and resource arrangements for relevant institutions and services
- Professional and political: focusing on the leadership, professional and practice issues for those working or volunteering in relevant institutions

In January 2018 the Inquiry launched an awareness campaign across England and Wales to publicise **the Truth Project**, with an aim is to ensure that victims and survivors of child sexual abuse are aware of the Truth Project and have the opportunity to speak to the Inquiry if they wish. A national awareness raising campaign has used billboards, radio commercials, and print advertisements in national and regional newspapers and social media to ensure victims and survivors are aware of it. Anyone who was sexually abused as a child where there was an institutional failure can report their accounts in a safe, private, confidential environment. This includes anyone who reported their sexual abuse to a person in authority, where the report was not properly acted upon.

Our response to this project is that we are obtaining electronic information to support in raising awareness and developing a site on our intranet page where these materials are stored. Our monthly virtual notice board will help raise the awareness of the campaign and during safeguarding week in June this year we will continue to promote this campaign.

Current position of CHFT

- All safeguarding policies and procedures have been reviewed to ensure they are compliant with best practice and in line with legislation.
- We attended a stakeholder event in October 2017
- We promoted this during our last Safeguarding Week in October 2017 through posters and leaflets at our hospital stall.
- We have reviewed the IICSA directive regarding the destruction and retention of identified documents and this is embedded in our Records Management Policy.

OUR KEY ACHIEVEMENTS 2017-18

a) Continued compliance with the Mental Health Act (1983), improved data capturing of patients who are sectioned under the Act. Joint workings with SWYPFT to ensure systems are robust.
b) Planned training for Duty Matrons and Site Commanders on the receipt and scrutiny of Mental Health Act papers, and understanding the role of security and use of restrictive interventions to enable appropriate detention of patients under the Act.
c) Continued work embedding knowledge and skills in all areas regarding MCA and DoLS
d) Ensuring scrutiny of all referrals made by CHFT staff to Children's Social Care – work continues through training and supervision
e) Continued work and challenge to ensure robust Children and Adults data collection
f) Development and implementation of a CSE risk assessment in the Emergency Department and work towards roll out throughout the trust. This work is carried over to 2018-19
g) Further work and embedding of monitoring of training for junior medical staff
h) Update of the Supervision policy and Trust wide supervision strategy with recording of supervision on ESR completed.
i) Improved capture of adult safeguarding referrals and concerns via the Datix reporting system when these relate to other providers
j) Improved collaboration with Social Services colleagues, both referrals relating to CHFT care to ensure that learning is shared as widely as possible and development needs can be followed up through the safeguarding subgroups and referrals relating

to the care of other providers to obtain feedback on the appropriateness of our referrals

k) We have worked closely and continue to work with the Risk Department and social services colleagues in Calderdale and Kirklees where orange and red incidents are of a safeguarding concern.
l) Safeguarding Champions have been identified throughout the organisation and part of this role will require them to be trained to facilitate safeguarding supervision in line with their staff requirements to help improve compliance. Training has been delivered in January and March and 42 Champions are trained to date with a further date arranged for 23.5.17.
m) Update of the Adult Safeguarding Policy and development of a separate MCA DoLS Policy
n) Development of a Safeguarding Dashboard that is aligned to the Safeguarding Strategy
o) Further audits were carried out on the Adult Safeguarding Policy and two audits on MCA DoLS Trust wide audit in relation to Adults.
p) The Safeguarding team were involved in Safeguarding Week in October 2017
q) The FGM guideline is being reviewed and updated to include Department of Health recommendations regarding risk assessments.
r) Development of a CSE Risk Assessment for the Emergency Department and completion of the CSE action plan
s) Active support to Kirklees children's services improvement plan
t) To ensure that following go live with EPR the system continues to support statutory and regulatory compliance.
u) To review the risk associated if the DV Hub funding is not continued.
v) Implemented MCA DoLS training as part of the Essential Skills Framework for the Trust and this is now being delivered at 3 separate levels of training. Level 1 and 2 are eLearning; Level 3 is a classroom session.
w) Hosted a Trust wide event – Mental Capacity and Mental Health in the Acute Setting which concentrated on the similarities and differences between the MCA and the MHA. This event was attended by other partner agencies such as the Police, SWYPFT and social care.
x) Delivered awareness around the 'See me and Care Campaign' at CHFT Compassionate care in Practice Nursing and Midwifery Conference in September 2017. We continue to raise this as part of the Safeguarding Adults Level 3 training.
y) A team member has won the CHFT Star award for their innovative practice and contribution in setting up the Domestic Abuse Hub in Calderdale. Recognition was also made by the member of staff receiving a District Chief Superintendent Commendation Award for this contribution
z) We have developed and implemented a Trust wide Network of Safeguarding Champions within ward and department areas, and hold regular meetings with our Champions
aa) We have significantly improved our Safeguarding training and Prevent Health Wrap training compliance at all levels.
bb) We reviewed our training and ensured that NICE guidance Domestic Abuse training as part of all levels of Safeguarding training and have delivered bespoke training to Departments within the Trust

cc) Developed a monthly virtual newsletter that is circulated Trust Wide to all staff that delivers key messages and safeguarding new
dd) Developed new intranet pages with key information and resources
ee) Promoted and implemented specific FGM training

OUR SAFEGUARDING STRATEGY 2018-2019

In line with the Trust 5 year strategy to deliver outstanding compassionate care to the communities we serve, as a safeguarding team we put the patient first, we go see, we do the must dos and we work together to get results.
We will continue to implement and organisational approach to safeguarding and promoting the welfare of children, young people and adults ensuring that this is embedded across all divisions and services provided by the Trust and in every aspect of the Trust's work.

There will be robust governance arrangements around the safeguarding agenda and staff working within CHFT will be able to discharge their statutory responsibities within their professional boundaries supported by the Integrated Safeguarding team.

This will work towards the Trusts overall goals of: Transforming and Improving Patient Care, Keeping the Base Safe, A workforce for the Future and Financial Sustainability.

Our key Priorities for this year are:
Prevent

- To review the Prevent Policy in September 2018.
- Complete an annual audit of any incidents (2017-18) relating to risks of radicalisation
- Promotion of the eLearning training package on ESR with Divisional support to meet the Trust target of 95%.

Adult Safeguarding

- To review the Allegations Policy to include new PIPOT (Persons in a Position of Trust) Guidance issued by the Safeguarding Adults Board. The revised Care Act 2014 in 2016 removed the Designated Adult Safeguarding Manager role (DASM) and was replaces with a new section on allegations management.
- Review the Adult Safeguarding Policy in line with the updated Multi-agency Adult safeguarding procedures in quarter 1.
- To continue to embed 'Making Safeguarding Personal' and work with partners to put patients at the heart of what we by embedding this culture, and to work with adult social care and gain assurance that referrers are given feedback from concerns raised
- To ensure learning from incidents is embedded through the incident and review group
- Continue to develop systems that are lean and accessible for staff at times of high demand and impact.
- To arrange and further training in relation to Missing Persons Policy with Police partner and audit against policy
- We can probably anticipate that referrals relating to pressure ulcers may increase over the next 12 months with more consistent reporting due to the new guidance. More work is needed to get the same level of consistency in relation to falls

reporting.
- Further analysis and reporting will be developed over the next 12 months to aim to report on outcomes more consistently as indicated in the Making Safeguarding Personal Agenda

Pressure Ulcers
- Progress and embed the use of the decision tool at orange panel meetings and evaluate its effectiveness through the safeguarding committee meeting

Mental Capacity Act and DoLS
- To continue to support wards in completing their own DoLS applications
- Deliver bespoke training regarding MCA to maternity services

Mental health
- The Scheme of delegation under the MHA is currently in DRAFT to progress this policy.
- Review the MHA protocol in line with legislative changes in the Police and Crime Police and Crime Act 2017.This Act presented implications to the Mental Health Act 1983 and changes came into effect on 11 December 2017 to sections 135 and 136 of the Mental Health Act 1983.

Safeguarding Children
- Continue to embed and provide safeguarding supervision in line with CHFT supervision strategy
- To work closely with the Risk Department regarding requests for Court statements

Child Sexual Exploitation
- In conjunction with National working group (NWG) to develop a national screening tool for use in healthcare, particularly the ED department
- Audit of CSE flagged records to ensure all contacts were appropriately actioned at the time of attendance

FGM
- Roll out the use of the FGM risk assessment tool
- Update the FGM guideline to reflect the new risk assessment
- Development of the Maternity FGM guideline for all Trust areas

Training
- MCA DoLS and Adult Safeguarding Level 3 have plans in place to ensure this trajectory is on track for 95 % compliance by the end of Quarter 2.
- To continue to encourage Divisions to complete training and consistently raise the profile of safeguarding training and delivery of 95% training compliance

Serious Incidents
- Continue to build links with Risk and safeguarding

CONCLUSION

The Safeguarding Annual report demonstrates that safeguarding children, young people, families and vulnerable adults remains a Trust key priority. It demonstrates that CHFT is meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework.
The Trust has responded to these changes and to ensure that everyone is aware of their own individual responsibilities as part of a wider multi-agency partnership arrangement.

Whilst significant progress and achievements have been made in all the key safeguarding agenda's detailed in this report, the team have prioritised and identified the key strategic developments required for 2018-19. These may change in line with other Trust priorities and the wider partnership priorities.

Our key underpinning message is that Safeguarding is everybody's responsibility regardless of their role within the Trust.

Calderdale and Huddersfield NHS Foundation Trust

Safeguarding Annual Report

2017-2018

Foreword

Calderdale and Huddersfield NHS Foundation Trust, is committed to ensure that safeguarding its patients, staff and the wider community is given the highest priority in all that the Trust does. All safeguarding work across the Trust is underpinned by the Trust values by demonstrating our behaviours, known as our four pillars; putting patient's first, we go see, we do the must-dos and we work together to get results.

CHFT is committed to ensuring that safeguarding is part of its core business and recognises that safeguarding children, young people and adults is a shared responsibility and is seen as everyone's business. Effective multiagency partnership working across the Districts of Kirklees and Calderdale ensures that the most vulnerable of our society are protected from harm. We work closely to protect individual human rights, treat individuals with dignity and respect and safeguard from all forms of abuse and neglect.

During this challenging time for all NHS Trusts we have used our existing resources to safeguard those most vulnerable in society and are creating a culture of safeguarding as part of our core business.

Contents

INTRODUCTION

Safeguarding is a statutory responsibility of all NHS organisations as detailed under the Care Act (2014), and the Children Act (1989/2004). Legislation and guidance is built upon the principle that the welfare of the most vulnerable in our society is paramount and that all statutory services consider and promote the needs of children, families and adults at risk.

This is a combined children and adults report that describes all areas of safeguarding activity. The report describes how the Children and Adults team work together across the Trust and demonstrates to the Trust Board and external agencies how Calderdale and Huddersfield NHS Foundation Trust discharges its statutory duties in relation to:

- Registration standards, Health and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13.
- CQC national standards of quality and safety - Outcomes 7-11: Essential standards of quality and safety.
- The Children Act (1989).
- The Sexual Offences Act (2003)
- Children Act (2004) - Statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11.
- Care Act (2014)
- "Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework"
- Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document (2014).
- Working Together to Safeguard Children (2015).
- The Mental Capacity Act (2005) and Deprivation of Liberty safeguards amendment in 2007.

The 2017- 2018 Annual report is the 5th Annual report and provides the Trust Board with an overview of the national and local context of safeguarding and areas of practice included in safeguarding within the Trust. The report will show performance activity and inform the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks, and how these are mitigated. The Safeguarding strategy as part of this report will describe priorities for 2018-19.

GOVERNANCE ARRANGEMENTS

The Executive Lead for Safeguarding Children and Adults is the Chief Nurse. The Chief Nurse is responsible for ensuring that there are robust and effective arrangements for safeguarding adults and children within CHFT. This responsibility is delegated to the Deputy Chief Nurse.

The Head of Safeguarding provides strategic support and direction to the governance and safeguarding arrangements within CHFT, and for ensuring systems and processes are robust and effective. The Head of Safeguarding is responsible for key safeguarding staff and reports directly to the Deputy Chief Nurse. CHFT is represented at the Local Safeguarding Adults and Children's Boards for both Calderdale and Kirklees. CHFT has active Local Safeguarding Board membership and attendance at the Domestic Abuse Boards for both Calderdale and Kirklees Local Authorities. Designated Doctors employed by CHFT attend the Local Safeguarding Children Boards as part of their Designated role. The Trust attends the Local Child Death overview panel meetings with representation from the SUDIC Paediatrician and midwifery service.

Named and Designated Safeguarding Nurses along with the Matron for Learning Disability attend the sub-groups of the local Safeguarding Boards and contribute to multi-agency collaboration and partnership working.

The key functions of the Local Safeguarding Boards are to develop and publish a strategic plan about how members and partners contribute, publish an annual report of the effectiveness of the Board, and commission SARs for any cases that meet the criteria.

The Safeguarding Team links closely with other key departments such as Risk and Governance, Human Resources, and also Patient Safety and Quality Boards within Divisions.

The Safeguarding Committee reports directly to the Quality Committee and provides twice yearly updates. This has raised the profile and accountability of safeguarding within the Trust and ensures lines of accountability are aligned within the Trusts Governance Structure and directly with the Trust Board.

Operationally the Safeguarding Committee has in place 3 sub-groups, Learning and Audit, Training and Policy, and Incident and Review Subgroup. Safeguarding Subgroups provide a forum to bring together key senior professional and operational managers. Within the subgroups the terms of reference describe accountability for reporting, escalating and assurance. Each subgroup will communicate with the other where there are shared agendas. The individual Groups report directly to the Safeguarding Committee and support

the Chief Nurse in discharging their responsibilities in relation to safeguarding and strengthening accountability.

All statutory posts for Named Nurses for Children, Looked After children, Adults, Midwifery and the Named Doctor are in place and have been throughout the year.

CHFT hosts two Designated Doctors for Safeguarding Children, two Designated Doctors for Looked After Children and a Designated and Named Nurse for Looked After Children for Calderdale. The Designated Nurse for Kirklees is employed by Locala. These roles are directly commissioned through the Clinical Commissioning Group (CCG).

The safeguarding team play a pivotal role in supporting colleagues in carrying out their safeguarding responsibilities. Work has continued with other partner agencies across Kirklees and Calderdale to ensure CHFT is discharging its statutory responsibilities.

PREVENT

The Counter-Terrorism and Security Act 2015 places a duty on CHFT to have; 'due regard to the need to prevent people from being drawn into terrorism.'

CONTEST, is the UK national counter-terrorism strategy, and one of the elements of it is Prevent, which aims to stop people becoming terrorists or supporting terrorism. The NHS is a key strategic partner in the PREVENT work stream, as it is recognised that healthcare professionals may meet and treat people who are vulnerable to radicalisation.

The Act with relevance to PREVENT includes a duty on specified bodies, including the police, prisons, local authorities, schools, universities and health, to have due regard to preventing people being drawn into terrorism. It also makes Channel (the voluntary programme for people at risk of radicalisation) a legal requirement for public bodies so that it is delivered consistently across the country.

The Statutory guidance issued under section 29 of the Counter-Terrorism and Security Act 2015 became statute on 1 July 2015. The Counter-terrorism strategy has several strands:

- Pursue - to disrupt terrorist activity and stop attacks;
- Prevent - to stop people becoming or supporting violent extremists and build safer and stronger communities;
- Protect - strengthening the UK's infrastructure to stop or increase resilience to any possible attack;
- Prepare - should an attack occur then ensure prompt response and lessen the impact of the attack.

PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence. The overall principle of agencies including health providers is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation.

PREVENT has 3 national objectives:

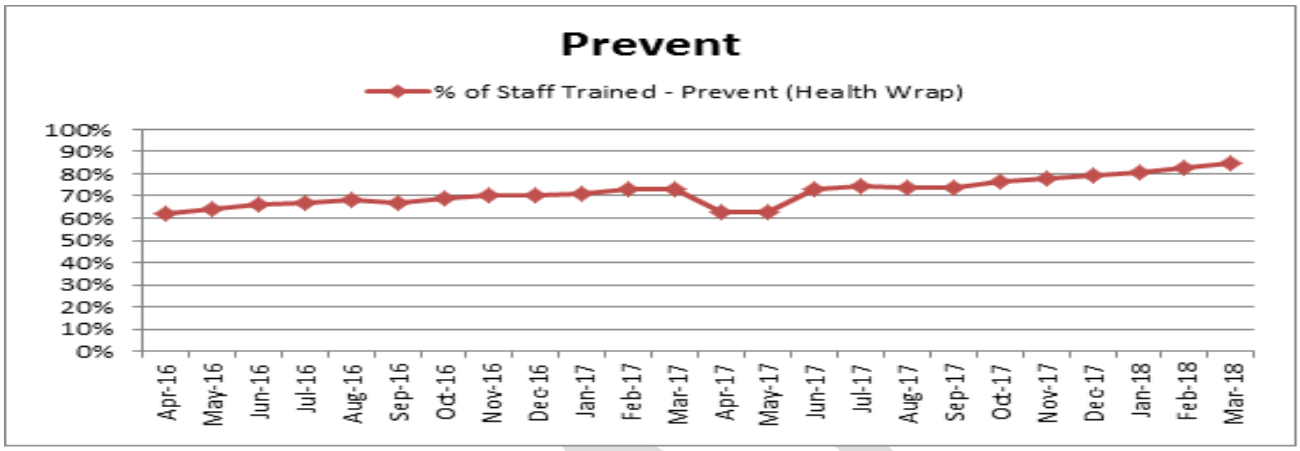
- Objective 1: respond to the ideological challenge of terrorism and the threat we face from those who promote it.
- Objective 2: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
- Objective 3: work with sectors and institutions where there are risks of radicalisation which we need to address.

This duty is incorporated into the NHS Standard Contract 2017-19, and the National Variation Agreement.

Current position of CHFT

- CHFT's Prevent Policy describes how the Prevent Strategy is implemented in CHFT.
- CHFT Prevent Lead is the Named Nurse for Safeguarding Adults, who is supported by the Head of Safeguarding. Both act as points of contact for Regional Prevent Coordinators. These two roles work in partnership to comply with the reporting requirements to NHSE. On a quarterly basis, data is requested and submitted to the Regional Prevent Coordinator (NHS England) of Prevent activities undertaken by the Trust which includes training figures.
- The Trust Safeguarding Committee receives an quarterly update regarding Prevent
- CHFT safeguarding team provides representation at Channel panels within the local Districts.
- PREVENT training compliance is monitored monthly at the safeguarding committee meeting and quarterly updates are submitted to the Regional Prevent Coordinator for Health (NHS England).
- In line with the Prevent Training Competencies Framework 2017 developed in order to meet the Prevent Duty and ensure a consistent approach to training Prevent training is delivered at level 1 and Level 3.
    - CHFT delivers Level 1 Prevent training as part of adult safeguarding level 1 mandatory eLearning training and is repeated every 3 years.
    - The Home Office Workshop to raise awareness about Prevent (WRAP) training (level 3) has been delivered as a classroom session during 2017/18. Ensuring staff complete this training has been delivered successfully over a 3 year period by Wrap facilitators registered with NHS England and the Home Office by a Trust team of facilitators.
    - The Trust has seen an increase of over 10% since last March and the overall Trust target is 95% with an NHS England target of 85% by March 2018. We have met our NHSE target of 85% by the end of March 2018. This was primarily due to a pro-active approach and continued engagement with committed trainers.
    - CHFT is considered an exemplar site in relation to the number of staff trained. This has been confirmed by the NHS Regional Prevent Coordinator.

**The graph below shows an increase year on year from August 2016 to March 2018 in achieving this 85% target. There is no comparator data available.*



Further work in 2017-18

- To review the Prevent Policy in September 2018.
- Complete an annual audit of any incidents (2017-18) relating to risks of radicalisation
- Promotion of the eLearning training package on ESR with Divisional support to meet the Trust target of 95%.

Calderdale Safeguarding Adults Board

Kirklees Safeguarding Adults Board — Partners in preventing abuse and neglect

ADULT SAFEGUARDING

Following the introduction of the Care Act (2014) adult safeguarding has been on a statutory footing since April 2015. To meet our statutory, regulatory, contractual and Safeguarding Board requirements and obligations there are robust governance arrangements, policies and procedures, and support mechanisms in place to ensure these requirements are met.

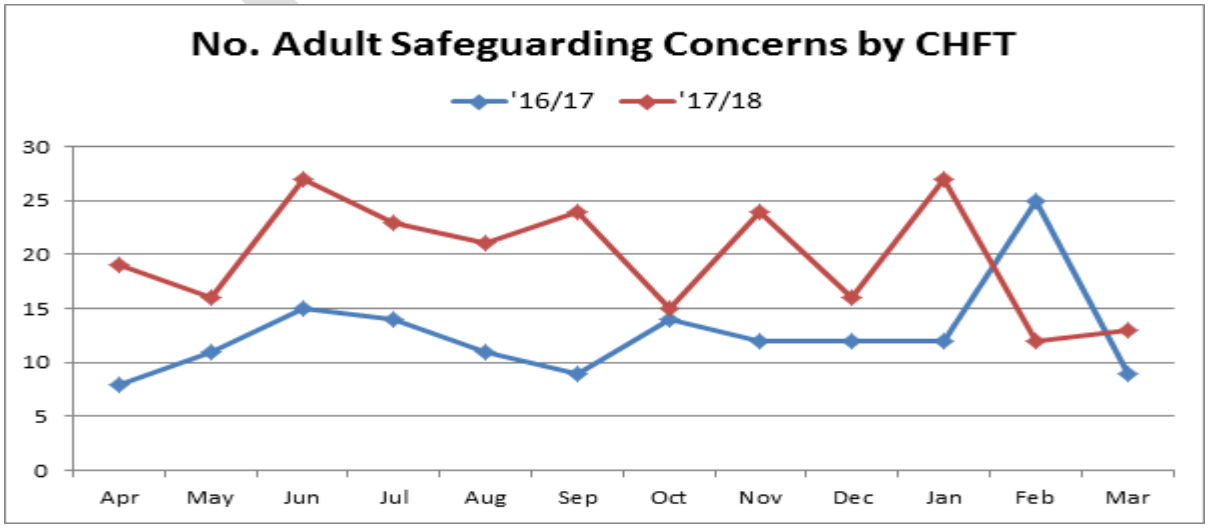
The team is the single point of contact for advice and support for all adult safeguarding concerns. A Named Lead and specialist advisor are in post and the safeguarding adults' staff continue to provide advice and practical support for a wide range of safeguarding issues relating to adults who may be at risk of abuse or neglect.

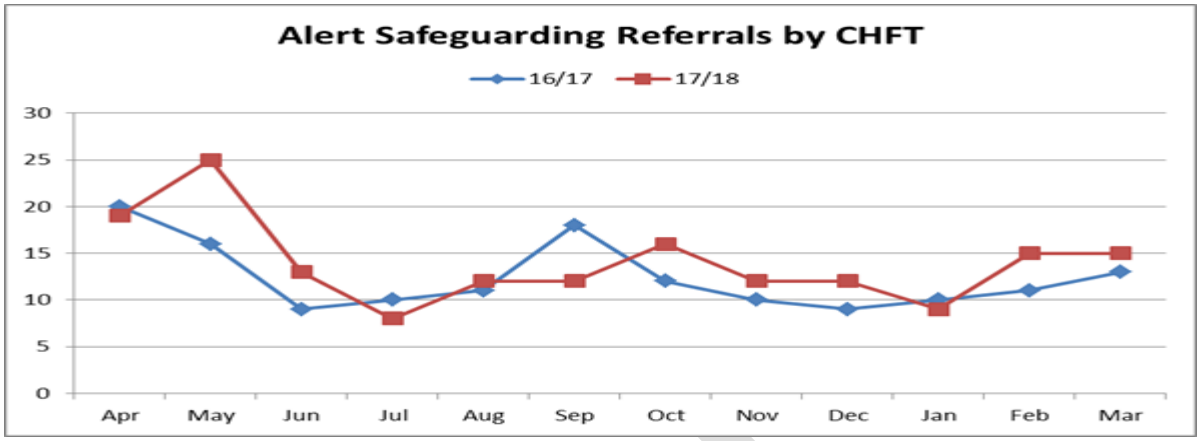
All Trust incidents are reviewed from a safeguarding perspective when initial reporting occurs to confirm or adjust the category of safeguarding concern: either level 1/ quality of care or level 2 safeguarding referral where harm has occurred and reporting into the multi-agency procedures is indicated. The Safeguarding committee has an overview of all allegations of abuse or neglect through reporting onto the safeguarding dashboard, deep dive analysis monthly for the Integrated Board Report and sharing of key messages at Divisional PSQB meetings.

The data does not include advice calls and support to wards and individual members of staff. All incident activity is recorded on Datix and there have been a total of 882 incidents recorded for 2017-18, compared to 2016-17 activity where there were a total of 574 reported incidents. This activity includes referral made by CHFT and allegations against CHFT. There is an increase in activity of 308 incidents this year which equates to a 54% increase.

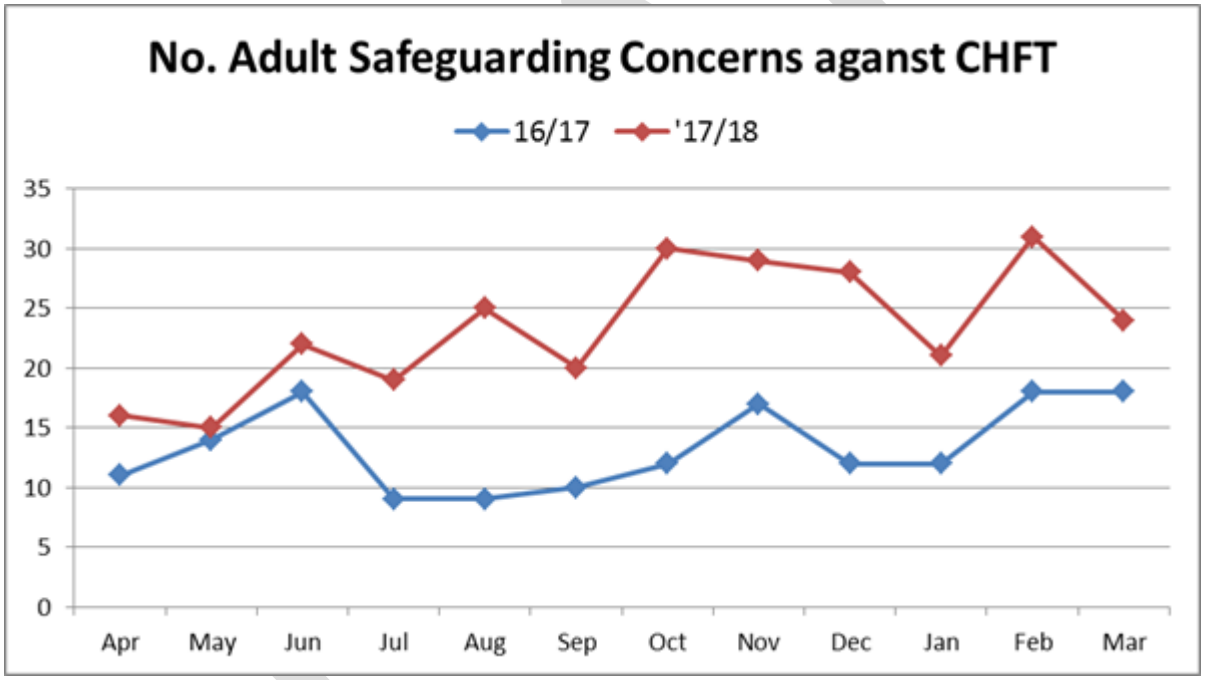
- Of these incidents 517 relate to quality of care issues. These are concerns that do not meet the threshold for referral and are reviewed by the safeguarding team and will be thematically analysed. These incidents are reviewed and investigated by the departments and divisions and learning is at department level.
- Of these incidents 365 met the section 42 Care Act Criteria for reporting into the West, North Yorkshire and York Multi-agency Safeguarding Procedures. This is an increase of 103 referrals compared to 2016-17. This includes referrals that are made by CHFT staff in relation to allegations of abuse or neglect or the risk of these on the part of other care providers and such allegations made against CHFT.
- The increased referrals assure ourselves that there are robust reporting arrangements in place and that training delivered is increasing awareness; not necessarily that more abuse is taking place.
- The largest category of abuse identified is recorded under the ‘neglect’ heading; further analysis of this category identified that discharge from hospital was involved with these equating to 85%; the remaining 15% refer to emotional, psychological, financial, physical and self-neglect.

**The following graphs illustrate the general overall increase in the numbers of concerns made by CHFT in the upward trend*

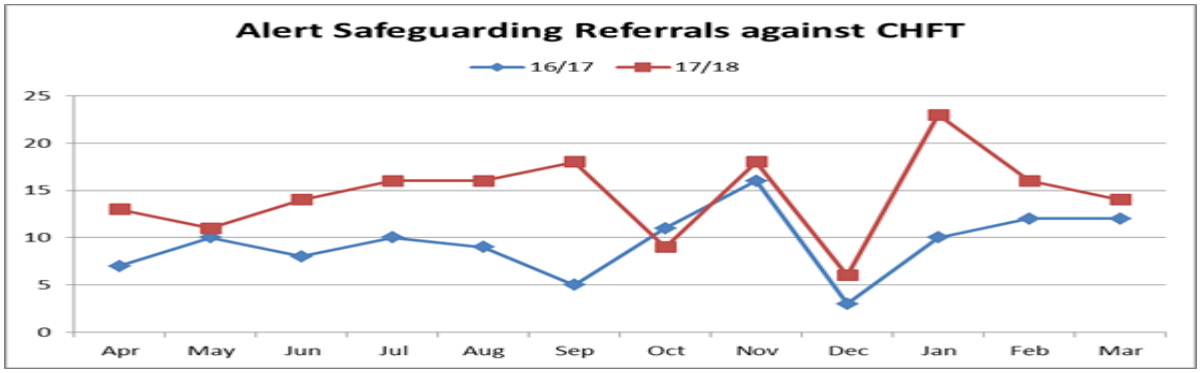




**There is an overall increase in the number of referrals made by CHFT staff into the multi-agency procedures*



**This shows us that there is an increase in concerns and referrals made against CHFT from 2016-17 to 2017-18.*



Current Position

- The Safeguarding Adults policy was updated in September 2017
- The development and implementation of the Safeguarding Committee Incident and Review Subgroup will have oversight of all incidents with a safeguarding concern that are currently being investigated through the safeguarding procedures.
- Developed a network of safeguarding Champions in wards and departments.
- Completion of the first Adult Safeguarding Policy audit awaiting analysis
- We have attended and delivered at the Nursing and Midwifery conference about 'Making Safeguarding Personal' in September 2018

.**Further work 2018-19**

- To review the Allegations Policy to include new PIPOT (Persons in a Position of Trust) Guidance issued by the Safeguarding Adults Board. The revised Care Act 2014 in 2016 removed the Designated Adult Safeguarding Manager role (DASM) and was replaces with a new section on allegations management.
- Review the Adult Safeguarding Policy in line with the updated Multi-agency Adult Safeguarding Procedures in quarter 1.
- To continue to embed 'Making Safeguarding Personal' and work with partners to put patients at the heart of what we do by embedding this culture, and to work with adult social care and gain assurance that referrers are given feedback from concerns raised and that a more consistent approach to referral thresholds is achieved.
- To ensure learning from incidents is embedded through the incident and review group
- Continue to develop systems that are lean and accessible for staff at times of high demand and impact.
- To arrange and deliver further training in relation to Missing Persons Policy with Police partner and audit against policy
- We can probably anticipate that referrals relating to pressure ulcers may increase over the next 12 months with more consistent reporting due to the new guidance. More work is needed to get the same level of consistency in relation to falls reporting.
- Further analysis and reporting will be developed over the next 12 months to aim to report on outcomes more consistently as indicated in the Making Safeguarding Personal Agenda

LEARNING DISABILITY

CHFT Learning Disability Matron champions and leads the Learning Disability (LD) service to ensure that all our vulnerable patients who use CHFT services have reasonable adjustments in place to ensure that people with a LD are treated in accordance with the Equality Act. All planned and acute admissions are overseen by our LD Matron who ensures that these reasonable adjustments are in place to ensure patients receive the right care, at the right time in the right place. Most of our patients with Learning Disabilities are offered side rooms. This has proved a challenge over the winter period pressures. One of our patients attended for multiple procedures during one anaesthetic and feedback received from mum stated 'the experience was great and staff were really good at meeting his individual needs.'

The LD Matron is pivotal in supporting the Adult Safeguarding team to deliver MCA DoLS and Adult Safeguarding training and ensuring that 'Making Safeguarding Personal' for patients with a LD is carried out and embedded, and that the outcomes that patients want in relation to safeguarding are listened to. The safeguarding committee receives quarterly reports in relation to numbers of admissions, DoLS/MHA. IMCA referrals, number of deaths and incidents. These are analysed and discussed. All deaths of patients with a LD are subject to a structured mortality review which is reported to the Trust Mortality Surveillance Group which has oversight of this. All deaths are reported to NHSE as per Learning Disability Mortality Review programme (LeDer) process.

CHFT is to be a pilot site in the first phase of the 'Treat Me Well' Campaign in association with Royal Mencap.

PRESSURE ULCERS

During 2017-18 the Safeguarding Team (adults) have worked closely with the Tissue Viability team to ensure that all category 3 / 4 and unstageable pressure ulcers are reviewed from a safeguarding perspective. The incident reporting system (Datix), is screened by the Tissue Viability team to ensure the severity grading of the incident is correct. All "orange" incidents then go to divisional panel for further investigation. The safeguarding team attend Divisional Orange panel meetings from a safeguarding perspective.

New guidance in Jan 2018 from the Department of Health and Social Care "Pressure Ulcers and the interface with a Safeguarding Enquiry: When to raise an Adults Safeguarding Concern (DH 2018), provided a framework to, identify if a pressure ulcer is primarily an issue for orange clinical investigation rather than a safeguarding enquiry led by the local authority. This requires completing a decision tool and based on the score determines if a safeguarding enquiry is raised with Gateway to Care. This has been approved by the Safeguarding Committee and is being shared with external organisations including Calderdale CCG and Calderdale Safeguarding Adults Board. Further discussion will also take place with Kirklees CCG and Kirklees Safeguarding Adults Board to promote a consistent Trust-wide approach.

Further work 2018-19

To progress and embed the use of the decision tool at orange panel meetings and evaluate its effectiveness through the safeguarding committee meeting

MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009). As such the Mental Capacity and Deprivation of Liberty Policy has been extracted from the Safeguarding Adults Policy and given separate status. This was ratified in September 2017 in conjunction with the implementation of MCA DoLS training as part of the essential skills framework approved by WEB. This strengthens current arrangements in place to support staff and vulnerable patients to ensure that their Liberty under Article 5 of the Human Rights Act is protected whilst in hospital.

Current and Historical Data

Year	Number of Urgent DoLS	Number Standard DoLS	Number Declined	Average p/month
2014	**11**	**5**	**0**	**0.9**
2015	**194**	**33**	**11**	**16**
2016 – 2017	**369**	**50**	**212**	**31**
2017-2018	**324**	**42**	**242**	**27**

**These figures suggest that there is a positive level of awareness and recognition of patients who may fall within the ACID test for DoLS. The increase in the number of declined from last year is mainly due to patients being discharged from hospital prior to assessments being undertaken.*

This year's data compared to last year's data has shown a slight decrease overall. However the figures suggest there is a positive awareness and recognition. The decrease in the number of applications was noted at the Safeguarding Committee meeting. It was noted that there was less movement of patients who were subject to a DoLS at the time and the overall complexity of the patients, and the change in approach due to the Court of Appeal in Ferreira (R (LF) v HM Senior Coroner for Inner South London & Ors [2017] EWCA Civ 31.

A number of urgent authorisations continue to lapse on a month on month basis as previously reported. This occurs when the Local Authority does not complete all its assessments within 14 days of the urgent authorisation being applied, because greater priority is given to other applications as these authorisations are likely to be for a longer time. In these cases the Safeguarding Team continues to monitor the patient to ensure that the deprivation is still valid, the patient still lacks capacity, all restrictions in place remain least restrictive whilst ensuring the patient remains safe on the ward, and that there are no objections to the DoL.

Legal Updates

The Government published their response in relation to the Law Commission report and draft Bill on 14th March 2018 which recommends that the DoLS scheme be replaced with the

Liberty Protection Safeguards (LiPS). The Government's final response to the report broadly agrees with the Liberty Protection Safeguards model, and as part of the review into the Mental Health Act, proposals that relate to the interface between the Mental Health Act and Mental Capacity Act will be considered as part of this. The Government will bring forward legislation to implement the model when parliamentary time allows ensuring that new safeguards fit with the future direction of the health and social care sector and engagement with stakeholders on implementation.

The Board will be further updated as to progress through Parliament and plans for implementation.

From the 3rd April 2017 the Policing and Crime Act has removed DOLS from being classed as state detention (as part of an amendment to Coroners and Justice Act 2009).

This removes the need for deaths (whilst a DOLS is in place) to be reported to the coroner; notwithstanding normal procedural requirements. However if someone has a DoLS which is not yet authorised, has not been applied for or it has lapsed it is still classed as a DoL.

The decision of the Court of Appeal in Ferreira (R (LF) v HM Senior Coroner for Inner South London & Ors [2017] EWCA Civ 31 has significantly changed the approach when considering a deprivation of liberty where physical healthcare needs are being met in the hospital setting. DoLS does not apply in settings and circumstances where the patient is in need of life sustaining treatment, which could include treatment in a critical care setting (e.g. ICU). It is hoped that during the review and reconsideration of authorisations in an acute setting this finding may also relate to such areas as coronary care and Acute Stroke Units.

Current Position CHFT

- Data around DoLS is captured monthly and reports are shared at the Safeguarding Committee meeting. The CQC are notified of all DoLS authorisations and outcomes. This is in line with the requirements of the legislation. All patients who are subject to an urgent or standard authorisation are monitored by the Safeguarding Team.
- The MCA DoLS policy has noted the changes to the Policing and Crime Act 2017 to reflect this change in statute
- MCA and DoLS training has been implemented in September 2017 as part of the essential skill framework for staff.
- Progress is being made with more teams attempting to complete applications, although it is noted that not all areas are completing these, and further work is being undertaken to encourage areas and give them the confidence with making their own applications
- Continued work embedding knowledge and skills in all areas regarding MCA DoLS
- A significant key achievement was that the team delivered 17 face to face sessions this year to 455 members of staff.
- Delivery of a bespoke MCA DoLS training sessions at the Surgery and Anaesthetics Audit day to over 110 medical staff in March 2018.
- We hosted Hempson's solicitors to deliver two sessions on how the MHA/MCA and DoLS interface in the Acute Trust. This was to 108 members of staff.

Further work 2018-19

- To continue to support wards in completing their own DoLS applications
- Deliver bespoke training regarding MCA/DoLS and Mental Health to maternity services

MENTAL HEALTH

We have worked in partnership with SWYPFT in the last 12month with the approval of the service level agreement, clinical working protocol. As part of partnership working it has been agreed that the safe guarding lead for CHFT will attend the MHA committee within SWYPFT and the lead for MHA will attend the safeguarding committee for CHFT. Copies of all MHA committee papers are made available to the CHFT safeguarding lead.

The “Hospital Managers” for the purpose of MHA reviews all had personal annual reviews as required by MHA code of practice. These were undertaken by a Non-Executive within SWYPFT. All were re approved for a further 12 months.

Statistical information regarding the use of the MHA has been provided to safeguarding lead on a monthly basis. No issue have been raised regarding the use of the Mental Health Act within CHFT. The implementation of the MHA is fully supported within CHFT by the mental health liaison team.

The law commission review of the MCA/Dols has been reported via the SWYPFT MHA committee. The government response has been received and the majority of which has been accepted.

The MHA is currently under Government review and the appointed chair is Sir Simon Wessley. This is being monitored and reported via the SWYPFT MHA committee.

24 October 2017 a copy of the revised regulations relating to Sections 135 and 136 MHA 1983 together with Department of Health guidance was made available. The implementation date was or 11 December 2017. This implementation is currently being monitored on a 2 weekly basis via the West Yorkshire STP.

Further work 2018-19

- The Scheme of delegation under the MHA is currently in draft and to progress this policy.
- Review the MHA protocol in line with legislative changes in the Police and Crime Police and Crime Act 2017.This Act presented implications to the Mental Health Act 1983 and changes came into effect on 11 December 2017 to sections 135 and 136 of the Mental Health Act 1983.

SAFEGUARDING CHILDREN AND YOUNG PEOPLE

CHFT is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children - 2015,' section 11 of the Children Act 2004 and to joint working with both the Calderdale and Kirklees Safeguarding Children Boards. The Trust works within the West Yorkshire Safeguarding Children Policies and Procedures for the protection of children within Calderdale and Huddersfield, and its relevant polices are aligned and refer to these documents.

There are no current vacant posts within the children's safeguarding service.

The Named Nurse for Safeguarding Children (Community) has provided additional support to the work around supervision, bespoke training for staff in the Emergency Department, the successful implementation and ongoing development of safeguarding champions to facilitate safeguarding supervision and the introduction of a new safeguarding strategy.

Current Position 2017-18

- A significant piece of work has been completed by reviewing the Safeguarding Supervision Policy and the implementation of a supervision strategy developing new ways of working to ensure that all staff who require mandatory safeguarding children's supervision have been allocated this on their ESR. The team have utilised existing resources and structures to introduce this new way of working.
- CHFT Safeguarding Team work closely with the Safeguarding Children's Boards for Kirklees and Calderdale, Children's Services and the Clinical Commissioning Groups Designated Professionals for Safeguarding Children. They achieve this by delivering multi-agency training, by attending multi-agency meetings, Safeguarding Board subgroup meetings and undertaking pro-active multi-agency work to support the safeguarding Boards in devolving statutory Trust responsibities to ensure children and young people are kept safe.
- The Team represent the Trust at internal and external meetings, training events and case reviews/lessons learned reviews.
- The introduction and development of the Virtual Notice Board to deliver key safeguarding messages monthly Trust wide
- New intranet pages have been updated and developed as a resource for staff
- CP-IS was successfully implemented within Maternity on 19th February 2018 and Paediatrics on the 29th March 2018. Kirklees Local Authority went 'live' in January 2018 with CP-IS
- Flags are added to all patient records that relate to high risk Domestic Abuse (MARAC) , CSE, Child protection plans, looked after children and FGM. A flag is a tool for staff to use when presenting with a child or young person in a healthcare setting and helps identify vulnerability
- The Children Safeguarding Policy was reviewed and updated

Further work 2018-19

- Continue to embed and provide safeguarding supervision in line with CHFT supervision strategy
- To work closely with the Risk Department regarding requests for Court statements

Performance Data Children

The way data is now captured and presented has changed. All incidents that relate to children and young people are reported onto Datix and the numbers of referrals made to Children's social care are recorded on the safeguarding dashboard.

Further information is collected at the request of the Safeguarding Children Boards and shared on a quarterly basis. This information provided by CHFT informs the Safeguarding Children Boards and their subgroups of activity relating to attendances of children and young people in the Emergency Department. This data supports and informs partners and contributes to multi-agency working and safeguarding of vulnerable children and young people.

The team also support staff to provide court and police statements.

This data shows a decrease in the reporting of incidents. Further analysis regarding themes, patterns and trends will be reported on a quarterly basis to the Safeguarding Committee Meeting.

Incidents Reported on Datix	2016 - 2017	2017-2018
Child Safeguarding Concerns	55	52
Child Safeguarding Referrals	22	17
TOTAL	77	69

Referrals made to Children's Social Care by CHFT	2017-2018
Kirklees	29
Calderdale	29
TOTAL	58

Ongoing Challenges

The team are not assured that they are aware of all referrals made to children's social care when the thresholds of early intervention and safeguarding are met. The team continue to raise awareness of ensuring that the Safeguarding Children team have overview of all referrals made to children's social care by departments and ward areas though training, supervision and awareness raising.

CHILD SEXUAL EXPLOITATION

From February 2017 there was a revised statutory definition of CSE.

'CSE is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'

Current Position 2017-18

- CHFT Children's and Adults safeguarding policy & domestic abuse policy reflects guidance re CSE
- We have an identified CSE Lead
- Young people at risk of CSE are flagged on the electronic patient record system.
- Training for staff in relation to CSE which is included in detail in level 3 safeguarding children training & specific safeguarding training for A&E staff. Learning disseminated from case reviews relating to CSE via CHFT learning and audit sub group and virtual noticeboard.
- CHFT contribute to the multiagency CSE hub meetings in both Kirklees and Calderdale by providing written reports containing relevant health information to share with partners.
- CHFT contribute to KSCB and CSCB operational CSE meeting and action plan
- CHFT have developed use of an under 18 safeguarding risk assessment proforma; which includes CSE, this is used in the Integrated Sexual health Service (ISHS), Maternity and Gynaecology services.
- Any pregnant young people identified as risk of CSE referred to multiagency Supporting Women in Antenatal Services (SWANS) Kirklees/ MAPLAG Calderdale meeting for risk assessment

Further work 2018-19

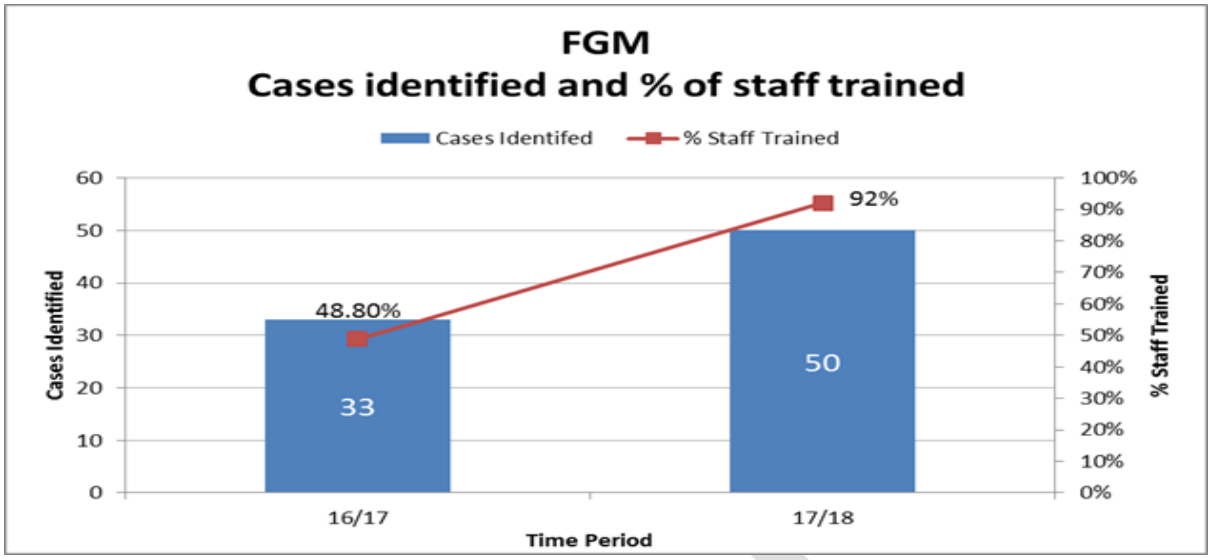
- In conjunction with National working group (NWG) to develop a national screening tool for use in healthcare, particularly the ED department
- Audit of CSE flagged records to ensure all contacts were appropriately actioned at the time of attendance

FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM) encompasses “All procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs, for non-therapeutic reasons.” FGM can have far reaching consequences for the physical, psychological and sexual health of those women and girls affected. It is a violation of their human rights, a form of child abuse and is illegal in the UK. With increasing international migration, the UK has become host to a large number of women affected by FGM. Research suggest 279,500 women and girls in the UK have undergone FGM and a further 22,000 girls are at risk of the procedure.

Current Position 2017-18

- We have an identified FGM Lead
- CHFT has an FGM guideline which includes a flow chart to support staff with enquiring and assessing the levels of risk in relation to FGM. Statutory FGM reporting is carried out and the numbers of cases are also reported internally through the Safeguarding Committee Meeting.
- FGM is routinely asked within maternity services
- Routine flagging of records if a mother identified as being a survivor of FGM
- From January 2017 FGM training became an essential skill for staff working in FSS, the Emergency Department, the Safeguarding Team, Health Visitors and the Integrated Sexual health Service. This training is also delivered in the levels of Safeguarding training for Children and Adults. Our training compliance has increased significantly this year by 43% to 92%
- The Named Midwife attends FGM task and finish groups for both Calderdale and Kirklees
- Mandatory reporting of all cases of FGM is embedded within CHFT; reported quarterly to the DoH and monthly at the safeguarding committee meeting
- We have included FGM training in safeguarding training also
- The safeguarding team have developed an under 18 safeguarding risk assessment proforma that was initially developed and used in Integrated Sexual Health Service (ISHS) which includes FGM. This has now been adapted for use in the Gynaecology assessment unit and is to be embedded into practice throughout maternity services. This was seen as good practice when CQC visited in January 2018.
- This is to assess the risk of any females under 18 that may present as a survivor or at risk of FGM. If a woman is identified as a survivor of FGM during pregnancy, the women are reviewed by the obstetric team and a data collection form is completed. Leaflets and information is provided to identify families of FGM cases. This is given to survivors of FGM and staff to raise awareness.



**This data shows the increase in awareness of staff regarding FGM due to the newly introduced eLearning training in January 2017; there is a rise in the number of referrals made compared to 2016-17.*

Further work 2018-19

- Roll out the use of the FGM risk assessment tool
- Update the FGM guideline to reflect the new risk assessment
- Development of the Maternity FGM guideline for all Trust areas

DOMESTIC ABUSE

The Domestic Abuse agenda continues to be a significant agenda for the Trust and a number of initiatives have been implemented.

CHFT has submitted a self-assessment for the Domestic Violence and Abuse Quality Mark. This standard promotes consistent and high quality service provision to women, children and men affected by domestic violence and abuse. This assessment reflects CHFT's own practice and to identify what steps we need to take to demonstrate we can achieve the standards. The West Yorkshire Domestic Violence Quality Mark, developed in 2017, has been adapted from the Safer Leeds Domestic Violence Quality Mark, created in 2005.

Our self-assessment and supporting documentation was submitted at the end of January 2018. We are currently waiting to hear the outcome of this.

CHFT hosts the Calderdale Commissioned Domestic Abuse (DA) Health Service which is located in Calderdale Domestic Abuse Hub in the Police station. Being a part of this service enables us to lead in our development and support of staff.

The DA Health Service is part of the CHFT Safeguarding team. This is a team of safeguarding adult and children named nurses who also promote and support the agenda of DA across all divisions in the trust. The safeguarding team are all highly trained professionals who all have a background/working practice of domestic abuse and working with adults/children who have experienced DA.

The Specialist Advisor for DA supports the DA Hub operationally on behalf of health services. The DA Lead role supports Occupational Health and managers of staff who are victims/perpetrators of DA e.g. safety management plans. The role leads on policy and procedures and represents the Trust at strategic and operational multi-agency meetings specific to DA. Maternity Services have a full time Specialist Midwife for domestic abuse. The role includes: case-loading highest risk pregnant women, clinical supervision with generic community midwives who have women on their caseload subject to DA, facilitation of training, awareness raising, maternity Guideline/pathway/policy development, attendance at MARAC (Kirklees only) representation for pregnant women disclosing DA.

HRI has benefitted from a hospital based Independent Domestic Violence Advocate (IDVA) working alongside the DA lead in facilitating training and embedding the IDVA role in ED and maternity services

The service provides health information from all multi-agency partners in order to manage high and medium risk incidents in cases of Domestic Abuse. The health information is on behalf of all health agencies in Calderdale and actions are then shared out to the appropriate health professionals involved in order to reduce duplication, allow a more coordinated approach and early identification of any unmet health needs.

Number of CHFT Referrals	2015 -2016	2016 - 2017	2017-18
To MARAC	27	37 (Kirklees) 60 (Calderdale)	61 (Kirklees) 59 (Calderdale)
TOTAL	27	97	120

**There has been an increase of 37 referrals this year across both Local areas. Kirklees has seen a steady increase in referrals from ED which is believed to be due to the promotion of the Domestic Abuse Pathways by the Hospital IDVA who is based at HRI.*

By Department	2015 -2016	2016 - 2017	2017-18
Emergency Department	19	48	85
Maternity	8	9	25
Community		3	10

This data is for CHFT referrals only and does not include referrals made by GP's, SWYFT or LOCALA. Huddersfield Royal Infirmary referrals data has only been collected since May 2016.

There is a dedicated worker from Pennine Domestic Violence Group who works into HRI Emergency Department providing twice weekly drop in sessions to collect referrals, support staff and raise the awareness of CHFT DA pathway and referral system.

The data evidences that as awareness is raised there is an increase in the identification of DA and referrals that are made. It is anticipated these figures will continue to increase as awareness improves across all health providers.

Number of Datix Alerts	2014-2015	2015-2016	2016-2017	2017-2018
Domestic Abuse/violence	4	6	22	28

**This is Gwen Clyde-Evans receiving her Star award from Owen at the Police Station in Halifax with members of the DA Hub for her contribution to the development of the Hub in Calderdale.*

** Gwen also received a District Chief Superintendents commendation.*

Ongoing risks/challenges

- The ongoing stability of the DA Commissioned Health Role in the DA Hub (Calderdale) remains uncertain. A report was presented to the Safeguarding Committee meeting on the 12th July 2017 which outlined the cost savings of the DA Health Role with a view to continued funding on behalf of the Health Partnership.
    - Before accessing specialist domestic abuse support each hospital victim costs an average of £4,500 per year to hospital, community and mental health services (Safe Lives 2016).
    - In 2016 there were 135 hospital victims which cost £607,500
    - By contributing to the DA Hub with a dedicated health team and using the principles of the IRIS model by establishing integrated pathways and specialist training for health professionals the principle is to engage victims in specialist support as early as possible, thereby reducing the likelihood of further incidents (and ongoing emotional, societal and financial costs)
    - In estimating savings an outcome of the work of the DA Health team specifically relates to reduction in visits to ED as a result of earlier engagement.

Since April 2016 to May 2017 the role of the DA health team in the Hub has led to:

- An additional 70 referrals from CHFT to the Hub (60 ED, Health Visiting, maternity and Surgical Ward) when compared to the previous year where a total was 19. So, the likelihood of a second visit to ED is reduced for 60 individuals. **Saving of at least £270,000 (60x £4,500).**
- 10 referrals from other health services that have previously never referred to MARAC before – Insight health care, GP's, Mental health Liaison, psychology. DA is less likely to escalate for these individuals; making a visit to ED less likely. **Saving of £45,000 (10x £4,500). This does not take into account possible savings from other health services.**

- There is a review with CCG colleagues regarding the ongoing stability of the DA hub service and how this service will continue without agreed commissioning arrangements and the risk in maintaining this service and local authority are in place to agree next steps.

Future Plans 2018-19

- Commissioning of DA Hub health service for the future 2018-19 remains uncertain. It is certain that by not having this health service there will need to be a review of how across the health partnership contributes into the Hub on a daily basis. There is a review with CCG colleagues regarding the ongoing stability of the DA Hub. We have mitigated this risk until August 2018

CHILDREN LOOKED AFTER TEAM CALDERDALE

Our Children Looked After Health Team are based at Brighouse Health Centre and are the CHFT commissioned service who work in partnership with Calderdale Metropolitan Borough Council (CMBC) to ensure that the health needs of looked after children (LAC) and young people in Calderdale are addressed. The health team provides advice and support to health and social care practitioners in order to improve health outcomes for looked after children and young people. A Looked after Child is subject to a care order (placed into care of local authorities by order of a court) and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live within foster homes, residential placements or with family members (connected carer's).

A Care Leaver is a young person who has been looked after for at least 13 weeks since the age of 14, and who was in care on their 16th birthday. This definition has been extended following the introduction of The Children and Social Work Act which received Royal Assent on 27th April 2017.The Act includes provision about: Extension of local authority support to Care Leavers to age 25, including provision of Personal Advisers, assessment of the needs of former relevant children and preparation of a Pathway Plan;

Following the CQC Children Looked After inspection in April 2016; the following recommendations were made;

- Review the staffing in the children looked-after team to ensure resources are in place to deliver the commissioned service that should be afforded to all children looked-after placed in Calderdale.
- Ensure that care leavers receive timely health passports and information to help them prepare for adulthood and are well supported in line with the service specification.

Despite recommendations being made by CQC to address the issues, progress has been limited on aspects of the CQC action plan, which resulted in entries being made to the CHFT risk register.

Progress toward CQC recommendations:

- The CLA health service specification has been rewritten and signed off by contracting and commissioning leads with an agreed reconfiguration of the service.
- Funding for the Designated Nurse CLA based in CHFT will be converted to fund 1.3 WTE specialist nurse posts with the Designated Nurse role being held by the Designated Nurse for Safeguarding Children (CCG)

- Public Health commissioner has secured agreement from Locala for initial short term and concurrent longer term secondments into the CLA health service.

Future challenges:

- Interface between operational and designated post holder to facilitate performance monitoring and service development.
- Day to day performance management of the service – Escalation process
- Supervision and line management of non CHFT workforce
- Embedding new staff members into the service in a short timeframe without disturbing the performance of the service
- Continued funding of Care Leaver passports by CMBC
- Securing larger room space at Brighouse Health Centre to accommodate new staff members

To note a separate Children Looked After report will be presented in more detail to the Board.

LOOKED AFTER CHILDREN IN KIRKLEES

The Looked After Children's Health Team covers the whole of Kirklees not just the Huddersfield area. The Designated Doctor and Medical Advisers are based at Huddersfield Royal Infirmary and the Designated Nurse and Specialist LAC nurses are employed by Locala but based within Children's Social Care at Civic Centre 1 with access to Social Care's IT system. During the last year funding was secured from the CCGs for an additional part-time nursing post.

Looked after children health services in Kirklees perform well in meeting the required timescales set out in statutory guidance.

For 2017-18 98% of initial health assessments (IHA) were undertaken within the statutory 20 day timescale against a target (given by the CCGs) of 95%, whilst 95% of review health assessments (RHA) have been undertaken within the required timescale. There are delays in RHAs for children placed out-of-area with only 71% being completed within timescales as we are reliant on other organisations giving priority to this work. Significant efforts are made to forecast any risks and track delays to out-of-area reviews taking place to help ensure children receive the levels of support they need irrespective of where they are placed and children placed within the surrounding area are seen by the Kirklees LAC nurses for their RHAs.

The Kirklees LAC Health Team had their Children Looked After and Safeguarding CQC Inspection in January 2018. A draft report has been received and an Action Plan is being developed.

Progress

In addition to carrying out more review health assessments for children placed out of area the extra nursing time for the team has allowed:-

- Dedicated weekly nurse time at the Social Care No. 11 Drop in
- Care leavers letter completed in a timely fashion
- Teenage pregnancy spreadsheet developed to collate information

- Attendance at Personal Advisors meetings to advise and build relationships
- Development of 'Coping with Crying' resource for carers

There was a pilot study of the 'We value your opinion' questionnaire with young people from the LAC and Care Leaver's service. 129 questionnaires were returned and the information received has been analysed. The young people are now completing their own SDQ forms to input their opinions of their mental health to their annual health assessment. Some positive ideas were put forward to improve communication.

Priorities for 2018-19

- These will be largely based on the CQC Action Plan

A separate Looked After Children Report for Kirklees will be presented to the Board with information about progress against priorities and new priorities for 2018-19.

TRAINING

As outlined within the safeguarding training strategy for CHFT, the Trust undertakes to support and contribute to training health professionals/ workers who come into contact with children to ensure they attain competencies appropriate to their role. The Trust also supports staff to attend the multi-agency training provided by the local safeguarding boards and external agencies.

A significant piece of work has taken place to review all staff groups within CHFT this year that require mandatory safeguarding children and adults training. This was completed in Q1 and re-reviewed in Q3. This involved ensuring that all staff groups were reviewed in line with the Intercollegiate Document for Safeguarding Children and the Draft Intercollegiate Document for Safeguarding Adults.

These new figures and compliance reflect the increased numbers of staff that are required to complete a higher level of training.

	28.03.2017			01.12.2017			05.04.2018			Compliance	Compliance
	Sum of Eligible	Sum of Compliant	% Compliance	Sum of Eligible	Sum of Compliant	% Compliance	Sum of Eligible	Sum of Compliant	% Compliance	increase in 3 months	increase in 12 months
Female Genital Mutilation	730	353	48.36%	550	403	73.27%	492	454	92.28%	19.00%	43.92%
Prevent WRAP - No Renewal	5899	4386	74.35%	4745	3724	78.48%	4527	3852	85.09%	6.61%	10.74%
Mental Capacity Act - 3 Years				455	189	41.54%	445	323	72.58%	31.05%	72.58%
Mental Capacity Act Level 2 - 3 Years				3279	2696	82.22%	3089	2911	94.24%	12.02%	94.24%
Mental Capacity Act Level 3 - 3 Years				734	343	46.73%	688	528	76.74%	30.01%	76.74%
Safeguarding Adults - Level 1 - 3 Years	1454	1257	86.45%	1560	1466	93.97%	1602	1589	99.19%	5.21%	12.74%
Safeguarding Adults Level 2 - 3 Years	3637	2702	74.29%	3635	2958	81.38%	3444	3257	94.57%	13.19%	20.28%
Safeguarding Adults Level 3 - 3 Years	529	216	40.83%	596	374	62.75%	572	437	76.40%	13.65%	35.57%
Safeguarding Children - Level 1 - 3 Years	1455	1259	86.53%	1560	1466	93.97%	1602	1589	99.19%	5.21%	12.66%
Safeguarding Children Level 2 - 3 Years	3837	2894	75.42%	3741	3108	83.08%	3547	3377	95.21%	12.13%	19.78%
Safeguarding Children Level 3 - 3 Years	603	418	69.32%	574	453	78.92%	543	483	88.95%	10.03%	19.63%

Trust targets are met for level 1 and level 2 Children's safeguarding training.

We are very close to meeting 95% compliance in FGM, adult's level 2 and Children's level 3 training.

Prevent has met NHSE target of 85% by the end of March 2018

MCA DoLS and Adult Safeguarding Level 3 have plans in place to ensure this trajectory is on track for 95 % compliance by the end of Quarter 2.

All training has shown significant growth and increase, mainly due to the commitment of trainers and successful engagement with Divisional Colleagues.

Further work 2018-19

- To deliver on the training strategy for MCA DoLS and Adult Safeguarding Level 3 to ensure this trajectory is on track for 95 % compliance by the end of Quarter 2, and deliver minimal training for quarter 4.
- To continue to encourage Divisions to complete training and consistently raise the profile of safeguarding training and delivery of 95% training compliance

SERIOUS CASE REVIEWS, SERIOUS ADULT REVIEWS and DOMESTIC HOMICIDE REVIEWES

Under Regulation 5 of The Children Act (2004), The Care Act (2014), and under Section 9 of the Domestic Violence and Victims Act (2004), statutory duties apply in cases of Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews.

The purposes of reviews enable Local Safeguarding Boards and Community Partnerships to fulfil their obligations under each of these Acts and for us as a partner agency to contribute to the carrying out of a review, identify any lessons to be learned and apply these lessons to future practice.

Each Act defines a slightly different obligation and review of a case in relation to adults, children and domestic homicides.

Key themes in each review enable services to look at establishing what lessons to be learned about how professionals/ agencies (individually and together), work to safeguard children and/or adults at risk; review the effectiveness of local safeguarding procedures (multi-agency and single agency) and inform and improve local inter-agency practice.

The Safeguarding Team have fulfilled partnership requests for information and contributed to a number of reviews that have been published and are ongoing.

CHFT Position

- The Trust participates fully in both the Serious Case Review process for children and the Serious Adult Review process. The Trust also works in partnership with Community Safety Partnerships in relation to the Domestic Homicide review process, which may include representation and participation by the Trust. We receive requests from both local authority areas and local authorities out of this area.
- The Trust is fully committed to identifying the learning with regards to safeguarding and review processes thus promoting the welfare of those who are vulnerable and to make changes that will improve practice, multi-agency working and outcomes.
- Any finalised overview reports and individual management reports are presented

through the Trust and partner agency governance structure. The actions for the Trust are monitored through the Review and Incident Subgroup of the Safeguarding Committee meeting. Minutes of the group go to the Safeguarding committee meeting. There have been a total of 13 requests this year for information.

Cases for 2017/18

- **Serious Case Reviews**
  - There has been one new Serious Case Review's commissioned by the Local Safeguarding Children Board in Calderdale, and involvement in a Learning lessons review from out of area.
  - The Trust is currently involved in 4 cases from previous years at varying stages of progress.

- **Serious Adult Reviews**
  - There has been 2 new Serious Adult Reviews commissioned by the Local Safeguarding Adult Board in Calderdale.
  - The Trust is currently involved in 2 cases from previous years where action plans have been re-visited by the Safeguarding Board.

- **Domestic Homicide Reviews**
  - There have been no new DHR's commissioned locally.
  - The Trust is currently involved in 4 DHRs from previous years

AUDIT

A number of audits have taken place this last year. These are presented to the Safeguarding Committee for discussion and action.

- Statutory Section 11 (Children's Act 2004) audits have been undertaken and completed for both Calderdale and Kirklees Safeguarding Children's Board. The safeguarding team have contributed and been involved in the Section 11 Challenge event for Calderdale this year.
- A comprehensive audit schedule was presented at the Safeguarding Committee for approval and implementation through the Learning and Audit subgroup of the Committee .This framework and schedule will provide the group and the committee the assurance that systems and process are in place and any gaps and learning identified is implemented and reported on.

COMPLAINTS

All complaints are triaged and any complaints with a safeguarding aspect have this identified on the triage form and safeguarding staff are notified of these.
Learning this year has been the need to train the patient advice team further on recognising safeguarding issues raised through phone calls they receive and escalating immediately to a senior level.,

A monthly meeting takes place with the Governance and Risk team and Head of safeguarding. At this meeting active safeguarding cases / incidents / complaints / claims / inquests with safeguarding aspects are discussed in terms of next steps and ensuring we all have an awareness of ongoing cases. There is discussion on individual cases

with members of the team as needed through the year and the Legal Services team has helped in supporting obtaining statements for court proceedings when needed.

SERIOUS INCIDENTS

For serious incidents with a safeguarding aspect it is usual to seek a safeguarding expert view at draft report stage or as an assigned expert investigator working with the lead investigator. .

The Senior Risk Manager has reported to the Safeguarding Committee on serious incidents during the year. From February 2018 a sub group has been established to allow for more in-depth review of cases. Going forwards the Senior Risk Manager will share serious Incident reports and provide assurances on delivery of actions. Key highlights will continue to be notified on a monthly basis to the safeguarding committee which the Senior Risk manager is also a member of.

As part of a serious incident action plan; partnership training was facilitated by our Trust Solicitors Hempson's.

Further Work 2018-19

- We will continue to build on these links during 2018/19.

EXTERNAL REVIEW AND CHALLENGE EVENTS

- In January 2018 there was a review of health services for Children Looked-after and Safeguarding in Kirklees conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups. The CCG has received a draft inspection that is currently undergoing factual accuracy checks by all Health partners. This is likely to be published shortly and the Board will be updated as to progress regarding this.

- A similar review took place on 25 - 29 April 2016 for Calderdale. Progress is now being made on the Children's Looked After Action plan after securing additional resource and funding for this service which is hosted by CHFT. The outstanding action plans are now progressing. Individual action plans are monitored through the CCG arrangements with oversight from the Designated Nurse for Safeguarding Children.

Ofsted inspected Kirklees Children's Social Care in September and October 2016, focusing on local services for children in need of help and protection, looked after children and care leavers. The Independent Safeguarding Children Board was also inspected and an overall assessment of inadequate was made. Adoption performance and the experience and progress of care leavers were assessed as requiring improvement.

- The Department for Education approved the Children's Services Improvement Partnership between Kirklees Council and Leeds City Council. Senior managers from Leeds are working with Kirklees to deliver an agreed Ten Point Improvement Plan. This work is overseen by Eleanor Brazil through chairing the Children's Services Improvement Board, which includes senior local politicians and senior managers from partner organisations within the

Kirklees district.
- Kirklees Council are awaiting feedback from the latest Ofsted monitoring visit in April 2018

CHFT continues to support and attend the Safeguarding Children's Board and provide representation and membership to all of its subgroups to support in delivering the Safeguarding Children's Boards action plan.

INDEPENDENT INQUIRY INTO CHILD SEXUAL ABUSE (IICSA, FORMERLY THE GODDARD INQUIRY)

This Inquiry is the largest and most ambitious public inquiry ever established in the UK. Its purpose is to consider the extent to which all institutions in England and Wales have failed in their duty of care to protect children from sexual abuse and exploitation, and what steps they might take to stop that abuse in future. It has no cut-off date, and in this task enquiries may be made concerning events occurring many years or even decades ago. It is independent of Government and will allow victims and survivors to share their experiences privately and confidentially

Current information suggests that at least one child in every 20 has experienced sexual abuse, and there are likely to be many more instances that go unreported and uncounted. The Inquiry was set up to uncover and remedy failures that have led to this happening.

The Inquiry is headed by a Chair and supported by a three-strong Panel and a Victim and Survivors' Consultative Panel. The Inquiry is committed to delivering an outcome within a credible timeframe and expects to have made substantial progress by 2020. Interim reports will be published which will include tangible and achievable recommendations.

The Inquiry's work is divided into three core projects:
- The Research Project: to capture the big picture and identify patterns of abuse
- The Public Hearings Project: to identify and examine case-studies of institutional failings
- The Truth Project: to enable victims and survivors to share their experience

The evidence received in all three projects will inform the overall conclusions and recommendations of the Inquiry.

There are four thematic strands that are the focus of the work and recommendations:

- Cultural: examining the attitudes, behaviours and values within institutions that prevent us from stopping child sexual abuse
- Structural: looking at the legislative, governance and organisational frameworks within and between institutions
- Financial: considering the financial, funding and resource arrangements for relevant institutions and services
- Professional and political: focusing on the leadership, professional and practice issues for those working or volunteering in relevant institutions

In January 2018 the Inquiry launched an awareness campaign across England and Wales to publicise **the Truth Project**, with an aim is to ensure that victims and survivors of child sexual abuse are aware of the Truth Project and have the opportunity to speak to the Inquiry if they wish. A national awareness raising campaign has used billboards, radio commercials, and print advertisements in national and regional newspapers and social media to ensure victims and survivors are aware of it. Anyone who was sexually abused as a child where there was an institutional failure can report their accounts in a safe, private, confidential environment. This includes anyone who reported their sexual abuse to a person in authority, where the report was not properly acted upon.

Our response to this project is that we are obtaining electronic information to support in raising awareness and developing a site on our intranet page where these materials are stored. Our monthly virtual notice board will help raise the awareness of the campaign and during safeguarding week in June this year we will continue to promote this campaign.

Current position of CHFT

- All safeguarding policies and procedures have been reviewed to ensure they are compliant with best practice and in line with legislation.
- We attended a stakeholder event in October 2017
- We promoted this during our last Safeguarding Week in October 2017 through posters and leaflets at our hospital stall.
- We have reviewed the IICSA directive regarding the destruction and retention of identified documents and this is embedded in our Records Management Policy.

OUR KEY ACHIEVEMENTS 2017-18

a) Continued compliance with the Mental Health Act (1983), improved data capturing of patients who are sectioned under the Act. Joint workings with SWYPFT to ensure systems are robust.
b) Planned training for Duty Matrons and Site Commanders on the receipt and scrutiny of Mental Health Act papers, and understanding the role of security and use of restrictive interventions to enable appropriate detention of patients under the Act.
c) Continued work embedding knowledge and skills in all areas regarding MCA and DoLS
d) Ensuring scrutiny of all referrals made by CHFT staff to Children's Social Care – work continues through training and supervision
e) Continued work and challenge to ensure robust Children and Adults data collection
f) Development and implementation of a CSE risk assessment in the Emergency Department and work towards roll out throughout the trust. This work is carried over to 2018-19
g) Further work and embedding of monitoring of training for junior medical staff
h) Update of the Supervision policy and Trust wide supervision strategy with recording of supervision on ESR completed.
i) Improved capture of adult safeguarding referrals and concerns via the Datix reporting system when these relate to other providers
j) Improved collaboration with Social Services colleagues, both referrals relating to CHFT care to ensure that learning is shared as widely as possible and development needs can be followed up through the safeguarding subgroups and referrals relating

to the care of other providers to obtain feedback on the appropriateness of our referrals

k) We have worked closely and continue to work with the Risk Department and social services colleagues in Calderdale and Kirklees where orange and red incidents are of a safeguarding concern.
l) Safeguarding Champions have been identified throughout the organisation and part of this role will require them to be trained to facilitate safeguarding supervision in line with their staff requirements to help improve compliance. Training has been delivered in January and March and 42 Champions are trained to date with a further date arranged for 23.5.17.
m) Update of the Adult Safeguarding Policy and development of a separate MCA DoLS Policy
n) Development of a Safeguarding Dashboard that is aligned to the Safeguarding Strategy
o) Further audits were carried out on the Adult Safeguarding Policy and two audits on MCA DoLS Trust wide audit in relation to Adults.
p) The Safeguarding team were involved in Safeguarding Week in October 2017
q) The FGM guideline is being reviewed and updated to include Department of Health recommendations regarding risk assessments.
r) Development of a CSE Risk Assessment for the Emergency Department and completion of the CSE action plan
s) Active support to Kirklees children's services improvement plan
t) To ensure that following go live with EPR the system continues to support statutory and regulatory compliance.
u) To review the risk associated if the DV Hub funding is not continued.
v) Implemented MCA DoLS training as part of the Essential Skills Framework for the Trust and this is now being delivered at 3 separate levels of training. Level 1 and 2 are eLearning; Level 3 is a classroom session.
w) Hosted a Trust wide event – Mental Capacity and Mental Health in the Acute Setting which concentrated on the similarities and differences between the MCA and the MHA. This event was attended by other partner agencies such as the Police, SWYPFT and social care.
x) Delivered awareness around the 'See me and Care Campaign' at CHFT Compassionate care in Practice Nursing and Midwifery Conference in September 2017. We continue to raise this as part of the Safeguarding Adults Level 3 training.
y) A team member has won the CHFT Star award for their innovative practice and contribution in setting up the Domestic Abuse Hub in Calderdale. Recognition was also made by the member of staff receiving a District Chief Superintendent Commendation Award for this contribution
z) We have developed and implemented a Trust wide Network of Safeguarding Champions within ward and department areas, and hold regular meetings with our Champions
aa) We have significantly improved our Safeguarding training and Prevent Health Wrap training compliance at all levels.
bb) We reviewed our training and ensured that NICE guidance Domestic Abuse training as part of all levels of Safeguarding training and have delivered bespoke training to Departments within the Trust

cc) Developed a monthly virtual newsletter that is circulated Trust Wide to all staff that delivers key messages and safeguarding new
dd) Developed new intranet pages with key information and resources
ee) Promoted and implemented specific FGM training

OUR SAFEGUARDING STRATEGY 2018-2019

In line with the Trust 5 year strategy to deliver outstanding compassionate care to the communities we serve, as a safeguarding team we put the patient first, we go see, we do the must dos and we work together to get results.
We will continue to implement and organisational approach to safeguarding and promoting the welfare of children, young people and adults ensuring that this is embedded across all divisions and services provided by the Trust and in every aspect of the Trust's work.

There will be robust governance arrangements around the safeguarding agenda and staff working within CHFT will be able to discharge their statutory responsibities within their professional boundaries supported by the Integrated Safeguarding team.

This will work towards the Trusts overall goals of: Transforming and Improving Patient Care, Keeping the Base Safe, A workforce for the Future and Financial Sustainability.

Our key Priorities for this year are:

Prevent

- To review the Prevent Policy in September 2018.
- Complete an annual audit of any incidents (2017-18) relating to risks of radicalisation
- Promotion of the eLearning training package on ESR with Divisional support to meet the Trust target of 95%.

Adult Safeguarding

- To review the Allegations Policy to include new PIPOT (Persons in a Position of Trust) Guidance issued by the Safeguarding Adults Board. The revised Care Act 2014 in 2016 removed the Designated Adult Safeguarding Manager role (DASM) and was replaces with a new section on allegations management.
- Review the Adult Safeguarding Policy in line with the updated Multi-agency Adult safeguarding procedures in quarter 1.
- To continue to embed 'Making Safeguarding Personal' and work with partners to put patients at the heart of what we by embedding this culture, and to work with adult social care and gain assurance that referrers are given feedback from concerns raised
- To ensure learning from incidents is embedded through the incident and review group
- Continue to develop systems that are lean and accessible for staff at times of high demand and impact.
- To arrange and further training in relation to Missing Persons Policy with Police partner and audit against policy
- We can probably anticipate that referrals relating to pressure ulcers may increase over the next 12 months with more consistent reporting due to the new guidance.

- More work is needed to get the same level of consistency in relation to falls reporting.
- Further analysis and reporting will be developed over the next 12 months to aim to report on outcomes more consistently as indicated in the Making Safeguarding Personal Agenda

Pressure Ulcers

- Progress and embed the use of the decision tool at orange panel meetings and evaluate its effectiveness through the safeguarding committee meeting

Mental Capacity Act and DoLS

- To continue to support wards in completing their own DoLS applications
- Deliver bespoke training regarding MCA to maternity services

Mental health

- The Scheme of delegation under the MHA is currently in DRAFT to progress this policy.
- Review the MHA protocol in line with legislative changes in the Police and Crime Police and Crime Act 2017.This Act presented implications to the Mental Health Act 1983 and changes came into effect on 11 December 2017 to sections 135 and 136 of the Mental Health Act 1983.

Safeguarding Children

- Continue to embed and provide safeguarding supervision in line with CHFT supervision strategy
- To work closely with the Risk Department regarding requests for Court statements

Child Sexual Exploitation

- In conjunction with National working group (NWG) to develop a national screening tool for use in healthcare, particularly the ED department
- Audit of CSE flagged records to ensure all contacts were appropriately actioned at the time of attendance

FGM

- Roll out the use of the FGM risk assessment tool
- Update the FGM guideline to reflect the new risk assessment
- Development of the Maternity FGM guideline for all Trust areas

Training

- To deliver on the training strategy for MCA DoLS and Adult Safeguarding Level 3 to ensure this trajectory is on track for 95 % compliance by the end of Quarter 2, and deliver minimal training for quarter 4
- To continue to encourage Divisions to complete training and consistently raise the profile of safeguarding training and delivery of 95% training compliance

Serious Incidents

- Continue to build links with Risk and safeguarding

CONCLUSION

The Safeguarding Annual report demonstrates that safeguarding children, young people, families and vulnerable adults remains a Trust key priority. It demonstrates that CHFT is meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework.

The Trust has responded to these changes and to ensure that everyone is aware of their own individual responsibilities as part of a wider multi-agency partnership arrangement.

Whilst significant progress and achievements have been made in all the key safeguarding agenda's detailed in this report, the team have prioritised and identified the key strategic developments required for 2018-19. These may change in line with other Trust priorities and the wider partnership priorities.

Our key underpinning message is that Safeguarding is everybody's responsibility regardless of their role within the Trust.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Michelle Bamforth, Assistant to DON - Workforce Assurance Manager
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Hard Truths safe staffing paper - This report is to assure the Trust Board of Directors that robust mechanisms are in place to set and monitor nursing and midwifery staffing levels, and work is underway to meet the expectations set out in the NQB national recommendations	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Nursing and Midwifery Workforce Steering Group Finance and Performance Committee	
Governance Requirements: N/A	
Sustainability Implications: None	

Executive Summary

Summary:

Patient safety is a key priority for CHFT. The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England has continued to issue guidance from November 2013 onwards, building upon the ten key recommendations made to optimise nursing, midwifery and care staffing capacity and capability. This report is to assure the Trust Board of Directors that robust mechanisms are in place to set and monitor nursing and midwifery staffing levels, and work is underway to meet the expectations set out in the NQB national recommendations

Main Body

Purpose:

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's ten expectations) and the Care Quality Commission. The paper will provide assurances that nursing and midwifery staffing, capacity and capabilities are monitored, reviewed and established in line with national guidance.

Background/Overview:

This paper is submitted six monthly to provide assurance to the Board around safe staffing

The Issue:

This paper acknowledges the challenges facing the Nursing and Midwifery workforce, and the Trust's response to this national issue.

Next Steps:

Recommendations are highlighted in this paper.

Recommendations:

The Board is asked to accept this paper as further evidence and assurance of the management of this complex workforce issue.

Appendix

Attachment:

COMBINED HARD TRUTHS REPORT MAY 2018.pdf

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS	
PAPER TITLE: Safe Staffing Bi-Annual Report (Hard Truths)	**REPORTING AUTHOR:** Brendan Brown – Chief Nurse/Deputy Chief Executive L Rudge , Deputy Chief Nurse M Bamforth, Head Nurse
DATE OF MEETING: **3 May 2018**	**SPONSORING DIRECTOR:** B Brown, Chief Nurse, Deputy Chief Executive
STRATEGIC DIRECTION – AREA: • Keeping the base safe • A workforce for the future	**ACTIONS REQUESTED:** • To receive
PREVIOUS FORUMS: Not applicable	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link: http://nww.cht.nhs.uk/index.php?id=12474**	
EXECUTIVE SUMMARY: Patient safety is a key priority for CHFT. The National Quality Board (NQB), on behalf of the Care Quality Commission, Chief Inspector of Hospitals and Chief Nursing Officer of England has continued to issue guidance from November 2013 onwards, building upon the ten key recommendations made to optimise nursing, midwifery and care staffing capacity and capability. This report is to assure the Trust Board of Directors that robust mechanisms are in place to set and monitor nursing and midwifery staffing levels, and work is underway to meet the expectations set out in the NQB national recommendations.	
FINANCIAL IMPLICATIONS OF THIS REPORT: Enclosed within report.	
RECOMMENDATION: To receive this report as assurance of the continued management of the nursing and midwifery workforce agenda.	
APPENDIX ATTACHED: YES	

CONTENTS	
1.0	Introduction
2.0	Planned versus actual fill rates
3.0	Recruitment: position and plans
4.0	Ensuring safer staffing
5.0	Red flagged incidents and quality impact
6.0	Quality Metrics
7.0	Care Hours per Patient day
8.0	Temporary staffing and financial position
9.0	External staffing review
10.0	Conclusion

1.0 Introduction

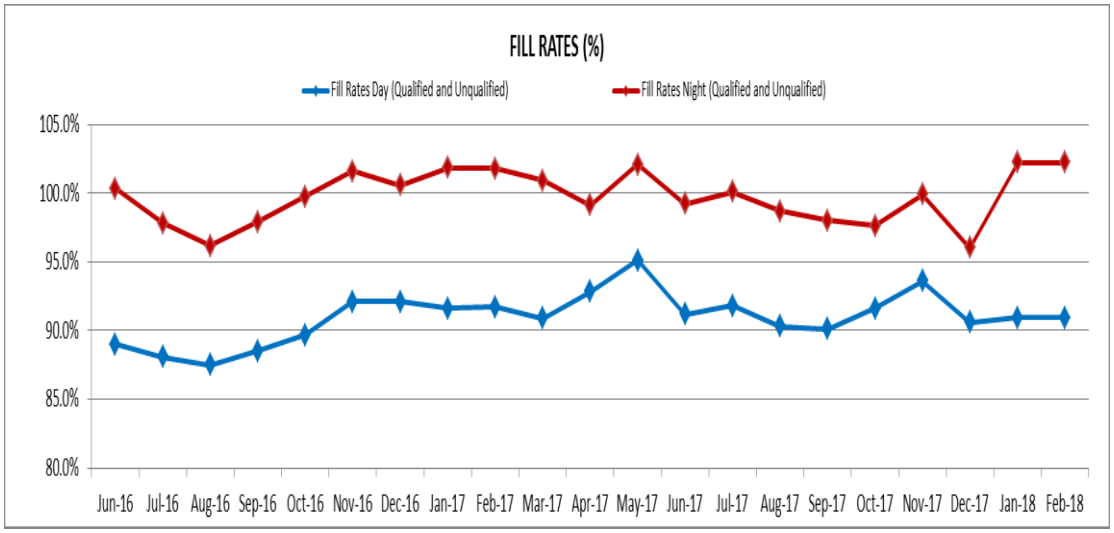
The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's ten expectations) and the Care Quality Commission. The paper will provide assurances that nursing and midwifery staffing, capacity and capabilities are monitored, reviewed and established in line with national guidance.

2.0 Planned versus actual fill rates:

The Board is advised that the Trust continues to comply with the requirements to upload and publish the aggregated monthly average nursing and care assistant staffing data for inpatient areas. Average shift fill rates identify the actual staffing levels in place against what was planned.

Fill rates are monitored and interrogated on a monthly basis by the Nursing and Midwifery Workforce Steering Group and by the Associate Directors of Nursing within the clinical divisions.

As an example, the table below indicates that average fill rates have been maintained over the last year. Whilst this enables assurance that safe staffing levels are being realised, this has been achieved through a level of non-contracted bank/agency staff support. More detail by ward and area is available in **Appendix 1**



Within CHFT staffing levels are reviewed and scrutinised at regular periods daily. This daily monitoring of nurse staffing levels ensures levels are operationally managed appropriately according to risk, taking into consideration the acuity and dependency of patients to ensure that all wards achieve safe staffing levels.

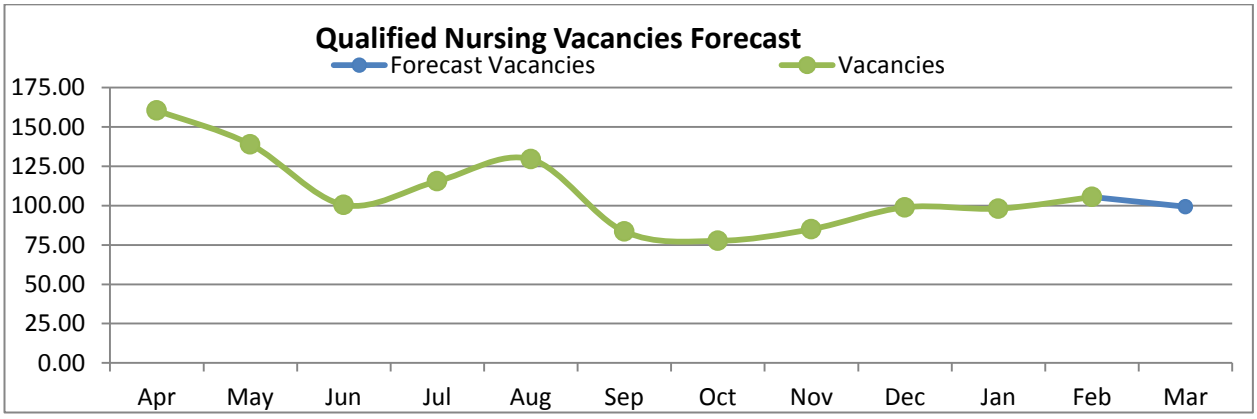
3.0 Recruitment position:

The table below reports the current Trust's nursing, midwifery and additional clinical services staffing vacancy position from ESR (March 2018)

Qualified			
Row Labels	Sum of Actual (FTE)	Sum of Budgeted (FTE)	Sum of Vacancies (FTE)
372 Community L3	184.60	184.95	0.35
372 Corporate L3	73.71	73.78	0.07
372 Families & Specialist Services L3	401.80	416.06	14.26
372 Health Informatics L3	1.71	0.00	-1.71
372 Medical L3	531.79	633.96	102.17
372 Surgery & Anaesthetics L3	417.16	471.24	54.08
Grand Total	**1610.77**	**1779.99**	**169.22**

Unqualified			
Row Labels	Sum of Actual (FTE)	Sum of Budgeted (FTE)	Sum of Vacancies (FTE)
372 Community L3	90.91	76.39	-14.52
372 Corporate L3	25.87	30.00	4.13
372 Estates & Facilities L3	4.00	3.00	-1.00
372 Families & Specialist Services L3	297.91	322.76	24.85
372 Medical L3	364.13	370.43	6.30
372 Pharmacy Manufacturing Unit L3	21.69	22.29	0.60
372 Surgery & Anaesthetics L3	266.41	261.74	-4.67
Grand Total	**1070.92**	**1086.61**	**15.69**

The band 5 registered nurse and midwifery vacancy factor is encompassed in the afomentioned table. The number of Band 5 vacancies across the clinical divisions is: **105.46 WTE.** The below table shows the band 5 nursing trajectory. To note the above described HCA vacancy is inclusive of all staffing groups coded within ESR as "additional clinical services". This includes pathology, haematology and microbiology staff, as well as pharmacy, medical records and radiology staff. Most inpatient areas do not carry a vacancy factor for HCA and recruitment plans are in place for all known HCA vacancies.



3.1 Oversees Recruitment

As part of the strategy to increase the nursing workforce and reduce the use of temporary workforce the Trust carried out an overseas recruitment project in March 2017.

The trajectory for the recruitment phase has been slowed down by national policy around entry requirements. The Trust has responded to the NMC's announcement on alternative English qualifications which will be accepted to expedite deployment to the UK. The Trust has welcomed 8 Pilipino nurses to the organisation with further expected in quarter 1.

3.2 Domestic Recruitment

Domestic recruitment of Registered Nurses remains a priority to the Trust. Three successful recruitment fairs have been hosted on site and a further event is planned for May 2018.

The Trust has achieved its highest number of new graduate recruits for several years. This has been attributed to increasing the placement capacity for undergraduate nurses – giving exposure to the trust for new employees and attending multiple regional careers fairs.

The Trust is also working closely with Huddersfield University to further increase the capacity to host pre-registration nursing students within the organisation. This year on year sustainable increase will contribute to the number of local graduating nurses who can then be recruited by the Trust

In addition, the Trust continues to work closely with Bradford University to facilitate the training of nurses wishing to return to practice. Since September 2016 the Trust has offered candidates the opportunity to be employed as a Band 3 trainee whilst completing the programme of study at the university.

3.2.1 Clinical academic role

CHFT are working in partnership with the University of Huddersfield on the development of a "clinical academic" role. This will be part funded by the Trust (band 5 inpatient position), and part funded by the HEI. The successful applicant will spend a portion of the week working with academic staff on research projects, academic commitments and delivery. This exciting and unique opportunity opens another career pathway for CHFT staff as well as leading on research projects which will ultimately influence and change patient care delivery. Recruitment plans are in place and it is envisaged that the role will be live by May 2018. The University are keen to evaluate the success with the potential to implement further posts in the future.

3.3 Retention

To improve retention rates within the nursing workforce the Clinical Education team have developed a new preceptorship policy and document. This is in line with national frameworks and approved by Health Education England (HEE). The package is supported by a comprehensive induction to employment and an on-going year-long graduate programme. This is offered to all new Registrants and staff new to the organisation.

CHFT have contributed to NHSI's national retention programme. This focused programme of work assists provider Trusts with the development and implementation of improvement measures to support nurse retention, through the application of guidance and good practice. Areas of focus for the Trusts are:

- Further work on the retention of experienced and long service staff
- Career progression opportunities for the Band 5 workforce (Implementation of the "Calderdale Framework" methodology within medical/elderly services to develop a more sustainable workforce
- Calderdale Framework is also being project managed by the community division focusing on the DN service.
- In addition, the Trust is working closely with Huddersfield University and HEE to appraise the apprenticeships route into nurse training. Ministerial approval of the pre-registration standards was confirmed in November 2017. Once this is finalised, firm plans and a recruitment strategy can be put into place for September 2018 recruitment.
- The Trust has also increased the number of Advanced Clinical Practitioners (ACP) roles to support innovations and modernisation of the clinical workforce.

3.4 Workforce Modernisation

CHFT are part of Health Education England's (HEE) National Nursing Associate (NAs) pilot scheme. The multi-site model is now operational with trainees having completed their first academic year. Recent government announcements support the continued investment in this role and the Nursing and Midwifery Council are in the process of applying regulation to this role.

Draft standards are currently out for public consultation. The organisation is to upscale their current project and train an additional 20 Nursing Associates from June 2018.

4.0 Ensuring safe Staffing:

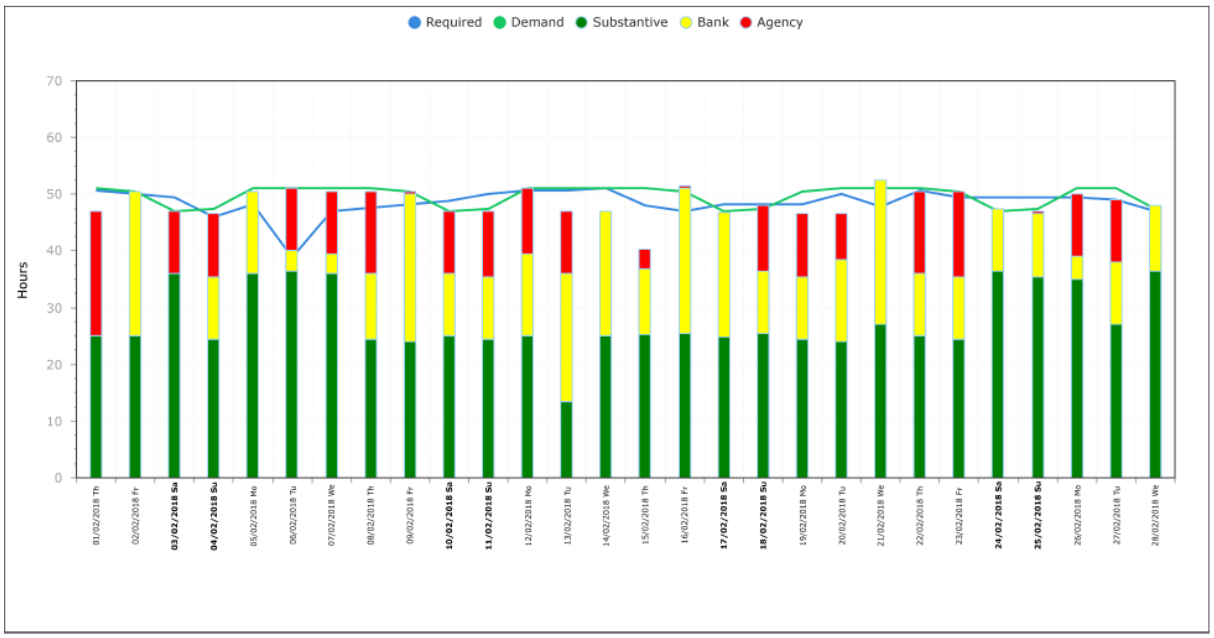
The safety brief reviews are now completed each day between the matrons & nurse director's in order to ensure safe staffing levels in all areas. Staffing levels are reviewed with the support of the site staffing tool. To strengthen this process, staffing levels will be assessed directly from the live rostering system and safe care tool as implementation of the modules completes

4.1 Acuity and Dependency Studies

To support the recommended establishment reviews CHFT have historically run bi-annual patient acuity and dependency studies.

It is widely recognised that professional judgment should play a part in the process around safe staffing levels in conjunction with other methodologies. CHFT are transitioning into acuity scoring using the safe care module. Once live the Trust will have daily, real time data that clearly shown demand against actual staffing levels. The table below details how acuity is tracked over the month for an area and provides insight into how staffing levels are flexed not only to meet required safe staffing levels but also demand worked out on patient acuity.

HRI Ward 10 Surgical HRI 471001 L5 (Night): Required vs Actual Hours



5.0 Red flagged incidents:

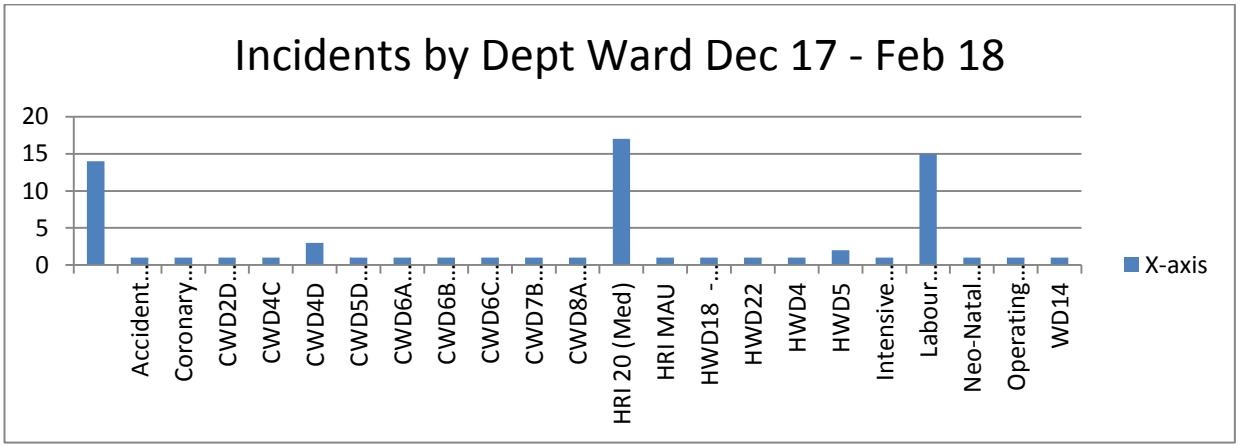
Red flags are currently reported via the Datix system and are designed to support the nurse in charge of a shift to assess systematically that the available nursing staff for each shift, or at least each 24hour period, is adequate to meet the actual nursing needs of patients on that ward.

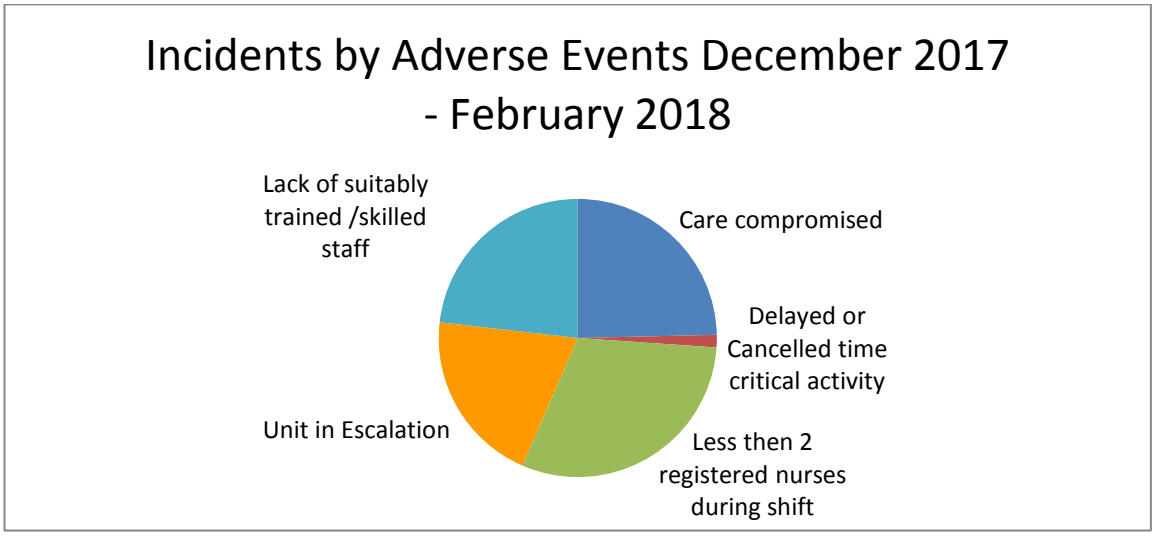
When they are reported immediate response by the Registered nurse in charge of the ward is required. Appropriate actions are taken such as allocation or redeployment of additional nursing staff to the ward. These issues are also considered at the daily staffing safety briefs.

To strengthen this process and ensure timely response, red flags will eventually be recorded on the safe care system. Training plans and a role out milestone trajectory is in place to support this. All ward areas will be reporting red flags alongside patient acuity data by June 2018.

In addition it is important to keep records of the on-the-day assessments of actual nursing staffing requirements and reported red flags so that these can be used to inform future planning of ward nursing establishment levels.

The following table illustrates the number of “Red Flags “identified over the last three months:





As illustrated the most frequently reported red flags are related to

- Reduced staffing levels,

- Comprised care
- Lack of suitably trained staff.

These issues are being addressed by methodologies already described in this paper such as, implementation of safe care live, Allocate rostering system and work through the Nursing and Midwifery strategy group

6.0 Quality Metrics:

The following table describes the percentage achievement of harm free care delivered by the Trust per clinical division.

Appendix 2 articulates this in greater detail, giving assurance that standards of care are being maintained.

Division	Jan-18	Feb-18	Mar-18
Children, Women's & Family Services	100.00%	100.00%	100.00%
COMMUNITY	94.03%	94.09%	95.18%
Medical Division	90.41%	87.53%	88.65%
Surgery & Anaesthetics Division	92.47%	96.37%	94.30%
Trust	92.70%	92.30%	92.50%

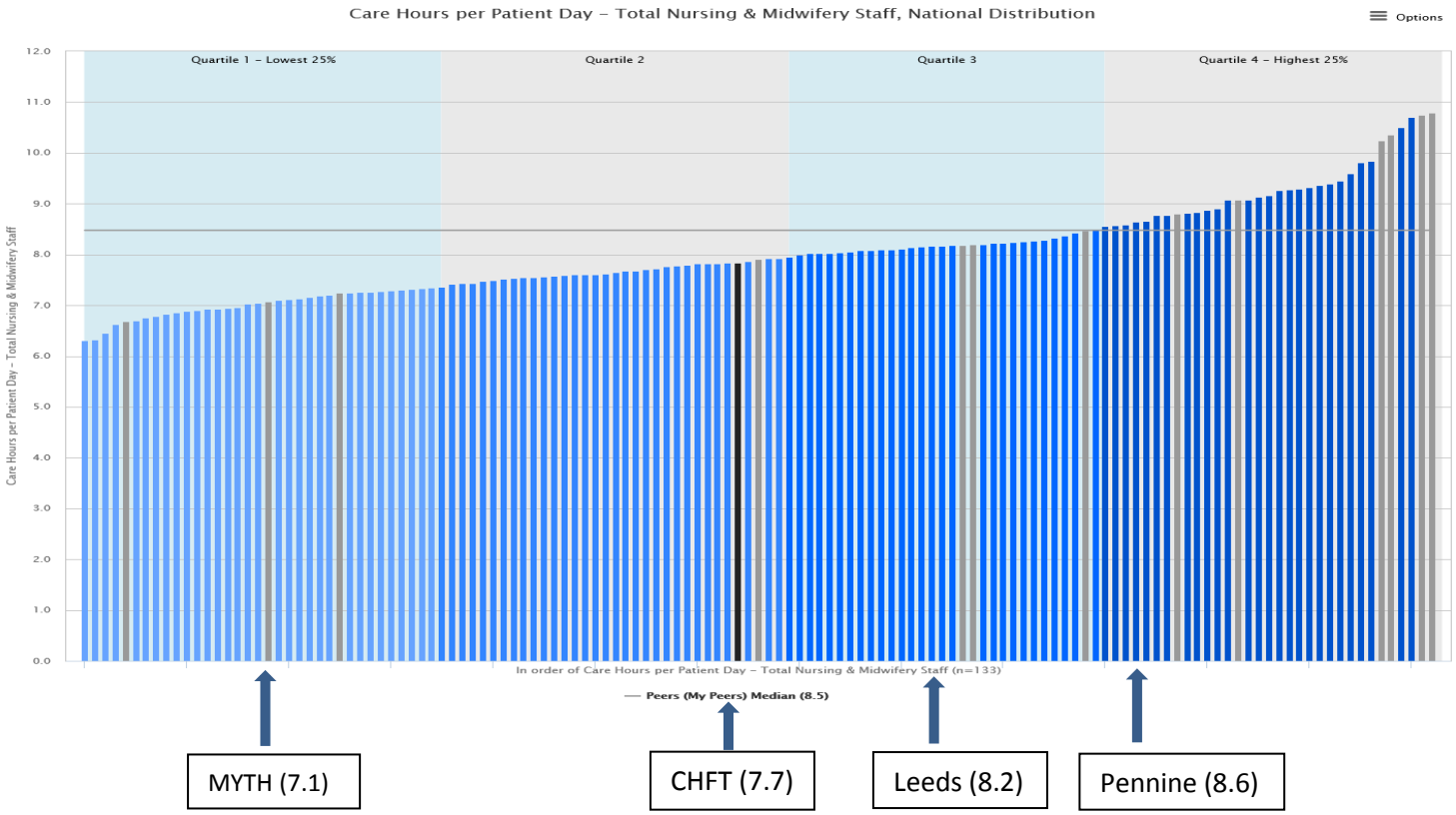
7.0 Care Hours per Patient Day (CHPPD)

In line with the updated NQB guidance, CHFT report monthly on CHPPD data. This metric is included at Trust level in the monthly Integrated Performance Report Carter dashboard to the Trust Board of Directors.

Average CHPPD levels recorded at CHFT over the last four months have maintained between 7.5 and 7.9. CHPPD (see **Appendix 1**).

The table below details how CHFT's CHPPD levels compare with regional West Yorkshire Acute Trusts. CHFT currently sit on the median line, confirming that the staffing establishment is in line with national trends.

National CHPPD Data from the Model Hospital Portal March 2018



CHPPD data is reviewed monthly by the Nursing and Midwifery Workforce Steering Group and the divisional Associate Directors of Nursing.

Overall the Trust has shown an improving picture in achieving planned CHPPD hours. The overall average is affected by an element of consistent over achievement within divisions. Interrogation of the data indicates that care hours greater than planned are due to increased patient acuity and dependency.

CHPPD methodology is applied to the nursing and midwifery workforce in three of the four clinical divisions. Nationally, CHPPD is not applied to community nursing provision.

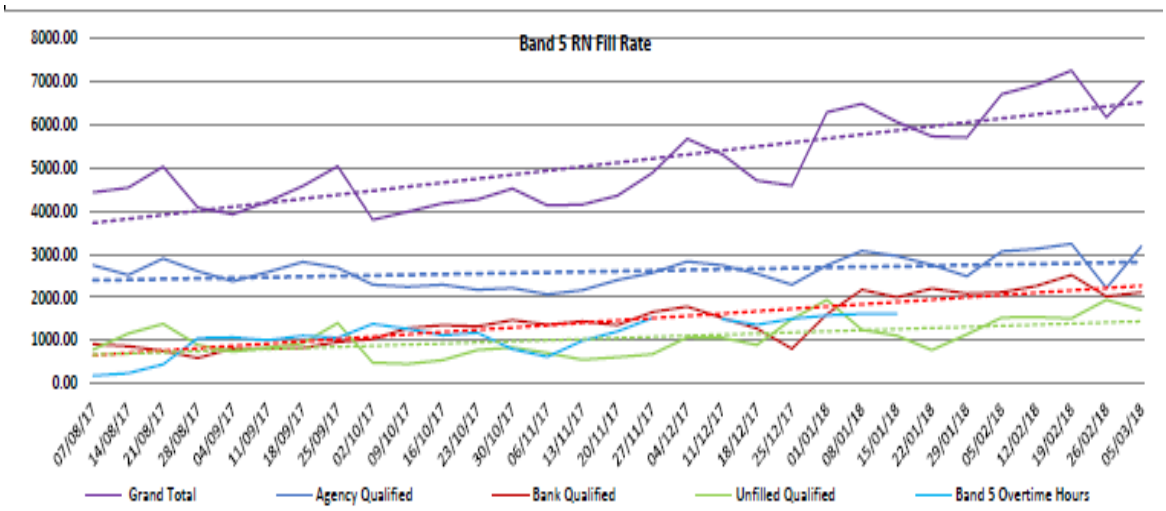
8.0 Financial position:

The current position is projecting a year end forecast that is higher than planned. Agency demand for Registered Nurses needs to continually reduce; both from a patient safety and variable pay spend perspective. Whilst CHFT have observed an increase within the substantive nursing workforce, we have continued to utilise agency nurses to support safe staffing levels in the absence of sufficient substantive supply. The current vacancy factor has been compounded with the use of additional capacity beds and surge in demand due to national winter pressures.

Nursing Expenditure April 2017 to March 2018

Nursing, Midwifery & HCA Pay Expenditure	2017/18 Actual Expenditure											2017/18 Forecast Expenditure	
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Forecast Year End
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Substantive Pay	7,244	7,343	7,293	7,000	7,011	6,889	7,000	7,050	7,009	7,143	7,012	6,923	84,918
Agency	448	475	598	630	365	564	846	453	793	577	625	711	7,086
Bank	226	247	225	249	245	218	366	425	343	428	438	311	3,719
Additional Basic Pay	80	47	45	38	44	28	46	37	38	37	56	52	549
Overtime	273	122	64	104	100	102	86	92	100	73	112	109	1,337
Total Nursing Expenditure	8,270	8,235	8,225	8,020	7,766	7,802	8,345	8,057	8,282	8,259	8,241	8,107	97,608
Planned Nursing Expenditure	8,078	8,078	8,025	7,688	7,667	7,335	7,493	7,496	7,535	7,539	7,497	7,503	91,935
Variance	192	157	200	333	98	466	852	561	747	720	744	603	5,673

Bands 5 fill rates:



The above table illustrates that the Trust is seeing a positive response to the 20% enhancement offered to band 5 staff for picking up bank shifts. February 2018 saw the highest YTD bank fill rates (43%). Agency spend remains constant, however demand continues to increase.

9.0 External staffing review:

In February 2018, the Chief Nurse/Deputy Chief Executive commissioned an independent review of the nursing and midwifery staffing establishment levels at the Trust. This was in order to provide independent quality assurance.

An expert panel comprising of senior nurses and managers from NHS Improvement, the Royal College of Nursing and a number of NHS acute trusts was convened to undertake a review, led by NHS Improvement, supported by Hull and East Yorkshire Trust. The review took place at Huddersfield Royal Infirmary on 13th February 2018.

The review concluded that:

- Nursing establishment levels at CHFT were set in accordance with NQB guidance
- That Board level reporting on safer staffing is undertaken in line with national guidance
- Discussions with the senior team & clinical colleagues affirmed that establishment levels were fair, appropriate and that teams were engaged with the establishment review process
- The review found no excess staffing levels and concluded that there is clear governance over how establishment levels are calculated.

The Full report is contained within **Appendix 3**

10. Conclusion

Nursing and Midwifery establishments are set, monitored and financed at appropriate levels in the Trust. The Trust continues to respond to both the local and national challenges in relation to the recruitment and retention of the workforce The nursing workforce manages this with clear oversight and governance arrangements in place to ensure that safe and sustainable staffing levels are achieved to ensure high quality compassionate care across the trust.

STAFFING - CHPPD & FILL RATES (FEB 2018)

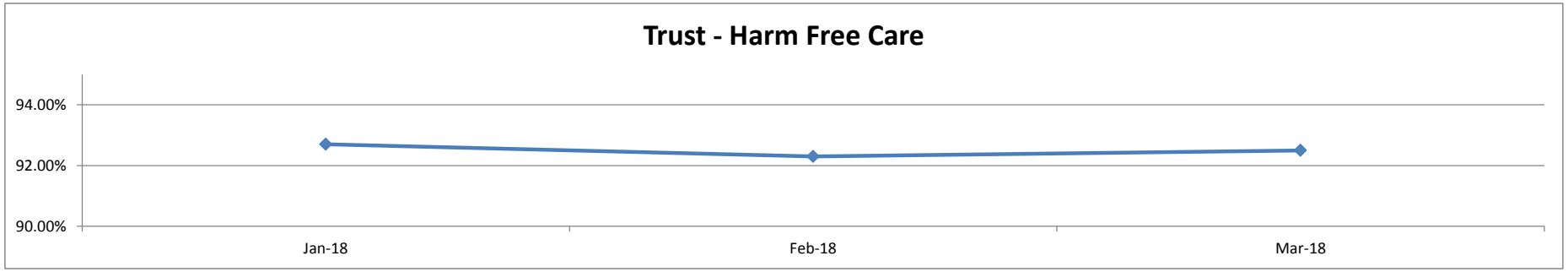
	Total CHPPD						Fill Rates Day		Fill Rates Night		Vacancy Position		Feb-18			
	Registered Midwives/Nurses		Care Staff		Overall		QUAL	UN-QUAL	QUAL	UN-QUAL	Rn Vacancies ESR	Band 2 Vacancies ESR	MSSA (post cases)	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls
	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL										
CRH ACUTE FLOOR	6.1	5.7	5.1	4.8	11.2	10.3	92.2%	83.9%	95.2%	101.9%	6.95	0		1	0	5
HRI MAU	6.1	5.7	5.7	4.8	11.8	10.9	92.9%	86.8%	96.0%	95.4%	0	0			1	14
HRI Ward 5	3.0	2.7	2.5	2.8	5.6	6.0	81.4%	127.4%	98.0%	141.1%	2	0		1	0	13
WARD 15	3.8	3.1	3.8	2.9	7.5	6.9	71.9%	101.0%	96.4%	99.1%	4.5	4.3			1	8
WARD 5C	3.3	3.2	2.2	2.2	5.6	5.6	95.1%	91.2%	98.2%	143.2%	3.28	0			1	0
WARD 6	4.9	4.6	3.5	3.4	8.4	8.4	85.6%	103.7%	104.9%	130.2%	2.4	2			2	12
WARD 6BC	2.9	2.7	1.8	1.9	4.7	4.5	88.6%	98.9%	96.2%	103.6%	0	0		1	0	3
WARD 5B	5.9	4.1	3.0	2.9	8.9	6.9	66.4%	89.8%	74.1%	98.2%	4.74	0			1	1
WARD 6A	2.8	2.4	2.2	1.8	5.0	4.7	83.1%	91.3%	92.9%	135.7%	2.2	1.6			0	1
WARD CCU	7.8	6.9	1.1	3.0	8.9	7.9	83.1%	84.4%	98.8%	-	0	0			1	1
WARD 7B	4.2	4.1	3.3	2.9	7.5	7.8	96.1%	111.6%	98.3%	114.3%	5.9	0			2	2
WARD 7C	8.3	6.1	3.2	4.5	11.5	10.3	75.0%	106.0%	71.4%	200.0%	0	0			0	4
WARD 8	3.4	2.9	3.1	3.4	6.5	7.4	78.6%	146.7%	95.4%	144.5%	7.11	0			1	5
WARD 12	4.3	3.2	1.9	2.0	6.2	5.3	75.1%	97.8%	76.1%	139.3%	2.68	2.5			1	5
WARD 17	3.9	3.2	2.4	2.2	6.4	5.4	73.3%	84.2%	100.0%	98.2%	1.91	0			3	2
WARD 8C	2.4	2.4	1.9	2.1	4.3	4.8	96.9%	105.8%	99.9%	193.3%	6.38	1			0	3
WARD 20	3.5	2.8	3.5	2.6	7.1	6.2	74.4%	92.7%	86.6%	97.2%	4.5	0			6	9
WARD 21	4.6	4.2	4.6	3.7	9.1	8.4	87.7%	88.2%	96.4%	100.0%	7.15	2			3	10
ICU	36.8	32.6	3.6	16.3	40.4	35.3	91.2%	74.3%	86.2%	-	3.77	0			7	0
WARD 3	3.5	3.6	2.3	3.1	5.8	6.9	107.2%	103.6%	100.0%	215.8%	0.46	1.59			1	6
WARD 8AB	8.1	5.6	4.8	3.7	12.9	9.2	73.1%	61.4%	65.8%	119.3%	2.57	0			1	5
WARD 8D	4.0	4.0	2.1	3.2	6.1	7.2	99.2%	87.5%	99.8%	-	1.87	0			0	2
WARD 10	4.1	3.1	1.9	2.6	6.0	5.9	86.0%	101.5%	65.0%	232.5%	7.81	0			1	1
WARD 11	3.2	3.2	2.1	2.5	5.3	5.8	96.6%	86.2%	99.8%	270.5%	2.66	0			0	1
WARD 19	4.5	3.9	3.7	3.8	8.2	8.3	81.5%	119.2%	95.5%	118.9%	1.92	0			2	7
WARD 22	2.6	2.6	2.6	2.2	5.2	5.4	98.4%	103.9%	100.0%	121.4%	1.55	2			1	3
SAU HRI	7.1	6.6	2.8	3.9	10.0	9.4	88.2%	94.1%	99.0%	110.6%	4.27	0			2	0
WARD LDRP	19.5	16.8	3.8	9.7	23.3	19.9	86.6%	79.0%	85.3%	85.9%	0	5.48			0	0
WARD NICU	10.0	8.7	3.7	5.0	13.7	10.4	91.3%	32.9%	83.1%	60.7%	0.86	2.5			0	0
WARD 1D	3.9	3.7	1.4	2.1	5.3	4.9	91.5%	83.0%	100.0%	100.0%	1.72	0			0	0
WARD 3ABCD	7.9	8.1	1.9	4.4	9.9	9.6	94.6%	66.1%	112.2%	122.2%	0	3.5			0	0
WARD 4C	4.2	5.4	2.4	3.0	6.6	7.5	162.8%	83.6%	96.4%	92.9%	3	3.46			0	0
WARD 9	4.3	3.7	1.7	2.6	6.0	5.3	78.1%	87.8%	100.0%	100.0%	2.14	0.57			0	0
Trust	**5.2**	**4.6**	**0.1**	**3.3**	**8.1**	**7.7**	**86.63%**	**94.74%**	**92.12%**	**121.45%**						

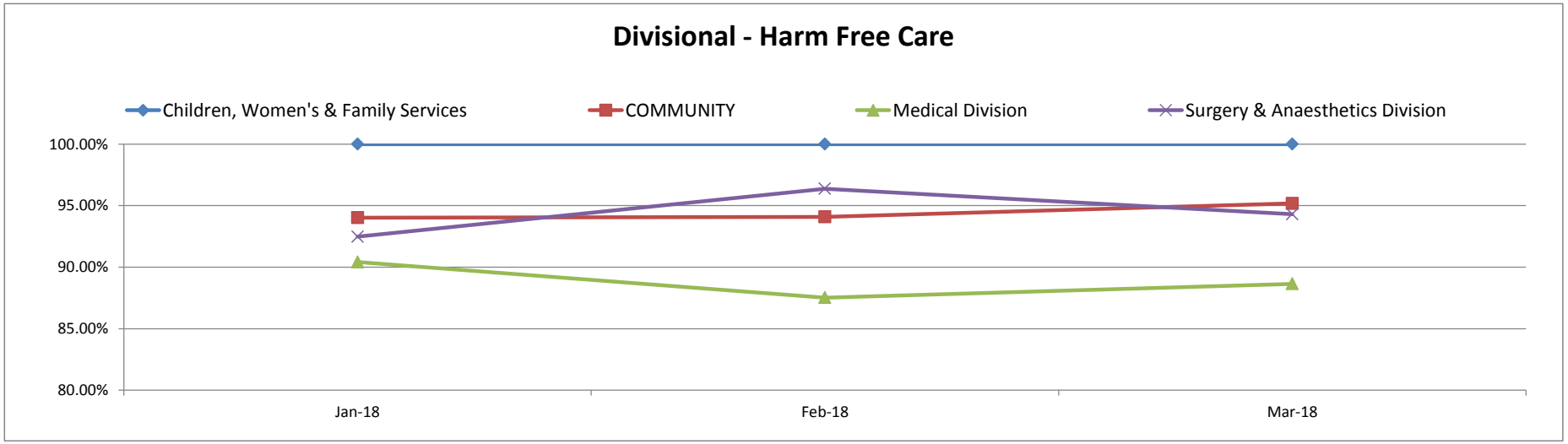
Calderdale and Huddersfield NHS
NHS Foundation Trust

STAFFING - CHPPD & FILL RATES (MARCH 2018)

	Total CHPPD						Fill Rates Day		Fill Rates Night		Vacancy Position		Mar-18			
	Registered Midwives/Nurses		Care Staff		Overall		QUAL	UN-QUAL	QUAL	UN-QUAL	Rn Vacancies ESR	Band 2 Vacancies ESR	MSSA (post cases)	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls
	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL										
CRH ACUTE FLOOR	6.5	5.9	5.4	4.8	11.9	10.2	92.4%	70.9%	89.8%	92.0%	6.95	0			0	3
HRI MAU	5.7	5.2	5.3	4.4	11.0	10.2	93.0%	90.2%	90.5%	97.8%	0	0			1	16
HRI Ward 5	3.6	3.0	3.0	3.1	6.6	6.8	75.7%	123.6%	96.0%	130.4%	2	0			1	10
WARD 15	3.7	3.1	3.7	2.7	7.3	6.5	78.3%	90.7%	91.9%	93.5%	4.5	4.3			0	6
WARD 5C	3.2	3.0	2.2	2.1	5.4	5.6	90.6%	107.2%	94.9%	154.8%	3.28	0			0	1
WARD 6	4.1	3.8	2.9	2.6	7.0	6.9	92.3%	103.1%	91.3%	117.7%	2.4	2	1		0	9
WARD 6BC	2.9	2.7	1.8	1.9	4.7	4.5	92.0%	96.8%	93.0%	112.9%	0	0			0	9
WARD 5B	6.8	4.8	3.5	3.3	10.4	7.6	68.7%	71.8%	72.6%	93.6%	4.74	0			2	2
WARD 6A	2.6	2.2	2.1	1.9	4.7	4.3	75.1%	82.5%	100.0%	148.4%	2.2	1.6			0	5
WARD CCU	8.5	7.6	1.2	3.3	9.7	8.7	82.9%	88.3%	98.9%	-	0	0			0	2
WARD 7B	4.0	4.1	3.1	2.8	7.2	7.5	102.2%	107.7%	99.9%	109.7%	5.9	0			0	3
WARD 7C	8.3	5.8	3.2	4.3	11.5	10.0	69.4%	111.1%	70.2%	187.0%	0	0			0	9
WARD 8	3.2	2.8	2.9	3.3	6.1	7.2	79.7%	151.0%	94.3%	154.9%	7.11	0			3	7
WARD 12	4.0	3.1	1.7	2.1	5.7	5.5	82.4%	108.9%	72.0%	212.9%	2.68	2.5			0	8
WARD 17	3.6	3.0	2.2	2.0	5.9	5.1	74.7%	90.7%	97.8%	98.4%	1.91	0			3	3
WARD 8C	2.6	2.4	2.0	2.3	4.6	4.9	90.3%	91.9%	98.8%	189.4%	6.38	1	1		1	1
WARD 20	3.5	2.7	3.5	2.5	7.1	5.8	73.2%	83.7%	79.2%	97.6%	4.5	0			0	13
WARD 21	4.3	3.7	4.3	3.4	8.7	7.8	78.9%	94.7%	94.2%	96.7%	7.15	2			0	2
ICU	37.3	34.5	3.7	17.5	40.9	36.7	94.7%	57.8%	90.8%	-	3.77	0			2	0
WARD 3	3.8	3.7	2.7	3.1	6.4	7.0	101.4%	95.8%	95.2%	188.7%	0.46	1.59			0	6
WARD 8AB	6.9	4.7	3.8	3.2	10.8	8.1	75.3%	86.4%	59.1%	96.8%	2.57	0			1	1
WARD 8D	3.4	3.3	1.8	2.5	5.3	5.9	96.0%	87.6%	95.2%	-	1.87	0			1	2
WARD 10	4.1	3.3	2.1	2.7	6.2	6.1	89.9%	100.3%	68.8%	223.0%	7.81	0			0	4
WARD 11	3.4	3.2	2.1	2.5	5.5	5.7	94.8%	81.0%	96.9%	241.7%	2.66	0			3	6
WARD 19	4.7	4.1	3.9	4.2	8.6	9.1	78.7%	128.1%	98.8%	130.0%	1.92	0			3	5
WARD 22	2.7	2.6	2.7	2.0	5.3	5.2	96.9%	94.3%	98.4%	101.6%	1.55	2			1	7
SAU HRI	7.0	6.5	3.0	3.8	10.1	9.6	86.4%	102.1%	99.1%	109.7%	4.27	0			0	1
WARD LDRP	17.8	15.0	3.4	8.6	21.2	17.8	86.5%	79.0%	81.9%	88.7%	0	5.48			0	0
WARD NICU	8.4	7.7	3.1	4.5	11.5	9.3	96.3%	40.8%	89.0%	62.9%	0.86	2.5			0	0
WARD 1D	3.4	3.1	1.2	1.8	4.6	4.2	87.3%	100.0%	98.6%	96.8%	1.72	0			0	0
WARD 3ABCD	7.6	8.7	2.0	4.7	9.6	10.4	101.6%	82.6%	130.2%	104.1%	0	3.5			0	1
WARD 4C	4.2	5.6	2.4	3.2	6.7	7.7	163.3%	76.7%	99.9%	98.6%	3	3.46			0	0
WARD 9	3.5	2.8	1.4	2.1	4.9	4.2	67.2%	100.0%	100.0%	100.0%	2.14	0.57			0	0
Trust	**5.1**	**4.5**	**0.1**	**3.2**	**7.9**	**7.4**	**86.85%**	**94.08%**	**91.40%**	**118.28%**						

Divison	Jan-18	Feb-18	Mar-18
Children, Women's & Family Services	100.00%	100.00%	100.00%
COMMUNITY	94.03%	94.09%	95.18%
Medical Division	90.41%	87.53%	88.65%
Surgery & Anaesthetics Division	92.47%	96.37%	94.30%
Trust	92.70%	92.30%	92.50%





Hull and East Yorkshire Hospitals NHS Trust

NHS Improvement

Independent Assurance Review into Nursing and Midwifery Staffing Levels at Calderdale and Huddersfield NHS Foundation Trust

13th February 2018

Lead Authors

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Version: Final Version 5

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

1. Context

The Chief Nurse/Deputy Chief Executive of Calderdale and Huddersfield NHS Foundation Trust, Mr Brendan Brown, commissioned an independent review of the nursing and midwifery staffing establishment levels at the Trust. This was in order to provide independent quality assurance of them to the Trust.

An expert panel comprising senior nurses and managers from NHS Improvement, the Royal College of Nursing and a number of NHS acute trusts was convened to undertake a review, led by NHS Improvement, supported by Hull and East Yorkshire Hospitals NHS Trust (Appendix One refers). The review took place at Huddersfield Royal Infirmary on 13th February 2018.

2. Terms of Reference

2.1 Terms of Reference

The terms of reference were agreed, as follows:

a. Review nursing and midwifery staffing across the Trust for the past year, including funded establishment, vacancies and fill rates compared to the recommendations from the National Quality Board.
b. Undertake ward and department visits, including discussions with the lead nurses to observe staffing levels, management of rotas, escalation processes for staff shortages and use of temporary staff
c. Benchmark CHFT with similar hospitals on the staffing data publically available. The will include Care Hours Per Patient Day (CHPPD), shift fill rate, and skill mix
d. Perform a baseline assessment using the NICE Guidance assessment tool
e. Review actions the Trust has taken to manage its use of temporary staffing
f. Review the Trust's governance, reporting and management of the nursing and midwifery agenda
g. Consider further actions or mitigation the Trust should consider in its response to the challenges of the nursing and midwifery workforce agenda

2.2 Methodology

The methodology was agreed, as follows:

a. Introduction to CHFT and work undertaken to date
b. Review of evidence submitted by CHFT
c. Site tour and ward visits
d. Focus Group interviews with nursing and midwifery staffing leaders

A comprehensive pack of information was supplied to each member of the review team in advance of the assessment. This comprised:

- Safer Staffing reports to the Board of Directors for November 2016, June 2017, December 2017
- National Quality Board (NQB) Guidance, CHFT's position in accordance with this, CHFT's guidance for staffing reviews
- Bi annual acuity reports
- Datasets from safe care live acuity reporting
- Milestone plan describing CHFT work to date on the roll out of safe care live
- CHPPD by division
- Ward level dashboards
- Safe Staffing red flags – 4 months data
- Unify2 data (Safer Staffing Returns)
- Divisional packs – detailing workforce models
- Staffing Assurance – the ongoing assurance work of the nursing and midwifery strategy group

3. Review Findings

The review team undertook a full day of reviews comprising a presentation from the Chief Nurse/DCEO and interviews and focus groups with Associate Directors of Nursing, Heads of Nursing, Matrons and Sisters/Charge Nurses, along with ward visits.

Firstly, it is important to acknowledge the really positive reception given to each member of the review team by officers of the Trust. The team was made very welcome and the preparation for the assessment visit and supporting information were very comprehensive. Collectively, staff were all extremely welcoming, open, honest, professional and transparent and were very generous with their time. A wide range of views and interpretations were gathered and these were fair, balanced and appropriate.

The panel took some time to consolidate its views and were in unanimous agreement of the review findings, which are, as follows:

I. Nursing and midwifery establishments were set appropriately at CHFT, in accordance with the requirements of the National Quality Board (NQB) and good professional practice. However, these establishments cannot be achieved currently without heavy reliance on temporary staffing. It was also considered that the Trust may not have exhausted all alternative skill mix review opportunities and/or the use of new/support roles of different professionals within the ward establishments to address the registered nurse workforce gap.

II. Board reporting is undertaken according to the NQB's required standards and a comprehensive range of information is provided to the Board of Directors. There is opportunity to strengthen Board and operational reporting, whilst making this more succinct. The review team observed the potential for increased use and understanding of the Care Hours Per Patient Day (CHPPD) metric [part of the Lord Carter Productivity and Efficiency work] to inform safe staffing levels and provide assurance.

III. Discussions with the senior nurses and midwives and senior sisters/charge nurses identified that they believed their establishments to be set at fair and appropriate levels. They also confirmed that they were consulted with when these were reviewed and decided, and this was supported by finance colleagues. These staff also agreed that the budget management information provided to them was clear to understand. This is all really positive. However, generally the Senior Sisters/Charge Nurses' understanding of the establishment mark-up percentages was lacking (this was the position almost across all of the teams we spoke with.) It is essential that these budget holders understand exactly what they already have a funded allowance (mark-up) for, e.g. sickness, annual

leave, professional development, etc., otherwise this might not be being managed judiciously and may be contributing to extra costs above funded budget levels.
There were no clear controls for monitoring or controlling this headroom at the point of rota sign off and, also, at operational levels as rotas changed due to sickness. This presents an opportunity for the Trust.

IV. The review team found no 'excess staff', i.e. there was no apparent evidence of any area being over-established above need and requirement. There is good governance over how establishments are calculated, which includes the 'all-essential' professional view, as per NQB guidance. It is important that the integrity of the experienced and senior nurses and midwives are trusted and acknowledged in this respect. This does not mean that they should not be challenged or required to justify their assessments. However, the review team found that CHFT's senior nurses and midwives understand their business in this regard.

V. Whilst not looked at to any significant level of detail, there was no reason to suggest that standards of care that were observed on ward visits were not of a high standard, with engaged sisters and charge nurses.

VI. The review team found that the Trust has significant challenges with nursing and midwifery expenditure, specifically in relation to agency spend. The Trust's Budget for N&M staffing is circa. £91.94 million. Projected spend for FYE 2017/18 is expected to be in the region of £97.6 million, which represents a £5.67 million overspend. However, agency expenditure for the year is expected to be in the region of £7m. This is the main problem. The review team believes this is where the best gains may be obtained to help bring expenditure more in line with budget. This is by restricting demand through better rota management, robust approval systems and processes and reducing the premium costs associated with agency. Full recommendations are made later in this report.

VII. In addition, information obtained at focus groups suggested that there are some habits or cultural behaviours when booking agency staff that would benefit from more robust management and challenge. An example given by a Band 7 Ward Manager suggested that they place their substantive staff more frequently on the weekday shifts as they know the higher weekend pay rates will attract agency, bank and overtime staff, so they will have a better chance of fillings these shifts, albeit more expensively. Whilst arguably intuitive, agency staff are being used at the higher cost periods, which contributes to the overall problem. This could be mitigated by allocating the available substantive staff to cover these weekend shifts. It is recognised that that this would have to be balanced across the working weeks to avoid the risk of the majority of core staffing always working unsocial hours, as this would likely have an adverse impact on retention and staff satisfaction. Also, there is a quality benefit to patients and the Trust by having substantive staff on duty at weekends and out of hours periods.

VIII. The Trust was working to a fill rate metric of 80% when determining the need for temporary workforce. The review team considered that this 'blanket' style approach may not always be necessary. Each situation needs to be judged on its individual merits and validated by a suitably experienced senior nurse, as there may be alternatives to using agency staff on occasions. The review team recommends that a combination of CHPPD, harm and patient dependency rates and further consideration of alternative roles and unregistered support staff may be safer and more sustainable, whilst still being able to meet the needs of patients. This may also release savings and reduce the need for agency on some wards with an increased use of support staff.

IX. With specific reference to midwifery staffing levels, these were set appropriately and the ADN/Head of Midwifery was able to give robust examples as to how her team was flexible and creative in terms of how they provide a safe service to women and their babies. A 1:29 midwife to birth ratio is appropriate and within acceptable levels. Whilst it is accepted that birth numbers are expected to decline this year, caution is advised about any intention to reduce midwifery staffing levels by sheer linear analysis and 'trimming at the edges' as this is neither safe nor appropriate. However, with these caveats, the Trust should still explore actively any cost savings that can be made without compromising patient safety. The only way that substantive midwifery changes will be able to be made is if the Trust changes its services delivery model and consolidates it service provision.

X. It was clear that the Trust is working in uncertain times, in that five extra wards were open at the time of the assessment visit. One of these was reported to be open for 14 months and with no substantive budget. This is due to winter pressures and is not uncommon in many acute trusts at that time of year. Nonetheless, this is a significant number of 'extra' beds and only serves to dilute the substantive nursing workforce. The review found the approach to these extra wards from the senior nurses and midwives to be professional and 'good spirited'. However, all the time these wards are open, they are contributing to the overall cost base and will be increasing the need across the Trust for expensive agency staff. The 'spreading' of substantive staff to cover 'extra' beds may potentially lead to increased clinical risk and reduced productivity, including increased length of stay for patients. It is recommended that the Trust reviews these 'extra' beds and develops a shared-system plan with all partners to reduce this number as soon as is practicable.

XI. The Trust has a very skilled and dedicated e-roster team. They have done good work rolling out the Allocate Healthroster e-roster system and are rolling out the SafeCare module and Insights reporting, also. This is really important work if the Trust is to get into a more 'real-time' information and safer staffing assurance position. Also, this will strengthen real-time monitoring of patient harms and 'red flags'. Moreover, this will help with closer roster scrutiny in order to ensure best productivity and efficiency of the Nursing and Midwifery workforce and the 'Lord Carter' work. An example of the information that these

systems provide is in relation to the number/percentage of agency staff used by each day of the week. CHFT's current 'Insights' analysis shows the greatest use of agency staff is on Saturdays and Sundays, at 15.38% (Sat) and 17.79% (Sun), compared with 12.9%-14% during Mon-Fri. These higher usage days coincide with higher bank, agency and overtime pay rates (and costs therefore) and this represents an area for greater attention by the Trust.

XII. Sometimes, relatively low numbers of staff were unavailable due to high sickness, annual leave and carers' leave etc. and this requires further review by the Trust. The Trust was an outlier in this measure. This has been seen in other Trusts that do not always manage actively time in lieu to stop significant time accrual. Where Trusts have worked with NHSI in this area, they have actively managed this metric back to within budgeted levels and significant savings have been achieved. Full and 'live' e-rostering will enable this to monitored more effectively and more closely, also.

XIII. CHFT benchmarks as 'high' (in the upper quartile) in terms of the skill mix of RN's to consultant medical staff. Also, the Trust is in the lower quartile for employment of non-registered staff. This benchmark suggests skill-mix opportunities exist at the Trust, which may help to improve financial efficiency. It is recommended that the Trust has a clear plan for where the non-registered workforce will be deployed and how these will be used to support RGN vacancies rather than increasing CHPPD.

XIV. The Trust's staff bank had been unable to supply the level of demand for unregistered staff support i.e. Band 4 or below. This means that, on some occasions, agency Band 5s were being used to cover Band 4 positions. The recommendation is for the Trust to appoint sufficient unregistered bank staff to eliminate the need for expensive unregistered agency staff.

XV. In view of the national shortage of available registered nurses, there is an opportunity for the Trust to consider employing more unregistered support staff to help fill RN vacancy gaps and strengthen the overall numbers of nursing and care staff. In turn, this will help to reduce the reliance on agency staff.

XVI. The review team welcomed the work describing the changes to the procurement of variable staff and pay. These included ceasing to employ from poorly performing agencies, increasing bank pay rates, creating Standard Operating Procedures relating to agency booking and aligning the agency budgets to wards. Work needs to be done to ensure that Ward mangers transact these plans, as described, so that better assurance can be provided to the Chief Nurse, Executive and Board of Directors.

XVII. There may be opportunities to work with other provider trusts in the STP to consider whether bank pay rates could be standardised across organisations as a more collective approach to reducing the dependency on expensive agency staff. This may help to add more stability and reduce competition between trusts.

4. Recommendations

The review panel accepts there are some limitations in terms of covering such a comprehensive range of ground and issues in only one day and accepts that some of its recommendations may already be being addressed or considered by the Trust. As such, these are offered merely for the Trust's consideration:

i. The Trust has a significant challenge with N&M spend in relation to agency staff and provides its best opportunity for targeting efforts and possible cost efficiencies. Things that the Trust should consider, include:
ii. Improved controls for the booking of agency staff and their disposition by day of the week, alongside greater challenge to B7 nurses to achieve better deployment across their rotas
iii. Management of the trusts demand for agency by control headroom to within budgeted establishment and considering reduced fill rates.
iv. Negotiating with other local trusts to develop a combined approach/consortium to use their collective 'buying power' to negotiating pay rates with the high cost agencies.
v. The trust should consider setting up a bank of band 4 staff and enhancing the bank for other unqualified staff
vi. Consider extending weekly pay arrangements for all bank staff.
vii. Continue to support the rollout of the Allocate e-roster, SafeCare and Insights information reports. This will help with many things, including:
    a. Improved daily/real-time safer staffing assessments and assurance to the Chief Nurse/DCEO
    b. More regular acuity and dependency assessments to assist with staff deployments
    c. Better recording of staffing 'red flags'
    d. Assists with the bi-annual N&M establishments (NQB requirements)
    e. Improved rota efficiency – excess hours, down time, Carter metrics, sickness/absence, etc.
    f. There also appeared to be a limited number of shift patterns available; Allocate will help the trust to understand if more flexibility with shift patterns may help in terms of increasing availability.
    g. Always setting the rosters at least 12 weeks in advance
    h. Urgent prioritisation/consideration should be given to the planned rollout of the community allocate model.
    i. Improve the understanding of the Ward Sisters/Charge Nurses and Matrons in relation to the current 22% percentage head room mark-up within establishments, and ensure that the Ward Managers are following the agreed Trust strategy for the reduction of agency

spending. Only limited assurance could be found by the reviewing team (i.e. Maternity Services) that this was happening. There appears to be no checks and balances to identify variance from the Trust's protocol. This is important so that budget holders are held accountable and understand how well they are managing their annual leave, study leave, etc. alongside their usage of variable pay and productivity and efficiency metrics. This may help to reduce the Trust's outlying position of reduced availability of staff.

viii. The information provided to the Board of Directors is significant and comprehensive. However, this could be simplified and some suggestions have been offered to the Chief Nurse to assist with this. Another suggestion would be to present CHPPD data alongside quality and establishment metrics so that a more 'rounded' assessment can be made. This is increasingly the direction we are seeing Trusts move towards.

ix. With regard to the Maternity model, the Trust could make substantive midwifery staffing costs if it was to consolidate its provision model, e.g. consolidate the two birthing units into one. With the midwifery levels as they are currently, only big service-model provision changes like this will generate the levels of savings needed and may increase clinical outcomes for women/babies, also, by concentrating experienced staff into fewer units.

x. The review team suggests a review of specialist nursing and midwifery provision is undertaken if it hasn't been already. This was not considered by the review team but could be an area for attention as they often comprise highly banded staff. Also, the job plans of the specialists nurses in community services indicates variation of delivery, reduced time in direct care and that a significant proportion of their time is spent on administrative tasks. Sometimes, by organising these into better team structures with appropriate administrative support, greater efficiencies can be realised.

xi. Consideration needs to be given at a ward level of setting the fill rate metric at 80%; this may release efficiencies on some wards with an increased use of support staff.

xii. The Safer Staffing guidance and NQB guidance is as a consequence of the Francis Report(s) findings. It is essential that this and the care and safety of patients is at the forefront of the Trust's business. The review team believes that CHFT does have this focus and the range of suggestions from the review team can be addressed reasonably without changing this focus or incurring additional costs.

Nonetheless, it is recommended that any changes to systems and process and monitored closely by the senior nursing and midwifery teams to ensure that there are no adverse impacts on patients and staff.

The review team trusts that this review is useful to the Trust and helps to guide where further work might be helpful. Members of the review team would be happy to present its findings to the Trust should that be required. Please do not hesitate to get back to the review team should any clarification and/or further help be required.

For and on Behalf of the Review Team:

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Appendix I. Review Team

Review Contributors

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Julie Molyneux	Deputy Director of Nursing	East Lancashire Hospitals NHS Trust
Rebecca Hoskins	Assistant Director of Nursing	York Teaching Hospital NHS Foundation Trust

External Scrutiny of the Findings Requested From

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report - Please refer to the full report for the Trust's overall Performance Score for March 2018	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board – Thursday 26th April 2018 and Quality Committee – Monday 30th April 2018	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

March's Performance Score has improved by 5 percentage points to 62%. The SAFE domain has returned to green with PPH and Category 4 pressure ulcers back on target. CARING domain has maintained its amber performance, but did not achieve the FFT levels expected in A&E and Community. EFFECTIVE improved, mainly due to no MRSAs, unlike February 2018. The RESPONSIVE domain deteriorated with only 1 out of 4 Stroke indicators achieving target, Cancer maintained its good performance. EFFICIENCY & FINANCE improved slightly with better Theatre utilisation.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to note the contents of the report and the overall performance score for March 2018.

Appendix

Attachment:

Integrated Performance Report Mar 2018.pdf

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

March 2018

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

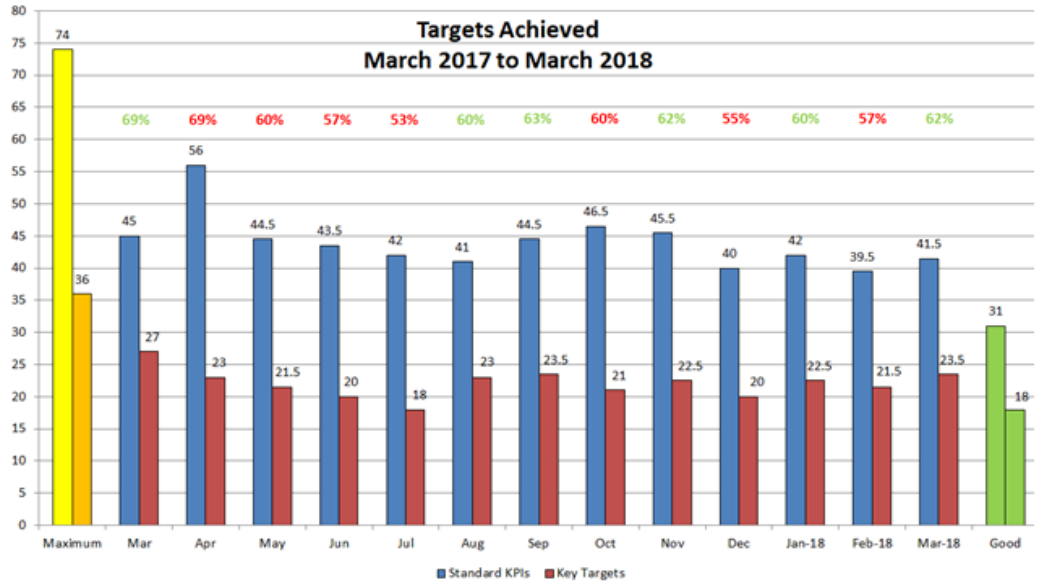
Performance Summary

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. There were no such cases this month.

Comparing March 2018 performance to March 2017 performance

March 2018 performance **(61.5%)** was **7.7 percentage points (56 points)** worse than **March 2017 (69.2%)**. The main areas of deterioration are ECS, 4 Finance metrics and Mandatory Training.



Comparing 12 months' cumulative performance to March with same period in 2016/17

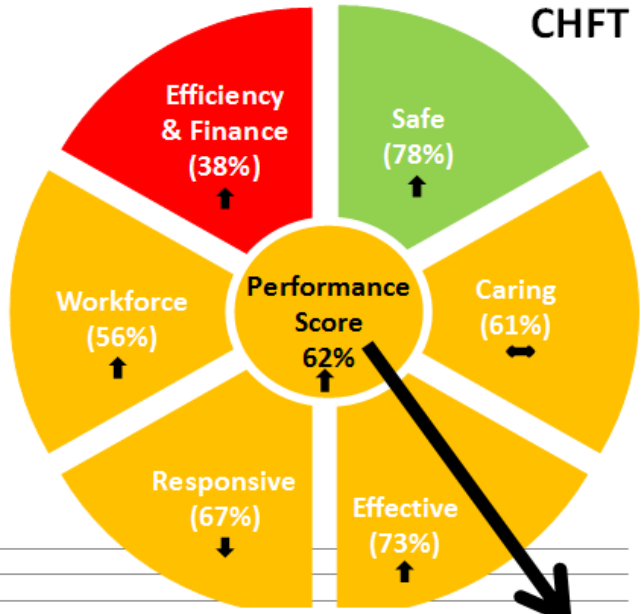
Period to March 2018's performance **(59.8%)** was **3 percentage points** worse than **period to March 2017 (62.8%)**. The main area of deterioration was **Mandatory Training**, this is only compensated by an equivalent improvement in **Sickness Absence**. Other contributory areas are **Cancer 2 week waits and 62 day RTT, Diagnostic Waits, FFT A & E Survey, I&E, CIP** and **Activity**. **SHMI and HSMR** have improved.

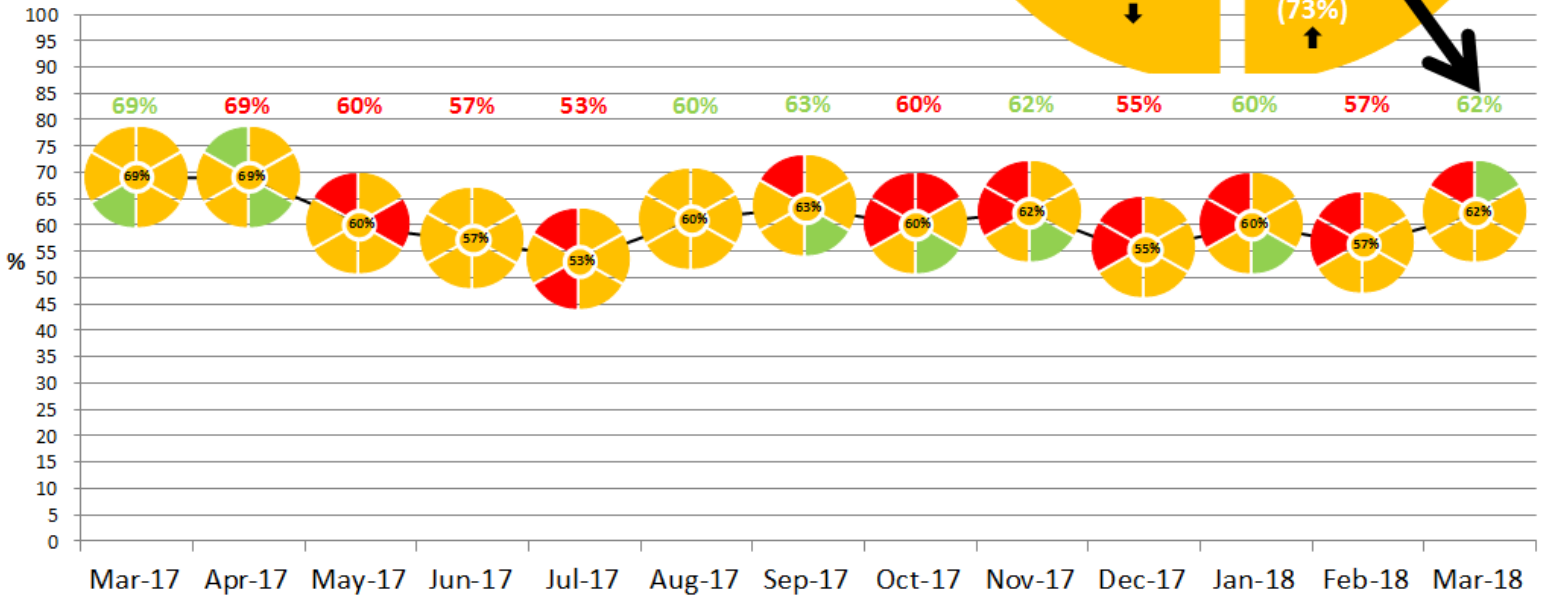
Performance Summary

March

RAG Movement

March's Performance Score has improved by 5 percentage points to 62%. The SAFE domain has returned to green with PPH and Category 4 pressure ulcers back on target. CARING domain has maintained its amber performance but did not achieve the FFT levels expected in A&E and Community. EFFECTIVE improved mainly due to no MRSAs unlike February. The RESPONSIVE domain deteriorated with only 1 out of 4 Stroke indicators achieving target, Cancer maintained its good performance. EFFICIENCY & FINANCE improved slightly with better Theatre utilisation.





SINGLE OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	FFT IP FFT Maternity FFT Community
FFT OP FFT A&E	
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
CDiff Cases	Preventable Cdiff
MRSA	SHMI
HSMR	

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

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.6%	97.6%	⬅➡	96.3%
	Inpatient Complaints per 1000 bed days	2.2	2.6	⬆	TBC
EFFECTIVE	Average Length of Stay - Overall	4.93	4.78	⬇	5.17
	Delayed Transfers of Care	2.70%	1.89%	⬇	3.5%
	Green Cross Patients (Snapshot at month end)	108	124	⬆	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	85.19	86.16	⬆	100
	Theatre Utilisation (TT) - Trust	80.5%	80.7%	⬇	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	1.07%	0.76%	⬇	0.6%
	Emergency Care Standard 4 hours	85.29%	87.46%	⬇	95%
	% Incomplete Pathways <18 Weeks	93.75%	92.76%	⬆	92%
	62 Day GP Referral to Treatment	90.9%	88.2%	⬆	85%
SAFE	% Harm Free Care	92.50%	92.30%	⬆	95.0%
	Number of Outliers (Bed Days)	889	907	⬆	495
	Number of Serious Incidents	4	6	⬆	0
	Never Events	0	0	⬅➡	0

MOST IMPROVED

Mandatory Training - Fire Safety and Safeguarding both green with Data Security Awareness and Infection Control both amber. Excellent improvement over the last 2 months of the year.

All key cancer targets maintained for the 5th consecutive month.

HSMR and SHMI have both improved significantly during 2017/18.

MOST DETERIORATED

Friends and Family Test A & E Survey - % would recommend the Service - Performance at 82.1% lowest since May 2017. Full year 85% against 88.5% last year

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

ACTIONS

Splitting this by site shows that the issues are at the HRI site; the team is looking at the feedback and how this reduction can be addressed. Both CDU's have also taken a dip in their response rate and this has been fed back to clinical teams so that they can drive an improvement here.

Arrow direction count ⬅➡ 2 ⬆ 9 ⬇ 8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.4	7.7	⬇	
Sickness Absence Rate	4.41%	4.75%	⬆	4.0%
Turnover rate (%) (Rolling 12m)	12.95%	12.87%	⬇	12.3%
Vacancy	362.39	331.07	⬇	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q2	79.0%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q2	57.0%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£13.77	-£17.90	🔴
Expenditure vs Plan var (£m)	-£1.55	£1.36	🟡
Liquidity (Days)	-34.30	-23.92	🔴
I&E: Surplus / (Deficit) var - Control Total basis (£m)	-£7.97	-£10.38	🔴
CIP var (£m)	-£2.09	-£1.02	🔴
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	17.67%	14.97%	🔴

Executive Summary

The report covers the period from March 2017 to allow comparison with historic performance. However the key messages and targets relate to March 2018 for the financial year 2017/18.

Area	Domain
Safe	• **% Harm Free Care** - Performance at 92.5% was below full year 93.66%, both below target and 16/17 94.26%. Going forward the Medicine division will have a matron and ward manager leading on the audits to ensure a high level of accuracy.
Caring	• **Complaints closed within timeframe** - Of the 48 complaints closed in March, 52% were closed within target timeframe. With continued support from the Divisional triumvirate, the backlog of breaching complaints is expected to be cleared by the end of May. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 90.6% still below 95.7% target. The planned Q3 review was delayed and now a Q3 + Q4 review will take place in April to inform future patient experience plans. • **Friends and Family Test A & E Survey -** Response Rate is still around 10% which is below the 13.3% target. 17/18 figures at 10.2% below last year's performance of 12.7%.% would recommend has fallen to lowest performance since May 2017 at 82%. Full year 85% against 88.5% last year. Splitting this by site shows that the issues are at the HRI site; the team is looking at the feedback and how this reduction can be addressed. Both CDU's have also taken a dip in their response rate and this has been fed back to clinical teams so that they can drive an improvement here. • **Friends and Family Test Community -** Response Rate has dropped slightly to 2.8% and needs to reach the 3.5% target. A working group has been established that has reviewed the process of collecting data. From May we will revert to collecting FFT data on a daily basis so we should start to see an improvement in response rates from then.
Effective	• **Clostridium Difficile Cases** - There were 7 cases in March making 40 for the year against 32 last year. The Infection control plan continues to be worked through, the local ward assurance tool is now in use. Performance from this will go to PSQBs in the future. C.Diff (preventable cases) are still within tolerance. • **E.Coli - Post 48 Hours** - There were 4 cases in March with year end total just one above last year's total. E.Coli is being managed through a health economy action plan as they look to reduce incidences in the community and hospital environment. The Trust regularly feeds into this plan. Numbers continue within variation and known to be increasing nationally. • **Mortality Reviews** - 24.4% lowest performance since July 2017. A step by step guide has been developed to support consultants and SAS doctors to perform ISRs with face to face support where required. Structured Judgement reviewers are requested to be completed within 2 weeks of allocation and are being discussed at the LfD panel. • **% Sign and Symptom as a Primary Diagnosis** - Performance has worsened again to 10.4% same as full year performance which is above last year's 8.6%. The audit work continues within specialties and S&S cohorts. Discussions are taking place regards the replacement of 2 wte coders that retired at the end of March. The team also have a number of sickness issues and staff on maternity leave. Recruitment is in process.

Background Context

During March all divisions were keeping services running smoothly whilst preparing for the CQC revisit. The Trust had a planned Use of Resources review and 2 unannounced CQC inspections.

All teams were focussed on completing annual plans with work on activity phasing, capacity and demand planning and actions to reduce agency spend.

The Health & Social care system continued to be busy in March with prolonged increased acuity and demand culminatling in increased volumes of 'stranded' patients i.e. those with a LOS over 7 days. The Trust remained at OPEL 3 and the system continued with 3 times weekly Silver calls.

Escalation beds on both sites remained open to support increased bed occupancy and routine elective inpatients remained restricted.

There were sporadic outbreaks of Norovirus which closed some capacity and restricted flow.

Learning from January was used to plan for Easter and all agreed actions were implemented before the bank holiday which secured greater resilience through and after the bank holiday.

Executive Summary

The report covers the period from March 2017 to allow comparison with historic performance. However the key messages and targets relate to March 2018 for the financial year 2017/18.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** 85.29% in March, (86.67% all types) - Silver command has remained in place throughout March, focus on additional out of hospital capacity remains in place but challenging increasing LOS in both acute beds and Community Place. Full winter plans remain in place including only operating on emergency, cancer and time critical patients; admission avoidance remains key with increases to frailty and ambulatory services. • **Stroke** - only % stroke patients thrombolysed within 1 hour achieved target at 100% although only % stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival did not improve year on year. A review of the three missed targets has been undertaken with more detail within the domain narrative. Work continues on the Stroke ISR action plan through the Stroke Action Team and the Stroke Clinical Governance meeting and this is reviewed via the monthly Directorate PRM. • **38 Day Referral to Tertiary** - 45% for 2017/18 compared to 42.4% last year. The Red2Green methodology is to be applied to Urology, Head and Neck and Lower GI pathways from April which will track pathways in relation to being on track and meeting key milestone dates (green) and those which are off track and in breach of key milestones (red). This additonal alerting system will give greater visability to the patients who are not progressing as quickly as they might through the pathways and enable further conversation to help expedite diagnostics and treatment.
Workforce	• **Overall Sickness absence/Return to Work Interviews -** Sickness rates improved in February both long and short term to overall rate of 4.41%. Return to Work Interviews deteriorated to 58.5%. Attendance management sessions are being held across divisions. • **All 5 Mandatory Training** focus areas have improved in-month with Fire Safety on target and Safeguarding achieving target, Data Security and Infection Control just below target.
Finance	• **Finance**: Reported end deficit position of £47.68m, on a control total basis (excluding the impact of loss of Sustainability and Transformation funding (STF)) the reported year to date deficit position is £23.91m an adverse variance of £7.97m compared with the control total of £15.94m; • Delivery of CIP is £17.91m this is below the planned level of £20.00m; • Capital expenditure is £1.23m above plan; • Cash position is £2.00m, slightly above the planned level; • A Use of Resources score of level 3, in line with the plan. At the year end the gap to our control total was £7.97m which is in line with the position agreed with NHSI at Month 9. This excludes the impact of loss of STF funding. £7.4m of performance based STF funding has been lost based on Q1 & 2 A&E performance and financial performance in M7-12. This has been partially offset by the decision to allocate the Trust £2.89m of 'bonus' STF funding as part of a general distribution to organisations that agreed their 17/18 Control Totals. It should be noted that whilst the overall position is in line with the forecast and NHSI expectations there were a number of significant movements from forecast in Month 12. The divisional positions were materially worse than forecast across FSS (£0.17m), Surgery (0.38m) and Medicine (0.25m) with the adverse movement being predominantly driven by medical and nursing pay. This adverse movement was compensated largely by central technical benefits including £0.7m from the revaluation of investment property within the Joint Venture, £0.2m VAT rebate and £0.4m reduction to depreciation. Once again, these benefits are in the main non-recurrent and have contributed to a total of £18m of one-off benefits that have been realised in year.

Background Context

In order to support a sustained increase in acute activity within the Trust a decision was made in March to suspend the Huddersfield Birth Centre service until April 16th. During this period birth centre bed capacity was released to support inpatient activity within Surgery and Medicine.

Following support to progress replacement of the MRI scanner on the CRH site, the capital group responsible for delivering this scheme met for the first time in March.

The Pathology management team met with colleagues from Mid-Yorkshire Hospital and Leeds Teaching Hospital to discuss further opportunities to develop partnership working across the 3 Trusts.

We were commended on a number of strong areas of performance by NHSI during the Use of Resources review including use of biosimilars in Pharmacy (top 10% in the country), cost per test in Pathology (top quartile) and use of extended practice in Radiology and Pathology.

The Community division responded to the CQC unannounced inspections that were undertaken in March that involved an inspection within the Community Place.

Divisions continued to focus on activity and CIP schemes for 2018/19 and robust annual planning.

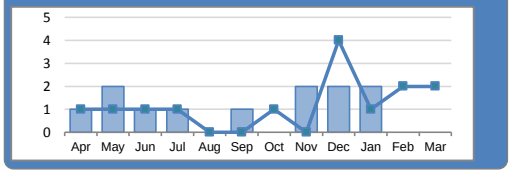
Safe, Effective, Caring, Responsive - Community Key messages

Area	Reality	Response	Result
Safe	**Falls Incidents** There were 19 incidents reported in February related to a fall. This included a serious incident that is currently under investigation. Service line feedback suggests this is in part related to improved reporting within the division.	**Falls Incidents** Each falls incident is reported via DATIX. The division presented a recent report to March PSQB meeting which identified falls make up the highest 3 incident categories which are CHFT attributable. Division will undertake a deep dive in this area.	**Falls Incidents** To develop an informed understanding around the upward trend of falls reporting within the division. A deep dive undertaken by an expert within this field will ensue best practice is being adhered to across the division and any key learning is shared promoting patient safety. **By when: Review May 2018** **Accountable: ADN**
Effective	**Leg Ulcer healing rate** There is one patient with a leg ulcer that has not healed within 12 weeks out of 20 patients receiving treatment.	**Leg ulcer healing rate** The patient's case has been reviewed by the clinical manager. The patient declined elements of the recommended care which may have impacted upon healing rates. However the ulcer continued to show steady improvements, healing at 15 weeks.	**Leg ulcer healing rate** Continued focus on leg ulcers will maintain high rates of healing within 12 weeks and support achievement of the wound CQUIN. **By when: May 2018** **Accountable: ADN**
Caring	**FFT** Our FFT results for March show that 97.5% of respondents would recommend our services compared to 96.4% in February, an increase of 1.1 percentage points. On a year to date basis this figure has increased to 91.9% (91.4% in February). The response rate has reduced from 3.4% to 2.8% which needs addressing.	**FFT** A working group has been established that has reviewed the process of collecting data. From May we will revert to collecting FFT data on a daily basis so we should start to see an improvement in response rates from then.	**FFT** We will continue to monitor the response rate and process of collecting and reporting data and should see an improvement by the end of May. **By when: Review May 2018** **Accountable: Director of Operations**
Responsiveness	**Waiting Time for Children's services** This area continues to be highlighted as a high risk on our risk register. The main challenges are in Speech and Language therapies with 172 children waiting at Huddersfield and 273 at Calderdale. The Huddersfield waiting time is currently 10 weeks whilst the Calderdale waiting time has decreased to 21 weeks.	**Waiting Time for Children's services** Locum support is in place and successful applicants are being appointed, awaiting start dates. Deep dive of Paediatric SALT service requested and to present to WEB in April.	**Waiting Time for Children's services** We will continue to monitor the waiting times and prioritise new patient clinics to reduce waiting times. **By when: April 2018** **Accountable: Head of Therapy Professions**

Dashboard - Community

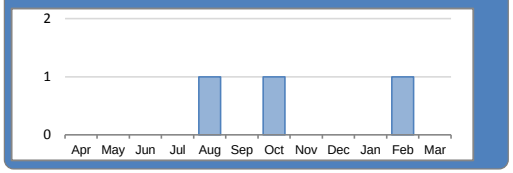
Safe

Community acquired grade 3 or 4 pressure ulcers



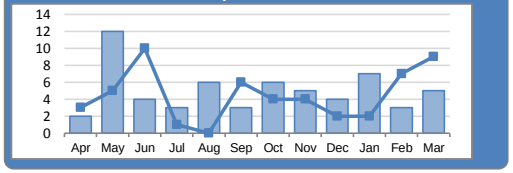
One month in arrears

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

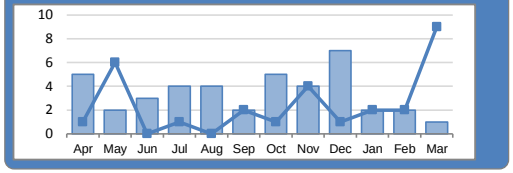


One month in arrears - Orange + Red Harms Only

Incidents - New Harms Safety Thermometer

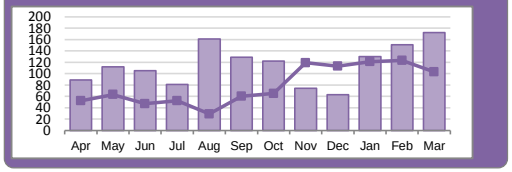


Medication Incidents

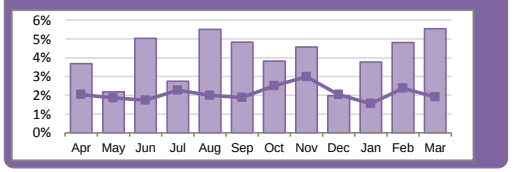


Effective

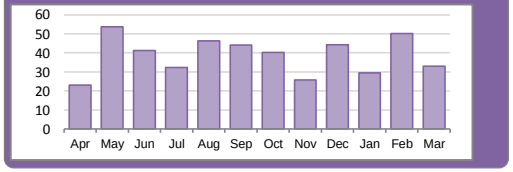
Number of Hospital admissions avoided by Community Nursing services



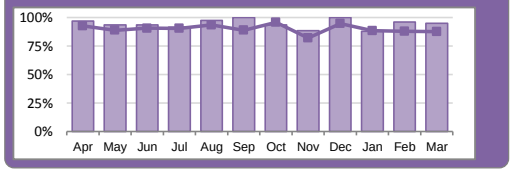
Patients who attended A&E while on a Community Matron Caseload, who readmitted within 30 days



Intermediate Care Bed base (Average Days)

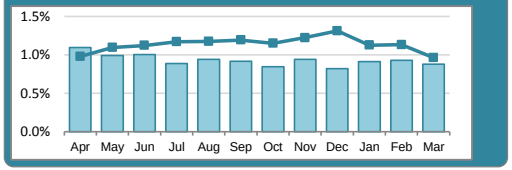


House Bound leg ulcers healed within 12 weeks

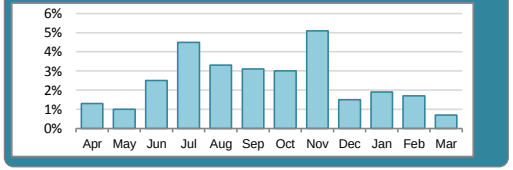


Caring

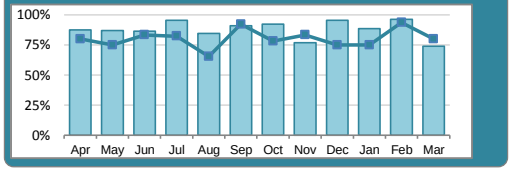
Community No Access Visits Adult Nursing



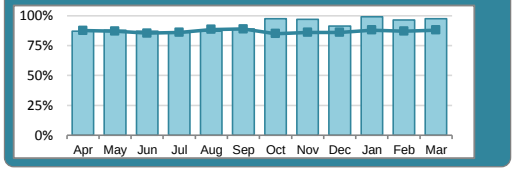
Intermediate Care Readmission rate



End of life patient died in preferred place of death

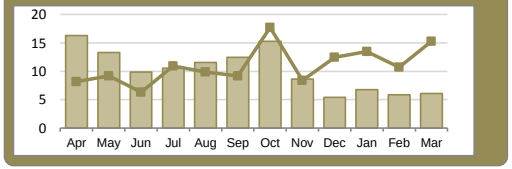


Friends and Family Test- Likely to recommend

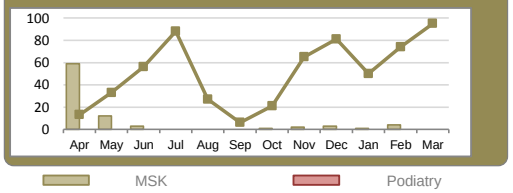


Responsive

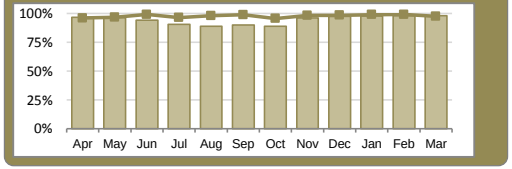
Average time to start of reablement (days)



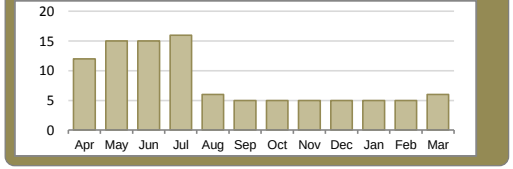
Appointment Slot Issues for MSK & Podiatry



Waiting Times - 18 week RTT

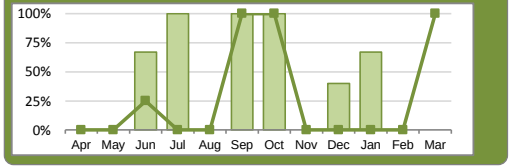


Waiting Times - Physiotherapy Routine (Weeks)

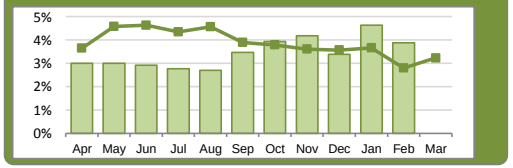


Well Led

% Complaints closed within target timeframe

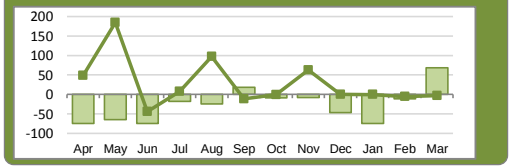


Staff sickness rate

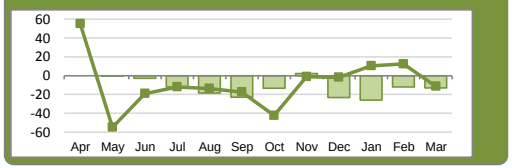


One month in arrears

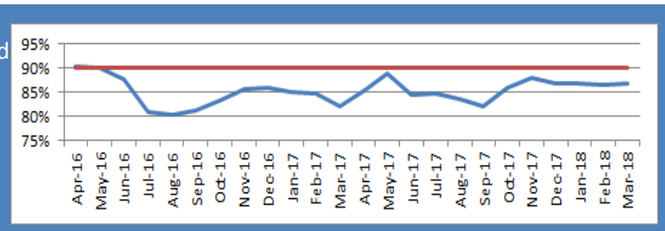
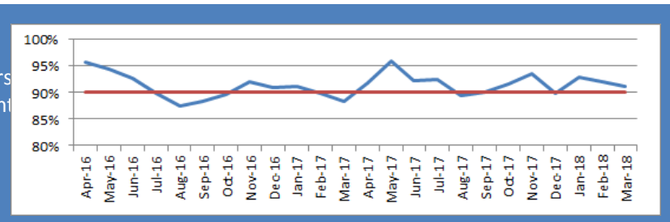
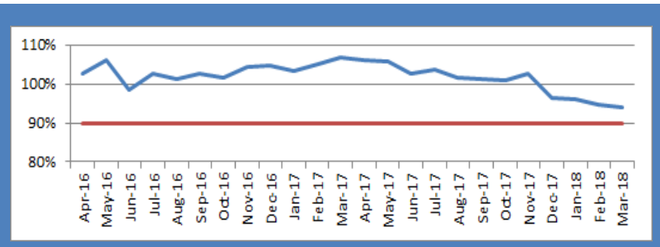
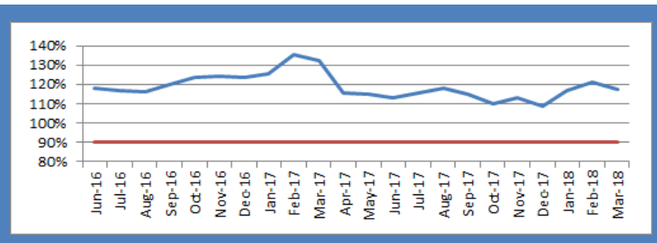
Finance - Planned variance against actual (£'000)



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



Hard Truths: Safe Staffing 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.	86.85% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - 5b 68.7% - 7a/d 73.2% - 7c 69.4% - 17 74.7% - 20 73.2% - 9 67.2%	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 reported in March 2018 are due to a level of vacancy and the teams not being able to achieve their WFM.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	91.40% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - ward 5b 72.6% - ward 7c 70.2% - ward 8a/b 59.1% - ward 10 68.8% - ward 12 72%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. The low fill rates are due to teams supporting additional capacity beds, a level of vacancy, a level of sicknees and embedding new WFM to support re-configuration of medical services. The low fill on ward 8a/b is due to the variable bed base.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	94.08% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - ICU 57.8% - NICU 40.8% - Ward 3ABCD 66.1% - 5b 71.8%	The low HCA fill rates in March are attributed to flucuating bed capacity, support of additional capacity ward, a level of HCA vacancy within the FSS division and re-configuration of medical services. This is managed on a daily basis against the acuity of the work load. Recruitment plans are in place for all vacant posts. 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.	118.28% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% - NICU 62.9%	NICU had a fill rate of less than 75%. This is managed operationally by the senior team. Fill rate in excess of 100% can be attributed to supporting 1-1 requirements and support of reduced RN fill.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	DAY						NIGHT						Care Hours Per Patient Day							
	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	MSSA (post cases)	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month Behind)	Falls	Total RN vacancies	Total HCA vacancies
	Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual										
CRH ACUTE FLOOR	3162	2922.17	2883	2043.83	92.4%	70.9%	2728	2,450.25	2046	1,881.50	89.8%	92.0%	11.9	10.2			0	3	6.95	0
HRI MAU	2046	1903.5	2139	1928.83	93.0%	90.2%	1705	1,543.83	1364	1,333.75	90.5%	97.8%	11.0	10.2			1	16	0	0
HRI Ward 5 (previously ward 4)	1674	1266.5	1209	1494.5	75.7%	123.6%	1023	981.75	1023	1,333.83	96.0%	130.4%	6.6	6.8			1	10	2	0
WARD 15	2046	1601.42	2046	1855.92	78.3%	90.7%	1364	1253	1364	1276	91.9%	93.5%	7.3	6.5			0	6	4.5	4.3
WARD 5C	1069.5	968.97	837	897.33	90.6%	107.2%	682	647.50	341	528	94.9%	154.8%	5.4	5.6			0	1	3.28	0
WARD 6	1674	1545.42	1209	1246.67	92.3%	103.1%	1023	934.17	682	803	91.3%	117.7%	7.0	6.9	1		0	9	2.4	2
WARD 6BC	1674	1540.5	1209	1170.67	92.0%	96.8%	1364	1269	682	770	93.0%	112.9%	4.7	4.5			0	9	0	0
WARD 5B	2046	1405	1069.5	768.1667	68.7%	71.8%	1364	990.00	682	638.5	72.6%	93.6%	10.4	7.6			2	2	4.74	0
WARD 6A	976.5	733	976.5	805.5	75.1%	82.5%	682	682.00	341	506.00	100.0%	148.4%	4.7	4.3			0	5	2.2	1.6
WARD CCU	1674	1387.92	372	328.5	82.9%	88.3%	1023	1012	0	22	98.9%	-	9.7	8.7			0	2	0	0
WARD 7AD	1674	1225.83	1581	2108.08	73.2%	133.3%	1023	1012	1023	1138	98.9%	111.2%	6.5	6.8			0	6	1.19	0
WARD 7B	837	855.58	837	901.5	102.2%	107.7%	682	681.5	341	374.00	99.9%	109.7%	7.2	7.5			0	3	5.9	0
WARD 7C	1674	1161.53	837	930	69.4%	111.1%	1364	957	341	637.5	70.2%	187.0%	11.5	10.0			0	9	0	0
WARD 8	1441.5	1148.83	1209	1825.5	79.7%	151.0%	1023	965.00	1023	1585	94.3%	154.9%	6.1	7.2			3	7	7.11	0
WARD 12	1674	1379	837	911.67	82.4%	108.9%	1023	737	341	726	72.0%	212.9%	5.7	5.5			0	8	2.68	2.5
WARD 17	2046	1528.75	1209	1096.5	74.7%	90.7%	1023	1,001.00	682	671.00	97.8%	98.4%	5.9	5.1			3	3	1.91	0
WARD 8C	837	755.83	837	769.33	90.3%	91.9%	682	674.00	341	645.83	98.8%	189.4%	4.6	4.9	1		1	1	6.38	1
WARD 20	2046	1496.83	2046	1711.92	73.2%	83.7%	1364	1,080.75	1364	1331.5	79.2%	97.6%	7.1	5.8			0	13	4.5	0
WARD 21	1534.5	1210.15	1534.5	1453.5	78.9%	94.7%	1069.5	1007	1069.5	1034.5	94.2%	96.7%	8.7	7.8			0	2	7.15	2
ICU	4030	3817.75	821.5	474.5	94.7%	57.8%	4278	3884	0	11.5	90.8%	-	40.9	36.7			2	0	3.77	0
WARD 3	945.5	959	821.5	786.83	101.4%	95.8%	713	678.5	356.5	672.75	95.2%	188.7%	6.4	7.0			0	6	0.46	1.59
WARD 8AB	1054	793.9	821.5	710.17	75.3%	86.4%	1069.5	632.5	356.5	345	59.1%	96.8%	10.8	8.1			1	1	2.57	0
WARD 8D	821.5	788.67	821.5	719.63	96.0%	87.6%	713	678.50	0	460	95.2%	-	5.3	5.9			1	2	1.87	0
WARD 10	1302	1170.58	821.5	824	89.9%	100.3%	1069.5	736.00	356.5	795.00	68.8%	223.0%	6.2	6.1			0	4	7.81	0
WARD 11	1534.5	1455.42	1302	1055	94.8%	81.0%	1069.5	1036.5	356.5	861.75	96.9%	241.7%	5.5	5.7			3	6	2.66	0
WARD 19	1643	1292.67	1178	1508.83	78.7%	128.1%	1069.5	1,056.50	1069.5	1390	98.8%	130.0%	8.6	9.1			3	5	1.92	0
WARD 22	1178	1140.92	1178	1110.58	96.9%	94.3%	713	701.50	713	724.5	98.4%	101.6%	5.3	5.2			1	7	1.55	2
SAU HRI	1891	1633.92	1069.5	1091.67	86.4%	102.1%	1426	1,413.58	356.5	391	99.1%	109.7%	10.1	9.6			0	1	4.27	0
WARD LDRP	4278	3699.52	945.5	746.67	86.5%	79.0%	4278	3504.17	713	632.55	81.9%	88.7%	21.2	17.8			0	0	0	5.48
WARD NICU	2247.5	2163.45	930	379.68	96.3%	40.8%	2139	1,904.00	713	448.5	89.0%	62.9%	11.5	9.3			0	0	0.86	2.5
WARD 1D	1302	1136.5	356.5	356.5	87.3%	100.0%	713	702.75	356.5	345	98.6%	96.8%	4.6	4.2			0	0	1.72	0
WARD 3ABCD	3425.5	3480.92	1178	973	101.6%	82.6%	2495.5	3248	356.5	371	130.2%	104.1%	9.6	10.4			0	1	0	3.5
WARD 4C	713	1164.08	465	356.67	163.3%	76.7%	713	712.5	356.5	351.5	99.9%	98.6%	6.7	7.7			0	0	3	3.46
WARD 9	1069.5	718.83	356.5	356.5	67.2%	100.0%	713	713	356.5	356.5	100.0%	100.0%	4.9	4.2			0	0	2.14	0.57
Trust	**59241**	**51452.86**	**37944**	**35698.1**	**86.85%**	**94.08%**	**45384**	**41480.8**	**21467.5**	**25392.5**	**91.40%**	**118.28%**	**7.9**	**7.4**						

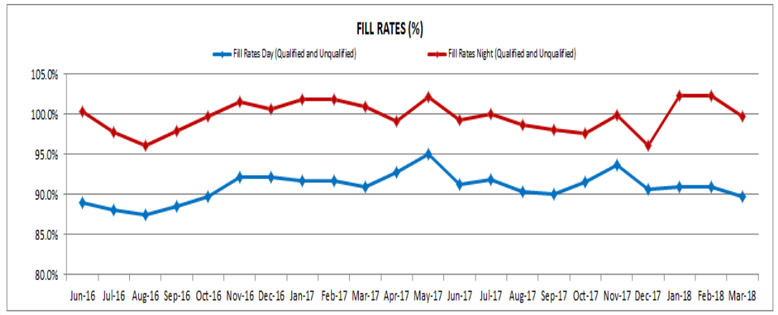
Hard Truths: Safe Staffing Levels (3)

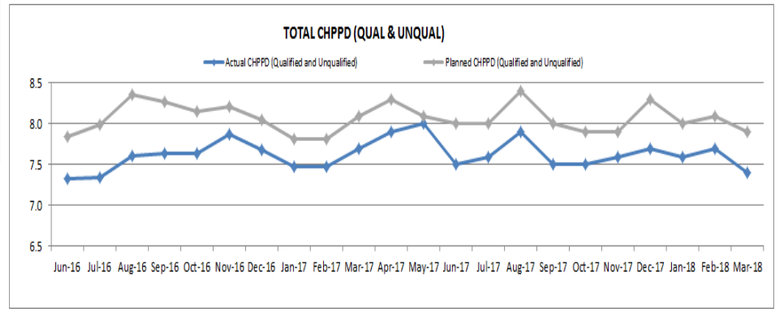
Care Hours per Patient Day

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

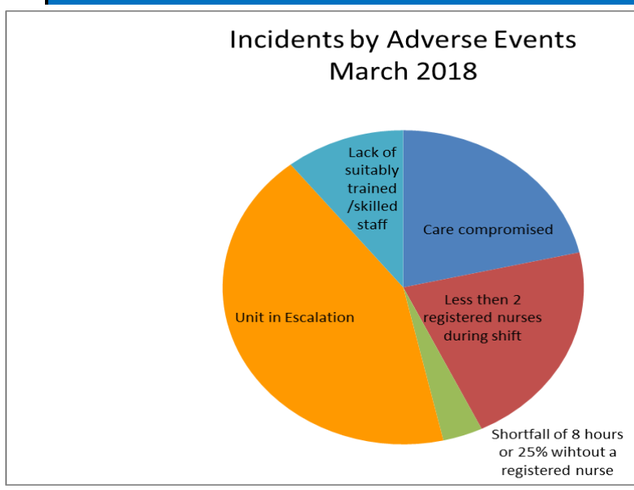
	Jan-18	Feb-18	**Mar-18**
Fill Rates Day (Qualified and Unqualified)	90.96%	90.96%	89.70%
Fill Rates Night (Qualified and Unqualified)	102.24%	102.24%	99.70%
Planned CHPPD (Qualified and Unqualified)	8.0	8.1	7.9
Actual CHPPD (Qualified and Unqualified)	7.6	7.7	7.4

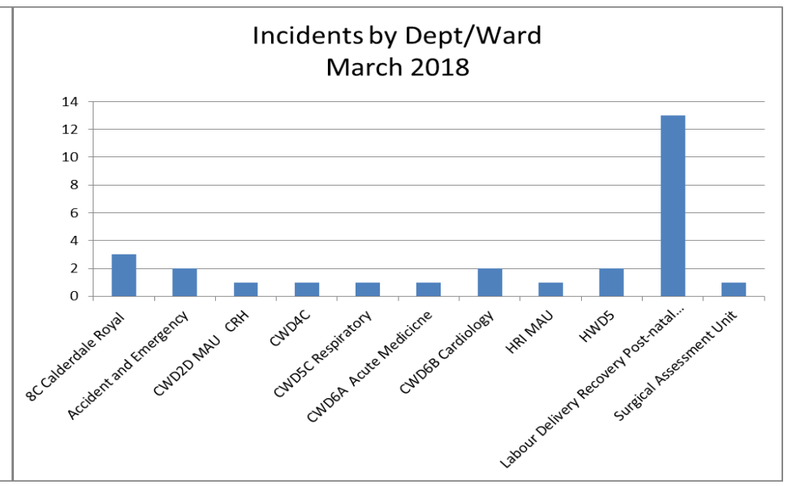
A review of April 2018 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 23 clinical areas of the 34 reviewed having CHPPD less than planned. 11 areas reported CHPPD slightly in excess of those planned. Areas with CHPPD more than planned were due to additional 1-1's requested throughout the month due to patient acuity in the departments.





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 correct 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 **28 Trust Wide Red shifts** declared in **March 2018** . Their has been an increase in red flagged incidents this month. Some attributed to the newly implemented Standard operating procedure (SOP) for high cost agency staffing which requires submission of a datix.

As illustrated above the most frequently recorded red flagged incident is related to "unit in escalation" within the FSS division

No datix's reported in March 2018 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. A range of actions are being developed and undertaken to recruit and retain the nursing workforce, and to develop data collection and reporting to support the nursing workforce.

On-going activity:

1.The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce and going forward the fill rates for individual areas will improve as these team members become established in the workforce numbers. Focused recruitment continues for this specific area.

2. Further recruitment event planned for May 2018.

3. Applications from international recruitment projects are progressing well and the first 8 nurses have arrived in Trust, with a further 5 planned for deployment in May/June 2018.

4. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NAs who started in post in April 2017. A proposal has being developed to up-scale the project in line with the national and regional workforce plans. A second cohort of 20 trainees will begin the programme in Spring 2018. Recruitment underway.

5. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment and retention of the graduate workforce. This has been further enhanced by the development of a year long graduate programme to support and develop new starters.

6. 4 Additional clinical educators have been recruited to the medical division. They will have a real focus on supporting new graduates and overseas nurses to the workforce.

7. A new module of E roster called safe care is currently being introduced across the divisions, benefits will be better reporting of red flag events, real-time data of staffing position against acuity.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Philippa Russell, Senior Finance Manager
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Financial Commentary for NHS Improvement - Month 12 - The attached commentary was submitted to NHS Improvement on the 24th of Apr 2018 alongside the Month 12 Monthly Monitoring financial return.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

For information - see attached

Main Body

Purpose:

See attached

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

To note

Appendix

Attachment:

NHSI Financial Commentary Month 12 Final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

2017/18, NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

The notes below provide a management commentary on the financial position of Calderdale & Huddersfield NHS Foundation Trust for the year ending 31 March 2018.

1. Income and Expenditure position

The Trust has delivered the position committed to NHSI in year, as a result of successfully implementing a number of recovery actions. The year-end deficit of £47.68m (including impairments) drives a variance from control total of £7.97m, this is a small improvement on the £8m variance agreed in month 9. It is also in line with the estimate discussed with regulators in March 2017.

The following key actions were taken in order to deliver the agreed position:

- The set-up of the SPV in-year driving £1.5m benefit plus associated technical accounting benefits;
- A negotiated settlement with ISS delivering a further £4.2m benefit for which signing of contract agreements is pending;
- Agreeing an early year end settlement with the two main local commissioners removing risk around securing CQUIN, winter funding and activity fluctuations.
- In addition, this position includes £1.9m of winter funding (£1m of which was contingent upon delivery of the agreed forecast); and £1m revenue to capital transfer both of which were supported by NHSI.

These specific actions are in addition to a programme of grip and control heightening scrutiny and escalation on pay and non-pay expenditure. All of these actions fit within the Trust's strong governance processes.

This successful delivery is against the backdrop of the financial risk highlighted to NHSI at the 2017/18 planning stage based upon the financial impact of EPR implementation in year and the scale of the CIP challenge being planned at £20m (5.4%) against which £17m was identified as achievable. In actual fact, £17.9m of CIP was delivered in year and the financial position was held at the committed level in spite of unforeseen and unprecedented winter pressures.

2017/18 Year end position

The year-end position at headline level is illustrated below:

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	374.74	360.97	(13.77)
Expenditure	(365.65)	(367.20)	(1.55)
EBITDA	**9.09**	**(6.23)**	**(15.32)**
Non-Operating items	(38.93)	(41.45)	(2.52)
Surplus / (Deficit)	**(29.84)**	**(47.68)**	**(17.83)**
Less: Items excluded from Control Total	13.90	19.25	5.35
Less: Loss of STF funding	0.00	7.40	7.40
Less: Bonus STF funding	0.00	(2.89)	(2.89)
Surplus / (Deficit) Control Total basis	**(15.94)**	**(23.91)**	**(7.97)**

- Delivery of CIP of £17.91m against the planned level of £20.00m.
- Capital expenditure of £15.62m, this is above the planned level of £14.39m.
- Cash balance of £2.00m against a plan of £1.91m.
- Use of Resources score of level 3, in line with the plan.

2. Statement of Financial Position and Cash Flow

At the end of March 2018 the Trust had a cash balance of £2.00m, just above the planned level of £1.91m.

The key cash flow variances for the year compared to plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	(17.83)
	Non cash flows in operating deficit	4.16
	Other working capital movements	(1.74)
	Sub Total	**(15.42)**
Investing activities	Capital expenditure	(1.16)
	Movement in capital creditors / Other	0.11
	Sub Total	**(1.05)**
Financing activities	Net drawdown of external DoH cash support	16.24
	Other financing activities	0.28
	Sub Total	**16.52**
	Grand Total	**0.05**

Operating activities

Operating activities show an adverse variance of £15.42m variance against the plan. This reflects the impact of the I&E variance of £7.98m, the loss of £7.40m performance STF funding and the adverse cash impact of £1.74m working capital variances, offset by bonus STF funding of £2.88m. The variance in non-cash flows within the deficit position includes impairments that were £5.21m higher than planned offset by the upward revaluation of Joint Venture assets which were £0.68m higher than planned. The adverse working capital variance is driven by: higher than planned receivables of £8.23m (this includes the STF bonus payment) and a small increase in inventories, offset by higher than planned payables of £6.62m.

Investing activities (Capital)

Capital expenditure was £1.16m higher than planned following agreement with NHS Improvement to increase Capital expenditure to reflect higher than planned capitalised salaries.

Financing activities

Borrowing to support capital expenditure is £8.00m in the year to date in line with plan. In addition the Trust has received £31.30m of Revenue Support linked to deficit and STF funding requirements and a further £5.70m of working capital support. This is £16.24m more than planned: £10.54m linked to additional deficit funding requirements and working capital support that is £5.7m higher than planned.

3. Use of Resources (UOR) rating

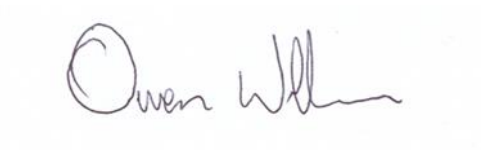
Against the UOR the Trust stands at level 3 in line with plan. Within this the Trust has successfully contained agency expenditure below the agreed ceiling delivering a material reduction on last year's expenditure. This a significant achievement in the face of continued staffing pressures exacerbated by exceptional winter pressures.

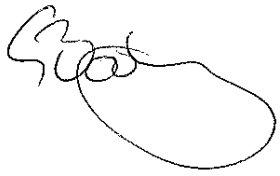
4. Summary

The year-end financial position has been delivered at a level consistent with the scale of risk described at the 2017/18 planning stage. Specific risks were described against the financial impact of EPR implementation and the scale of the CIP challenge and these were borne out in reality alongside unprecedented winter pressure. The fact that the Trust has delivered the financial position agreed in-year with NHSI against this backdrop is testament to the organisation's commitment to containing the financial deficit alongside delivery of strong operational performance, patient safety and care.

This position has been secured through a recovery programme encompassing grip and control actions alongside a number of innovative accounting solutions. It should be noted, as has been highlighted to NHSI previously, that a number of these actions are non-recurrent; the underlying position carried forward into 2018/19 is an even greater challenge.

The Trust continues to strive to do all that it can to manage this position, including planning for CIP at a significantly higher level than the national funding expectation; implementing a programme of system wide recovery that is being developed in partnership with commissioners; and continuing to be at the forefront of Trusts pursuing innovative solutions to drive best value. All of this accompanies the Trust's longer term transformation plans as described in the reconfiguration business case.





Owen Williams
Chief Executive

Gary Boothby
Executive Director of Finance

BOARD OF DIRECTORS	
PAPER TITLE: 2018/19 BUDGET BOOK	**REPORTING AUTHOR:** Philippa Russell
DATE OF MEETING: 3rd April 2018	**SPONSORING DIRECTOR:** Gary Boothby
STRATEGIC DIRECTION – AREA: • Financial Sustainability	**ACTIONS REQUESTED:** • To approve
PREVIOUS FORUMS:	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	
EXECUTIVE SUMMARY: (inc. Purpose/Background/Overview/Issue/Next Steps) 2018/19 Budget Book details the Trust's finalised budget for Income and Expenditure, Cash and Capital as per the final plan submitted to NHS Improvement on the 30th of April 2018.	
FINANCIAL IMPLICATIONS OF THIS REPORT: The Trust will be monitored against this plan by NHS Improvement.	
RECOMMENDATION: For approval	
APPENDIX ATTACHED: YES	

NHS
Calderdale and Huddersfield
NHS Foundation Trust

BUDGET BOOK
2018-19

compassionate care

2018/19 Financial Plan - Overview

I&E Summary

The year-end financial position for 2017/18 was delivered at a level consistent with the scale of risk described at the 2017/18 planning stage and in line with the position agreed with NHSI in December 2017. Specific risks were described against the financial impact of EPR implementation and the scale of the CIP challenge and these were borne out in reality alongside unprecedented winter pressure. The Trust delivered the financial position agreed in-year and met the agency trajectory set at £16.8m against this backdrop. The 2017/18 financial position was secured through a recovery programme encompassing grip and control actions alongside a number of innovative accounting solutions. It should be noted, as has been highlighted to NHSI previously, that a number of these actions were non-recurrent; the underlying position carried forward into 2018/19 is a much greater challenge.

The underlying operational performance in 2017/18 would drive a greater adverse financial variance. This is due to a number of a number non-recurrent income and expenditure benefits supporting the position, including a £4.2m negotiated settlement with the PFI facilities management provider; release of prior year accruals and £1.5m plus associated technical benefits associated with the set-up of the Estates SPV; non-recurrent commissioner and national income, for example that in support of the Emergency Care Standard and Winter. This is in addition to the release of the full £2m contingency reserve available for this financial year and other non-recurrent CIP delivery. The total one-off benefits in 2017/18 are in excess of £19.0m.

Control total 2018/19

The Trust's allocated control total has reduced from a £26.04m deficit (excluding Sustainability and Transformation Funding (STF)) in 2017/18 to a £22.56m deficit in 2018/19. Provider Sustainability Funding (previously STF) has increased from £10.10m to £14.20m, but this is only available if the Trust accept the above control total.
The Trust has not been able to accept the control total for 2018/19. The final plan submission to NHS Improvement submitted on the 30th of April 2018 describes a financial deficit position of £43.1m which is a £20.5m adverse variance to the control total.

The plan assumes delivery of £18.0m new CIP in 2018/19 which when combined with the full year effect of 2017/18 CIP represents 5.6% of operating costs. This challenging target is set in recognition of the scale of recovery that is required and in acknowledgement of specific strategic and technical opportunities that exist and would be expected to stretch the achievable value.

Capital Summary

The capital plan submission has been restrained to £7.56m to fit within the means of internally generated capital funds net of PFI commitments and capital loan repayments. This is planned to be supplemented by: £0.7m planned spend on CRH energy efficient lighting, supported by an interest free Salix loan (£1.2m over 18/19 and 19/20); and £0.7m of PDC awarded (out of a total of £2m across 18/19 and 19/20) for the National Pathology Exchange (NPEX) project. A further £0.2m is assumed to be funded from donations.
As might be expected given the condition of the Trust's Huddersfield Royal Infirmary site the immediate capital requirements, which have been prioritised based upon risk assessment, exceed the £7.56m internal funding available. As such, emergency capital bids have been submitted for support in 18/19 for: HRI backlog maintenance, ED Resuscitation and ICU Refurbishment £4.9m (plus £4.8m 19/20); MRI scanner, Aseptic Unit and Gamma camera £3.4m (combined). As per the published guidance, these investment requirements to support a clear patient safety need, have not been included the planning submission on an affordability basis. Therefore, a successful funding award would increase the trusts capital spend above the current plan in year.
The longer term solution to address the estate issues is bound in the plan for service reconfiguration. The capital plan includes an initial investment of £1.4m in support of hospital services reconfiguration enabling work.

18/19 Plan: Income & Expenditure

Income & Expenditure	17/18 Budget	17/18 Actual	18/19 Plan (Excl. CIP)	18/19 CIP	18/19 Total Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income	334.68	319.26	315.64	1.23	316.87
Other Income	40.05	43.19	40.48	0.45	40.93
TOTAL INCOME	374.74	362.45	356.12	1.68	357.80
Medical	(67.97)	(68.59)	(71.53)	3.25	(68.28)
Nursing	(74.81)	(75.24)	(78.02)	3.76	(74.26)
Sci Tech & Ther	(28.79)	(28.20)	(29.52)	0.58	(28.94)
Support to clinical staff	(29.49)	(35.63)	(35.26)	0.30	(34.96)
Any Other Spend	(3.65)	(1.39)	(3.27)	0.01	(3.26)
Managers and infrastructure support	(36.40)	(36.05)	(39.64)	1.53	(38.11)
PAY EXPENDITURE	(241.10)	(245.11)	(257.25)	9.43	(247.81)
Drugs	(35.34)	(35.13)	(36.38)	0.28	(36.10)
Clinical Supplies & Services	(32.76)	(28.00)	(31.10)	2.42	(28.68)
Other Costs	(56.46)	(58.98)	(65.34)	3.18	(62.16)
NON PAY EXPENDITURE	(124.55)	(122.11)	(132.83)	5.89	(126.94)
TOTAL EXPENSES	(365.65)	(367.21)	(390.07)	15.32	(374.75)
EBITDA	**9.09**	**(4.77)**	**(33.96)**	**17.00**	**(16.96)**
Non Operating Expenditure	(38.93)	(42.91)	(27.01)	1.00	(26.01)
TOTAL SURPLUS/(DEFICIT)	**(29.84)**	**(47.68)**	**(60.96)**	**18.00**	**(42.96)**
Less: STF funding	(10.10)	(5.58)	0.00		
Less: Items excluded from Control Total	13.90	19.25	(0.08)	0.00	(0.08)
TOTAL SURPLUS/(DEFICIT) on a Control Total Basis	**(26.04)**	**(34.01)**	**(61.05)**	**18.00**	**(43.05)**
18/19 Control Total					**(22.56)**
Variance from Control Total		**(7.97)**			**(20.49)**

Overview:
This budget is aligned to the planning submission made to NHS Improvement as at 30 April 2018. Planned deficit is £43.05m, a £22.5m variance from the 18/19 control total.

Key Assumptions:
- £22.56m Control Total not accepted. £14.20m available Provider Sustainability Funding (PSF) not assumed in the plan.
- Efficiency challenge is £18m CIP, £16.7m already allocated to Divisions, £0.5m identified but not yet allocated plus a further £0.8m planning gap (held as negative reserve)
- Income calculated using HRG4+ Planning Tariff and adjusted to reflect agreed Aligned Incentive Contract with two main commissioners.
- Contingency Reserves of £2m held, including £1m allocated as a Winter Reserve.
- New Revenue loans assumed at 1.5% interest rate with a contingency held against possible interest rate increases.
- Pay awards of 1% have been applied to pay budgets, as advised by national guidance pending a decision regarding funding of additional pay awards.
- Pay Increments have been funded based on current pay scales.
- Non Pay inflation only applied in key pressure areas including contracts where RPI uplift applies .

18/19 Plan: Statement of Financial Position

Statement of Financial Position	17/18 Budget As at 31 Mar 18 £'m	17/18 Actual As at 31 Mar 18 £'m	18/19 Plan As at 31 Mar 19 £'m
Non Current Assets			
Property, Plant & Equipment	150.39	147.14	145.58
On B/S PFI assets	71.63	79.44	78.22
Investment in Joint Venture	2.87	3.76	3.96
Other	2.68	2.90	2.90
	227.56	233.24	230.65
Current Assets			
Inventories	6.62	6.84	6.84
Receivables	13.38	22.34	19.46
Other	6.47	3.50	3.50
Cash	1.91	2.00	1.91
	28.37	34.68	31.71
Current Liabilities			
Loans	(2.79)	(15.66)	(2.21)
Deferred Income	(0.68)	(1.32)	(1.32)
Payables	(35.11)	(40.91)	(38.25)
Provisions	(1.58)	(1.54)	(1.54)
PFI Leases	(1.48)	(1.61)	(1.70)
	(41.64)	(61.04)	(45.01)
Non Current Liabilities			
Loans	(84.84)	(88.20)	(142.62)
PFI Leases	(74.53)	(74.40)	(72.70)
Provisions	(2.44)	(2.16)	(2.16)
Other	(1.33)	(1.30)	(1.30)
	(163.14)	(166.07)	(218.79)
TOTAL ASSETS EMPLOYED	**51.15**	**40.82**	**(1.44)**
Taxpayers Equity			
Public Dividend Capital	116.19	116.19	116.89
Income & Exp Reserve	(99.78)	(114.68)	(157.64)
Revaluation Reserve	34.74	39.31	39.31
TOTAL TAXPAYERS EQUITY	**51.15**	**40.82**	**(1.44)**

Key Assumptions:

- No asset valuation adjustments are assumed.
- Cash is assumed to be balanced to £1.9m at the end of each month in line with Department of Health borrowing requirements.

18/19 Plan: Statement of Cash Flow

Statement of Cash Flow	17/18 Budget £'m	17/18 Actual £'m	18/19 Plan £'m
Surplus/(deficit) from Operations	**(29.84)**	**(47.68)**	**(42.96)**
non-cash flows in operating surplus/(deficit)			
Non-cash donations/grants credited to income	(0.20)	(0.66)	(0.20)
Depreciation and amortisation	10.76	10.58	11.93
Other operating non-cash (income)/ expenses	14.10	13.69	14.01
Impairments	14.00	19.21	0.00
	38.66	**42.82**	**25.74**
Operating Cash flows before movements in working capital	**8.82**	**(4.85)**	**(17.23)**
Increase/(Decrease) in working capital	**0.32**	**(1.43)**	**0.51**
Net cash inflow/(outflow) from operating activities	9.14	(6.28)	(16.72)
Net cash inflow/(outflow() from investing activities			
Capital Expenditure	(14.39)	(15.54)	(8.94)
Proceeds on disposal of property, plant and equipment	0.00	0.00	0.00
Increase/(decrease) in Capital Creditors	(4.94)	(4.83)	(0.88)
Other cash flows from investing activities	0.04	0.04	0.04
	(19.29)	**(20.33)**	**(9.78)**
Net cash inflow/(outflow) before financing	**(10.15)**	**(26.61)**	**(26.49)**
Net cash inflow/(outflow) from financing activities			
Public Dividend Capital Received	0.00	0.00	0.70
Drawdown of Loans	28.76	46.13	56.63
PDC Dividends paid	(1.78)	(1.48)	0.14
Repayment of Loan	(2.92)	(4.04)	(15.66)
Financing	(13.82)	(13.82)	(15.41)
Non-Current Movements	(0.09)	(0.11)	0.00
	10.15	**26.67**	**26.40**
Net increase/(decrease) in cash	**0.01**	**0.06**	**(0.10)**
Opening cash	1.94	1.94	2.00
Closing cash	**1.95**	**2.00**	**1.90**

Key Assumptions:

- Borrowing requirement is assessed to be £56.63m: £43.05m for Revenue support, £12.90m refinancing of existing Distressed Funding Loan (due for repayment in February 2019) and £0.68m interest free Salix Loan for Capital.
- Public Dividend Capital (PDC) of £0.70m is assumed for the National Pathology Exchange project, (total approved is £2m over 2 years).
- All other capital expenditure to be managed within internally generated funds.
- The actions taken to minimise the deficit in 2017/18 carry a legacy working capital pressure into 2018/19. A number of the non-recurrent recovery actions in 2017/18 are either non cash backed or have a time lag to the realisation of cash. Additional working capital support is not included in the draft plan submission however a separate case may need to be made for this.
- The Trust received £2.9m of bonus STF in 2017/18 as part of the general distribution, this is not assumed to be repayable in 2018/19 in cash terms.

18/19 Plan: Activity & Income

Activity	17/18 Budget	17/18 Actual	18/19 Plan (Excl. CIP)	18/19 CIP	18/19 Total Plan
	Spells	Spells	Spells	Spells	Spells
NHS Clinical Income					
Elective	7,958	5,699	6,163	0	6,163
Non Elective	50,873	56,176	56,749	0	56,749
Daycase	38,132	34,988	36,487	0	36,487
Outpatients	359,602	319,636	324,381	0	324,381
A & E	155,414	148,387	153,337	0	153,337
Other-NHS Clinical	1,755,435	1,796,709	1,889,945	0	1,889,945
TOTAL SPELLS	2,367,414	2,361,594	2,467,062	0	2,467,062

Income	17/18 Budget	17/18 Actual	18/19 Plan (Excl. CIP)	18/19 CIP	18/19 Total Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income					
Elective	22.36	16.95	19.51	0.00	19.51
Non Elective	95.53	100.26	101.38	0.00	101.38
Daycase	26.51	25.12	26.27	0.00	26.27
Outpatients	41.84	37.38	37.57	0.00	37.57
A & E	19.24	17.88	18.58	0.00	18.58
Other-NHS Clinical	112.12	109.40	105.50	1.23	106.72
CQUIN	6.99	6.67	6.85	0.00	6.85
Sustainability & Transformation Funding (STF)	10.10	5.58	(0.00)		
Other Income	40.05	43.19	40.48	0.45	40.93
TOTAL INCOME	374.74	362.45	356.12	1.68	357.80

Key Assumptions:

An Aligned Incentive Contract has been agreed between the Trust and the two main local commissioners, Greater Huddersfield CCG and Calderdale CCG. Notably this protects the Trust against: any loss as a result of Sepsis coding guidance; CQUIN performance risk; and contract penalties.

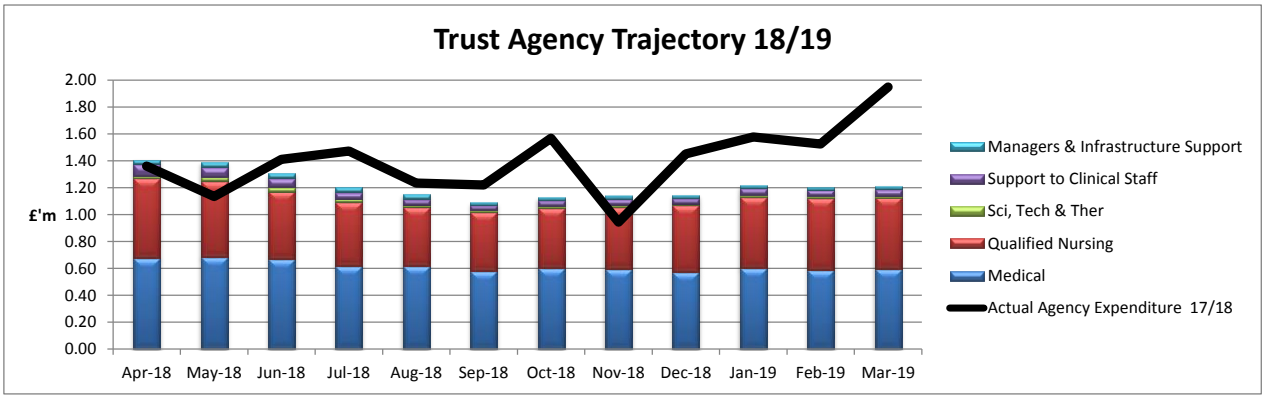
Heads of Terms have been negotiated and agreed and signed by all parties.

The make-up of the contract value is line with anticipated 2018/19 activity based on latest divisional projections and capacity modelling. In addition to this baseline growth is planned at 2.3% for Non Elective and 1.1% for A&E in line with national guidance, plus additional MSK funding and £1m in respect of winter. Offsetting these, QIPP is applied at £2.6m. The total net value secures divisional activity plans whilst the winter plan will be a commitment against reserves.

18/19 Plan: Agency Trajectory

Agency Trajectory 18/19	Apr-18 £'m	May-18 £'m	Jun-18 £'m	Jul-18 £'m	Aug-18 £'m	Sep-18 £'m	Oct-18 £'m	Nov-18 £'m	Dec-18 £'m	Jan-19 £'m	Feb-19 £'m	Mar-19 £'m	Total £'m
Medical	0.68	0.69	0.67	0.62	0.62	0.58	0.60	0.60	0.58	0.61	0.59	0.60	7.42
Qualified Nursing	0.59	0.56	0.50	0.47	0.44	0.44	0.45	0.46	0.49	0.53	0.53	0.53	5.99
Sci, Tech & Ther	0.02	0.03	0.03	0.03	0.02	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.23
Support to Clinical Staff	0.09	0.07	0.06	0.05	0.04	0.04	0.04	0.05	0.04	0.05	0.05	0.05	0.63
Managers & Infrastructure Support	0.03	0.04	0.04	0.04	0.04	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.36
Total	1.41	1.39	1.31	1.21	1.16	1.09	1.13	1.14	1.15	1.22	1.21	1.21	14.63

Actual Agency Expenditure 17/18	1.36	1.14	1.41	1.47	1.24	1.22	1.57	0.94	1.45	1.58	1.53	1.95	16.86



Key Assumptions:

- Assumes Agency expenditure will be kept within NHS Improvement cap at £14.63m.
- This represents a significant reduction from Agency expenditure in 17/18 at £16.86m.
- £3m of CIP is committed to reducing agency predominantly impacting from September onwards. Further actions are required in addition to CIP to deliver £0.4m agency reduction to contain spend within the ceiling.
- Use of Resources metric does include measurement of performance against the cap.

18/19 Plan: Reserves

Reserves Summary	18/19 Plan £'m	Notes
Uncommitted General Reserve		
Contingency Reserve	1.00	Assumed as Pay in Plan
Winter Reserve	1.00	Assumed as Pay in Plan
	2.00	
Planning Gap		
Unidentified CIP	(0.82)	
Portfolio CIP - unallocated to Divisions	(0.50)	Medical Portfolio stretch target
	(1.32)	
Committed Reserves		
Innovation Fund	0.65	To be transferred to Divisions once costs are incurred
Approved Business Cases	0.18	To be transferred to Divisions once costs are incurred
Pressures / Developments not yet approved	0.75	To be transferred to Divisions once approval confirmed
	1.58	
TOTAL RESERVES	**2.26**	

Key Assumptions:

- £2m Contingency Reserve includes a £1m Winter fund.
- CIP Planning gap of £0.82m has been held in Reserve pending identification of schemes to deliver the additional savings.
- Medical Portfolio stretch target of £0.5m is still at scoping stage and has not yet been allocated to Divisional budgets.

18/19 Plan: Capital

Scheme Category	Capital Schemes	18/19 Plan £'m
IT	Ascribe (Pharmacy)	0.50
	Active Directory	0.30
	Core servers/Infrastructure	0.10
	Clinical systems	0.10
		1.00
Built Environment	Full Business Case - Reconfiguration	1.40
	6 Facet Survey - Works	1.20
	Hospital building External & Internal	0.10
	Ventilation (A&E) and design for FY 19/20	0.15
	Pipework & Compliance	0.20
	Electrics	0.05
	Fire Doors	0.15
	Asbestos Removal	0.10
	Main Entrance WC	0.28
		3.63
Other	Divisional Equipment (Incl. HPS)	0.74
	PFI lifecycle costs	1.59
	Contingency	0.60
		2.93
Total Internally Funded		**7.56**
Funded by Public Dividend Capital (DHSC)	National Pathology Exchange scheme	0.70
Funded by Loan (Salix)	Energy Efficiency - CRH	0.68
Funded from donations		0.20
TOTAL CAPITAL EXPENDITURE		**9.14**

Key Assumptions:

- Internally generated funds from Depreciation (£11.93), are also required to cover the cost of repayments on the PFI (£1.61m) and Capital Loans (£2.76m), leaving only £7.56m available for Capital Expenditure.
- This is planned to be supplemented by: £0.7m planned spend on CRH energy efficient lighting, supported by an interest free Salix loan (£1.2m over 18/19 and 19/20); and £0.7m of PDC awarded (out of a total of £2m across 18/19 and 19/20) for the National Pathology Exchange (NPEX) project. A further £0.2m is assumed to be funded from donations.
- Emergency capital bids have been submitted for support in 18/19 for: HRI backlog maintenance, ED Resuscitation and ICU Refurbishment £4.9m (plus £4.8m 19/20); MRI scanner, Aseptic Unit and Gamma camera £3.4m (combined). These have not been included within the 18/19 plan as they have not yet been approved.

18/19 Plan: Investments

Category	Description	18/19 Plan £'000
Pressures	Agency Premium	1,919
	Additional Bed Capacity	1,794
	Sendaway tests	1,177
	EPR revenue cost pressures	1,060
	Software and Licences	1,025
	Reduction in clinical non-contracted income	981
	Non Operating Expenditure	779
	Reduction in Capitalised Salaries	549
	High demand for 1 to 1s	511
	Managers and Infrastructure Staff	319
	Leases and Maintenance costs	197
	Unfunded Phlebotomy posts	150
	Education funding changes	136
	Bowel Screening SLA	116
	WYAAT contribution	116
	Clinical Excellence Awards	100
	Radiology Outsourcing	71
	Reduction in Other Income	54
	Other budgetary pressures	1,302
	Vacancy Factor	(2,225)
		10,133
Developments	Innovation Fund FYE	648
	Other Developments	247
		895
Activity	Changes to Clinical Contract activity 17/18	9,054
	18/19 QIPP	2,600
	Other Activity Growth	78
	Activity Risk Reserve	(335)
	Winter Funding	(1,048)
	Changes to Clinical Contract activity 18/19	(1,405)
	Clinical Contract Income growth	(2,886)
		6,058
TOTAL INVESTMENTS		**17,086**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 3rd May 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from the sub-committees.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from the sub-committees:
- Quality Committee – verbal update from meeting 30.4.18
- Finance and Performance Committee – minutes of 3.4.18 and verbal update from meeting held 27.4.18
- Audit and Risk Committee - verbal update from meeting 18.4.18

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the updates and minutes from the sub-committees:
- Quality Committee – verbal update from meeting 30.4.18
- Finance and Performance Committee – minutes of 3.4.18 and verbal update from meeting held 27.4.18
- Audit and Risk Committee - verbal update from meeting 18.4.18

Appendix

Attachment:

Draft Minutes of the FP Committee held 030418.pdf

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Tuesday 3 April 2018, 9.00am – 12.00noon 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
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)
Owen Williams	Chief Executive

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance
Philip Lewer	Chairperson
Brian Moore	Lead Governor (Observer)
Betty Sewell	PA (Minutes)

ITEM

068/18 WELCOME AND INTRODUCTIONS

The Chair welcomed Philip Lewer, Chairperson, to his first F&P Committee meeting.

069/18 APOLOGIES FOR ABSENCE

There were no apologies to note.

070/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

071/18 MINUTES OF THE MEETING HELD 23 FEBRUARY 2018 & 19 March 2018

The Committee approved the minutes of the meetings held 23 February and 19 March subject to a number of minor changes.

072/18 MATTERS ARISING AND ACTION LOG

The following Matters Arising were updated:

061/18: Nursing Costs – Owen Williams explained that following feedback from colleagues, communication with regard to 'banding/grading' will be reviewed and an update will be given to the Committee at the next meeting – **OW, 27 April 2018.**

024/18: **Performance Indicators** – Initial discussions have taken place and proposals are being developed to take to a future Board Workshop. Once agreed they will come back to all relevant Committees – **HB/VP, 27 April 2018**.

043/18: Allocation of STF Nationally – following concerns of inconsistency of the allocation of STF with organisations nationally, conversations have taken place with NHS I and they have confirmed that treatment is the same for all organisations. If

organisations are choosing to report that they will achieve STF and are following the appeal process, this will be a hit at year-end. Following further discussions it was agreed that a review through Board Reports the year-end position for both Leeds and Salford should be followed up.

ACTION: To review Board Reports for the year-end position for both Leeds and Salford, report to come back to Committee. – **GB, 5 June 2018**

073/18 MONTH 11 FINANCE REPORT

The Deputy Director of Finance reported that the position at Month 11 is a year to date deficit of £35.27m. On a control total basis this is an adverse variance from plan of £10.38m, excluding the impact of loss of Sustainability and Transformation funding (STF). The forecast position incorporates a gap to control total of £8m which in turn drives the loss of £7.40m STF. The £8m gap remains unchanged from the position reported in Month 11 and is reliant upon a number of elements including winter funding, revenue to capital transfer, finalisation of contract agreements relating to the SPV and the negotiated settlement with ISS. It was noted that a risk was flagged last week in relation to ISS, however, negotiations are continuing with a view to signing contracts by Friday 13 April 2018.

It was also noted that full year CIP is forecast to be £18m which is lower than the original plan of £20m. Capital forecast is slightly over plan by £1m which is linked to the recovery actions and Cash is broadly in line with the planned position.

It was suggested that if anyone sill required any further information with regard to the underlying position they should catch up with Kirsty Archer following the meeting.

Discussions took place with regard to Activity and it was agreed to have a sense of grip going forward there should be an overview of the first 3 weeks of in year performance, in addition a review of the activity trend over the last 12 months and a trajectory for next year.

ACTION: To provide an overview of the first 3 weeks of in year performance, in addition a review of the activity trends over the last 12 months and a trajectory for next year – **PO/GB/AB to discuss how this is presented.**

It was noted that Activity for April has been phased which reflects change-over and a 4 day bank holiday.

With regard to Cash, a question was raised with regard to our processors on Debt Collection, it was noted that good processes are in place which have been recognised by NHS I. We have an Account Manager approach where senior finance colleagues are assigned to accounts with long-standing issues. This process has been extended with more focus at the Weekly Senior Finance Team meeting. In terms of the Provisions, we are providing for everything over 90 days in the first instance and then removing items from the provision by exception. This will be reviewed at Year-End as the guidance has been strengthened from an Audit point of view.

In addition, it was noted that invoices are being paid between 50/56 days, this situation is not solely due to the cash challenge. It was explained that we have

recently moved to a new shared ledger system with the North East Patches. The system has had glitches resulting in the organisation receiving an increasing number of letters from suppliers threatening to put us on 'stop', we are working with the provider to remedy these challenges. With regard to 'write-offs' it was noted that the debt stands for a period of 6 years and are not written off without everything possible being done to recover the debt.

The Committee **NOTED** the Month 11 financial position.

074/18 2018/19 PLAN UPDATE & CONTRACT UPDATE

The Director of Finance provided a presentation which gave an update to the 2018/19 Plan and set out intention to move to an Aligned Incentive Contract (AIC). The presentation will be circulated following this meeting.

It was noted that following a review and challenge of divisional pressures the residual deficit has been reduced from the draft plan submission, it was confirmed that Divisions have signed up to these values. In terms of our regulator position, the draft plan was submitted in line with the timetable to NHS I, they were due to come back and review our plan this week, however, they postponed this meeting and it will now take place on the 25 April 2018.

It was suggested that NEDs should take every opportunity to challenge validity with Divisional leadership.

With regard to the Contract form, following further discussions with our Commissioners they have put forward a proposal which offered very little difference, in value terms, between Payments by Results (PbR) or AIC, therefore, at this point in time we have agreed in principle to an AIC, subject to agreeing Heads of Terms.

It was noted that there had been an increase in the number of Trusts who have also agreed to an AIC in some form or other and that this is the direction of travel.

Discussions took place with regard to the areas which influenced the decision including our exposure if we under-trade and our longer term plans especially for digital transformation which could be high-risk within a PbR contract. With regard to activity, the real opportunity would be to try to find a different way to deliver safe patient care as this would become the Trusts' benefit, however, if activity increases, there would be an opportunity to go back to Commissioners. It was agreed that we are taking out a large amount of uncertainty when we can plan around a fixed amount.

The challenge is how the Contract is constructed and there is still work to do with regard to the 'cap and collar' arrangements. From an operation point of view some winter plans are covered but not as much as it cost us this year. It is really important that within the Heads of Terms a trigger point has got to be clear.

Owen Williams highlighted the changing nature of Clinical Commissioning Groups (CCGs) and referenced that today was the first working day in Birmingham where 3 CCGs are coming together with a population of 1.2m (for information please see the link below) and it may be that we have to be proactive in influencing the changing

nature of GGS.

https://www.birminghamandsolihullccg.nhs.uk/

It was noted that an additional point to be highlighted was the capacity required linked to non-elective growth and the winter pressure and how this impacts on agency staffing which is considered within our Use of Resources score.

With regard to CIP we continue to assume £18m with £9.8m at Gateway 2, and ££5.2m at Gateway 1, which leaves a residual gap of £3m to be identified to specific schemes based on opportunities identified. With more robust plans in place it was felt that we are in a better position than previously.

With regard to the Capital Plan, which is based on depreciation, it is in line with available internal funding of £7.2m based on risk assessment of schemes. Some high-risk schemes are not on the plan as we have been advised by NHS I there are areas which are most likely to get central funding. It was suggested that all members of the Board must have sight of the risk assessment around the Capital Plan and it was requested that a bespoke document for the Board to be sighted around the known risks. Risk has been discussed and highlighted with our regulators.

It was noted that the borrowing requirement for 2018/19 is planned at £43.1m in addition to the Salix loan planned for energy efficient lighting for CRH.

ACTION: To provide a bespoke document for the Board highlighting the risk assessment based on the Capital Plan – **GB, 27/4/18**

The Committee **NOTED** the updated 2018/19 Plan.

075/18 2018/19 CASH FUNDING REQUIREMENT

The Deputy Director of Finance presented a paper which outlined the request to the Board to seek their approval for the resolution required to support the Uncommitted Interim Revenue support facility application.

It was noted that we have assumed within our Plans we continue to borrow at an interest rate of 1.5%, however, rates can change on a month by month basis. If we were to get to a position where we are in 'Special Measures', we could see an interest rate increase to 6% which would be an additional risk.

It was noted that initial feedback from our Use of Resources assessment was positive.

The Committee supported the **RECOMMENDATION** to the Board.

076/18 CIP UPDATE

CIP was discussed as part of other agenda items and there was nothing further to add.

077/18 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the following key points to note:-

In terms of improvements the following were noted

- Ambulance Turnaround Time
- Stroke performance
- DNA rates
- #NF gets a best practice tariff as well as a best practice guidance
- Cancer indicators have improved; focus will now be on the 38 day referrals with new rules coming into force.
- Delayed Transfer of care is in a good position as well as HSMR and SHIMI.
- Emergency Care Standards is in the better than average category looking at national benchmarking.
- Mandatory Training
- Sickness is better than last year but there was deterioration in January.
- We have a high vacancy rate and a high escalation in capacity with up to 88 additional beds open during February which has caused pressures.

In terms of challenges the following were noted:

- Activity and Income
- Electives are down, Non-electives are up
- Stranded patients are a concern at the moment these are patients who have a length of stay over 7 days. Support has been requested from NHS I and the Emergency Care Improvement Programme and we are holding a Multi-disciplinary Accelerated Discharge Event (MADE) on the 12 April and feedback will be available before the next Committee meeting for update.
- Data Quality – post EPR our RTT incomplete waiting lists is still very high and this has been picked up by our Regulators who have asked for a full self-assessment. Internal Audit have been commissioned to review the self-assessment before it is submitted to NHS I. There is also a cohort of patients showing on the system as waiting longer than 3 months past their due date for follow up. This is a concern and following a clinical validation an administrative validation will take place.
- Challenges remain with regard to Theatre Utilisation
- During February we have had infection prevention control issues and over the last few months ward closures, due to the Norovirus/c-Diff outbreaks, have not helped with flow. There is a focus within the Infection Prevention Control Committee led by the Medical Director.
- Children's Speech and Language therapies access has been challenging with issues between Commissioners and the Local Authority which has allowed quite a significant waiting list to develop.

ACTION: To update the Committee with regard to the MADE event – **HB, 27/4/18**

The Committee acknowledged the challenging quarter and **NOTED** the contents of the report and the overall performance score for February.

078/18 MONTH 11 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee received the Month 11 commentary on the financial return which would be submitted to NHS Improvement.

The Committee **APPROVED** the Month 11 commentary.

079/18 REVIEW OF F&P COMMITTEE TERMS OF REFERENCE

The Chief Operating Officer requested that additional mention to Operating Performance should be included in the Terms of Reference, it was agreed that these would be discussed outside this forum and an amended version would come back to the next meeting.

ACTION: Helen Barker to provide additional points of reference relating to Operating Performance and an amended set of Terms of Reference would be reviewed at the next meeting – **HB, 27 April 2018**.

080/18 MINUTES FROM SUB-COMMITTIEES

The Committee received and noted the following sub-committee minutes:

- Draft Commercial Investment & Strategy Committee Minutes from the meeting held 22 March 2018.
- Draft Capital Management Group Minutes from the meeting held 14 March 2018.
- CMG – Terms of Reference were received and approved by the Committee

081/18 WORK PLAN

The Work Plan was reviewed and noted by the Committee.

Owen Williams agreed to discuss with Mandy Griffin a broader Board session with regard to EPR.

082/18 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following areas of discussion for cascading to the Board:
Financial year to date – on plan to achieve Forecast
Activity Trend for last 12 months
This year's deficit discussed
Aligned Incentive Contract (AIC) – Committee supports the decision on the basis of reducing risk.
Capital Plan noted and Risks highlighted
CIP a better position noted with the majority of schemes recurrent
Cash Funding Requirements and supportive of the recommendation to the Board
From an Operational point of view – broad range of improvements across a wide area.

083/18 REVIEW OF MEETING

Nothing to minute.

084/18 ANY OTHER BUSINESS

There were no items to discuss.

DATE AND TIME OF NEXT MEETING

Friday, 27 April 2018, 10.00am – 1.00pm

Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE