Calderdale and Huddersfield NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 1 March 2018 at 9.00 am
Venue: Boardroom, HRI

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE	TIMING (INDICATIVE)
1	Welcome and introductions: Veronica Maher, Public Elected Governor Linzi Smith, Staff Elected Governor Dr Peter Bamber, Staff Elected Governor Brian Moore, Lead Governor	Chair	**VERBAL**	**Note**	**1 min**
2	Apologies for absence: Brendan Brown (Lindsay Rudge, Deputy Director of Nursing and Juliette Cosgrove, Assistant Director of Quality and Safety to attend) Alastair Graham, Non-Executive Director	Chair	**VERBAL**	**Note**	**1 min**
3	Declaration of interests	All	**VERBAL**	**Receive**	**1 min**
Standing items					
4	Minutes of the previous meeting held on 1 February 2018	Chair	**APP A**	**Approve**	**5 mins**
5	Action log and matters arising:	Chair	**APP B**	**Review**	**5 mins**
6	Chairman's Report a. Appointment of Chair b. Feedback from Conference with NHSI on QIS held 12.2.18	Chair	**VERBAL**	**Note**	**5 mins**
7	Chief Executive's Report	Chief Executive	**VERBAL**	**Note**	**5 mins**
Keeping the base safe					
8	Wholly Owned Subsidiary	Chief Executive/ Executive Director of Planning, E&F	**APP C** **Presentation to follow**	**Approve**	**30 mins**
9	Quarterly Quality Report and Quality Improvement Strategy	Assistant Director of Quality & Safety	**APP D** **APP D1**	**Approve**	**10 mins**
10	High Level Risk Register	Assistant Director of Quality & Safety	**APP E**	**Approve**	**10 mins**

11	Care of the Acutely Ill Patient Report	Executive Medical Director	**APP F**	**Approve**	**10 mins**
12	Governance Report a. Board Skills and Competencies Self-Assessment 2017-2018 b. Board Workplan c. BOD Terms of Reference d. Use of Trust Seal	Company Secretary	**APP G**	**Approve**	**5 mins**
13	Learning from Deaths Report	Executive Medical Director/ Dr Sal Uka, Associate Medical Director	**APP H**	**Approve**	**10 mins**
14	Integrated Performance Report	Chief Operating Officer	**APP I**	**Approve**	**10 mins**
Financial Sustainability					
15	Month 10 – 2017-2018 – Financial Narrative	Executive Director of Finance	**APP J**	**Approve**	**20 mins**
Transforming and improving patient care – no items					
A workforce for the future – no items					
16	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 29.1.18 and verbal update from meeting 26.2.18 ▪ Finance and Performance Committee – minutes of 30.1.19 and verbal update from meeting 23.2.18 ▪ Workforce Well Led Committee – minutes from meeting 14.2.18 ▪ Audit and Risk Committee – minutes from meeting held 24.1.18 ▪ Draft Minutes Council of Governors Meeting – 23.1.18		**APP K**	**Receive**	**15 mins**
Date and time of next meeting Thursday 5 April 2018 commencing at 9.00 am **Venue: Hospital Boardroom, HRI**					**Approx 143 mins**

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st March 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 1.2.18 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 1 February 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 1 February 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 minutes of the last Public Board of Directors Meeting held on Thursday 1 February 2018

Appendix

Attachment:

DRAFT - PUBLIC BOD MINS - 1.2.18 (3).pdf

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 1 February 2018 at 9am in the Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

Andrew Haigh	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
Phil Oldfield	Non-Executive Director
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)
Amber Fox	Shadowing the Board Secretary
Mandy Griffin	Managing Director Digital Health
Mike Lodge	Senior Scrutiny Support Officer – Calderdale Council (for item 18)
Victoria Pickles	Company Secretary
Stuart Smith	Director of Adults and Childrens Services – Calderdale Council (for item 18)

OBSERVER

Brian Moore	Publicly Elected Governor – Lead Governor
Philip Lewer	

15/18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, particularly Suzanne Dunkley who had taken up the post of Executive Director of Workforce and Organisational Development with effect from 1 February 2018 and Brian Moore and Amber Fox.

16/18 APOLOGIES FOR ABSENCE

Apologies were received from:
Di Wharmby, Publicly Elected Governor.

17/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

18/18 MINUTES OF THE MEETING HELD 4 JANUARY 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.

19/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG

190/17 PATIENT STORY – The Chair advised that a decision had been made to defer the EPR/Serious Incident Investigation reporting deep-dive as it was felt that the Patient Flow and Winter Pressures presentation arranged was more relevant at the current time.
STATUS: OPEN ON ACTION LOG

8/18 HIGH LEVEL RISK REGISTER - It was noted the Company Secretary and the Head of Governance and Risk had met with Andy Nelson and Alastair Graham on Monday 29 January 2018 to review the High Level Risk Register/Board Assurance Framework.
STATUS: CLOSED ON ACTION LOG

191/17 GOVERNANCE REPORT – All Board members were reminded to return their self-assessments (skills and expertise template) to the Board Secretary. It was agreed that the Board Secretary would remind Board members who had not responded.
ACTION: BOARD SECRETARY
STATUS: OPEN ON ACTION LOG

162/17 IPR – GREEN X PATIENTS – This information would be picked up in the Patient Story later in the meeting.
STATUS: **CLOSED ON ACTION LOG**

162/17 IPR – SAFER PATIENT PROGRAMME – This action would be picked up in the Patient Story later .
STATUS: **CLOSED ON ACTION LOG**

147/17a. ESTATES – CAP FUNDING REDUCTION – Discussed at the Commercial Investment Strategy meeting. There is a plan to re-visit this on the Risk Register which has a current rating of 20. The report will be received before the end of the financial year as part of the budget setting.
STATUS: **CLOSED ON ACTION LOG**

11/17 IPR ACTION CARDS – The Chief Operating Officer agreed to circulate a briefing to the Non-Executive Directors to explain the process around the use of these cards.
STATUS: OPEN ON ACTION LOG

13/18 GUARDIAN OF SAFE WORKING – Requirements were clarified with the Guardian last week, 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.
STATUS: OPEN ON ACTION LOG

20/18 CHAIR'S REPORT

Chair's Recruitment Process Update

The Chair reported that the Nomination and Remuneration Committee (Council of Governors) were due to interview two candidates on Friday 2 February 2018 for the post of Chair of the Trust.
OUTCOME: The Board NOTED the Chairman's report

21/18 CHIEF EXECUTIVE'S REPORT

It was noted that the Chief Executive had recently circulated two reports to the Board: Update on PFI and 'Strengthening the relationship between health and local government' from the West Yorkshire and Harrogate Health Partnership System Leadership Executive Group. The Chief Executive encouraged all Board members to read these two documents.

Discussion took place regarding the documents and concern expressed that during the next quarter further deterioration in NHS funding could be expected particularly within the Acute sector.

It was noted that the Full Business Case Sub Committee of the Board were due to meet

ary and these documents would be considered there. The Exe
Director of Finance reported that new guidance on Sustainabillity and Transformation Funding was expected to be issued shortly.

Following the recent national media interest, the Chief Executive confirmed that the Trust had no dealings with Carillion.

OUTCOME: The Board NOTED the Chief Executive's report

22/18 PATIENT/STAFF STORY/QUALITY REPORT DEEP DIVE

Chief Operating Officer updated the Board on managing patient flow and winter pressures.

The presentation gave the Board an overview of the work which had been undertaken by Trust staff to alleviate some of the patient flow challenges which had been faced due to winter pressures. Also contained within the presentation were examples of two patient stories, one of a poor experience and one a good experience.

The Board were given an insight into the many actions which had been undertaken from lessons learnt during the last few weeks. It was noted that work had already commenced on preparing the future Winter Plan.

The key issues from the presentation were:

- We still remain at OPEL 3 with many actions continuing including daily silver (tactical) meetings chaired by the Chief Operating Officer.
- 46 escalation beds are still in use, 22 more than winter plan
- Our performance position and positive impact on our patients' experience is one of the best regionally.
- The actions that have been taken have made a significant impact on our ability to manage the unprecedented pressures we have witnessed and provide our patients safe, quality care with an improved experience

The Board thanked Helen Barker for the deep-dive presentation on the challenges facing the Trust now and into the future.
As a result of lessons learnt, discussions were taking place with all partners to mainstream the actions. The Chief Operating Officer advised that at the end of the quarter she would bring a paper to Board updating on the winter planning arrangements and conversations with partners.

ACTION: COO – BOD AGENDA ITEM – DATE TBC

The Chief Executive felt that the effects of EPR as an enabler to the work of the teams should not be underestimated and examples were given of work in the Trust and Community. It was suggested that wherever possible, during Board to Ward visits etc., the Board should express in person their appreciation.
It was suggested the actions the Trust undertook during winter pressures is shared as a positive story. The COO reported GPs on Huddersfield side has been in touch to review next year's planning and a meeting is taking place in February.

OUTCOME: The Board RECEIVED the deep-dive presentation into Patient Flow and Winter Pressures.

23/18 HIGH LEVEL RISK REGISTER

The Executive Director of Nursing reported the risks scoring 15 or above within the organisation which highlights 11 risks. These had been discussed in detail at the Executive Board, Finance and Performance Committee, Quality Committee and Risk and Compliance Group. It was noted that a revised paper had been circulated following discussion at the Quality Committee meeting which included risk 7147 'EPR financial risk medical division'.

6967 (25): Non-delivery of 2017/18 financial plan
7062 (20): Capital programme
6903 (20): Estates/ ICU risk, HRI
7049 (20): EPR financial risk
5806 (20): Urgent estates schemes not undertaken
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
6658 (20): Patient flow
6441 (20): Divisional income Surgery and Anaesthetics
7147 (20): Divisional income Medicine

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

Risks with reduced scores
The score for the mortality risk, 4783, has been reduced to 12 due to sustained improvements in the mortality reported levels and has therefore been removed from the high level risk register.

New risks
Risk 7147 relating to an EPR financial risk within the Medical Division has been added at a risk score of 20. This score is consistent with a Surgery Division EPR financial risk score.

Risk 6949 from the Family and Specialist Services Division has been added, regarding delivery of the Blood Transfusion service, at a risk score of 15.

Work is ongoing on EPR risks that are 15+.

Finance are drafting 2018/19 financial risks and these are being reviewed by Finance and Performance Committee on 30 January 2018.

Closed risks
There were no closed risks during the month.

It was noted there were only 2 falls with harm to patients in December.

Risk 7062 – The Risk Register has been reduced to reflect the capital relating to the 18/19 Programme and will be considered alongside the FBC.

Risk 6345 – There will still be a shortfall in the number of trained nurses the Trust can recruit. There are 3 international so far and 12 are expected. This will have a big impact on morale. Discussion took place regarding the risks and the Executive Director of Nursing advised that nurse recruitments were being made.

OUTCOME: The Board APPROVED the High Level Risk Register

24/18 BOARD ASSURANCE FRAMEWORK
The Company Secretary presented the Board Assurance Framework for review and approval.

The Company Secretary gave feedback on the meeting with Non Executive Directors and agree that this would be used as part of the end of year review. There was discussion around how the Board Assurance Framework is largely externally focused, e.g. 7 day services, WYAAT.

A number of these risks have been through the sub-committees.

Andy Nelson expressed concern that there is a disconnect between the target and the score as some of the risks never seem to move. There will be some additional learning following the Risk Appetite session. The Director of Transformation and Partnerships commented that the risks reflect strategic challenges such as the reconfiguration which are long term and therefore can be somewhat static on the BAF.
The Company Secretary commented that the Board Assurance Framework is normally received every quarter; therefore, the next version will be received in May. **OUTCOME: The Board APPROVED the revised Board Assurance Framework.**

25/18 GOVERNANCE REPORT COUNCIL OF GOVERNORS ELECTION TIMETABLE

The Company Secretary presented the Council of Governors Election Timetable which the Council of Governors had approved at its meeting on the 23 January 2018. The election process would be independently overseen by the Electoral Reform Service and the process would commence on the 10 and 23 April 2018 with briefing sessions for prospective Governors. The election results would be issued to the Trust on 4 July 2018.

The aim is that the new Governors will be in place before the next Annual General Meeting (AGM).

The Chief Executive suggested further work was needed to encourage a more inclusive membership and potential governors. The Executive Director of Workforce and OD explained Kirklees have a Young Employee's Network that could be explored.

ACTION: DWoD/Company Secretary

OUTCOME: The Board **APPROVED** the Council of Governors Election Timetable

26/18 FREEDOM TO SPEAK-UP/WHISTLEBLOWING ANNUAL REPORT

Dr David Anderson as appointed Guardian for Freedom to Speak-up introduced the Freedom to Speak-up/Whistleblowing Annual Report.

It was noted that no concerns had been logged on the Trust's Raising Concerns log to date,. Two queries had been raised as potential whistleblowing concerns during 2017, but these did not progress to be formally logged as Concerns under the Raising Concerns Policy. Since the introduction of "Ask Owen" within the Trust in September 2015, almost 200 questions had been responded to. These had come from all divisions and multidisciplinary groups. The issues covered included both national and local health economy topics including reconfiguration proposals, as well as CHFT specific topics. Key themes had included: Working environment, car parking, staff recognition, our use of agency and secondments. This has led to a number of improvements being made.
The Board appreciated that a substantial amount of work had been undertaken to develop an open and transparent culture within the Trust but there were still areas for improvement and these would be addressed during 2018.
The Chairman announced Dr David Anderson will be finishing in his role later this year and this role would be passed to another colleague.

Karen Heaton asked if other Trusts had used alternative routes and Dr Anderson agreed that he would investigate this further.

ACTION: Dr David Anderson

OUTCOME: The Board of Directors RECEIVED and NOTED the content of this report.

27/18 DIRECTOR OF INFECTION, PREVENTION AND CONTROL QUARTERLY REPORT

The Medical Director reported that there had been 3 cases of MRSA, (1 post case and 2 pre case.

A total of 23 C.Difficile cases breached, of which the majority of cases were non-preventable.

oing to reduce the numbers of E.Coli and Sepsis.

It was reported there has been pressure on isolation breaches this year due to pressure of beds; however, the Trust maintains a good performance compared to our peers.

Richard Hopkin reported the Audit and Risk Committee had discussed the internal audit which identified that there has been a lack of completion for risk assessments and Bristol stool charts. The Medical Director confirmed that there is improvement work ongoing to try to rectify this which had been a result of challenges with documentation within EPR.
OUTCOME: The Board RECEIVED and NOTED the contents of the report

28/18 EQUALITY AND INCLUSION ANNUAL REPORT

The Company Secretary presented the Equality and Inclusion annual report which has been a joint effort with Workforce colleagues and provides a snapshot of the ongoing work.

Part of this work is to present progress against the Trust's objectives to a public panel in March 2018. This feedback, on top of work already completed, will be brought together in a report for the Well-Led Committee in April / May 2018.

Discussion took place regarding the large amount of data within the document without analysis and it was agreed that this would be reviewed next year.

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 - Company Secretary to include on the agenda for a future Board workshop

The Executive Director of Workforce and OD also suggested that this include agreement of a narrative around why a more diverse workforce is better. Alastair Graham suggested is would be useful if there are other examples around the country to respond to best practice to focus on the elements which are having a bigger impact.

Putting Patient First Strategy will link into this strategy at the Well-Led Committee. The patient and public element will be complete by the middle to end of April 2018.

ACTION – Suzanne Dunkley / Karen Heaton to explore the workforce element timeline

OUTCOME: The Board APPROVED the Annual Report being formally published on the Trust's website and supported the ongoing work within the Trust.

29/18 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 noted:-

- December's Performance Score has deteriorated by 8 percentage points to 54%
- All domains have deteriorated in month
- The CARING domain has dropped significantly due to FFT IP survey 'would recommend' and both Community FFT indicators missing target
- The EFFECTIVE domain has moved to AMBER due to a drop in the infection control and the fractured neck of femur performance
- The RESPONSIVE domain is still AMBER with underperformance against all four stroke targets. However good performance had been maintained across the cancer metrics
- EFFICIENCY & FINANCE has improved with Day-Cases and A&E activity achieving target in-month, however Agency expenditure and Capital both deteriorated to RED in month
- WORKFORCE has deteriorated further with all five Mandatory Training focus areas

[illegible]t and a decline in sickness absence performance.

It was noted the Workforce and Well Led Committee will receive the IPR report on Monday.

The Chief Executive reported that during the remaining two months of the financial year there will be direct support to Divisions to achieve these targets.

The Board agreed that leadership was key to achieving the targets although staff had a personal responsibility to ensure that they were compliant against Mandatory Training. They asked that weighting of mandatory training set against other targets should be reviewed

It was noted that discussions were taking place at Quality Committee and Finance and Performance Committee to focus on the actions to be undertaken to address the year-end position.

OUTCOME: The Board **RECEIVED** the Integrated Board Report and **NOTED** December's position

30/18 MONTH 9 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance presented the Month 9 Financial Narrative.

The Month 9 position is a year to date deficit of £26.34m. On a control total basis this is an adverse variance from plan of £5.55m; excluding the impact of loss of Sustainability and Transformation funding (STF) of £3.86m that has been lost based on Q1 & 2 A&E performance and financial performance in Q3. When loss of STF funding is included the total adverse variance is £9.41m compared with a control total of £16.87m.

Since appealing the 17/18 £15.9m control total deficit in January 2017, it was noted that the Trust's Board had 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.

As discussed with NHSI in recent Financial Recovery meetings, in year these concerns have increased as the underlying financial position has continued to deteriorate. The underlying operational performance would drive an adverse financial variance of £15.1m to the year to date planned position (excluding the impact of lost STF funding) and in the first 6 months of the year the planned position was only achieved through a number of non-recurrent income and expenditure benefits totalling £7.53m, including a £3.5m negotiated settlement with the PFI facilities management provider in support of CIP delivery. This is in addition to the release in the year to date of the full £2m contingency reserve available for this financial year.

In Quarter 3 the Trust has been unable to deliver the financial plan reporting an adverse variance of £5.55m of which £1.77m related to Month 9. 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 just over £8m year to date.

As already 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

both activity and income which indicates that activity levels are 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. Financial recovery plans are being implemented details of which are shown below in section 4.

Discussion took place regarding the effects of cancelling elective care during January will have on the Trust going forward.

OUTCOME: The Board NOTED the contents of the report

31/18 CALDERDALE CARES MOVING FORWARD ON HEALTH AND SOCIAL CARE

Stuart Smith, Director of Adults and Childrens Services and Mike Lodge, Scutiny Support Officer from Calderdale Council attended the meeting to present the Calderdale Cares proposal.

This work is being carried out following the Government, stating there needs to be a joined up System by 2020. The objective is to agree in principle this quarter with a commitment by the end of March 2019 on how to deliver Calderdale Cares.

It was recommended that the plan be shared with the GP Alliance in Calderdale and Kirklees Local Medical Committee.

It was advised there needs to be a clear understanding on the context of the reconfiguration. The Director of Transformation and Partnerships agreed it would be an important step forward in integrated working with the Calderdale Vanguard and the Trust's own Community provision. Developing more robust structures would help reduce emergency admissions.

The Health and Well Being Board have asked for a Communication and Engagement Strategy by 1 March 2018. It was agreed there needs to be more focus from a patient perspective. The Company Secretary suggested reviewing the engagement work undertaken by the local Clinical Commissioning Group two years' previously on community provision as a starting point.

Alistair Graham supported the direction of travel and asked if the shadow year will be long enough to go through the issues in the pilots prior to wider go-live in April 2019.The Director of Adults and Childrens Services explained that there would be a lot of hard work required over the next 12 months to get to a position by April 2019.

OUTCOME: The Board **SUPPORTED** the Calderdale Cares moving forward on Health and Social Care in principle

32/18 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. David Anderson on behalf of Linda Patterson reported on the key items discussed at the meeting held on 29 January 2018 which had not been previously covered on the Board's agenda:

- Stroke assessment times and a separate area in A&E to be assessed
- Risk assessment of the Medical Division as discussed
- Mandatory training – work within Divisions is being undertaken to meet

- Update on CQC Preparation - sight on communications and amount of information

OUTCOME: The Board RECEIVED the minutes from the meeting held on 3 January 2018 and the verbal update of the meeting held on 29 January 2018.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 30 January 2018 which had not been previously covered on the Board's agenda.
The main areas discussed included:

The financial recovery plan and the need to get the trajectory right. The Committee had also discussed the cash position, the Nursing review costs and reducing cost base.

OUTCOME: The Board RECEIVED the minutes from the meeting held on 2 January 2018 and verbal update from 30 January 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 9 January 2018. The key items discussed at the meeting included mandatory training and the freedom to speak up report. She explained that the Trust would also be submitting comments on the proposed National Workforce Strategy as part of the consultation which ends in March 2018.

OUTCOME: The Board RECEIVED the minutes from the meeting held on the 9 January 2018.

d. Audit and Risk Committee

Richard Hopkin, Chair of the Audit and Risk Committee gave a verbal update from the meeting held on 24 January 2018. The key items discussed at the meeting included: Declaration of interests – it was reported that the new system for declarations of interest for Band 7 and above within the Trust was not as far ahead as we would like and further work was underway.

- Year-end Plan – Finance and External Audit had reviewed risks to year–end audit around around EPR asset evaluation, estates SUV and increased risk regarding financial sustainability.
- Two Internal Audit reports had been received with limited assurance regarding Compliance Register and Infection, Prevention and Control.
- Discussion had taken place regarding the value of the Audit and Risk Committee receiving the minutes from the relevant sub-committees sometimes 3 months after the meetings. Ways of resolving this such as items for escalation to summarise the minutes was being pursued.

OUTCOME: The Board RECEIVED the verbal feedback from the meeting held on the 24 January 2018.

DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 1 March 2018 commencing at 9.00 am in the Boardroom, Huddersfield Royal Infirmary.

The Chair thanked everyone for their contribution and closed the public meeting at 11:47 am.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st March 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 1 March 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 1 March 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 1 March 2018

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

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		April 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		April 2018		
7.12.17 191/17	**GOVERNANCE REPORT – SKILLS & COMPETENCIES** All Board members to complete their self-assessment and return to the Board Secretary	ALL	**1.2.18** **All Board members were reminded to return their self-assessment submissions to the Board Secretary before 21.2.18 in order that a composite report can be prepared for the March 2018 BoD meeting.**	March 2018		1.3.18
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	JE		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
	meeting					
2.11.17 147/17a.	**ESTATES – CAP FUNDING REDUCTION** Exec Director Planning, E&F agreed to discuss with Exec DoF the balancing of works and a paper would be brought to a future meeting.	LH/GB	**1.2.18 Discussed at Commercial Investment Strategy meeting. Plan to re-visit this on the Risk Register which has a current rating of 20. Report will be received before the end of the financial year as part of the budget setting.**			1.2.18 CLOSED
4.1.18 9/18	**PREPARATION FOR THE GENERAL DATA PROTECTION REGULATIONS (GDPR)** Presentation received. It was agreed that 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.	MG		May 2018		
1.1.18 13/18	**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.**	TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 March 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
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.**	Feb 2018		
1.2.18 25/18	**GOVERNANCE REPORT – COUNCIL OF GOVERNORS ELECTION TIMETABLE** The Chief Executive suggested further work was needed to encourage a more inclusive membership and potential governors. The Executive Director of Workforce and OD explained Kirklees have a Young Employee's Network that could be explored.	SD/VP		TBC		
1.2.18 26/18	**FREEDOM TO SPEAK-UP/WHISTLEBLOWING ANNUAL REPORT** Karen Heaton asked if other Trusts had used alternative routes and Dr Anderson agreed that he would investigate this further.	DA		TBC		
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			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
	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.**					

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, 1st March 2018	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Quarterly Quality Report - Q3 2017-18 - The paper summarises progress on quality for the period April 2017 to September 2017.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The attached quality report was presented to the Quality Committee on 26 February 2018.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper, together with a presentation at the meeting, provides an update on quality indicators and quality account priorities as at the end of December 2017, quarter 3 of 2017/18.

Main Body

Purpose:

To provide an assurance to Board members regarding work to improve quality of services and present quality data relating to Q3 2017/18.

Background/Overview:

A quarterly quality report is provided to the Board to share data regarding progress with quality improvement priorities and the 2017/18 quality account priorities.

The Issue:

A presentation on the key quality data as at Q3 2017/18 will be provided at the Board meeting.

The enclosed report has been previously discussed at the Quality Committee. The report summarises the information shared with the Board on quality over the last three months, which included an update on the work of a multi- disciplinary community based team, stroke services, serious incident reporting, learning from deaths and safeguarding.

Information on the 2017/18 quality account priorities of sepsis screening for in patients, discharge planning and learning from complaints at quarter 3 is also included within the enclosed quality report.

Next Steps:

The Board will continue to receive updates on service quality issues through papers presented to the Board.

The next formal update on quality will be presented to the Board when it reviews the Trust's Quality Account for 2017/18 as part of the sign off of annual accounts in May 2018...

Recommendations:

The Board is asked to note the quality reporting for the first three months of 2017/18, quality data as at quarter 3 2017/18 and the update on the three quality account priorities.

Appendix

Attachment:

Quality Report Q3 2017 18 QC.pdf

QUALITY COMMITTEE	
PAPER TITLE: QUALITY REPORT for Quarter 3, 2017/18 INCLUDING QUALITY ACCOUNT 2017/18	**REPORTING AUTHORS:** Juliette Cosgrove, Associate Director Quality and Safety Andrea McCourt, Head of Governance and Risk
DATE OF MEETING: Monday, 26th February 2018	**SPONSORING DIRECTOR:** Brendan Brown - Chief Nurse / Executive Director of Quality
STRATEGIC DIRECTION – AREA: • Keeping the base safe	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUMS: None	
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

This paper summarises:

i. assurances on quality that have been presented to the Board of Directors between October and December 2017
ii. an update on the three quality account priorities for 2017/18 for quarter 3.
iii. a presentation on quality indicators as at quarter, 2017/18

1. Quality reports to the Board:

During the three month period October to December 2017 five reports relating to quality were presented to the Board which included: an update on the work of a multi- disciplinary community based team, stroke services, serious incident reporting, learning from deaths and safeguarding.

1.1 Multi-disciplinary community based team

At the Board meeting on 5 October 2017 two therapists shared information about work across Calderdale undertaken by the Support and Independence Team, a mulit-disciplinary, community based team who receive a diverse range of referrals for care including referrals from Gateway to Care. The service was illustrated by the patient story of a man who had been diagnosed with HIV 16 years previously who had deteriorated that the team assessed and supported, with an outcome of the team's interventions resulting in an increased independence, self-esteem, mobility and overall physical wellbeing of the patient.

1.2 Stroke Services

At the Board meeting on 2 November 2017 the Board received a presentation on Stroke Services detailing progress made with actions in response to a peer review in 2016 which identified that the services had received a national SSNAP audit rating of D, had high crude mortality, high length of stay, high number of nursing vacancies and not all patients were being seen by therapy staff within the required timescale.

Progress described included an improved assessment from the national SSNAP audit rating, which had been assessed as and maintained as SSNAP audit rating of B for the last 12 months, an increase of two high dependency beds, a reduction in rehabilitation beds and focus on getting patients back into their own environment, an increase in therapy input increased, improved senior leadership, recruitment and multi-disciplinary team working with reductions in mortality. Next steps were noted regarding assessment beds, therapy input, radiology and raising awareness for stroke patients to be transferred to the Stroke Unit as soon as possible.

1.3 Serious Incident Deep Dive

On 7 December 2017 the Board received a detailed presentation on the Trust's Serious Incident reporting position, outlining the incident reporting process, that 1% of all incidents reported were serious incidents. The presentation included a breakdown of the serious incidents together with assurance on the process and investigation times involved. The duty of candour regulations was discussed. It was noted that significant assurance that the Trust is learning from serious incidents and moderate harm incidents had been reported by internal auditors in November 2017.

The Board heard about work to support investigators to improve the number of serious incident reports delivered in a timely way.

1.4 Learning from Deaths

The Board received it's first report on Learning from Deaths on 7 December 2017. This confirmed that the Trust's policy on Learning from Deaths, developed in line with National Quality Board guidance from March 2017, had been approved in September 2017. The process and resources for undertaking structured judgement reviews was detailed. The report provided the first data relating to quarter 2 2017/18 and noted 24 deaths required a structured judgement review. Of the 20 deaths reviewed two had been deemed probably avoidable and are being investigated within the Trust's incident reporting procedures. Emerging themes form the reviews were escalation to senior staff and decisions about ceilings of care. Future reports will continue to Board, with data presented one quarter in arrears.

1.5 Safeguarding Adults and Children

On 7 December 2017 the Board received a six month report on safeguarding activity for adults and children for the period April to September 2017. The report detailed key achievements and developments in a number of areas including the Mental Capacity Act, deprivation of liberty safeguards, training, supervision, progress with actions from external inspections and developments planned.

2. Update on 2017/18 Quality Priorities, Quarter 3 2017/18

An update on the three quality account priorities for 2017/18, sepsis screening for in patients, discharge planning and learning from complaints is given below. Sepsis and discharge planning are CQUINs for 2017/18.

2.1 Sepsis Screening for in patients

Sepsis is an infection which starts in one part of the body but spreads via the blood and can prove fatal for some patients. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are thought to contribute to a number of preventable deaths.

The Trust is looking to improve the recognition of potential sepsis through a number of interventions.

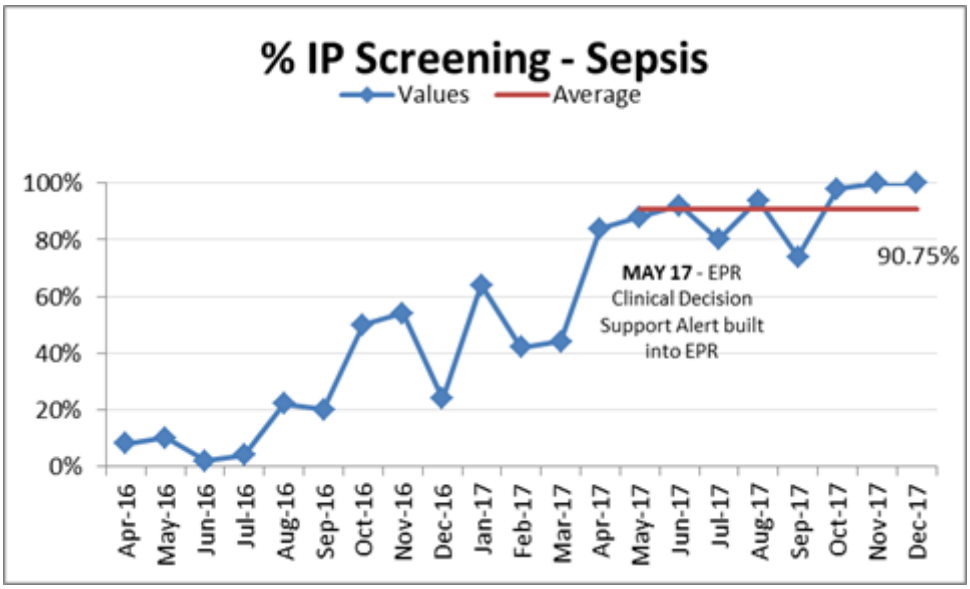
One key intervention centres on ensuring appropriate screening of patients with suspected sepsis. This screening will enable patients to commence treatments sooner and improve their overall outcomes. This is important for patients both arriving with us with sepsis and those that develop sepsis whilst under our care

There have been significant processes changes with the introduction of EPR in May 2017 and with further developments anticipated later this year. Previously CHFT used the clinical criteria of a NEWS (national early warning score) greater than 5 to trigger the clinical team to assess for sepsis using the sepsis screening bundle in the medical records. A second bundle supported clinicians to recognise and manage severe sepsis.

The Cerner EPR now in place within CHFT continuously monitors and "screens" inpatients for possible sepsis using a criteria with clinical and laboratory measures. If three clinical parameters, or two clinical parameters and one laboratory measurement are abnormal the system will trigger an alert to the clinical team to consider whether sepsis is present. If severe sepsis is identified the team are prompted to request and complete the adult sepsis 6 care plans which includes further investigations along with prescriptions for fluids and antibiotics.

How did we do

In line with other organisations using Cerner EPR it has been agreed that all adult inpatients are therefore screened for sepsis on a continuous basis. All adult admissions have a sepsis screen, with performance for ED and acute settings improved, at 99% and 100% respectively.



The current position is that the timely treatment of sepsis in emergency departments has improved to 75% but for acute in patent settings has deteriorated to 53% from the previous quarter performance of 74%.

The Sepsis Collaborative met twice during Q3 and reviewed sepsis CQUIN performance and the dashboard. It agreed a plan for the review of the Sepsis Policy and identified barriers to recognising sepsis, for which an action plan has been developed.

2.2 Discharge Planning

There is a considerable evidence base for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, both in terms of safety, experience and the needs for the patients when they are finally discharged. It also creates financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the

ability of emergency departments to respond to people's needs and increasing costs to local health economies.

Safe and timely discharge planning for all patients is an essential part of their overall plan of care and treatment. It is estimated that over 20% of discharges require some complex planning and coordination and for the other 80%of patient's good discharge planning is still essential.
To enable the most complex patients have an effective safe discharge and appropriate environment to return to after their stay, the Trust continues to work to enhance and develop the role of the discharge co-ordinator as Trusted Assessors so that these roles continue to be effective and work collaboratively with our partners.

For all of those other patients, improvement in discharge planning is a strong focus within the SAFER Programme with a number of improvement initiatives being implemented throughout Q4 2018.

Improvement work

The work in 2017/18 is a continuation of a transformational work started by the Trust in 2016/17 under the SAFER Patient Flow Programme.

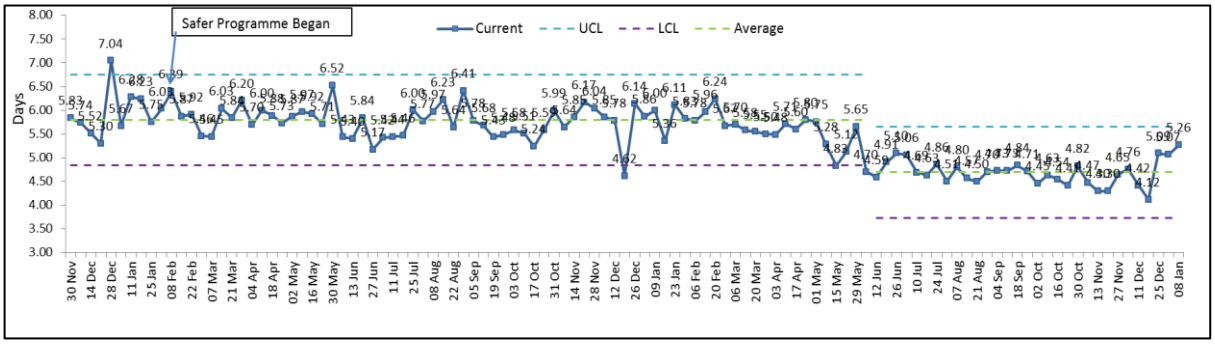
The work being undertaken is through three work streams: bed avoidance, bed efficiency and bed alternates.

Schemes implemented through the work streams to improve discharge are:

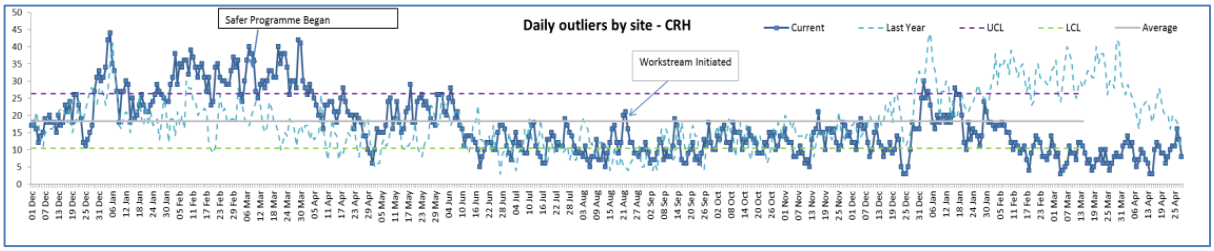
- Introduction of criteria led discharge
- Consultant ward round buddy
- Discharge Screening
- Trusted Assessor- reablement pathway
- Standardised MDT
- New discharge pathways- Continuing Health Care Pathway- Transitional Pathway for patients who are unable to return home due having limb injuries.
- Daily review and monitoring all patients who are medically for discharge.
- Weekly senior partner meeting to review patients with complex discharge needs.
- Further development of the transfer of care database.

How did we do?
The Trust has a number of KPIs to measure the impact of the work initiated to improve discharge planning.

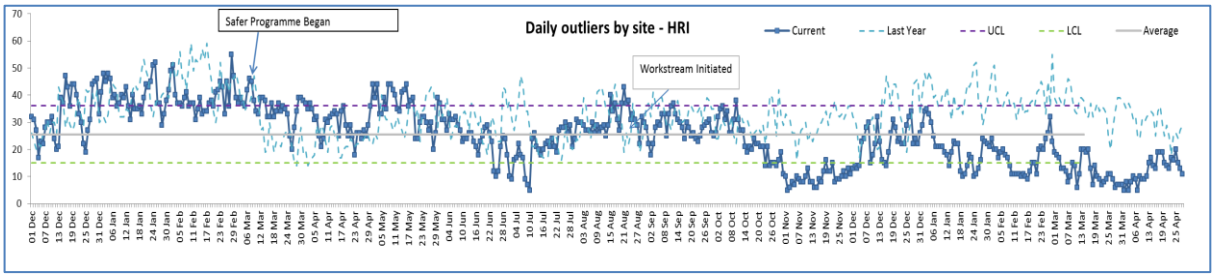
LOS



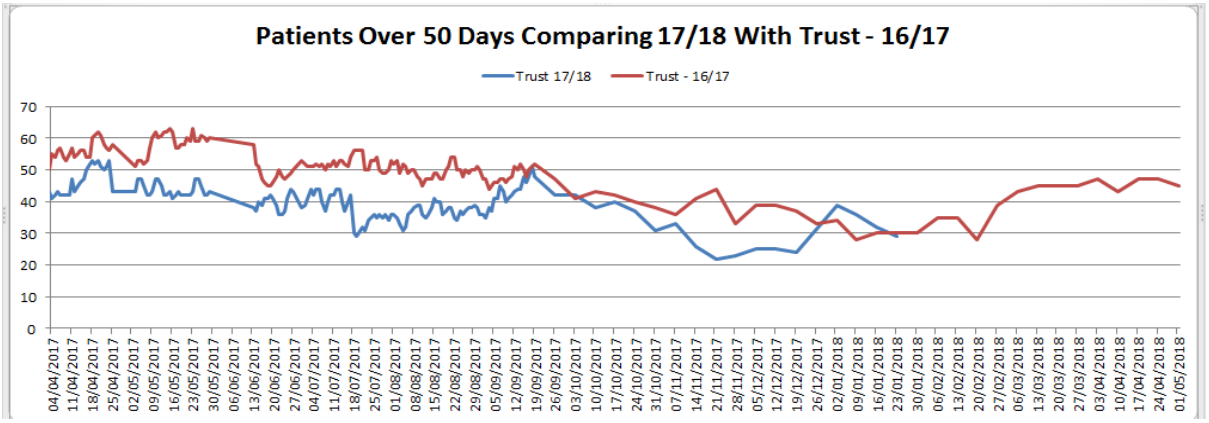
Outliers- Medical Patients In surgical Beds
CRH



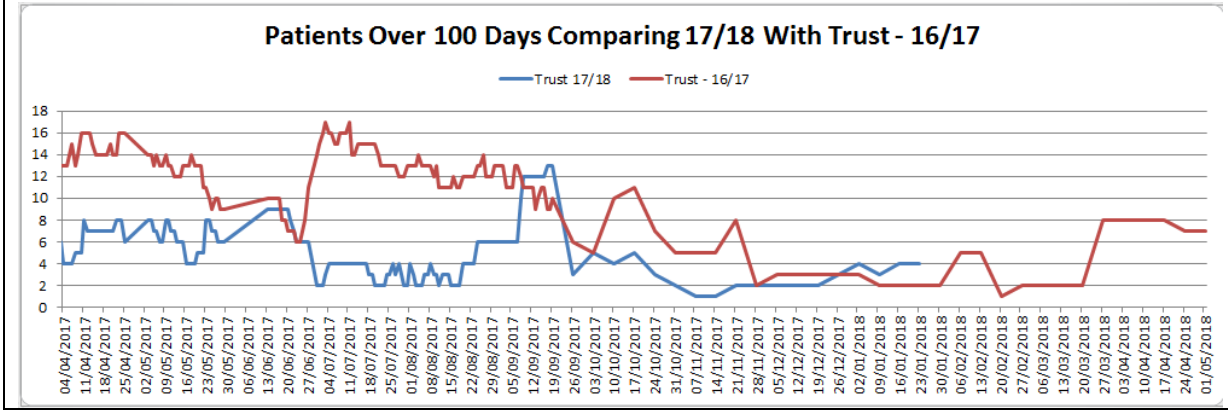
HRI



Patients in Hospital over 50 days



Patients in hospital over 100 days



Summary

The Trust wide, unplanned length of stay (LOS) has stabilised at around 4.5 days, the mean for Aug/Sept/Oct/Nov 2017 being 4.7 days. This improvement includes both more efficient management of patients on 'simpler' pathways and also a reduction in longer staying patients due to more effective management of patients with complex needs. The improvement in managing shorter stay patients (in line with the SAFER bundle principles) has in part been facilitated by the mobilisation of senior members of the wider SAFER team attending ward rounds/MDTs on a number of wards to challenge and coach medical and nursing on discharge planning. Whilst the reduction in longer stay and medically stable patients has been the focus of the dedicated discharge teams, over the last 18 months in conjunction with local authority partners which demonstrated a sustainable reduction in over 50 and 100 day LOS.

Evidence shows that when patients are outlied to other speciality inpatient beds for example medical patients into surgical beds, the length of stay for those patients increases. The reduction in medical patients outlying into surgical wards has continued to reduce since the beginning of the programme.

2.3. Learning from Complaints

Why we chose this
We receive a lot of positive feedback on our services throughout the year. However, when our patients are dissatisfied with the service they receive and make a formal complaint, we act on it. It is critical that we learn from patients' experiences of our services and make improvements. We plan to improve the quality of the response to complaints and increase learning from complaints.

Improvement work
The Parliamentary Health Service Ombudsman's report, Learning from Mistakes, July 2016, reiterated that training and accrediting sufficient investigators is crucial to improve learning from investigations. Therefore a new training package was devised to support staff in their investigative approach to patient complaints.

Increase in number of staff trained in complaints management
The Complaints Development have rolled out and undertaken a complaints investigations training course. The complaints training is a full day course looking at the legislation behind NHS complaints, tools and techniques for investigating a complaint, how to identify and disseminate learning.

Since the commencement of the course 76 members of staff have been trained in complaints management.

Positive feedback has been received from the evaluation, with attendees feeling more confident in managing complaints, understanding the need to plan and structure the investigation and increased awareness of the requirements for complaints responses and legislative requirements.

On reviewing of feedback forms and staff attending the course, we are looking to review the complaints training package to make it modular based instead of a full day, we hope that we will be able to target more staff this way.

Improving learning from complaints.

Learning from themes and trends relating to complaints about staff attitude in the Emergency Department, a 'customer service' workshop has been developed and is due to be started on 22 February 2018. It is hoped that this workshop will help realise how their action and attitude can effect patients and therefore reduce the number of complaints relating to staff attitude. Following the workshop complaints relating to staff attitude and behavior will be monitored for improvement.

Section 5 of the Q3 quarterly complaints report details divisional and Parliamentary and Health Service Ombudsman learning from complaints. To this section we have also added a feature on learning, where we take one piece of learning and provide a story around the complaint and learning to provide more context to the learning in a way that we hope will resonate with our staff. An example of this featured learning on communication from the Q2 complaints report, which was reviewed by the Patient Experience Group in Q3 is given below:

Poor communication with our services caused a patient unnecessary anxiety and distress. The communication breakdown started when he believed that his appointment with the consultant had not been made and had to chase this. When the patient was seen he was seen in the correct clinic but on the day he was seen by a different clinician in clinic. This caused the patient anxiety as the patient had prepared themselves to see one consultant and were only made aware of the change when they entered the consultation room. This caused a really poor experience for the patient and the complaint illustrated how going to a hospital appointment can have a big impact on patients and therefore it is really important to keep them updated of any changes, as this can help reduce patient's anxieties.

Unfortunately, our communication breakdown with this patient did not end there. The patient is hard of hearing and was receiving test results in relation to the investigation of a mass. Staff did not take the patient hearing needs into consideration, no one took the time to make sure the patient understood the results and therefore the patient left the appointment not understanding his diagnosis, which caused further upset and distress. The patient had to wait until he had a further appointment to receive a clear diagnosis.

The information we are providing patients can have a huge impact on their life and their emotional wellbeing. It is really important that we understand how best to communicate with patients, and ensure that they understand information that is being provided. It is important to ask people what is the best method of communication for them.

Other areas of learning

The quarterly complaints report is presented at the Patient Experience Group and shared with the council of governors. At the Patient Experience Group themes and trends are discussed with the divisional patient experience representatives who sit on this group.

During quarter 4 it is planned to request divisional leads to undertake work within the division to describe themes and trends, regarding reductions and increases in issues of concern to understand what is happening within the divisions to cause these and report back their finding to the Patient Experience Group and learning shared. An example of the learning from this is the Division of Surgery have seen a marked increase in the number of complaints for that quarter, the Divisional representative for surgery will now look into this increase from a Divisional level and report back the finding to the Patient Experience Group.

We have introduced a number of improve and learning initiatives with focus on a subject of learning instead of the source (examples Bite Sized Learning, Sharing Learning – Improving Care Newsletter, Improve@CHFT - social media group). Learning from complaints feeds into this wider learning.

Compliments regarding the Complaints Process

We have recently received the following compliment from a complainant after receiving their response:

"I appreciate the time and effort that has been put into the response. I am happy with the responses to the major areas of my concern and now have a much clearer

understanding of the discharge summary. Thanks again for the very detailed response".

This compliment shows that the time spent ensuring are complaints responses are of good quality is appreciated by complainants.

3. **Quarter 3 2017/18 Quality presentation**
   The attached presentation provides key points relating to quality indicators during quarter 3, 2017/18.

FINANCIAL IMPLICATIONS OF THIS REPORT:
None

RECOMMENDATION
The Quality Committee is asked to note the quality reporting for quarter 3, 2017/18 and the update on the three quality account priorities and that this report will be presented to the Board at it's meeting on 1 March 2018.

APPENDIX ATTACHED
Yes – quarter 3 2017/18 quarterly quality report

Quarterly Quality Report
Q3 2017-18

Quality Committee
26 February 2018

Board of Directors
1 March 2018

Calderdale and Huddersfield NHS Foundation Trust

Quality Framework

Summary

Indicator	Target	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18
HSMR	100	104.14	105.06	113.94	106.12	103.74	101.90	83.27	81.84	-
SHMI	100	108.9	111.3	113.88	112.21	113.34	112.88	90.44	-	-
A&E within 4Hr Performance (Incl. CH)	95%	95.08%	90.07%	94.10%	94.40%	93.81%	94.42%	90.58%	92.75%	91.09%
% VTE Risk Assessments	95%	95.30%	95.20%	95.10%	95.10%	95.10%	95.34%	91.44%	92.26%	97.00%
MRSA	0	6	0	0	0	1	1	2	1	0
C. Difficile	6	7	8	6	11	6	9	6	6	11
Friends and Family Response Rate (Inpatient)	26%	31.60%	31.30%	32.79%	34.96%	33.50%	33.98%	24.17%	32.01%	33.93%
Friends and Family Response Rate (A&E)	13%	10.30%	9.50%	14.50%	12.41%	13.73%	10.03%	7.90%	12.15%	10.62%
Staff Sickness (YTD)	< 4.00% - Green 4.01 -4.5 Amber >4.5% Red	4.96%	4.69%	4.45%	4.19%	4.38%	4.24%	3.84%	3.92%	4.37%

Quality Account and CQUIN

Quality Accounts

1. Discharge Planning

- Unplanned length of stay stabilised at 4.5 days due to:
  - more efficient management of patients on "simpler pathways"
  - more effective management of patients with complex needs
- SAFER team senior members coaching ward staff on discharge planning
- Sustained reduction in medical patients outlying into surgical wards.
- **2. Sepsis screening for in patients**:
- EPR 'clinical decision support algorithm' has been quality assured by the clinical teams. All adult admission have a sepsis screen, with performance for (ED) and acute in patient settings improved at (99% and 100% respectively)
- timely treatment of sepsis in ED improved to 75% but acute in patient settings deteriorated to 53% from the previous quarter performance of 74%

- **3. Learning from complaints**
- "Go See" visit to Emergency Department due to complaints about attitude – customer services workshop being planned
- Development of new report template for complex complaints to help identify learning by understanding what should have happened for patients and why this did not happen, based on PHSO approach to investigation

Quality Account and CQUIN

- **CQUINS**
- **On plan - highlights**
  - Flu Vaccination campaign started in Q3, on target to hit 70% + and achieve target
  - % offering advice and guidance responses within 2 days (improving GP access to a clinical lead prior to referring patients to secondary care) – agreed to work towards 80 % compliance by end of 2018/19. Current focus on getting robust processes in place.
  - % Appointment Slot Issues - focused worked in the Trust seeing reductions across specialities
  - Sepsis – see previous slide
- **Off plan**
  - Reduction in antibiotic consumption per 1,000 admissions – challenges in reducing consumptions rates
  - Preventing ill health by risky behaviours - alcohol and tobacco – no improvement noted. Gathering more baseline data to better understand our position.

Safe

- **Serious Incident Reports –** average length of time investigation reports overdue is reducing – 38 days in November compared to 76 in September 2017
- **Incident Reporting –** increased number of incidents in December due to push to increase reporting and patients being admitted with pressure ulcers being incorrectly reported as CHFT incidents

- **Safety Thermometer -** The target of 95% of patients being free of harm on safety thermometer day not achieved. Performance = 93%:

- "old" pressure ulcers / patients admitted with pressure ulcers
- Hospital acquired pressure ulcers, VTEs and urinary infections and catheters

Effective

- **VTE risk assessment**

  Performing above target at 97% following a full clinical review of the process and applicable patient cohorts.

- **Never Event D 148498 –** wrong site surgery, October 2017

  Patient procedure planned for right ureteroscopy and ureteral stent, left side stented (incorrect side)

  Recommendation from serious incident investigation – review of the use of the WHO checklist by surgical specialties to reduce the risk of this happening by making the operating side clearer as surgery commences

- **MRSA –** first quarter for some time with no MRSA infection

Responsive

- **Emergency Care 4 hour standard** – 91% against target of 95%, Winter pressures, flu and access to social care impacted front end flow.

- **Complaints**
- 38% (40) complaints overdue at end of Q3: Surgical (22), Medicine (13), FSS (4) and Community Division (1)
- No complaints more than 3 months overdue
- Patient experience lead in Surgical division commenced
- Weekly complaints panels in place with divisions with overdue complaints, plan to clear backlog of overdue complaints

Well Led

CQC

- Well-led action plan developed for CQC inspection from data submitted and further information requests. Areas of risk identified, action plan being overseen by CQC preparation group
- Plan of support for Board and colleagues in place as we prepare for the CQC inspection

Development

- Mid point review of CLIP leadership programme took place 21 November 2017. Both cohorts met together with the Chief Nurse, Chief Executive and Healthskills, positive feedback on what has been learnt and suggestions from delegates were accommodated into the programme by Healthskills
- Cohort 3 of leadership programme launched 13 November 2017 (14 staff)

Quality Improvement

- Development of QIL (Quality Improvement Lead) network to build quality improvement (QI) capability within the Trust and support the development of QI skills – network launch in Q4.
- Initial stage duty of candour – sustained at 100% at Q3

Quarterly Quality Report
Q3 2017-18

Quality Committee
26 February 2018

Board of Directors
1 March 2018

Calderdale and Huddersfield NHS Foundation Trust

Quality Framework

Summary

Indicator	Target	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18
HSMR	100	104.14	105.06	113.94	106.12	103.74	101.90	83.27	81.84	-
SHMI	100	108.9	111.3	113.88	112.21	113.34	112.88	90.44	-	-
A&E within 4Hr Performance (Incl. CH)	95%	95.08%	90.07%	94.10%	94.40%	93.81%	94.42%	90.58%	92.75%	91.09%
% VTE Risk Assessments	95%	95.30%	95.20%	95.10%	95.10%	95.10%	95.34%	91.44%	92.26%	97.00%
MRSA	0	6	0	0	0	1	1	2	1	0
C. Difficile	6	7	8	6	11	6	9	6	6	11
Friends and Family Response Rate (Inpatient)	26%	31.60%	31.30%	32.79%	34.96%	33.50%	33.98%	24.17%	32.01%	33.93%
Friends and Family Response Rate (A&E)	13%	10.30%	9.50%	14.50%	12.41%	13.73%	10.03%	7.90%	12.15%	10.62%
Staff Sickness (YTD)	< 4.00% - Green 4.01 -4.5 Amber >4.5% Red	4.96%	4.69%	4.45%	4.19%	4.38%	4.24%	3.84%	3.92%	4.37%

Quality Account and CQUIN

Quality Accounts

1. Discharge Planning

- Unplanned length of stay stabilised at 4.5 days due to:
  - more efficient management of patients on "simpler pathways"
  - more effective management of patients with complex needs
- SAFER team senior members coaching ward staff on discharge planning
- Sustained reduction in medical patients outlying into surgical wards.
- **2. Sepsis screening for in patients**:
- EPR 'clinical decision support algorithm' has been quality assured by the clinical teams. All adult admission have a sepsis screen, with performance for (ED) and acute in patient settings improved at (99% and 100% respectively)
- timely treatment of sepsis in ED improved to 75% but acute in patient settings deteriorated to 53% from the previous quarter performance of 74%

- **3. Learning from complaints**
- "Go See" visit to Emergency Department due to complaints about attitude – customer services workshop being planned
- Development of new report template for complex complaints to help identify learning by understanding what should have happened for patients and why this did not happen, based on PHSO approach to investigation

Quality Account and CQUIN

- **CQUINS**
- **On plan - highlights**
  - Flu Vaccination campaign started in Q3, on target to hit 70% + and achieve target
  - % offering advice and guidance responses within 2 days (improving GP access to a clinical lead prior to referring patients to secondary care) – agreed to work towards 80 % compliance by end of 2018/19. Current focus on getting robust processes in place.
  - % Appointment Slot Issues - focused worked in the Trust seeing reductions across specialities
  - Sepsis – see previous slide
- **Off plan**
  - Reduction in antibiotic consumption per 1,000 admissions – challenges in reducing consumptions rates
  - Preventing ill health by risky behaviours - alcohol and tobacco – no improvement noted. Gathering more baseline data to better understand our position.

Safe

- **Serious Incident Reports –** average length of time investigation reports overdue is reducing – 38 days in November compared to 76 in September 2017
- **Incident Reporting –** increased number of incidents in December due to push to increase reporting and patients being admitted with pressure ulcers being incorrectly reported as CHFT incidents

- **Safety Thermometer - ** The target of 95% of patients being free of harm on safety thermometer day not achieved. Performance = 93%:

- "old" pressure ulcers / patients admitted with pressure ulcers
- Hospital acquired pressure ulcers, VTEs and urinary infections and catheters

Effective

- **VTE risk assessment**

  Performing above target at 97% following a full clinical review of the process and applicable patient cohorts.

- **Never Event D 148498 –** wrong site surgery, October 2017

  Patient procedure planned for right ureteroscopy and ureteral stent, left side stented (incorrect side)

  Recommendation from serious incident investigation – review of the use of the WHO checklist by surgical specialties to reduce the risk of this happening by making the operating side clearer as surgery commences

- **MRSA –** first quarter for some time with no MRSA infection

Responsive

- **Emergency Care 4 hour standard** – 91% against target of 95%, Winter pressures, flu and access to social care impacted front end flow.

- **Complaints**
- 38% (40) complaints overdue at end of Q3: Surgical (22), Medicine (13), FSS (4) and Community Division (1)
- No complaints more than 3 months overdue
- Patient experience lead in Surgical division commenced
- Weekly complaints panels in place with divisions with overdue complaints, plan to clear backlog of overdue complaints

Well Led

CQC

- Well-led action plan developed for CQC inspection from data submitted and further information requests. Areas of risk identified, action plan being overseen by CQC preparation group
- Plan of support for Board and colleagues in place as we prepare for the CQC inspection

Development

- Mid point review of CLIP leadership programme took place 21 November 2017. Both cohorts met together with the Chief Nurse, Chief Executive and Healthskills, positive feedback on what has been learnt and suggestions from delegates were accommodated into the programme by Healthskills
- Cohort 3 of leadership programme launched 13 November 2017 (14 staff)

Quality Improvement

- Development of QIL (Quality Improvement Lead) network to build quality improvement (QI) capability within the Trust and support the development of QI skills – network launch in Q4.
- Initial stage duty of candour – sustained at 100% at Q3

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 1st March 2018	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Quality Improvement Strategy - The Board is asked to approve the Quality Improvement Strategy.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

In the current climate of significant financial and operational pressures the NHS must focus its efforts on improving the quality of care delivered whilst ensuring the best value.

The NHS five year forward view (Forward View) describes how services need to change to meet the needs of the population, and identified improvements in three main areas:
• improving quality of care
• improving the broader health and wellbeing of the population
• improving financial efficiency.

The NHS next stage review (Department of Health 2008) defined quality based on three criteria:
• safety: doing no harm to patients
• experience of care: this should be characterised by compassion, dignity and respect
• effectiveness of care: including preventing people from dying prematurely, enhancing quality of life and helping people to recover following episodes of ill health.

This definition has been adopted throughout the NHS in England and was used as the basis of the NHS Outcomes Framework and incorporated into the regulatory framework developed by the Care Quality Commission (CQC).
Considering all of the above the purpose of this document is to set out a three year strategy for Calderdale & Huddersfield Foundation Trust that will ensure we continually review care and strive to improve the services we offer to patients. We will do this by working with patients, our staff and partners using technology, best practice and innovative ideas. We will use our established “work together to get results” approach supported by specific quality improvement methods. The document outlines how we intend to achieve our strategic aims to:

• Improve outcomes for acutely ill patients
• Implement the End of Life Care Strategy
• Provide safe care
• Improve community services
• Demonstrate engagement and co-design

The strategy has four identified projects drivers:

• Leadership and Culture – In order for the strategy to be successful in improving outcomes for our patients the implementation and monitoring of the strategy will require leadership from every level of the organisation. Senior leaders, and boards in particular, play a vital role in creating a supportive culture and environment for quality improvement.
• Building Quality Improvement Capability – Enabling staff to identify their own areas for improvement and giving them the right tools and training to carry out tests of change, measure their impact and act on the results.
• Quality Improvement Measurement – Using good quality, deep dive data to define how we track interventions, measure our success, recognise and understand variation and therefore provide assurance to the Board.
• Learning Culture and Systems – Change is more likely to happen when staff are given opportunity to reflect on how things are done now and think about how they could be done better in the future. Feeding back to staff wherever possible. Sharing learning from investigations. Promoting the sharing of best practice and excellence.

We ask the Board to approve the Strategy and support its implementation Trust wide.

FINANCIAL IMPLICATIONS OF THIS REPORT:
Quality and finance are closely related through the many opportunities that exist to deliver better outcomes at lower cost (improving value).

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Organisational leads have been identified for each of the 5 aims. These leads and representatives from the Quality Directorate will form a Quality Improvement Strategy Implementation Group and will meet on a quarterly basis to develop the implementation plan, discuss progress and identified areas for improvement.
The Quality Committee will receive quarterly reports (starting in Q1 18/19) from the group on progress of the implementation plan to feed into the Board for assurance.

Recommendations:

To approve the Quality Improvement Strategy.

Appendix

Attachment:

Quality Improvement Strategy V5 Jan 2018 DRAFT.pdf

Quality Improvement Strategy

2018-2021

Why is a Quality Improvement Strategy needed?

No organisation is perfect…. improvements can always be made

"The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

"The quality of patient care should come before all other considerations in the leadership and conduct of the NHS, and […] patient safety is the keystone dimension of quality. The pursuit of continually improving safety should permeate every action and level in the NHS"

Berwick review (2013)

Calderdale and Huddersfield NHS Foundation Trust

What are we trying to accomplish?

The purpose of this document is to set out a three year strategy for Calderdale & Huddersfield Foundation Trust that will ensure we continually improve the service we offer to patients.

We will do this by working with patients, our staff and others using technology, best practice and innovative ideas.

Our strategic aims are to:

- **Improve outcomes for acutely ill patients**
- **Implement the End of Life Care Strategy**
- **Provide safe care**
- **Improve community services**
- **Demonstrate engagement and co-design**

The strategy was developed with our staff following a consultation workshop. Staff who participated specified they wanted the strategy to:

- **Be simple, clear and transferable to all services**
- **Be focused on quality not targets**
- **Enable sustainable change**

Calderdale and Huddersfield NHS Foundation Trust

Our achievements so far

Calderdale and Huddersfield NHS Foundation Trust has a strong history of quality improvement and over recent years has achieved:

- ✓ A reduction in MRSA and Clostridium Difficile hospital acquired infections
- ✓ Successful VTE prevention
- ✓ Improvement in care for people with dementia
- ✓ Implementation of care bundles
- ✓ Engagement with patients to improve hospital food
- ✓ Improvements in the care of acutely ill patients to reduce avoidable mortality
- ✓ Learning from Friends and Family Test

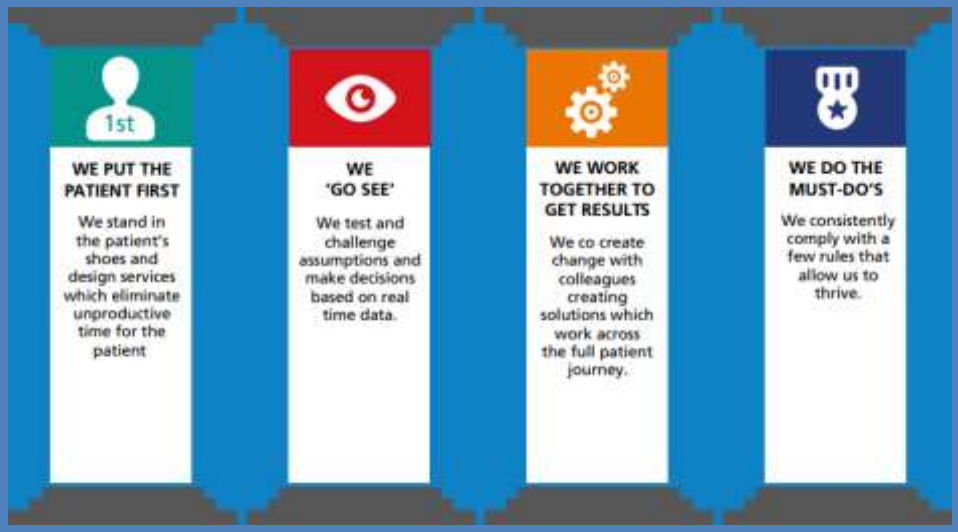
We want to build on these improvements, with a clear focus on what our patients and carers can expect, which is:

- Compassionate care
- Competent and committed staff
- An environment that is clean and safe
- Services developed in partnership with patients

Calderdale and Huddersfield NHS Foundation Trust

What quality improvement means to us

Combining the continuous efforts of everyone to make the changes that will lead to better patient outcomes, better system performance and better professional development.



The strategy promotes opportunities to put the Trust behaviours into practice - delivering high quality care and underpinning our approach to improve.

Calderdale and Huddersfield NHS Foundation Trust

Governance Structure

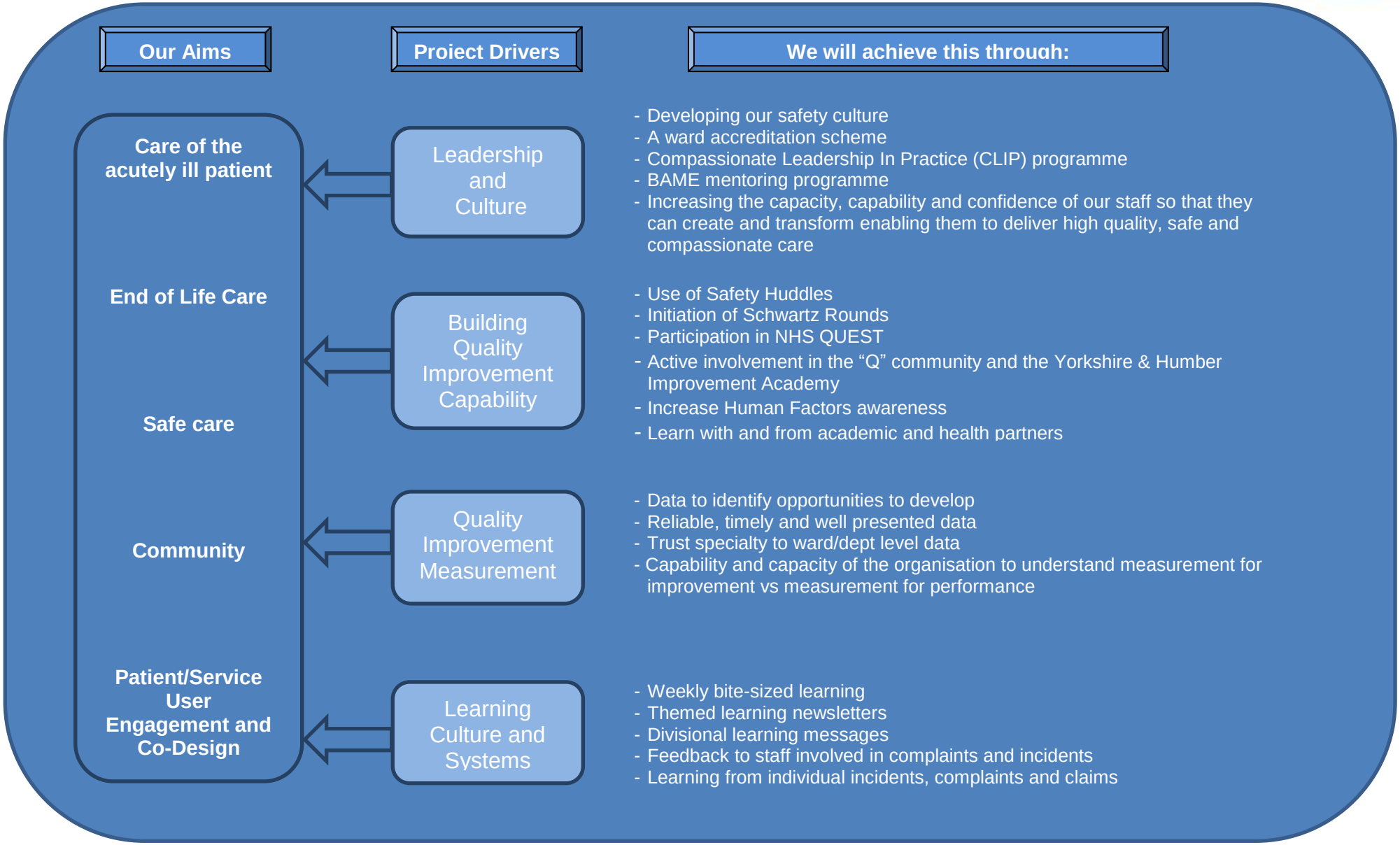
Within the Trust's Governance Structure, there are a number of groups who champion Quality Improvement opportunities. These groups are central to the delivery of the Quality Improvement Strategy.

Each group regularly reports to the Trust's Quality Committee, which is responsible for providing assurance to the Board on quality matters.

This structure will monitor delivery of the strategy, carrying out an annual review against the strategic aims and refocusing the primary drivers as required.

compassionate care

Calderdale and Huddersfield NHS Foundation Trust



Calderdale and Huddersfield NHS Foundation Trust

Aim 1
Improve outcomes for acutely ill patients

As measured by:

- Recognition, response and prevention of deteriorating patients
- Success of Sepsis interventions

We will:

Deterioration Programme

- Recognition
  - Quality and timely observation using National Early Waring Score (NEWS)
  - Use of NerveCentre for electronic observations Understanding barriers to escalating
- Response
  - Evaluate and refine escalation processes with NerveCentre, Outreach team and HOOP (Hospital Out Of Hours Programme)
- Prevention
  - Safety huddles
  - Handover

Sepsis interventions

- Sepsis screening for patients with NEWS ≥5
  - Patients admitted to Emergency Department
  - In-patients
  - Community patients
- Implement Sepsis care bundle
- Collaborative work with Clinical Commissioning Group and Yorkshire Ambulance Service

Calderdale and Huddersfield NHS Foundation Trust

Aim 2
Learning from Deaths – Umbrella Model

As measured by:

- Mortality Reviews
- High quality communication with those people identified as being in the last 12 months of life
- Coordinated, timely and equitable access to quality care
- The quality of care provided in the last hours and days of life
- Mortality reviews

We will:

- Use Experience Based Co-Design events to collaborate with staff, patients and carers to ensure positive changes to end of life care services
- Develop mandatory training regarding the care of patients who are supported by the Individualised Care of the Dying Document (ICODD) for clinicians
- Provide facilities for relatives to stay with patients who are being supported by the ICODD
- Increase communication skills training to all clinicians
- Enhance the support available to staff across the organisation and develop their skills
- Disseminate Faith Cards to all ward areas to advise on protocols on death for different religions
- Increase engagement with the local South Asian community to advise on end of life care issues and raise awareness of the support given and explain the philosophy behind the hospice movement

Learning from mortality

- Implement Structured Judgement Reviews
- Analyse data to identify areas for improvement
- Monitor HSMR and SHMI rates

Calderdale and Huddersfield NHS Foundation Trust

Aim 3
Safe Care
Provision of safe, harm-free care for all patients

As measured by:

- The Safety thermometer (harm-free care)
- Falls Prevention
- Reduction in Pressure Ulcers
- Reduction of Hospital Acquired VTE
- Reduction in Catheter-Associated UTI
- Reduction in cases of E-Coli
- Medicines Safety

We will:

- Improve organisational safety culture through better responses to safety incident data
- Continue work across acute and community services by the Falls Prevention Group to reduce the number of falls
- Implement best practice standards for the prevention of pressure ulcers within Directorate teams
- Improve learning form hospital acquired VTE
- Develop a comprehensive plan to deliver reductions in E-Coli
- Progress ongoing work to improve the safe and effective management of medicines

Calderdale and Huddersfield NHS Foundation Trust

Aim 4
Delivering High Quality Community Services

As measured by:

- No avoidable pressure ulcers
- Falls risk assessments and interventions to reduce admission to hospital due to falls
- Supporting people in care homes and reducing unnecessary trips to hospital
- Supporting discharge and reducing length of stay in hospital
- Reducing readmissions for patients on a community nursing caseload
- Supporting individuals and their families to remain in their preferred place of care

We will:

- Work in partnership with our patients
- Deliver agreed quality priorities/CQUIN
- Improve our falls service so that we can provide prevention, early response and rehabilitation
- Develop our integrated service offer with GPs, social care and hospital services
- Develop our intermediate care offer in order to effectively utilise the resources available to us
- Improve our wound care services by working with GPs, developing pathways and utilising best practice methodology
- Reduce our waiting times so that patients can access the service as quickly as possible
- Develop effective and efficient methods of working in order to support clinical staff to use their time for clinical activities more of the time
- Develop quality improvement capability across our workforce

Calderdale and Huddersfield NHS Foundation Trust

Aim 5
What matters to me

As measured by:

- Increased engagement opportunities
- Experience based co-design activities
- Reduction in waiting times
- Analysis of Friends and Family test themes
- Duty of Candour responses

We will:

- Work with service users and the public to design, monitor and improve the care we provide
- Increase the score and depth of patient/public engagement:
  - Asking for views and ideas for improving services
  - Involving service users on interview panels
  - Co-designing services (staff & patients/carers)
  - Increase the ways we engage with carers to both support and learn from them.
  - Work collaboratively with the wider healthcare community to identify engagement opportunities
- Seek, listen to and learn from feedback
- Promote an organisational culture of inclusive engagement, embracing diversity at every opportunity
- Develop the use of technology to communicate with patients and the public
- Be open with patients and carers when we make a mistake

Calderdale and Huddersfield NHS Foundation Trust

How will we know we are improving?

- Trust Board will lead on the implementation of the strategy
- Create an implementation plan
- Our leaders will be active in implemeting the startegy
- We will develop a dashboard of the measures to monitor performance
- Gather and share improvement stories
- The Quality Committee will report quarterly into Trust Board on the implementation and improvement progress

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, 1st March 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 16 February 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 shared with members of the Risk and Compliance Group via papers circulated . The meeting of 13 February 2018 was a virtual meeting.	
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.

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 16 February 2018.

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

iii. One new risk which has been added to the high level risk register during February 2018 - Risk 7169; financial risk relating to income and expenditure for 2018/19.

iv One risk has been removed from the high level risk register - Risk 6971; business continuity risk regarding endoscopy and hysteroscopy capacity. The risk score is reduced from 15 to 12 and will be managed within the surgical and anaesthetics divisional risk register. This has been agreed at the divisional Patient Safety Quality Board and through discussion between the chair of the Risk and Compliance Group and the Director of Operations for the division.

v. Ongoing discussion is taking place regarding risk 7147; an EPR financial risk for the Medical Division which was added to the high level risk register in January 2018. At the point of writing this paper this discussion has not yet been concluded, therefore the risk remains within the high level risk register.

Next Steps:

The EPR risk panel is meeting on 2 March 2018 and will review whether there are any risks arising from divisional digital boards triggering the threshold for consideration on the high level 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 appropriately managed.
ii. Approve the current risks on the risk register.

iii. Advise on any further risk treatment required.

Appendix

Attachment:

There is no PDF document attached to the paper.

HIGH LEVEL RISK REGISTER SUMMARY OF CHANGES

Risks as at 16th February 2018

TOP RISKS

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

6967 (25): Non-delivery of 2017/18 financial plan
7169 (25): Trust Financial Control 2018/19
7147 (20): EPR financial risk medical division 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

The Trust risk appetite is included below.

RISKS WITH INCREASED SCORE

None

RISKS WITH REDUCED SCORE

6971 – Endoscopy
This risk regarding business continuity for endoscopy and hysteroscopy has been reduced to a score of 12, following discussion within the Surgical and Anaesthetics Patient Safety Quality Board and discussion between the Chair of the Risk and Compliance Group and the Director of Operations for the division. The rationale for the reduction in score is given below:

- Decontamination facilities are up and running at both CRH and HRI
- The capital plan to replace decontamination facilities on track
- All patients now have a TCI date or received a procedure regaining endoscopy 6 week diagnostic target
- Both units have regained all access targets

NEW RISKS

7169 – 2018/2019 Income and Expenditure Risk

This risk for income and expenditure for 2018/19 has been reviewed at Finance and Performance Committee on 30th January 2018, and is added at a score of 25. Once the 2017/2018 financial position is confirmed, risk 6967 on income and expenditure will be removed.

CLOSED RISKS

None

1 MARCH 2018 – BOARD - SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 16.2.18

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead						
					Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Safety and Quality Risks										
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	6990	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/18	Medical Director (DB)	=16	=16	=16	=16	=16	=16
007	5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	=15	↑16	=16	=16	=16	=16
007	6829	Keeping the Base Safe	Aseptic Pharmacy Unit production	Director of Nursing	=15	=15	=15	=15	=15	=15
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
014	6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD (SD)	=16	=16	=16	=16	=16	=16
014	6977	Keeping the base safe	Mandatory training 2017/18	Director of Workforce and OD (SD)	=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
020	7046	Keeping the base safe	EPR Quality and safety risks	Exec Medical Director (DB)	=16	=16	=16	=16	=16	=16
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

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Finance Risks										
	7169	2018/19 income	Income and expenditure	Director of Finance (GB)						!25
021	6967	Financial sustainability	Non delivery of 2017/18 financial plan	Director of Finance (GB)	=25	=25	=25	=25	=25	=25
021 & 022	7049	Financial sustainability	EPR financial risk due to increased costs and decreased income	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
022	7062	Financial sustainability	Capital programme 2018/19	Director of Finance (GB)	!20	=20	=20	=20	=20	=20
021	6441	2017/18 income	Divisional income surgery and anaesthetics	Associate Director of Nursing, Surgery and Anaesthetics (JM)	!16	↑20	=20	=20	=20	=20
021	7147	2018/ 18 income	EPR financial risk medical division	Associate Director of Nursing, Medical Division (AM)					!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
009	7047	Keeping the base safe	EPR Performance – failed regulatory standards, contractual KPIs, patient / staff performance	Chief Operating Officer (HB)	=16	=16	=16	=16	=16	=16
People Risks										
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

TRUST RISK PROFILE AS AT 16/2/2018

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 = 6829 Pharmacy Aseptic Unit	= 6345 Nurse Staffing = 7049 Financial risk arising from EPR = 6658 Inefficient patient flow = 7078 Medical Staffing	= 6967 Not delivering 2017/18 financial plan ! 7169 Not delivering 2018/19 financial plan
Likely (4)				= 6300 CQC improvement actions = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 5862 Falls risk = 6990 CQUIN sepsis = 6977 mandatory training = 7046 EPR quality and safety risks = 7047 EPR Performance /regulatory/KPI risk arisisng from EPR	= 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 = 6441 Divisional income 2017/18 surgery and anaesthetics = 7147 EPR financial risk medical division
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**

NHS
The Health Informatics Service

Trust Board 1 March 2018
High Level Risk Register as at 16.2.18.

Risk No	Div	Dir	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6967	Trustwide	All Divisions	Apr-2017	Financial sustainability	The Trust is planning to deliver a £15.9m deficit in 2017/18. There is a high risk that the Trust fails to achieve its financial plans for 2017/18 due to: - £20m (5.3% efficiency) Cost Improvement Plan challenge is not fully delivered - loss of productivity during EPR implementation phase and unplanned revenue costs - inability to reduce costs should commissioner QIPP plans deliver as per their 17/18 plans - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level - Risk overlaps that referred to in Ref. 6441 (Surgical Division).	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach Financial recovery actions were agreed by Turnaround Executive on 13th June. Controls around use of agency staffing have been strengthened. For 2017/18 the Trust has been given a £16.86m ceiling level for agency expenditure by NHS Improvement. Agency spend is planned to reduce considerably from the level of expenditure seen in 16/17 if the Trust is to deliver the financial plan, and not exceed the ceiling. Year to date this planned reduction in expenditure has been achieved.	Lack of direct consequence to budget holders for poor budgetary management. Difficulty in identifying EPR benefits to offset additional committed resource. Nursing Agency spend above planned level. Not all Agency shifts booked through flexible workforce team.	20 5 x 4	25 5 x 5	15 5 x 3	**February 2018 Update** Whilst the Trust agreed the 17/18 Control Total of £15.9m, serious concerns about the achievability of this target have been raised with the regulator. It left the Trust with a planning gap of £3m that was added to the £17m CIP target. The organisation currently has plans for £17.95m of the £20m CIP target, but £2.1m of this forecast saving is currently considered at a high risk. In addition opperational pressures have resulted in a deteriorating financial position, with activity and income well below the planned level. EPR implementation has had a significant impact on productivity and the capture and coding of activity which continues to impact on clinical income. The corresponding underlying expenditure is above plan and in Month 10 the Trust reported a position that is £8.70m away from Control Total. In the first six months of the year achievement of the Control Total relied on the release of our entire Contingency Reserve and a number of non recurrent benefits that were one off in nature and cannot be repeated. As discussed with regulators the Trust is no longer forecasting to achieve the full year 17/18 Control Total and is reporting a forecast deficit of £45.25m, an adverse variance to plan of £15.41m. This variance incorporates a gap to control total of £8.00m which in turn drives the loss of Sustainability and Transformation funding (STF) of £7.40m. The scale of the financial impact is such that the risk score is likely to remain unchanged for the remainder of the financial year.	Mar-2018	Mar-2018	FPC	Gary Boothby	Philippa Russell

7169	Trustw e	All Div ons	Jan-20 3	Financ 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	Early indications are that there is a significant planning gap to control total for 18/19. Draft plans are to be submitted to NHS Improvement by 8th March 2018, at which point a decision will have to be made regarding acceptance (or not) of the 18/19 Control Total.	Mar-2018	Mar-20	FPC	Gary B by	Philipp ussell
6903	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	December 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. The Authorising Engineer (AE (V)) has concluded his annual report for the Trust on Ventilation and has strongly advised on installing mechanical ventilation for the HRI Resus area as the current method of ventilation does not meet regulatory standards. January 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Estates are looking at all options to mitigate any future risk of closure, 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.	Mar-2018	Dec-2018	RC	Lesley Hill	Chris Davies

7147	Medic	All Dir orates Medical	Dec-2 7	Finan sustainability	EPR Financial risk with increased costs and decreased income. Due to: Reduction in activity arising from increased time per patient in Outpatients leading to reduced templates, errors with booking process related to migration and build leading to DNAs etc, pre-assessment build impacting on elective activity & mapping issues impacting on overall income capture. Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff Increased costs to ensure timely and appropriate response to clinical & operational risks. See High level risk 7049	Developing financial recovery plans. Weekly activity and income meeting chaired by Director of Transformation and partnership. Weekly performance monitoring. Targeted improvement for those in greatest need. Activity coding issues being addressed. Continuing to shadow monitor activity using existing systems. Cymbio dashboard deployed from Day 1 of EPR, weekly Data Quality Board, validation expertise deployed and extended, retaining senior analytical support until post Bradford Go-live, increased Booking staff to maximise appointment booking. Stabilisation plan developed.	Adequate system build BAU Team capacity. Staff training.	20 4 x 5	20 4 x 5	0 0 x 0	Identification of staff training needs. Specialty delivery of recovery plans. System build changes identified and prioritised, BAU team capacity review. Education and training for clinical staff. Dec 2017 update - Financial recovery plans being developed, with a fortnightly medical divisional 'Access' meeting running which covers the issues / risks highlighted in risk 7147 below.. The Divisional Access meeting provides a forum whereby divisional colleagues can discuss, raise any concerns, highlight and action any pressures which may impact on the Medical division's ability to safely deliver a challenging 'Access' agenda; this includes EPR data capture issues, outpatients, procedure codes, elective activity, build issues etc. Ultimately though it is about how unsatisfactory performance will impact on patient care and safety, particularly if there are data quality / validation issues. The meeting provides a forum for discussion of complex issues highlighted by either the Divisional Information Team or SMT, providing advice and guidance where required on a series of KPIs in order to facilitate safe delivery of these standards. Contract income is impacted upon as a by-product of these actions **February 2018 Update** Contract income has been manually adjusted where recording is an issue, clinic outcome data well recorded and templates not reduced resulting in some overruning of clinics. Some financial impact remains but not material to the Medicine position. Significant score reduction will be confirmed at next Risk & Complaince committee	Mar-18	Mar-20	DB	Helen E ker	Ashwin rma
7049	Trustwide	All Divisions	Aug-2017	Financial sustainability	EPR Financial risk with increased costs and decreased income. Due to: Reduction in activity arising from increased time per patient in Outpatients leading to reduced templates, errors with booking process related to migration and build leading to DNAs etc, pre-assessment build impacting on elective activity & mapping issues impacting on overall income capture. Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff Increased costs to ensure timely and appropriate response to clinical & operational risks.	Developing financial recovery plans. Weekly activity and income meeting chaired by Director of Transformation and partnership, weekly Theatre scheduling now attended by an Executive. systems to capture activity. Weekly performance monitoring. Targeted improvement for those in greatest need. Activity coding issues being addressed. Continuing to shadow monitor activity using existing systems. Cymbio dashboard deployed from Day 1 of EPR, weekly Data Quality Board, validation expertise deployed and extended, retaining senior analytical support until post Bradford Go-live, increased Booking staff to maximise appointment booking. Stabilisation plan developed.	Adequate system build BAU Team capacity. Staff training.	20 4 x 5	20 4 x 5	0 0 x 0	Identification of staff training needs. Specialty delivery of recovery plans. System build changes identified and prioritised, BAU team capacity review. Education and training for clinical staff. Placing Coders in clinical areas **February Update** Data quality meeting reviews data capture and system issues with Divisional, Finance and THIS representation. Divisional financial recovery plans to address activity maximisation. Additional costs incurred being monitored with approvals to be taken through Commercial Investment Strategy Group and monthly financial monitoring. Discussions have taken place with regulators, NHSI with regards to the exceptional financial pressure incurred as a result of EPR implementation in-year and the impact on achievement of control total. Negotiations with commissioners have settled a position for 2017/18 which is inclusive of an agreed estimate for income impacted by data capture issues, thus mitigating further risk.	Mar-2018	Mar-2018	FC	Gary Boothby	Kirsty Archer

7062	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	**February 2018 Update** 2018/19 Capital Plan has been developed but is currently in excess of internally generated capital funds by £1.3m. Reviewed by Commercial Investment Strategy Committee on the 25th of January 2018. Trust is exploring alternative methods of increasing Capital Delegated Limits	Mar-2018	Jun-20	FPC	Gary B nby	Philipp ussell

7078	Corpo a	Workf e & Organisational Development	Oct-20 '	Keepir 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	January 2018 We have now issued work schedules for all those doctors in training who are due to start with CHFT in February 2018. The work schedules provide the trainee with their template rota along with the details of Rota Coordinators, The Guardian of Safe Working Hours, Educational and Clinical Supervisors and links to Trust policies. This information is extremely useful for our new doctors and can be found in one simple reference document. The intention is that this ensures new starters into the organisation have an awareness of the trust prior to commencing in post and therefore enhancing their induction and experience with us. Consultant recruitment has continued with successful appointments made in Respiratory Medicine and Anaesthesia. An AAC is scheduled for January 2018 when we will be interviewing for a new Consultant Microbiologist. CHFT has been working with Bradford to try and appoint to a Consultant Interventional Radiologist . An advert for a joint post is currently on NHS Jobs. Following the successful open evening to promote CESR and the development of our current SAS doctors, Health Education England have been in touch to confirm that they are happy to progress us as a Pilot site for CESR development. They have requested baseline data which will inform the support available. The rolling programme of recruitment and retention meetings focusing on medical and dental staff continues and has proved a useful method to ensure that all opportunities to fill vacancies have been explored . The meetings are chaired by the Deputy Medical Director and are intended to support Divisional colleagues to review vacancies and the costs associated with them, such as agency costs, bank costs and waiting list initiatives. **February 2018** No change	Mar-18	Mar-18	WF	David Eenhead	Pauline rth

6658	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]	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	20	9	December 2017 Winter Plan in place and being implemented, within the plan are specific actions to reduce 'exit block' and improve flow. Internal Silver Tactical Command in Place Winter monies available to support increased medical staff, weekend discharges and tracking clinical pathways. January 2018 Winter Plan remains in place.Tactical Command will be in place until the end of January 2018. Winter initiatives being reviewed. **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.	Mar-18	Mar-18	BOD	Helen E	Bev W
								4 x 5	4 x 5	3 x 3							

2827	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	Dec 2017 Some improvement in fill rates for Christmas week, but likely requirement for on-call Consultant cover overnight. Jan 2018 No significant change from last month **February 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	Mar-2018	Aug-20	WEB	David E enhead	Dr Mark avies/Mrs Caroline Smith
5806	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	December 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. The Capital Plan continues to progress on track which includes covering all statutory compliance i.e. Fire Safety, Water Safety, Ventilation, Structural Safety etc. The plan for 18/19 is now at the final stages of planning. January 18 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. 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. **February 2018 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.	Mar-2018	Mar-2018	RC	Lesley Hill	Paul Gilling / Chris Davies

6345	Corpo g	Workf e & Organisational Development	Jul-20	Keepir 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	**February 2018** Applicants from International recruitment trip to the Philippines are progressing. 119 offers were made in country, since March 2017; 10 candidates have withdrawn, 21 are yet to start their International English Language Test System (IELTS) training, 74 are completing their IELTS training including 12 with their exam booked before the end February. The Trust has offered 57 students the opportunity to change onto the Occupation English Test (OET) following the announcement from the NMC. Students who meet the criteria will be entered into the first available assessment centre week commencing 12 February. In addition to those in training, 6 candidates are progressing with their NMC application, 3 is going through the visa application process and 2 nurses are due to start with the Trust on 5 February 2018. The Trust are introducing 20 Nurse Associate roles during Spring 2018. These new training roles will support divisions with their nurse staffing supply in the future and is hoped to be an annual programme to support workforce planning. The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has continued. The January advert which closed on 22 January has produced 2 candidates within Surgical and 8 candidates within Medicine who are to be interviewed 12 February 2018. For February a further advertised for band 5 student nurse has also been issued to encourage final year university students to apply and provides additional information around the support offered to newly qualified nurses at CHFT. The Physician Associates (PAs) vacancy within Medicine for 2 additional PAs is currently at offer stage with 1 candidate awaiting to received examination results, the second candidate has withdrawn. Options are being reviewed as to whether to re-advertise just for Medicine or whether other opportunities exist within the Trust for PAs.	Mar-18	Dec-20	WF	Brenda rown, Suzanne Dunkley	Rachae ierce

6441	Surgery & Anaesthetics	All Directorates S&A	May-27	Financial sustainability	Risk of income being below planned levels for Division due to failure to delivery contract activity / income plan, inability to recover lost activity during EPR go live or planned level of activity in an appropriate case mix and inability to remove the equivalent total cost base to recognise this non delivery Resulting in non achievement of the Divisional planned contribution impacting on the Trusts ability to deliver its 17/18 I & E plan and remain a viable sustainable organisation	* Division Weekly activity / scheduling meeting attended by Executive lead " "Weekly Operational Performance meeting with Director of Operations * Monthly Business Meeting incorporating performance management' 'Revised activity forecast as at month 5 clinically owned and monitored weekly'' 'Ongoing review of recovery plans with a need to consider cost out equivalent to income loss' 'Data Quality Group meeting weekly to ensure data quality in place and all activity captured and income generated appropriately'	Not all specialties job plans linked to activity volumes * individual surgeon performance management to activity plans	12	4 x 3	20	5 x 4	12	4 x 3	January 2018 update Risk score remains at 20. The underlying forecast has deteriorated by £2m as a consequence of the National Agenda to managing the winter capacity. Ie cancellation of non urgent daycase, elective and outpatient activity. At a trust level it is recognised that there will be a level of increase income within non elective predominately within the Medicine financial position to compensate in part for this deterioration. Also at trust level the overall Control Total is being reviewed with NHSI around the level of non recurrent winter monies that will be allocated. Anna Basford has been appointed as the lead Director for planning for 18/19 with the Division. One key task will be the review of the core capacity available within the existing medical workforce. **February 2018 update** Risk score remains at 20. January actual is circa £750k better than first estimate in relation to the management of winter pressures. Positive impact on LIVE forecast to be reported at month 10.	Mar-2018	Mar-2018	DB	Helen Ecker	Will Ain[illegible]
6596	Corporate	Corporate Quality	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - 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 and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16	4 x 4	16	4 x 4	8	4 x 2	December 2017 Quality deep dive on serious incidents presented to Board meeting 7 December 2017. Need to identify and train 25 medical staff investigators shared with Deputy / Associate Medical Directors to progress. January 2018 Development of investigators pack to support investigators. Revised serious incident report template to improve level of analysis within serious incident reports. Effective investigations course being held 10 January 2018, with 20 staff booked to attend. **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.	Mar-18	Mar-2018	QC	Brendan Brown	Juliette Cosgrove

6598	Corpo g	Workf e & Organisational Development	Jan-20	Keepi the base safe	There is a risk of reporting low compliance against many of the agreed essential skills, therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely and competently. Some is this is due to the fact that many of the essential skills have only recently had a target audience set to enable compliance reporting. This means that completion of these newly added essential skills is still in the early stages resulting in low compliance. A RAG rating across compliance rates for all essential skills identified none in green, most in amber but some in red. There are frequent requests for new subjects to be added to the list with no formal review process in place to determine the suitability. Currently, requests for new essential skills are referred to Brendan Brown and Lindsay Rudge for a decision.	1/ A communications strategy has now been agreed and implement to inform colleagues of any newly added essential skills to ensure the highest possible level of early uptake. 2/ The lead for essential skills is working closely with the Subject Matter Experts (SMEs) to identify ways to drive up compliance for each particular essential skill, including exploring options around alternate delivery. Compliance reports are produced monthly and deviation compared to the previous month to track improvement and build on successes. 3/ A review of the maternity essential skills is underway to determine if all subjects currently on the essential skills require compliance reporting. For those on externally hosted sites, the review will explore whether the data can be extracted and added to ESR. If not, the compliance requirement will be reviewed and reporting delivered outside of ESR. 4/ In the absence of a formal review process, the Lead for Essential Skills has designed a proforma to capture the details of requests for new essential skills to ensure a clear audit trail is in place.	1/ Essential skills training data held has historically been inconsistent and patchy. 2/ Target audiences setting to allow compliance monitoring across all but 1 essential skill was completed in December. This means that some skills are newly added to colleagues requirements and as such compliance rates are low. 3/ Heavy focus on EPR training and implementation had an impact on staff being able to complete essential skills training due to time and resource implications. 4/ Now all clinical staff have been issued a bank contract there are some discrepancies with competencies assigned to bank position but not their substantive post. These are small in number. 5/ recent focus on mandatory training and appraisal has had an impact on staff completing essential skills training. 6/ A small number of maternity essential skills	16	16	12	January 2018 All SMEs have been asked to submit a plan of actions to improve compliance for their respective essential skill. The contents will be used to inform a paper to WEB late January / early February. Essential Skills lead co-ordinating this approach and supporting the SMEs to achieve the target trajectories via comms and attendance at relevant divisional forums. The maternity essential skills have been reviewed and some removed due to a constantly changing target audience. Some of the e-learning is done via external systems and therefore the completion data is not held in ESR. Best ways to export the data / report on compliance are being explored. **February 2018** Targeted efforts against many of the essential skills has resulted in significant increases in compliance although it remains unlikely that 95% compliance will be achieved across the board by 31.13.18. SMEs have provided planned actions and target trajectories although a number have stated that greater emphasis needs to be placed on individual professional responsibility for completing essential training rather than actions on the part of the SME. An e-learning package for PREVENT Wrap is now available but isn't compatible with ESR. It has therefore been agreed that a link to the e-learning will be added to the intranet with clear instructions on how to ensure compliance is awarded on completion. It is hoped this alternative will ease the pressure on the number of training dates required. Staff will have the option of the e-learning OR the classroom session in order to achieve compliance. With regards to the externally hosted maternity essential skills, an email has been sent to the company to enquire how best to access / import the completion data. Awaiting response.	Mar-18	Mar-20	WF	Suzanne Dunkley	Ruth M n
								4 x 4	4 x 4	4 x 3						

5862	Medic	All Dir orates Medical	Aug-23	Keepir the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, Cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. 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. Staffing levels due to vacancies and sickness. Inconsistent full multifactorial clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12	4 x 3	16	4 x 4	9	3 x 3	January 2018 update. Decembers number of falls have increased in number 172 with 2 harm falls. Extra capacity wards on each acute site has impacted on the number in month ,Community place(n-5) and CHFT community beds(n-4) have both had increased incidents in month. Slips and falls reported in the hospital grounds due to adverse weather have totalled 4 in month. ESR trajectory set to improve Falls prevention training. Reported compliance in Dec -57%. Falls policy revised in line with EPR introduction and includes the post falls management flow chart. Post falls safety huddle tool (FISH)now available on datix documents for capture immediate information and patient experience. Ward assurance tool to be used consistently to audit falls assessment and interventions for centralised compliance and actions for individual ward **February 2018.** Improvement work continues as above . Challenges as additional wards open to manage demand on both sites.147 falls in total in month,1 harm fall a reduction on previous 2 months. EPR compliance with falls prevention training now 69.97% for Trust	Mar-2018	Mar-20	PSQB	Brenda rown	Janette- ockroft

6300	Corpo a	Corpo e 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. We do not know the date of the next inspection We do not know when core service inspections will take place as these are unannounced visits	16 4 x 4	16 4 x 4	8 4 x 2	December 2017:Formal notification of Well Led Inspection received and data for Provider Information Request provided as required. A number of KLOE's have been identified as a result and plans are being developed to respond to these. Clear evidence of progress since the last inspection is also evident. A Trust Board workshop to be held in December to brief the Board on next steps. January 2018: continued development of plans to address any issues noted as part of the PIR submission and core service self-assessments (overall self-assessment of good for the Trust); Trust Board workshop held Dec 17; now receiving CQC monthly 'insight' reports which replace the intelligence monitoring reports – key messages shared at risk and compliance meetings; CQC relationship / engagement meetings continue to be held with our local Inspection team - from Jan 18 these will include attendance at meetings such as matrons, ward managers in addition to scheduled walk-throughs in clinical areas **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.	Mar-18	Apr-201	WEB	Brenda rown	Juliette sgrove

6977	Corpo a	Workf e & Organisational Development	May-2 7	Devel ng our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period. It was agreed at WEB (date?) that the target compliance would be set at 95%. This risk is exacerbated by the requirement to complete EPR training in the same timeframe and there was a temporary issue concerning the National IG e-learning package which was withdrawn over the months of March - April 2017. This has now been resolved and is available under the refreshed title of Data Control. Impact: - Colleagues practice without the necessary understanding of how their role contributes to the achievement of strategic direction/objectives and without the knowledge/competence to deliver compassionate care. 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.	Computer settings across the Trust have proved inconsistent. This can inhibit access to mandatory training and cause delays in compliance. This issue has been prioritised and a solution has been sourced. October 2017 - update: technical issues now resolved. Computer settings now consistent across the Trust.	16 4 x 4	16 4 x 4	4 4 x 1	December 17 The upload of the training by Junior Doctors is complete and they are now compliant in 3 out of the 5 key focus areas. For the remaining 2, a guide is in development to assist this section of staff. HRBP's and other key stakeholders are meeting on the 5 December to establish a plan to address non-compliance. January 18 Weekly compliance reports are produced for the Weekly Executive Board with actions to improve compliance before end of March 2018. A mandatory training summit is being held with key stakeholders from WOD on 22 January. **February 2018** Letters have been issued to individuals who are non-compliant or are due to expire before 31.3.18, signed by the divisional operations manager with a deadline to complete their learning by 28.2.18. A letter has also been issued by a non-executive director inviting specific areas to come to the workforce well-led committee and discuss plans to drive compliance. Weekly driving compliance meetings are taking place with the senior WOD team and the mandatory training lead to explore all options to improve compliance.	Mar-18	Mar-20	WF	Suzanne Dunkley	Ruth M n

7046	Trustw e	All Div ons	Aug-2 7	Keepi the base safe	EPR Clinical risk of patients receiving delayed access to care due to migration issues which placed incorrect location codes to activity; access issues for several members of staff resulting in delays. RTT build issue which does not place patients correctly onto the pathway. Electronic Discharge summary process not adhered to resulting in delayed information to GP. Lack of understanding on use of 'Encounters' leading to activity being connected with the incorrect episode. A 45 day purge of all activity within the Message Centre including correspondence unknown to users resulting in delayed distribution of correspondence. Reductions in outpatient activity & issues with appointment correspondence delaying access to review. Lack of familiarity with the system leading to an increased potential for clinical risk	Remedy on Demand for escalation of all system related issues for resolution. Stabilisation plan. Issues log populated by specialties, clinical and non-clinical staff to ensure all issues, risk, concerns were known and prioritised. All Divisions have own risk register and included in PSQB & Digital Modernisation Boards; high risks and risk changes reviewed at PRMs. Two weekly Operations Board with clear process for escalation. Datix reporting encouraged and all Red Datix received by Medical Director, Chief Nurse & Chief Operating Officer. Clinical Risk Panel established and Stabilisation plan in place SWAT team deployed to undertake Deep Dives/RCAs. DT meeting undertaken as required Visible leadership and feedback. Manual workarounds. Targeted support and training. On going training requirements identified and developed. Additional expert support deployed for Junior Doctor Change. Training & Access process for new and agency staff agreed. Access rights provided for all staff to undertake role as delivered pre-EPR	Response of external partner slow leading to delayed resolution. BAU team capacity & focus on BTHFT readiness Thematic review of incidents complaints, PALs etc. Adequate system build Training Review of access right. Robust audit of end to end pathways and documentation.	16 4 x 4	16 4 x 4	0 0 x 0	December Update Cerner are visiting the Trust to understand and assist to resolve issues on the 5th and 6th December Some SOPs have been updated and will be shared with the Ops Group early December January Update SOP process has been revised There is no longer a resource to undertake the access/roles, discussion being had CEO regarding the risk associated with this Project team contracts will end this month The action plan agreed with Cerner is being worked through **February 2018 Update** The correspondence backlog continues to be actioned, the key challenge currently is the validation of clinic letters. Weekly meetings chaired by the CEO continue to monitor progress 40 medical secretaries have undertaken further training to ensure there is an improved understanding of templates and encounters Further drop in sessions are planned The lesson plan for correspondence has been updated and will be utilised for training; it will also be circulated to be utilised for reference No further work undertaken regarding access rights The BAU team have undertaken further training to enable them to maintain and develop the system	Mar-18	Mar-20	QC	David E enhead	Alistair rris

7047	Medic	All Dir orates Medical	Aug-2 7	Keepi the base safe	EPR Performance risk of failed regulatory standards, contractual key performance indicators or other patient/staff focussed performance due to: Issues with data migration impacting on RTT pathways. Build/Configuration impacting on reporting data and pathway tracking. Delayed access for patient as a result of migration, build and staff familiarity. Patient satisfaction and reputational issues due to the perceived impact of the system as staff familiarise themselves. Staff satisfaction as they learn the new system or there are delays in resolving issues pertaining to patient care, flow and efficiency. Data Quality issues, duplications, incorrect pathways, coding all impacting on ability to report. Management capacity & capability to resolve issues with the new system and maintain sufficient focus on all KPIs. Management reports inaccurate and requiring additional validation before deployed delaying responsiveness. Management reports timeliness to comply with local and national reporting deadlines	Weekly Performance meetings, Weekly Data Quality Board, Additional Data Quality expertise and capacity, weekly activity review. Modelling of data to identify potential performance risks. Recruitment of additional staff into AED & Booking office. Shadow monitoring of activity using existing systems. Task and finish groups to address activity dips. Investigating areas of most concern. Manual recovery where poor recording is identified. Micromanagement of pathways. Working with IT to design appropriate reports. Use of Cymbio reports. Manual recording and collection of data. Stabilisation plan developed. Management capacity increases prioritised. All regulatory bodies kept informed proactively	Adequate system build. Availability of additional management capacity with correct skill set. Vacancies remain across all staff groups BAU capacity to support resolution of outstanding issues. Partner responsiveness & ability to find solutions. Several very large scale priorities to be managed. Communication and engagement	16	16	0	January 2018 Update Access to diagnostic CDS provided w/c 11/12/17 – but up to press appears to have delivered no benefit. Deeper analysis and support from Cymbio (Jim Plunkett) early January will enable more detail in next update. Other referrals have not been reported on Monthly Activity Return for past 3 months as figures so markedly different to pre-Cerner. Initial investigations into this started late December 2017. Previously closed Service Request relating to incorrect discharge time from A&E flowing through into Business Object reports needs reopening as is clear this should be corrected by Cerner and original response was not acceptable. This will be picked up with Steve Fincher on 17th January. It will also be added onto official Reporting Log element of 2 day action log **February 2018.** Trust has reported against all mandated regulatory standards since deplyment of EPR with performance on RTT incompletes remaining compliant however further work to ensure correct recoring at source and validation of data continues. Cohorts of activity within the data understood and proposal for bavklog clearance being discussed with commissioners. Data migration issues resolved. Weekly data quality Board in place. Current performance issues relate to demand pressures which EPR playing an increasingly positive role in the management of this. Proposal to reduce risk score for discussion at next Risk and Compliance Group	Mar-18	Mar-20	QC	Helen Ecker	Division Directors
								4 x 4	4 x 4	0 x 0							

6924	Trustw e	All Div ons	Feb-2(7	Keepir 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	**February 2018 update** Training package sourced by essential skills team from Preston the target audience set and the e-learning assigned accordingly on ESR. Compliance is presently at 32.85%. Package is aimed at any staff member who is responsible for initial placement check through interpretation of Xray. Support from radiology to identify target audience has been sourced. Class room sessions continue for nursing staff. Uptake remains variable and training figures static as not mandatory. Comms plan has been rolled out regarding 'No training , No touching ' in terms of access of NG tubes and this is supported by the Nutritional Policy which is now formatted and awaiting sign off at board. Nutritional Steering Committee to work through operationalisation and key priorities from the policy High use areas all have a key trainer identified who is responsible for ensuring that nursing staff are trained as per NPSA guidelines. Recent audit has highlighted concerns with record keeping post EPR. MUST completion has also been identified as a concern through ward assurance audits. Senior nursing team re visiting EPR optimisation and standardisation and plan to use clinical educators to support starting with focus on nutrition and hydration. Further task and finish group planned with chief nurse, recommendation will be made that the role of the CNS is changed to oversee patients who are receiving enteral nutrition. Also recommending that for nursing staff that this training is part of essential skills with possible opt out for staff who don't access which can then be tracked.	Mar-2018	May-20	QC	Brenda rown,	Jo Mido on

6949	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 HCPC 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. 5. Business continuity plan has not had a recent test with relevant stakeholders. 6. Failure to understand the reason why CHFT are not an employer of choice for Blood Transfusion/Haematology Biomedical Scientists.	10	5 x 2	15	5 x 3	5	5 x 1	3. Understand blockers to the recruitment process and determine options to expedite the process. 5. Organise a test for Business continuity plan with relevant stakeholders. Update 12/1/2018- BCP test planning meeting arranged for 15th Jan. Planning actual test for last week Feb 2018 6. Full root cause investigation to determine all contributory factors in the current failures to recruit and retain HCPC Biomedical Scientists and develop long term achievable solutions. 12/1/2018 Gavin Boyd investigating option for an independent person in trust to facilitate a root cause investigation. HB still trying to provide suitable time out date/vtime. **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	Mar-2018	Jul-2018	DB	Helen Exley	Rob Aitkinson

6715	Corpo	All Dir orates Corporate	Apr-20	Keepi 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 addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group.	20 4 x 5	15 3 x 5	6 3 x 2	Establish clinical documentation group Nov 2017 No change to existing controls December 2017 Bespoke training is being offered when documentation issues are identified, for example this month the team are concentrating on infection control. Documentation now being audited through the ward assurance tool. January 2018 Ward assurance including the audit of documentation is not well embedded and requires some further support, JM to meet with the Deputy Chief Nurse to discuss how assurance can be achieved. The optimisation booklet has been circulated to wards. JM to discuss details of reports that can support ward assurance. Lights on to be rolled out to managers so that they can understand where support is needed. **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.	Mar-18	Mar-18	WEB	Brenda rown	Jackie phy

6829	Family	Pharmacy	Aug-2015	Keeping the base safe	The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately [illegible] pa ready to administer injectable medicines with short expiry dates for direct patient care. Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service(SPS) on behalf of NHSE. The latest audit undertaken on 5 April 2017 rated the overall risk assessment to patient safety as high with two major deficiencies. It was strongly recommended that the workload is not increased in the HRI facility and consideration must be given to close the facility if a business case for replacement is not approved.Capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards to enable the closure of the HRI facility.	Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. Self-audits of the unit External Audits of the HRI unit will be undertaken by the Quality Control Service on behalf of NHSE every 6 months. Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance. The capacity plan of the HRI unit will not be exceeded. A strategy of buying in ready to administer injectable medicines will be implemented but there are concerns about the sustainability of the current pharmaceutical supply chain.	If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance' rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.	15	3 x 5	15	3 x 5	3	3 x 1	October 2017 The business case was taken to The Commercial Investment and Strategy Committee and was approved in principal with the need to find the best financial solution. The possible use of the PMU as part of the business case is to be considered. Nov 2017 re-audit 15/11/17 - still high risk with some actions taken to mitigate short term. still pursuing BC and possible use of PMU as an alternative Dec 17 - discussions ongoin re solution - meeting with HPS Fri 15th Dec to hopefully bring a resolution Jan 18 - still discussing options for the business case - preferred option still to locate at CRH and extend the current facilities **February 2018** Awaiting outcome of discussions - will be confirmed by end March 18	Mar-2018	Mar-20	DB	Brenda rown	Fiona S h
5747	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	1. Continue to seek long term locum cover; 2. Continue to try to recruit to the vacant post; 3. Progressing a regional approach to attract candidates to work regionally; 4. Progressing approach to further contingency using regional-wide approach. December 2017 update: Advert currently out for joint post (regional initiative in collaboration with Leeds and Bradford). Service still being supported by part time locum cover - continuing to seek long term locum cover. January 2018 update: Advert for joint post with Bradford closed on Friday 12 January 2018, with no applicants. February 2018 update: Full time locum in place for next 6 weeks; in discussion with neighbouring Trusts to consider long term solution. Raised at Divisional PRM for escalation to WYAAT CEOs	Mar-18	Apr-2018	DB	Helen Barker	Sarah Clenton

6011	Family Specialist Services	Pathology	May-24	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	15	3	5 x 3	5 x 3	3 x 1	January 2018 We have installed some of the Haemonetics equipment in December 2017, 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) **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)	Mar-2018	Mar-20	PSQB	David Eccleshead	Julie O'Gardan

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday, 1st March 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient Report - The Board are asked to approve the contents of the CAIP report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

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

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

The CAIP improvement plan is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Please see attached.

Appendix

Attachment:

CAIP BoD March 2018.pdf

Calderdale and Huddersfield NHS Foundation Trust

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors March 2018

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

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

The CAIP improvement plan is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee. Performance is measured in the CAIP dashboard and a brief progress against themes noted below.

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	**SHMI** Data released in December showed the SHMI for July 2016 to June 2017 = **101.87** (categorised as Band 2 – as expected. **HSMR** Data released in Feb 18 showed the HSMR for Nov 16 – Oct 17 is at 89.86 (within expected range). **Alerting Conditions** No alerting conditions in the latest release of data **Learning from Death** From December 2017 all deaths are being allocated for an ISR (Initial Screening Review). As a result the number of ISRs is improving however given the higher than average number of deaths in December and January the proportion remains about 30%. There is	SHMI and HSMR performance continues to be monitored and reported monthly to the Mortality Surveillance Group (MSG), all within expected range. The 'mortality risk' will be reviewed in the next six months and further reduced if this trajectory continues. There are plans to revise the allocation of ISRs and the online to tool to focus on screening for quality of care. An offer of training and a 'how to do an ISR' guide will be sent to all consultants and SAS doctors.

	also disquiet from certain consultants and consultant groups about performing these ISRs. Cases escalated for Structured judgement reviews (SJR) have all been reviewed. See LfD quarterly report.	
2) Reliability in clinical care	AKI and Sepsis continue to be prioritised for evidence-based care bundle improvement work. The Sepsis group have validated and agreed that the new EPR has a robust mechanism for screening all inpatients based on their clinical observations and associated lab tests. Screening performance for Sepsis is now 100%. AKI collaborative met in November to relaunch their improvement work.	The Sepsis group will continue to manage the performance of sepsis form completion when it triggers on EPR. In addition there are plans to measure performance in the Sepsis Six bundle through the EPR. Sepsis remains a standing agenda item at the Clinical Outcomes Group. The AKI group are continuing to develop agreed guidance to promote better patient care when AKI is alerted on EPR.
3) Early recognition and treatment of deteriorating patients.	The Deterioration Programme continues to focus on Recognition, Response and Prevention. In Recognition the focus remains timely and quality observations. Performance data on timeliness remains static however a deep dive into this has unveiled previously unknown rules within Nervecentre. These preconfigured rules determine whether the observations are on time or not. In addition there are plans to develop a programme to improve the quality of observations. With respect to Response there has been an audit looking at the response to patients who scored a	A task and finish meeting has been agreed to better understand practice and behaviours with observations and escalations. This will determine the need for a more specific quality improvement plan. The results of the audit are awaited but should inform if the need for more focussed measures to respond to patients who are unwell. Safety huddles are in place at CHFT. Until now the focus of these have been for falls and pressure sores. Wards will be supported to develop

	NEWS of 5 or more. This audit was conducted in and out of hours for 5 consecutive days. With respect to Prevention two inpatient wards are being supported to further develop their Safety Huddles to include earlier recognition of deterioration in patients.	safety huddles further using the EPR as a tool to support this.
4) End of life care	There continues to be sustained improvement in the percentage of DNACPR discussions taking place and being reviewed. On average this remains 93-94%.	Work is commencing regarding how best to incorporate the ICODD (integrated Care of the Dying Document) into EPR
5) Caring for frail patients	The changes to the pilot service delivered by the Calderdale Community team is that Virtual Ward will now in-reach to the HRI site and the CIT team will in reach to the CRH site. This then gives a service to both sites for the Calderdale patients. There has been a significant reduction in activity at CRH for frail patients however this is how the service is designed so this is correct. There will still be some frail patients going to CRH site that walk into ED or if the YAS teams have brought them with a possible respiratory or cardiovascular condition.	The location of frailty beds are currently being reviewed to assess the best place for them going forward. Calderdale Community team have been awarded the 'better care funding' to enable us to respond to YAS referrals in the future to prevent them coming to ED.
6) Clinical coding	Average diagnosis and average Charlson scores are now levelling out. Current performance on these indicators is in line with the top 25% in the country. Percentage of sign and symptoms is still high with a slight increase this month to 9.70%. Performance will be monitored in the coming months to see if this reduction is sustained.	The audit work continues within specialties and specific S&S groups e.g. patients discharged with a sign/symptom primary diagnosis, patients with S&S with a LOS >5 days, patients with a sign/symptom as a primary diagnosis who die within 30 days of discharge. Discussions are to take place regards replacement of 2wte coders due to retire end of FY.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st March 2018	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - MARCH 2018 - This report brings together governance items for review and approval by the Board	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: n/a	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together governance items for review and approval by the Board:
a. Board Workplan
b. Board Skills/Competencies
c. BOD Terms of Reference
d. Use of Trust Seal

Main Body

Purpose:

This report brings together governance items for review and approval by the Board:
a. Board Workplan
The Board work plan has been updated and is presented to the Board for review at (Appendix 1).
The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and APPROVE the work plan.

b. Board Skills/Competencies - Self-Declaration
As agreed, the the composite information regarding the Board Skills and Competencies is attached at (Appendix 2). This will be used to help identify any required development and also the assessment of what skills are required when consideration is given to future board vacancies.
The Board is asked to APPROVE the report.

c. BOD Terms of Reference
There were no significant changes required to the BOD Terms of Reference (appendix 3). The Terms of Reference and Annual Reports from the Sub Committees are expected to be presented to the BOD in May 2018
The Board is asked to APPROVE the BOD Terms of Reference

d. Use of Trust Seal
There have been no sealing of documents since reported to the Board in October 2017 the last report to the Board.
The Board is asked to NOTE the non-use of the Trust Seal.

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The board is asked to approve the recommendations above.

Appendix

Attachment:

COMBINED GOVERNANCE REPORT ATTACHMENTS.pdf

Calderdale and Huddersfield NHS Foundation Trust

BOARD SKILLS AND COMPETENCIES SELF-ASSESSMENT 2017-2018
Collated Template – as at 1 March 2018

The proposition for this assessment is that the Board can regard itself as competent if there is a good spread of in depth and working knowledge for each domain across the Executive Directors and Non-Executive Directors. This assessment is used to satisfy the Board that it is fit for purpose and to inform recruitment processes to ensure that any gaps that arise at short notice, or can be predicted through turnover, are filled.

The domains are determined by the Board, having regard to the provisions set out in the Code of Governance for Foundation Trusts by the Foundation Trust Regulator.

KEY:
E – denotes Essential domain
D – denotes Desirable domain
✓ - Area of sufficiency or strength – considers self competent
★ - Area requiring some development – moderate experience or skill
△ - No or little experience/skill – development required

		EXECUTIVE DIRECTORS	NON EXECUTIVE DIRECTORS
DOMAIN		**✓ - Area of sufficiency or strength – considers self competent** **★ - Area requiring some development – moderate experience or skill** **△ - No or little experience/skill – development required**	**✓ - Area of sufficiency or strength – considers self competent** **★ - Area requiring some development – moderate experience or skill** **△ - No or little experience/skill – development required**
Strategic risk & governance management	**E**	**7 - ✓** **0 - ★** **0 - △**	**7 - ✓** **1 - ★** **0 - △**

Financial expertise	**E**	7 - ✓ 0 - ★ 0 - △	7 - ✓ 1 - ★ 0 - △
Audit expertise	**E**	5 - ✓ 2 - ★ 0 - △	6 - ✓ 2 - ★ 0 - △
THIS expertise	**E**	3 - ✓ 4 - ★ 0 - △	6 - ✓ 2 - ★ 0 - △
Strategic thinking and practice	**E**	7 - ✓ 0 - ★ 0 - △	8 - ✓ 0 - ★ 0 - △
System management and system thinking to include customer relationship management and partnership working	**E**	7 - ✓ 0 - ★ 0 - △	6 - ✓ 2 - ★ 0 - △
Current and future policy environment	**E**	4 - ✓ 3 - ★ 0 - △	4 - ✓ 3 - ★ 1 - △
Leadership and organisational development	**E**	5 - ✓ 2 - ★ 0 - △	7 - ✓ 1 - ★ 0 - △
Improvement and change management	**E**	6 - ✓ 1 - ★ 0 - △	8 - ✓ 0 - ★ 0 - △
Performance management	**E**	7 - ✓ 0 - ★ 0 - △	7 - ✓ 1 - ★ 0 - △
Health and Social Care experience	**E**	4 - ✓ 2 - ★ 1 - △	5 - ✓ 2 - ★ 1 - △
Clinical quality &	**E**	4 - ✓ 2 - ★	2 - ✓ 4 - ★

interdependencies		1 - △	2 - △
Commercial focus & entrepreneurial skills	E	4 - ✓ 2 - ★ 1 - △	6 - ✓ 2 - ★ 0 - △
Human resources management	E	5 - ✓ 2 - ★ 0 - △	5 - ✓ 3 - ★ 0 - △
Legal awareness	D	0 - ✓ 7 - ★ 0 - △	2 - ✓ 5 - ★ 1 - △
Health & Safety	D	3 - ✓ 4 - ★ 0 - △	3 - ✓ 4 - ★ 1 - △
Corporate communication/media	D	4 - ✓ 3 - ★ 0 - △	5 - ✓ 2 - ★ 1 - △
Community Development experience	D	5 - ✓ 1 - ★ 1 - △	3 - ✓ 4 - ★ 1 - △
Ambassadorial skills to develop networks that complement the development of the Trust	D	5 - ✓ 2 - ★ 0 - △	5 - ✓ 1 - ★ 2 - △
Equality & Diversity experience	D	6 - ✓ 0 - ★ 1 - △	3 - ✓ 4 - ★ 1 - △
Knowledge as a Corporate Trustee	D	4 - ✓ 3 - ★ 0 - △	5 - ✓ 2 - ★ 1 - △
Formal Qualifications & Training – please specify field(s)		• 2 – not specified • BA (Hons), ACMA, CGMA, CPFA • MA (Distinction) Counselling Studies Advanced Health & Safety Certificate Diploma in Higher Education ENB 285 – Advanced Continuing Care of the Dying Patient ENB 998 – Teaching and Assessing in Clinical Practice ENB 931 – Care of the Dying Patient and Family RGN • MC ChB, ND, FRCPATH • BA Hons, FCIPD	• FCA, BA Economics, Trust Mentoring Training, Various building society training courses. • Degrees, Fellow of British Computer Society • Medical qualifications, MD, FRCS Diploma in Management • not specified • PO - Finance - ACA, Strategy/General Management – MBA • BA Hons Degree, Chartered Institute of Housing Professional Qualification, Diploma in Management Studies • Medical

		• **MBA, DMS, CBI**	• **FCA (Accountancy)**

Board Directors are also required to have an awareness of their personal impact in terms of Board working and behaviours. This will be continually assessed using both formal and informal evaluation tools.

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
Date of agenda setting/Feedback to Execs	20.3.18	16.4.18	21.5.18	18.6.18	16.7.18	20.8.18	17.9.18	15.10.18	19.11.18			
Date final reports required	28.3.18	25.4.18	30.5.18	27.6.18	25.7.18	29.8.18	26.9.19	24.10.18	28.11.18			
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework (Quarterly)	-	✓	-	-	✓	-	-	✓	-	-	✓	-
DIPC report	-	✓	-	Annual Report	✓	-	-	✓	-	-	✓	-
High Level Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Care of the acutely ill patient report	TBC			TBC			TBC			TBC		
Learning from Deaths – Quarterly Report			✓			✓			✓Q3			✓
Patient Survey				✓								✓
Quarterly Quality Slide Report + Presentation focussed on one topic (may be used as patient/staff story) (NB – Quality Account in Annual Report)		Quality A/cs	✓			✓			✓			✓
Colleague Engagement /Staff Survey (NB - Gold Standard by 2018 and Platinum Standard by 2020 agreed at 25.2.16 BOD)	✓						✓					✓

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
Nursing and Midwifery Staffing – Hard Truths Requirement		✓						✓				
Safeguarding update – Adults & Children		✓ Annual report							✓			
Review of progress against strategy (Qly)			✓					✓				
Plan on a Page Strategy Update			✓									
Quality Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Audit and Risk Committee update & mins		✓	✓		✓			✓		✓	✓	
F&P Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Well Led Workforce Committee update & mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes				✓		✓			✓			✓
Performance Management Framework – update on work from sub-committee workplans		✓										
Guardian of Safe Working Quarterly Report (? Anu Rajgopal to attend if avail – dates tbc)	✓			✓				✓				✓
Governance report: to include such items as:												
- Standing Orders/SFIs/SOD review								✓				
- Non-Executive appointments (+ Nov - SINED & Deputy)								✓				
- Board workplan			✓			✓			✓			✓
- Board skills / competency									✓			
- Code of Governance	✓											
- Board meeting dates			✓									
- Committee review and annual report												✓
- Annual review of NED roles								✓				
- Use of Trust Seal			✓			✓			✓			✓
- Quarterly Feedback from NHSI			✓			✓			✓			✓

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
- Declaration of Interests - BOD (annually)												✓
- Attendance Register (Apr+Oct 2018)	✓						✓					
- BOD TOR												✓
- Sub Committees Report and TOR		✓										
- Constitutional changes (+as required)								✓				
- Compliance with Licence Conditions (April 2018)	✓											
- Board to Ward Visits Feedback				✓				✓				✓
ANNUAL ITEMS												
Annual Plan	✓											
Annual Plan feedback from Monitor						✓						
Annual report and accounts (private)		✓ EO meeting										
Annual Quality Accounts		✓ EO										
Annual Governance Statement		✓ EO										
Appointment of Deputy Chair / SINED								✓				
Board Development Plan											✓	
Emergency Planning annual report						✓						
Fit and Proper Person Self-Declaration Register	✓											
HPS Annual Report		✓										
HPS Business Plan											✓	
Health and Safety annual report			✓					✓ (update)				
Capital Programme												✓
Equality & Inclusion				✓ (update)						✓ (AR)		

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
DIPC annual report (ALSO SEE REGULAR ITEMS)				✓								
Fire Safety annual report						✓						
Medical revalidation & appraisal					✓							
Whistleblowing Annual Report											✓	
Review of Board Sub Committee TOR												✓
Risk Appetite Statement								✓				
Winter Plan						✓			✓			
ONE-OFF ITEMS												
Council of Governors Elections	✓										✓	
Hospital Pharmacy Transformation Plan (AB)												
Risk Management Strategy										✓		
Workforce Strategy											✓	
LHRP Core Standards (LH/Ian Kilroy)							✓					
Performance management update								✓				
Update on OD and CLIP									✓			

Date of meeting	5 April 2018	3 May 2018	7 June 2018	5 July 2018	2 Aug 2018	6 Sept 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018	Jan 2019	Feb 2019	March 2019
STANDING PRIVATE AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Private minutes of sub-committees – as req'd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the WYAAT meeting							✓		✓			✓
ADDITIONAL PRIVATE ITEMS												
Reforecast financial plan							✓					
Contract update										✓	✓	✓
Board development plan	✓											
Feedback from Board development workshop			✓	✓		✓		✓				
A&E Delivery Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Property Partnership/St Luke's Hospital/PR (as required)												
Equality and Diversity		✓										
Sustainability and Transformation Plan									✓ (update)			
Private Finance and Performance Committee Minutes (private – as appropriate)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee in Common – Programme Directors' Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes from FBC Committee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

NHS
Calderdale and Huddersfield
NHS Foundation Trust

BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTIUTION

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, for the information of the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees. The practice and procedure of the meetings of the Board of Directors – and of its committees – are not set out here but are described in the Board's Standing Orders.

2. PURPOSE

The principle purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the ~~Membership~~ Council of Governors and some decisions of the Board of Directors require the approval of the Council of Governors~~Membership Council~~. The Board consists of executive directors, one of whom is the Chief Executive, and non-executive directors, one of whom is the Chair.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, local health organisations, local government authorities and others to provide safe,

accessible, effective and well governed services for patients, [service users, and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:
- Ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

4.3. Quality

The Board:
- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:
- Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Monitors and reviews management performance to ensure the Trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

4.5. Culture

The Board:
- Is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation Trust business;

- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:

- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS Improvement from time to time) and appropriate codes of conduct, accountability and openness applicable to foundation Trusts;
- Ensures that all elements of the Trust's licence relating to the Trust's governance arrangements are complied with;
- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures that all required returns and disclosures are made to the regulators;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation Trust business.
- Agrees the schedule of matters reserved for decision by the Board of directors;
- Ensures that the statutory duties of the Trust are effectively discharged;
- Acts as a corporate trustee for the Trust's charitable funds.

4.7. Risk management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.
- Ensures there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining committees of the Board of Directors with delegated powers as prescribed by the Trust's standing orders and/or by the Board of Directors from time to time:

4.9. Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its Governors~~membership councillors~~, members, staff and the local community.
- Meets its engagement obligations in respect of the Council of Governors~~Membership Council~~ and members and ensures that governors~~membership councillors~~ are equipped with the skills and knowledge

they need to undertake their role;
- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website.
- Publishes an annual report and annual accounts.

4.10. Finance

The Board:
- Ensures that the Trust operates effectively, efficiently, economically
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and membership council and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Council of Governors. ~~Membership Council.~~

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chairman and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors~~membership council~~.

7. ACCOUNTABILITY TO THE MEMBERSHIP COUNCIL

The non-executive directors are accountable to the Council of Governors ~~Membership Council~~ for the performance of the Board of Directors. To execute this accountability effectively, the non-executive directors will need the support of their executive director colleagues. A well-functioning accountability relationship will require the non-executive directors to provide Governors~~membership councillors~~ with a range of information on

how the Board has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the Trust. The non-executive directors will need to encourage questioning and be open to challenge as part of this relationship. The non-executives also should ensure that the Board as a whole allows membership councillors time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS

The Board of Directors will meet at least 9 times a calendar year.

9. QUORUM

Six directors including not less than three executives, and not less than three Non-Executive Directors shall form a quorum.

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the Trust secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the membership council and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

Formatted: Indent: Left: 0.62 cm, Tab stops: 1.25 cm, Left + Not at 1.45 cm

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the chair and chief executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

In order that the Board can be assured that it is operating at maximum effectiveness in discharging its responsibilities at set out in these terms of reference it shall self assess its performance following each Board meeting. Once a year a full review of effectiveness will be undertaken including attendance, decision making, assessment against responsibilities and completion of the business cycle.

FEBRUARY 2018

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday, 1st March 2018	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Learning from Deaths Report - Q3 - The Board are asked to approve the contents of the LfD Q3 Report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: -	
Governance Requirements: -	
Sustainability Implications: None	

Executive Summary

Summary:

The Board are asked to approve the contents of the Learning from Deaths Q3 report.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Please see attached.

Appendix

Attachment:

LfD report for Board of Directors (March 2018).pdf

LfD Q3 report for Board of Directors
March 2018

Initial Screening Reviews

In the last 12 months, there have been a 1,682 deaths, of these, 436 (26%) have been reviewed using the initial screening process that assesses the quality of care. The quality of care was assessed as either excellent or good in 71.3% (311) of cases reviewed. Poor or very poor care has triggered further investigation using structured judgement review (SJR) from July 2017 and prior to this using a similar approach.

From December 2017, initial screening reviews (ISR) have been allocated to consultants and SAS doctors across the trust. Despite the initial problems with access to the online tool and requests for training, a total of 75 ISRs have been completed. A number of one to one training sessions have been provided and simple guidelines have been developed and tested. An offer of further training support will be sent out with this guidance. The ambition remains to screen all deaths except those directed to a SJR.

Structured Judgement Reviews

A total of 29 deaths have been escalated for Structured Judgement Reviews (SJR) in Q3. The table below shows the reason for escalation for a SJR. The greatest number of cases escalated from the ISR process.

	Oct '17	Nov '17	Dec '17	Total
Escalated from ISR	2	8	1	12
Complaint	0	1	1	3
SI process	4	2	0	6
Elective	0	1	0	1
Learning Disability	0	1	0	1
Other including random selection	0	0	9	9
Total Requested	6	13	10[1]	29

[1]In December, one case was automatically escalated for SJR and had also been randomly selected for review.

The avoidability scores for the SJR are listed below:

1. Definitely avoidable 0
2. Strong evidence of avoidability 0
3. Probably avoidable, more than 50-50 2
4. Possibly avoidable, less than 50-50 9
5. Slight evidence of avoidability 5

Dr Sal Uka, Associate Medical Director

6. Definitely not avoidable. 13

Six cases had been reported as Serious Incidents on Datix and the SJR was performed to support the investigation. Of these, one case was found to have no avoidability issues, 3 cases were assessed as possibly avoidable and 2 cases were assessed as probably avoidable. These cases continue to be investigated under the Serious Incident investigation process.

In December as there was a higher than usual number of death and random sample of 9 cases of deaths between 25th and 27th December were allocated for a SJR. None of the completed SJRs have been assessed with an avoidability score or 3 or less.

Although the SJR in majority of cases have found no avoidability issues, there have been a number of learning themes identified where we can improve the quality of care, these include:

- Timely senior medical reviews
- Appropriate control of symptoms, particularly at the end of life
- Improving communication with patients, family and different healthcare professionals, particular on goals of care
- Earlier recognition of deterioration
- Better fluid management and recording of fluid balance
- Earlier recognition the dying phase and ensure good communication with the family

The majority of these themes are included within the work plans of the Deterioration Programme and the End of Life Groups. Effective communication and documentation of this remains a common theme seen not only in mortality reviews but also in complaints. This may need an alternative approach. Discussions are also taking place on how best to disseminate the learning from reviewing deaths. Representatives from the LfD panel attended medical clinical governance sessions on the 16th February 2018 to being this dialogue. It is planned that occurs quarterly in line with this board report. Future plans also include direct feedback to the team(s) involved in the patient's care and an annual LfD summit.

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, 1st March 2018	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: January 2018: Quality and Performance Report - The Board is asked to note the contents of the report and the overall performance score for January 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 22nd February 2018)	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

January's Performance Score has improved by 5 percentage points to 60%. All domains have improved scores with the exception of EFFICIENCY & FINANCE. The CARING domain has improved significantly due to FFT performance. The EFFECTIVE domain has returned to GREEN although #NoF is still below target. The RESPONSIVE domain has improved slightly, with 3 out of 4 Stroke targets now achieving target, plus cancer has maintained good performance for the third month running across all metrics. For ECS, the score reflects failure to deliver the 95% standard, but CHFT did achieve the NHSI agreed trajectory for January. EFFICIENCY & FINANCE has deteriorated with Day Cases and A&E activity both missing target in-month. WORKFORCE has improved slightly with better sickness absence rates, although all 5 Mandatory Training focus areas are still missing target.

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 January 2018

Appendix

Attachment:

Board Report Jan 2018.pdf

Board Report

January 2018

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

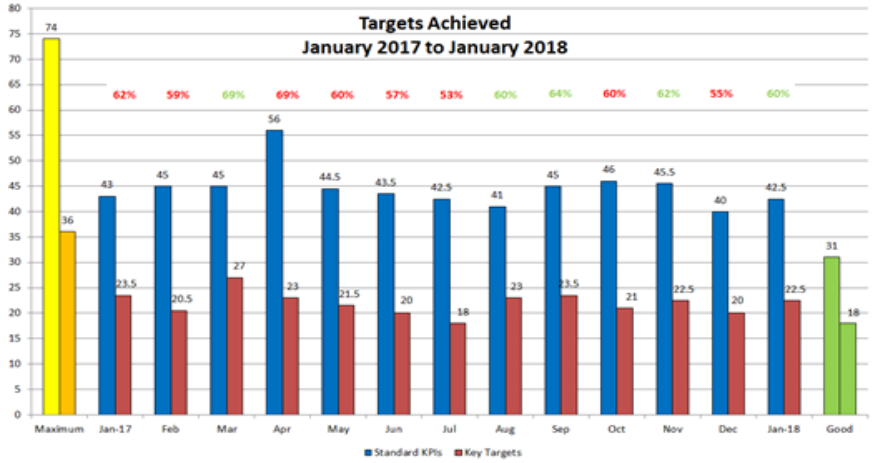
To Note

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.

For **January's** performance the VTE cohort has been updated which has resulted in minor improvements in performance between October and December.

Comparing January 2017 performance to January 2018 performance

January 2018 performance **(60%)** was **2 percentage points (18 points)** worse than **January 2017 (62%)**. The main areas of deterioration are **Mandatory Training (36 points)** and Finance (14 points). On the contrary in January 2017 SHMI and HSMR were worse.



Comparing 10 months' cumulative performance to January with same period in 2016/17

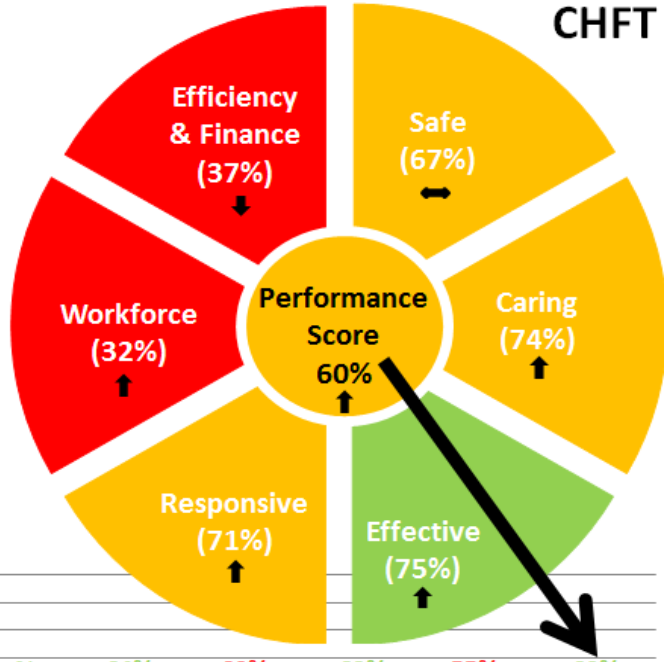
Period to January 2018's performance **(59.9%)** was **2 percentage points** worse than **period to January 2017 (61.8%)**. Again the main area of deterioration was **Mandatory Training**, this is only compensated by an equivalent improvement in **Sickness Absence**. Other contributory areas are **Cancer 2 week waits and 62 day RTT, Diagnostic Waits, FFT A & E Survey - Response Rate, I&E, CIP** and **Activity**. **SHMI and HSMR** have improved.

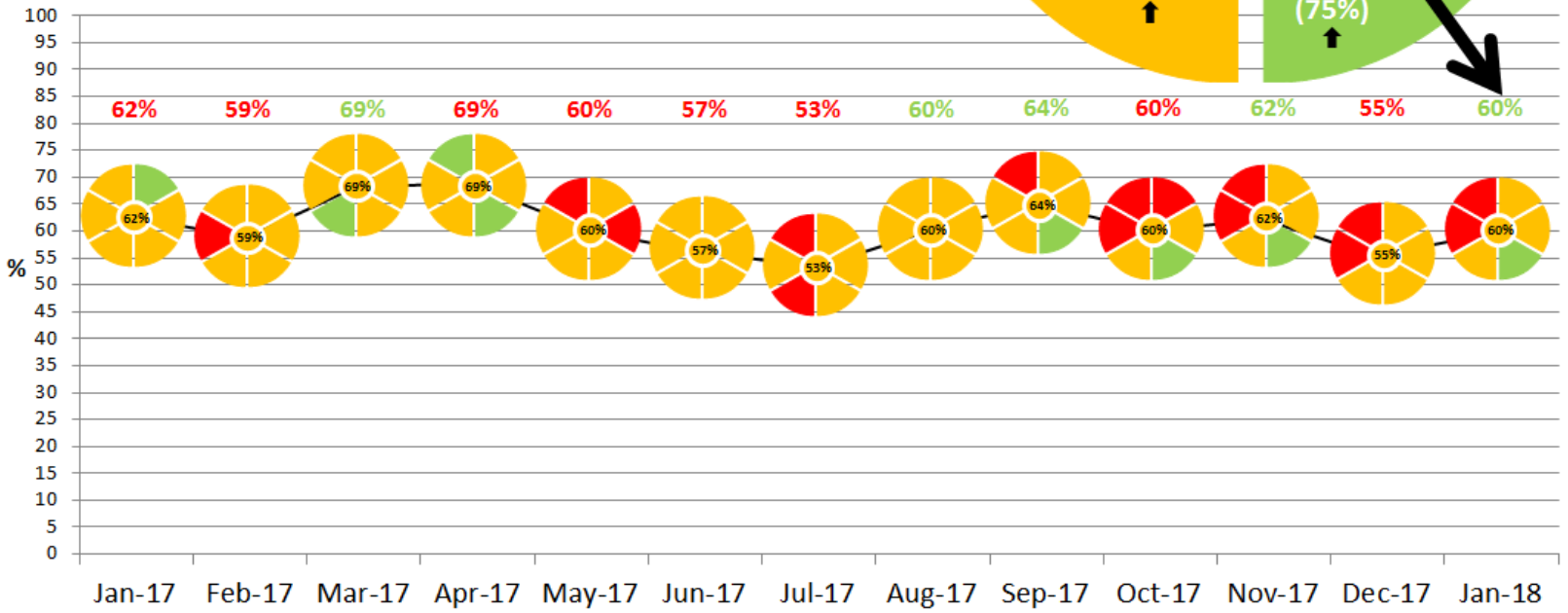
Performance Summary

January

RAG Movement

January's Performance Score has improved by 5 percentage points to 60%. All domains have improved scores with the exception of EFFICIENCY & FINANCE. The CARING domain has improved significantly due to FFT performance. The EFFECTIVE domain has returned to GREEN although #NoF is still below target. The RESPONSIVE domain has improved slightly with 3 out of 4 Stroke targets now achieving target plus cancer has maintained good performance for the third month running across all metrics. For ECS the score reflects failure to deliver the 95% standard but CHFT did achieve the NHSI agreed trajectory for January. EFFICIENCY & FINANCE has deteriorated with Day Cases and A&E activity both missing target in-month. WORKFORCE has improved slightly with better sickness absence rates although all 5 Mandatory Training focus areas are still missing target.





SINGLE OVERSIGHT FRAMEWORK

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

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	96.8%	96.2%	↑	96.3%
	Inpatient Complaints per 1000 bed days	2.3	1.9	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	4.74	4.41	↓	5.17
	Delayed Transfers of Care	2.05%	3.40%	↑	3.5%
	Green Cross Patients (Snapshot at month end)	117	100	↓	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	87.79	89.86	↑	100
	Theatre Utilisation (TT) - Trust	76.4%	80.6%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	1.09%	0.54%	↓	0.6%
	Emergency Care Standard 4 hours	90.76%	88.03%	↑	95%
	% Incomplete Pathways <18 Weeks	94.09%	92.61%	↑	92%
	62 Day GP Referral to Treatment	91.6%	88.1%	↑	85%
SAFE	% Harm Free Care	92.70%	93.45%	↓	95.0%
	Number of Outliers (Bed Days)	1136	991	↓	495
	Number of Serious Incidents	4	6	↑	0
	Never Events	0	0	↔	0

MOST IMPROVED

3 out of 4 Stroke metrics achieving target which is best performance for over 12 months plus peaks in 3 out of 4 individual metrics.

All key cancer targets maintained for the 3rd consecutive month.

% PPH ≥ 1500ml - all deliveries - lowest rate at 1.8% for over 12 months.

MOST DETERIORATED

Theatre utilisation was at one of its lowest levels at 76.4% reflective of the requirement to cancel all routine surgery.

Breach of Patient Charter (Sitreps booked within 28 days of cancellation) - There were 5 breaches resulting from cancellations which were unable to be rescheduled due to the bed/ED crisis when all non-emergency procedures were cancelled.

% Harm Free Care - lowest performance at 92.7% in over 12 months is being driven by a high number of patients being admitted with a pressure ulcer.

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

Where possible lists have been collated to avoid running of multiple low activity lists. Work continues with General Surgery and T&O on the testing of 'super-lists' with changes to staffing models to achieve greater utilisation. It is anticipated that these will be tested in March should bed capacity facilitate.

All patients have now be seen following these exceptional circumstances.

The ongoing pressure ulcer improvement collaborative is in place. The Trust will be submitting data to the national website directly from April, this will result in an opportunity to refresh the way in which data is being validated and recorded prior to submission to ensure the definitions around VTEs, Old vs New Ulcers are being accurately understood.

Arrow direction count ↔ 1 ↑ 9 ↓ 9

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.6	7.7	↓	
Sickness Absence Rate	4.34%	4.62%	↑	4.0%
Turnover rate (%) (Rolling 12m)	13.06%	13.05%	↓	12.3%
Vacancy	329.82	359.05	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	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) Q1	57.0%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£15.60	-£11.98	🔴
Expenditure vs Plan var (£m)	£1.93	£2.67	🟢
Liquidity (Days)	-21.78	-16.96	🟢
I&E: Surplus / (Deficit) var - Control Total basis (£m)	-£8.70	-£5.55	🔴
CIP var (£m)	-£0.58	£0.13	🔴
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	14.40%	14.25%	🔴

Executive Summary

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

Area	Domain
Safe	• **% Harm Free Care** - Performance at 92.7% which is lowest in over 12 months is being driven by a high number of patients being admitted with a pressure ulcer. The ongoing pressure ulcer improvement collaborative is in place. The Trust will be submitting data to the national website directly from April, this will result in an opportunity to refresh the way in which data is being validated and recorded prior to submission to ensure the definitions around VTEs, Old vs New Ulcers are being accurately understood. • **Category 4 Pressure Ulcers -** First category 4 since July.
Caring	• **Complaints closed within timeframe** - Of the 52 complaints closed in January, 54% were closed within target timeframe. Given recent pressures CHFT still aims to have backlog of complaints closed by the end of February. With senior divisional support this model will sustain an effective complaints procedure. Divisions have given assurance that contact is being made with complainants within 7 days. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance at 91.5% still below 95.7% target but best performance in over 12 months. In recognition that many feedback comments relate to long waits the matron for OPD has completed a 'go see' and has now introduced a traffic light escalation process to ensure patients are kept informed of any delays. Reports are now proactively shared with clinical teams across OP services and the teams can view specific comments in relation to services promoting increased ownership. • **Friends and Family Test A & E Survey -** Response Rate is still around 10% which is below the 13.3% target. In A&E specifically, FFT has been added to the daily huddle board to remind staff to complete. • **Friends and Family Test Community -** Response Rate was very low at 1.6% although % would recommend has peaked at 99.1%. The division has set up a piece of focussed work to understand why staff are not engaging in completing the FFT with their patients. Methodology that was put in place is being reviewed (one focused day a month).
Effective	• **Clostridium Difficile Cases** - There were a further 7 cases in January which adds up to 17 in the last 3 months. 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. • **E.Coli - Post 48 Hours** - There were 7 cases in January. 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. • **Mortality Reviews** - A step by step guide is being developed to support consultants and SAS doctors to perform ISRs with face to face support where required. The process of allocating ISRs is also being refined to ensure that reviews are shared fairly. Structured Judgement reviewers are being supported to discuss avoidable scores of 3 (probable) or 4 (possible) with a peer with all scores of 2 or 1 being discussed at the Learning from Deaths panel. Discussions are also taking in place on how best to feedback and disseminate learning from SJRs. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours** - Performance improved to 74% with further improvement expected in February. In order to enhance the management of all trauma patients, the team has worked with the COO to devise a clearer visual code to enable quicker identification of priority patients and schedule accordingly.

Background Context

The Health & Social care system continued to be busy in January with the Trust forced to operate fully in Silver command and control mode for the full month and a system Gold meeting taking place where actions failed to deliver required OPEL de-escalation.

Winter pressures, flu season and norovirus all impacted on the Trust's resilience and ability to support patient flow. The prevalence of norovirus increases the risk of confirmed C-Diff cases.

SPAs and clinics were cancelled to facilitate senior decision making in ED and front end wards. Routine surgery was not scheduled for the month and some day case capacity was cancelled last minute; in Medicine and Community services some routine outpatient activity was reduced to facilitate inreach. Work on EDDs has also been a focus throughout the month to try to create additional patient flow. Whilst performance against the 4 hour ECS was particularly challenging in December and the start of January there were promising signs of a strong recovery in the 2nd week of January resulting in achieving 90.76% for the month which was in line with NHSI trajectory.

Nurse staffing to support additional capacity was challenging and changes to internal bank rates were approved; high cost agency was supported to ensure safety was maintained.

Despite approvals for agency for nursing and medical staffing gaps remained as overall throughout the Health system there was competition for the same capacity leading to pressures for staff of all disciplines on duty.

The impact of reconfiguration continues to be reviewed and monitored, culminating in a large scale review in 2 months' time which will include a comprehensive review of the KPIs attached to the business case.

Executive Summary

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

Area	Domain
Responsive	• **Emergency Care Standard 4 hours** 91% in January, (92% all types) - The Divisions have a renewed focus on EDD's, DTOC's and medically fit for discharge performance has improved but hospital based clinical pathways now require specific focus as seen in the increased number of patients in the 0 - 10 and 10 - 50 day catagory. Silver command has been in place throughout January and was reinstated early February where performance deteriorated again. Actions were described in Patient story previously presented to Board. • **% Last Minute Cancellations to Elective Surgery/28 day breaches -** Within Surgery operational challenges were responsible for 33 'on day' cancellations on 2nd/3rd January. Excluding these 2 exceptional days, the remaining 14 for the rest of January were low in comparison with previous months. There were 5 breaches of the 28 day patient charter which ensures patients have their procedure within 28 days of their cancellation. These were rescheduled for early January then cancelled due to the bed/ED crisis when all non-emergency procedures were cancelled. All patients have now be seen following these exceptional circumstances. • **38 Day Referral to Tertiary** - at 30% lowest position since June. The Red2Green methodology is to be applied to Urology, Head and Neck and Lower GI pathways from March 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 -** Short term sickness was still above target in December although slightly below the November position. Return to Work Interviews are still below 50% for CHFT which are being addressed through the PRM process. Feedback from line managers indicates that RTW interviews are being undertaken, however, the recording of the interview date is the underlying issue in the majority of cases. HR Advisers are demonstrating workaround solutions by recording RTW interview dates through ESR manager self-service until a permanent solution can be found. A Task and finish group has been formed to identify a solution and will meet 16th February. • **Mandatory Training** is still behind on all 5 agreed topics. Divisions, led by the HR Business Partners, are developing action plans to improve mandatory training compliance by March 2018. This includes standing items at Divisional Board and Directorate PRMs, promotion of open learning sessions, FAQ guidance issued to all line managers and compliance lists sent to all line managers.
Finance	• **Finance**: Reported year to date deficit position of £30.81m, on a control total basis (excluding the impact of loss of Sustainability and Transformation funding (STF)) the reported year to date deficit position is £25.7m an adverse variance of £8.7m compared with the control total of £17m; • Delivery of CIP is £13.12m below the planned level of £13.69m; • Capital expenditure is £3.51m below plan due to revised timescales; • Cash position is £1.92m, in line with the planned level; • A Use of Resources score of level 3, in line with the plan. As at Month 10 the gap to CHFT's control total deficit is £8.7m. This is the level of financial improvement that the Trust required in order to be eligible for STF funding. £5.04m of STF funding has been lost based on Quarters 1 & 2 A&E performance and financial performance in M7-10. This is driving a total variance from control total of £13.74m, (excluding technical items excluded for control total purposes). However the reported position includes a number of non-recurrent benefits that in part offset the underlying operational deficit. The Trust is reporting a forecast deficit of £45.25m, an adverse variance to plan of £15.41m. This forecast position incorporates a gap to control total of £8.00m which in turn drives the loss of STF funding of £7.40m. The £8.00m gap remains unchanged from the position reported at the end of Quarter 3 and is contingent upon a number of recovery actions.

Background Context

Short-term Sickness remained high in December at 1.68% on a par with January/February 2017.

FSS services saw a peak in activity in January which matched that seen across the rest of the Trust. Services within the division supported this in a range of different ways:
- Radiology teams created additional inpatient scanning and reporting capacity to support speedy response
- Phlebotomy teams provided additional afternoon sessions to support inpatient areas
- Clinical teams within Paediatrics and Obstetrics and Gynaecology provided additional front-line support to support admission avoidance and timely discharge
- Pharmacy teams have been working additional hours to support timely discharge including providing additional support at weekends.

The Trust was recognised for the excellent work carried out in becoming one of the first sites nationally to implement an electronic referral service for GPs referring patients to secondary care.

January was a challenging month for delivery for all Community services, managing demand in the Community to keep people out of hospital, supporting hospital based services and coping with some difficult weather days.

The Frailty team continue to in-reach and support the front-end hospital services. With the reconfiguration of hospital services in Medicine, the Frailty team noted a significant reduction in elderly patients attending at CRH. Capacity was therefore increased at HRI to support Calderdale elderly patients who attended via Ambulance.

To support the pressures from 2nd January, Community provided support into hospital in the following ways:-
1. OP physiotherapy worked on wards to support rehabilitation to facilitate discharge.
2. Community matrons worked on wards to "pull" patients back to Community..
3. Respiratory specialist nurses and therapists worked with the respiratory team to increase the number of Early Supported Discharge patients.
4. A single point of contact was offered for ED to refer any patients with Flu to the Community nursing team in order to prevent an admission, where it was clinically safe to keep these patients at home.

Improvements to Mandatory Training have been a focus with Divisions in relation to workforce and an issue with data entry on ESR for Return to Work interviews has been noted and resolved.

Safe, Effective, Caring, Responsive - Community Key messages

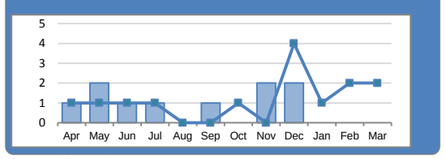
Area	Reality	Response	Result
Safe	Medication Incidents We are closely monitoring medication incidents within the Community division to gain assurance that we have safe processes in place to monitor, measure, report, record and investigate these incidents. This month there were 8 medication incidents reported. 2 of which could be directly linked to Community services, however on further investigation neither could have been prevented.	Medication Incidents Each medication incident is reported via DATIX, each Datix is reviewed by the Community division senior pharmacist. Any actions are then picked up and relayed to community team or if education, training is required this is actioned by the community pharmacist. These are reported into Board on a monthly basis and PSQB via a quarterly report.	Medication Incidents We anticipate that we can report a safe and effective process for identifying, investigating and learning from medication errors/incidents. By when: Review March 2018 Accountable: ADN
Effective	Leg Ulcer healing rate The leg ulcer healing rate has reduced this month. There are 3 patients with leg ulcers that have not healed within 12 weeks this month.	Leg ulcer healing rate Each patient with an ulcer that has taken longer than 12 weeks to heal has been reviewed by the clinical manager and the leg ulcer clinical specialist. Of the three patients this month each have been identified as having no additional actions required to support healing.	Leg ulcer healing rate Keeping this focus will maintain high rates of healing within 12 weeks and support achievement of the wound CQUIN. By when: March 2018 Accountable: ADN
Caring	FFT We have had an improved position in relation to FFT result (91%) in January, however this is in the context of a very poor response rate (1.9%).	FFT We have set up a piece of focused work to understand why staff are not engaging in completing the FFT with their patients. We are reviewing the methodology that we put in place (one focused day a month). We are sending the comments to teams and have recognised services where good comments have been received. We have engaged the support of reception staff to gain responses from clinic based services.	FFT We will continue to monitor the response rate and would recommend and drill down into comments so we can develop responses for improvement. By when: Review March 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 166 children waiting at Huddersfield and 253 at Calderdale. This is a worsening position.	Waiting Time for Children's services A review has been undertaken to understand what is required to reduce the waiting list. A locum SLT is being sought to support the team. This will be discussed with the CCG/Calderdale Council 14th February.	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: March 2018 Accountable: Head of Therapies

Dashboard - Community

Bar Chart = 17/18 figures Line graph = 16/17 figures

Safe

Community acquired grade 3 or 4 pressure ulcers

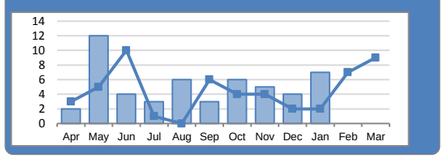


One month in arrears

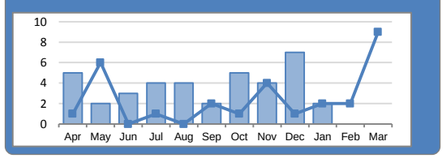
Falls that caused harm whilst patient was in receipt of Community Services inc IC Beds & Comm Place

One month in arrears

Incidents - New Harms

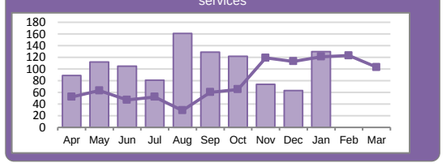


Medication Incidents

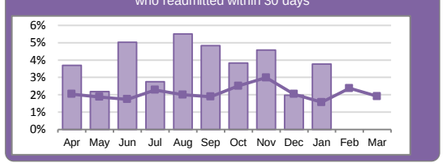


Effective

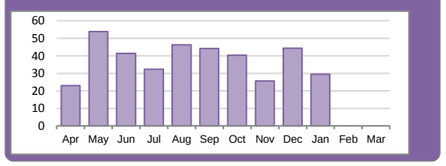
Number of Hospital admissions avoided by Community Nursing services



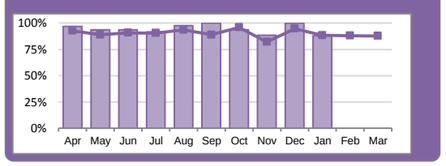
Patients who attended A&E while on a Community Matron Caseload, who readmitted within 30 days



Intermediate Care Bed base (Average Days)

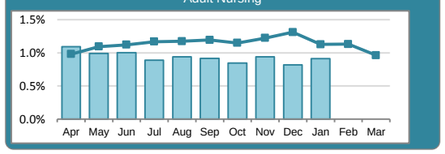


House Bound leg ulcers healed within 12 weeks

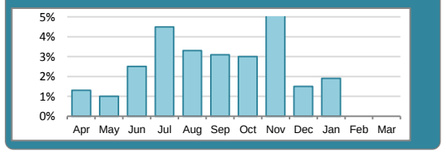


Caring

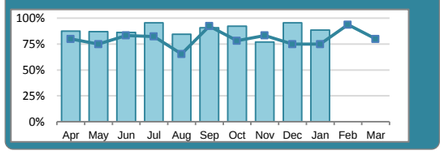
Community No Access Visits Adult Nursing



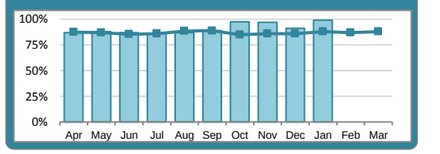
Intermediate Care Readmission rate



End of life patient died in preferred place of death

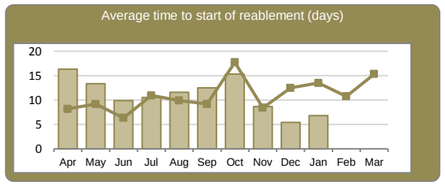


Friends and Family Test- Likely to recommend

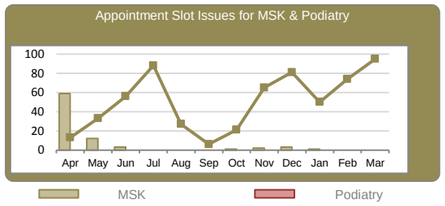


Responsive

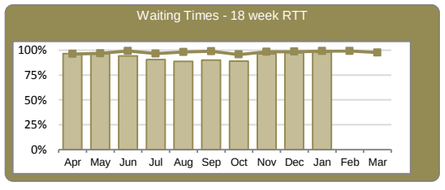
Average time to start of reablement (days)



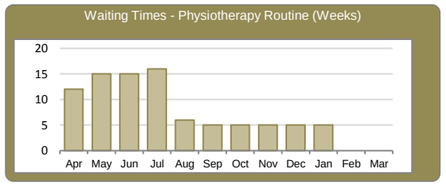
Appointment Slot Issues for MSK & Podiatry



Waiting Times - 18 week RTT

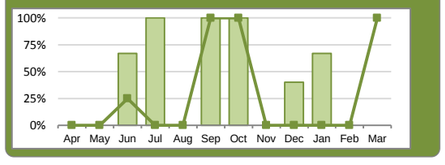


Waiting Times - Physiotherapy Routine (Weeks)

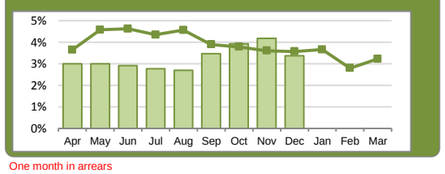


Well Led

% Complaints closed within target timeframe

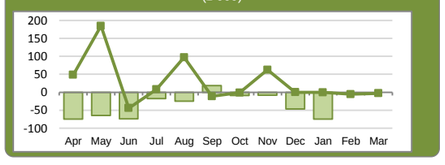


Staff sickness rate

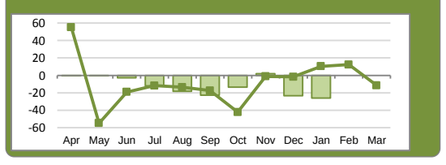


One month in arrears

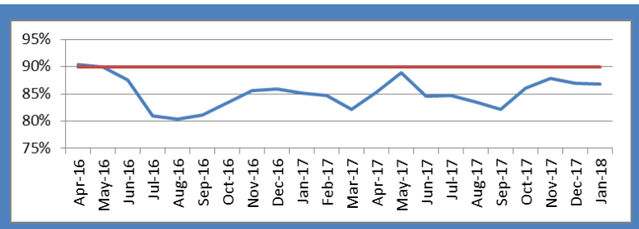
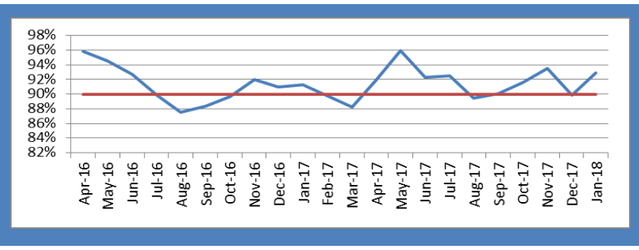
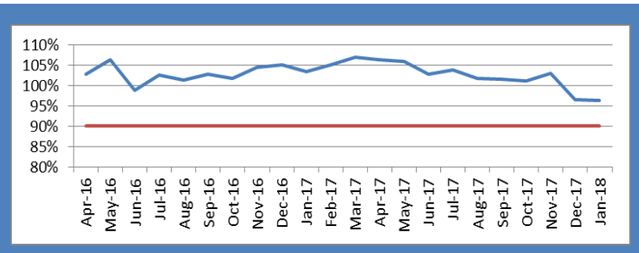
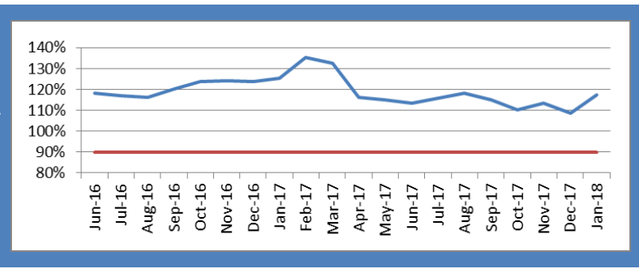
Finance - Planned variance against actual (£'000)



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.	87.26% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% - Ward 15 73.45% - 5b 69.4% - ward 12 73% - ward 20 74.7%	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 to ensure safe staffing against patient acuity and dependency is achieved.. The low fill's are due to a level of vacancy , the teams not being able to achieve their WFM and additional capacity beds.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	93.55% of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% - ward 12 69.9% - 8a/b 66.9% - ward 10 67.7%	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 sickness and staffing wards with a variable bed base model.
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	96.75% of expected Care Support Worker hours were achieved for Day shifts.		Staffing levels at day <75% - ICU 71.8% - 8A/B 71.8% - NICU40.5% - Ward 18 59.1%	The low HCA fill rates in January are attributed to fluctuating 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 workload. 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.	120.92% of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75%	There have been no shifts with fill rates below 75% recorded in January on either site. 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	2996.8	2883	2606.7	94.8%	90.4%	2728	2596	2046	2057	95.2%	100.5%	10.7	10.1			0	3	6.95	0
HRI MAU	2046	1748.5	2139	1703.5	85.5%	79.6%	1705	1573	1364	1386	92.3%	101.6%	12.4	11.0			3	10	0	0
HRI Ward 5 (previously ward 4)	1674	1474	1209	1510.5	88.1%	124.9%	1023	1023	1023	1427.5	100.0%	139.5%	5.8	6.4			0	11	2	0
WARD 15	2046	1501.55	2046	1773.5	73.4%	86.7%	1364	1364	1364	1342	100.0%	98.4%	7.8	6.8			1	10	4.5	4.3
WARD 5C	1069.5	933	837	834	87.2%	99.6%	682	682	341	341	100.0%	100.0%	5.0	4.7			1	2	3.28	0
WARD 6	1674	1570.6	1209	1214.5	93.8%	100.5%	1023	1118	682	824.5	109.3%	120.9%	8.5	8.8	1		4	8	2.4	2
WARD 6BC	1512	1404.5	1092	1115.5	92.9%	102.2%	1232	1221	616	616	99.1%	100.0%	4.6	4.5			3	5	0	0
WARD 5B	2083.5	1446.5	1107	1012	69.4%	91.4%	1364	1034	682	682	75.8%	100.0%	8.6	6.9			1	3	4.74	0
WARD 6A	976.5	777.4	976.5	829.4	79.6%	84.9%	682	682	341	594	100.0%	174.2%	5.1	4.9			0	5	2.2	1.6
WARD CCU	1674	1380	372	326.15	82.4%	87.7%	1023	1019	0	33	99.6%	-	8.2	7.4			0	2	0	0
WARD 7AD	1674	1345	1581	1853	80.3%	117.2%	1023	1001	1023	1122	97.8%	109.7%	6.9	6.9			0	0	1.19	0
WARD 7B	837	829.5	837	1028	99.1%	122.8%	682	682	341	407	100.0%	119.4%	7.1	7.7			0	0	5.9	0
WARD 7C	1674	1296	837	827.5	77.4%	98.9%	1364	1078	341	671	79.0%	196.8%	13.8	12.7			1	5	0	0
WARD 8	1441.5	1167.5	1209	1628.5	81.0%	134.7%	1023	990	1023	1485	96.8%	145.2%	6.6	7.5			1	2	7.11	0
WARD 12	1674	1221.5	837	1026.5	73.0%	122.6%	1023	715	341	649	69.9%	190.3%	5.7	5.4	1		0	1	2.68	2.5
WARD 17	2046	1650.8	1209	1139	80.7%	94.2%	1023	1012	682	682	98.9%	100.0%	6.2	5.6			1	3	1.91	0
WARD 8C	810	818	810	985.9	101.0%	121.7%	682	682	341	682	100.0%	200.0%	4.5	5.3			1	1	6.38	1
WARD 20	2046	1528	2046	1821.3	74.7%	89.0%	1364	1336	1364	1386	97.9%	101.6%	6.4	5.7			3	5	4.5	0
WARD 21	1534.5	1325.5	1534.5	1428	86.4%	93.1%	1069.5	954.5	1069.5	1059	89.2%	99.0%	8.8	8.0			0	5	7.15	2
ICU	4030	3847.5	821.5	590	95.5%	71.8%	4278	3983.5	0	57.5	93.1%	-	40.0	37.2			3	0	3.77	0
WARD 3	945.5	891.3	761.5	724	94.3%	95.1%	713	720.5	356.5	364	101.1%	102.1%	6.3	6.1			3	2	0.46	1.59
WARD 8AB	1068	833.5	964	692.5	78.0%	71.8%	977.5	654	264.5	552	66.9%	208.7%	11.0	9.2			1	3	2.57	0
WARD 8D	821.5	804	821.5	774	97.9%	94.2%	713	668.5	0	448.5	93.8%	-	6.3	7.2			0	1	1.87	0
WARD 10	1302	1091	761.5	953	83.8%	125.1%	1069.5	724.5	356.5	724.5	67.7%	203.2%	6.0	6.0			0	3	7.81	0
WARD 11	1485	1653	1260	1335	111.3%	106.0%	1035	1042	345	803.5	100.7%	232.9%	5.5	6.4			1	4	2.66	0
WARD 19	1643	1322	1178	1463.5	80.5%	124.2%	1069.5	1053.5	1069.5	1340.5	98.5%	125.3%	7.7	8.0			2	5	1.92	0
WARD 22	1178	1133.5	1178	1302.4	96.2%	110.6%	713	736	713	1045.5	103.2%	146.6%	5.6	6.2			1	2	1.55	2
SAU HRI	1891	1633.5	977.5	906	86.4%	92.7%	1380	1368.5	345	414	99.2%	120.0%	9.8	9.2			3	0	4.27	0
WARD LDRP	4278	3881	945.5	711	90.7%	75.2%	4278	3698.5	713	575	86.5%	80.6%	21.1	18.3			0	1	0	5.48
WARD NICU	2102.5	1821.5	870	352.5	86.6%	40.5%	2070	1771	690	529	85.6%	76.7%	11.0	8.6			0	0	0.86	2.5
WARD 1D	1242	1138.5	356.5	375.5	91.7%	105.3%	713	713	356.5	333.5	100.0%	93.5%	4.6	4.4			0	0	1.72	0
WARD 3ABCD	3140.5	3014	1208	926	96.0%	76.7%	2495.5	2583.5	356.5	369.1	103.5%	103.5%	8.1	7.8			0	1	0	3.5
WARD 4C	713	713	465	430	100.0%	92.5%	713	922	356.5	356.5	129.3%	100.0%	7.9	8.5			0	1	3	3.46
WARD 9	1069.5	900	356.5	325.5	84.2%	91.3%	713	713	356.5	352	100.0%	98.7%	5.2	4.8			0	0	2.14	0.57
WARD 18	793.5	704.5	138	81.5	88.8%	59.1%	713	660.5	0	0	92.6%	-	32.9	28.9			0	0	0	0
Trust	**59357.5**	**51796.45**	**37834**	**36605.9**	**87.26%**	**96.75%**	**45723.5**	**42775**	**21263.5**	**25711.1**	**93.55%**	**120.92%**	**8.0**	**7.6**						

Hard Truths: Safe Staffing Levels (3)

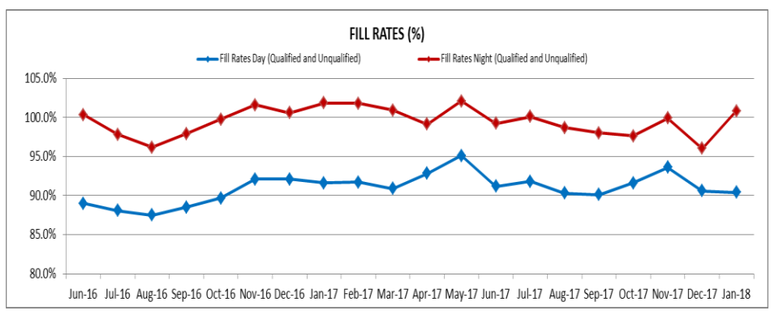
Care Hours per Patient Day

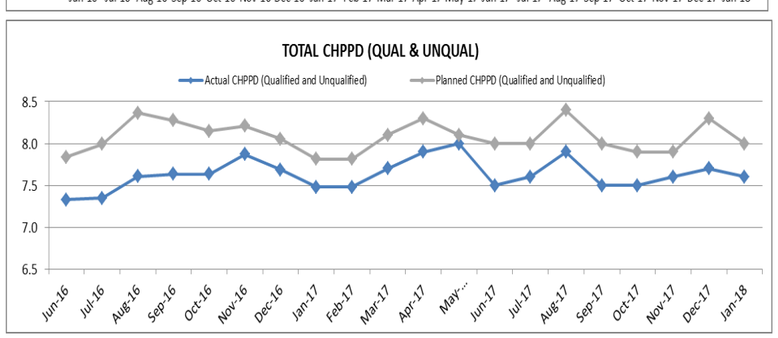
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Nov-17	Dec-17	**Jan-18**
Fill Rates Day (Qualified and Unqualified)	93.60%	90.61%	90.96%
Fill Rates Night (Qualified and Unqualified)	99.90%	96.04%	102.24%

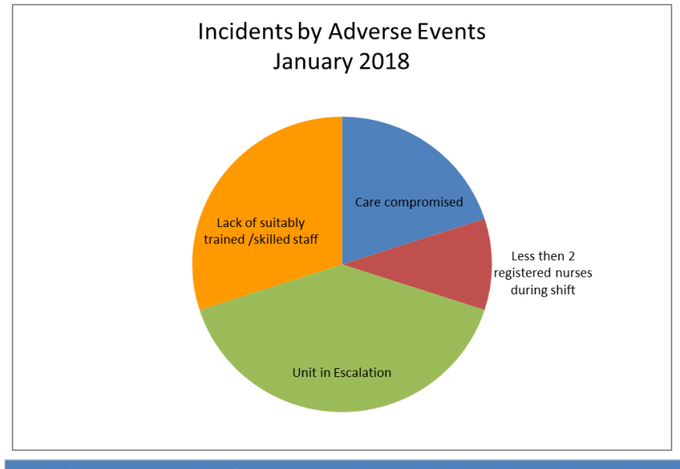
Planned CHPPD (Qualified and Unqualified)	7.9	8.3	8.0
Actual CHPPD (Qualified and Unqualified)	7.6	7.7	7.6

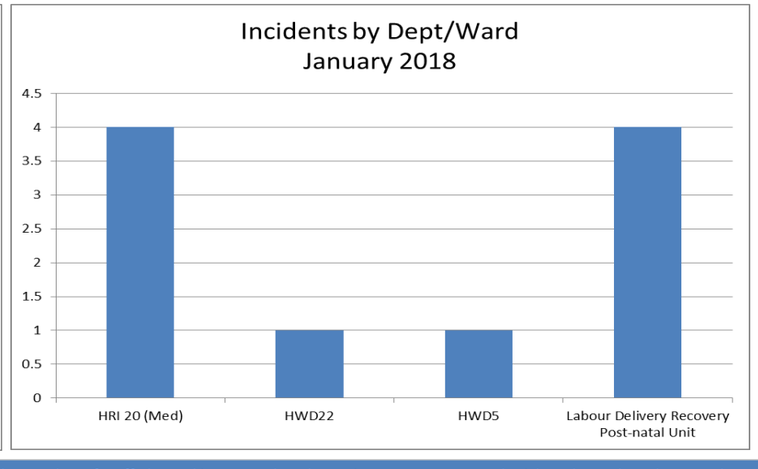
A review of January CHPPD data indicates that the combined (RN and carer staff) metric resulted in 25 clinical areas of the 37 reviewed had CHPPD less than planned. 2 areas reported CHPPD as planned. 10 areas reported CHPPD slightly in excess of those planned. Areas with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correc t but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through Datix. These are monitored daily b y the divisions and review monthly through the Nursing workforce strategy group.

There were **10 Trust Wide Red shifts** declared in **January**. Four reported within the medical division were concentrated to ward 20HRI. The incidents have been recorded as "compromised care" . This area has a lower than planned CHPPD level for the reported period. The low staffing level have been compounded by additi onal bed capacity open to support winter pressures, the deployment of the nursing workforce to manage this and the re-configuration of medical services

To support the unit whilst the new models of working are embedded and to review the quality impact - Bi-weekly touchpoints with the senior corporate and divisional nursing teams have been facilitated. HCA Posts generated as a result of reconfiguration of services have now been recruited to and going forword the staffing position should improve.

There have been 4 level 1, unit in escalation datix reports raised in the reporting period from the FSS division. These have been managed through the escalation process with no impact on care delivery. reported.

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 becomme established in the workforce numbers. Focused recruitment continue for this specific area.

2. Further recruitment event planned for March 2018.

3. Applications from international recruitment projects are progressing well and the first 3 nurses have arrived in Trust, with a further 9 planned for deployment in Feburary/March 2018

4.A review of the English language requirements to gain entry onto the register has been completed following announcements from the NMC that they would also accept the OET qualification. The Trust is to work with the recruitment agent to transfer current candidates onto this assessment process with the aim being to expediate deployment to the UK.

5. CHFT is a fast follower pilot for the Nursing Associate (NA) role and has 5 NA who started in post in April 2017. A proposal has been developed to up-scale the project in line with the national and regional workforce plans. It is hoped that a second cohort could be in training by Spring 2018.

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

7. 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.

8. A new module of E roster called safecare 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, 1st March 2018	**Sponsoring Director:** Gary Boothby, Executive Director of Finance
Title and brief summary: Financial Commentary for NHS Improvement - Month 10 - The attached commentary was submitted to NHS Improvement on the 15th of Feb 2018 alongside the Month 10 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 10 Final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 10 JANUARY 2018, NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

The notes below provide a management commentary on the financial position of Calderdale & Huddersfield NHS Foundation Trust at the end of January 2018.

The report is structured into three sections to describe:

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

1. Key Messages

The Month 10 position is a year to date deficit of £30.81m. On a control total basis this is an adverse variance from plan of £8.70m; excluding the impact of loss of Sustainability and Transformation funding (STF) of £5.04m that has been lost based on Q1 and 2 A&E performance and financial performance in Months 7-10. When loss of STF funding is included, the total adverse variance is £13.74m compared with a control total of £17.00m.

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.

As discussed with NHSI in recent Financial Recovery meetings, it is now clear that these concerns were well founded. Indeed, 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, including a £4.2m negotiated settlement with the PFI facilities management provider in support of CIP delivery, non recurrent income and release of prior year accruals and £1.9m associated with the set up of the Estates SPV. This is in addition to the release in the year to date of the full £2m contingency reserve available for this financial year.

Since Month 7 the Trust has been unable to deliver the financial plan reporting a year to date adverse variance of £8.70m of which £3.15m related to Month 10. 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 £9.5m year to date.

As reported in 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.

Month 10, January Position (Year to date)

The year to date position at headline level is illustrated below:

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	311.54	295.94	(15.60)
Expenditure	(307.56)	(305.63)	1.93
EBITDA	**3.98**	**(9.69)**	**(13.67)**
Non-Operating items	(34.90)	(21.12)	13.78
Surplus / (Deficit)	**(30.92)**	**(30.81)**	**0.11**
Less: Items excluded from Control Total	13.92	0.06	(13.86)
Less: Loss of STF funding	0.00	5.04	5.04
Surplus / (Deficit) Control Total basis	**(17.00)**	**(25.70)**	**(8.70)**

- Delivery of CIP of £13.12m against the planned level of £13.69m.
- Contingency reserves of £2.00m have been released against pressures.
- Capital expenditure of £10.14m, this is below the planned level of £13.65m.
- Cash balance of £1.92m against a plan of £1.90m.
- Use of Resources score of level 3, in line with the plan.
- Month 10 reported position is £0.61m better than forecast in Month 9.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

Operating Income

Operating Income is £15.60m below plan year to date.

NHS Clinical Income

The year to date NHS Clinical income position is £261.17m, £16.87m below the planned level.

The Clinical Contract income position for Month 10 is £9.54m below plan. There remain a number of areas where activity is either not captured within EPR or a change to patient data is required in order to accurately price the activity. However, an agreement in principle has been reached with Commissioners to secure the income position for both the year to date and forecast, which does provide a level of certainty.

The adverse variance is largely driven by both case mix and activity volumes due to a reduction in productivity following the implementation of EPR, in particular impacting on Outpatient, Daycase and Elective activity. The impact of EPR on income is calculated to be £5.3m in the year to date. The Trust has also seen an adverse variance due to HRG4+ Tariff changes, assessed to be in the region of £1.0m year to date and beyond the control of the Trust.

Direct Access, Maternity pathway, Adult Critical Care and NICU income which naturally fluctuate are all below plan with a combined impact of £0.47m and there has also been a reduction in income from Bowel Scope and Bowel Cancer screening following the Endoscopy fire earlier in the year. This is offset in Other

Income by an assumed insurance settlement that is yet to be finalised, and bears an element of risk. The cancellation of Elective and Daycase procedures due to winter pressures during January has resulted in the loss of income, offset to some extent by higher than planned Non Elective income. The net impact on income is assessed to be around £0.7m.

In addition, there is an adverse variance of £7.34m on NHS Clinical income that is outside of contract, of which £5.04m relates to the loss of Sustainability and Transformation funding, with the remaining variance due to lower than planned Cancer Drugs and Hep C drugs income of £1.9m (offset within High Cost Drugs expenditure) and a number of other smaller variances, offset by non-recurrent Accelerator zone funding of £0.77m and a non recurrent benefit of £0.95m following a comprehensive review of all prior year accruals.

The year to date reported position includes the loss of the £4.20m planned STF funding for Months 7 to 10 due to failure to achieve the planned financial performance, plus £0.84m for Quarters 1 and 2 linked to the A&E 4 hour performance target. A&E performance in Month 10 remained below trajectory at 90.80%.

Other income

Overall other income is above plan by £1.27m year to date. Increased sales activity within our commercial operations, in particular the Pharmacy Manufacturing Unit (£1.3m) and Health Informatics Service (£0.3m), and assumed income for the Endoscopy fire insurance claim, have been offset to some extent by slippage in recovery of the Apprentice Levy of £0.4m compared to plan and lower than planned Car Parking income of £0.6m.

Operating expenditure

There is a cumulative £1.93m favourable variance from plan within operating expenditure across the following areas:

Pay costs	£2.13m adverse variance
Drugs costs	£0.02m favourable variance
Clinical supply and other costs	£4.04m favourable variance

The year to date position includes the benefit to pay of releasing unspent all of our £2.00m Contingency Reserve and a number of non-recurrent benefits including: a £3.5m credit relating to a negotiated non-recurrent refund of PFI facilities management costs, non-recurrent benefits of £0.82m relating to prior year creditors, £1.52m of prior year benefits following a full review of accruals, (£0.95m income and £0.91m expenditure), the release of £0.38m of Provisions and non-recurrent income of £0.97m. The total of non-recurrent benefits in the year to date position is £7.53m.

Employee benefits expenses (Pay costs)

Pay costs are £2.13m higher than the planned level in the year to date, despite the release of Contingency Reserves of £2.00m and non recurrent benefits of £0.82m. Excluding these items and other material variances with an equal and opposite impact on Income, the underlying pressure on pay expenditure is around £4.7m. There are a number of cost drivers including the impact on Nursing pay of opening additional unplanned capacity, winter pressures, undelivered CIP and some higher than planned costs linked to EPR of up to £1m.

The Trust has seen a reduction in Agency costs compared to those reported in 16/17, particularly in Medical Staffing, where IR 35 has resulted in number of doctors transferring onto the payroll, although in some cases this has not resulted in a reduction in cost. However, nursing agency costs are higher than planned in part due to the demand from additional capacity, winter pressures and the requirements of one to one care and in part due to high agency premiums. The Trust is working with suppliers to reduce average agency rates and has implemented a number of measures to increase Bank availability including an increase in the rates offered and the option of weekly pay.

The Trust achieved the agency ceiling of £14.14m year to date, with total Agency expenditure of £13.38m.

Drug costs

Expenditure year to date on drugs is £0.02m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £2.21m below plan, offset by additional costs of £1.76m due to increased activity within the Pharmacy Manufacturing unit, (higher than planned sales are also generating additional income). Underlying drug budgets are therefore overspent by £0.47m.

Clinical supply and other costs

Clinical Support costs are £3.55m lower than planned. This underspend reflects an activity related underspend in clinical supplies of £2.73m, as well as a non-recurrent benefit of £0.82m relating to prior year creditors as described above.

Other costs are £0.49m lower than planned although this includes the £3.5m non recurrent benefit mentioned above and the release of £0.38m of provisions. Net of some profiling differences on CIP and higher cost of sales within commercial operations, the underlying cost pressure is £2.3m linked to EPR costs (£0.3m), diagnostic pressures, RPI inflationary pressures and higher than planned equipment maintenance costs.

Non-operating Items and Restructuring Costs

Non-operating expenditure is £13.78m lower than plan in the year to date. This variance includes the impact of the delay of a planned £14m impairment that is now forecast to be accounted for later in the year. The Trust has also seen higher than planned Depreciation of £0.27m following year end asset revaluations and an increase in PFI Contingent Rent due to March's high level of RPI on which the PFI contract uplift is based.

Cost Improvement Programme (CIP) delivery

In December 2016, the control total for 2017/18 of £15.9m was accepted, which drove the need for a challenging £17m (4.5%) CIP. At that point, the Trust had not agreed the two year 2017 – 2019 contract with its main commissioners. The successful resolution of the contractual position contributed to a further £3m challenge to the Trust's financial position as a result of a compromise reached. The revised income plans drove the need for a further £3m of efficiency savings, bringing the total CIP to £20m (5.3%), a position which has proved to be extremely challenging.

£13.12m of CIP has been delivered this year against a plan of £13.69m, an under performance of £0.57m. This position includes non-recurrent CIP of £3.5m relating to the refund of PFI facilities management costs mentioned above. The Trust is forecasting to deliver £17.95m of savings, including further non- recurrent savings of £1.9m linked to a project to launch a Special Purpose Vehicle for Estates. The reported forecast assumes that the full £17.95m will be delivered, but this remains challenging with a number of schemes still flagged as high risk.

It is also worth highlighting that almost half of the identified savings for this financial year are non-recurrent in nature and therefore do not improve our underlying operating position moving into 2018/19.

Statement of Financial Position and Cash Flow

At the end of January 2018 the Trust had a cash balance of £1.92m, just above the planned level of £1.90m.

The key cash flow variances for the year to date compared to plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	0.11
	Non cash flows in operating deficit	(13.60)
	Other working capital movements	(0.44)
	Sub Total	**(13.92)**
Investing activities	Capital expenditure	3.53
	Movement in capital creditors / Other	(1.83)
	Sub Total	**1.70**
Financing activities	Net drawdown of external DoH cash support	13.27
	Other financing activities	(1.08)
	Sub Total	**12.19**
	Grand Total	**(0.03)**

Operating activities

Operating activities show an adverse variance of £13.92m variance against the plan. This reflects the impact of the I&E variance of £8.70m and loss of £5.04m STF funding, plus the adverse cash impact of £0.44m working capital variances less the cash benefit of higher than planned Depreciation charges. Both the deficit and non-cash flows figures should be considered net of a £14m planned impairment which will now take place later in the year. The adverse working capital variance is driven by: a reduction in the level of creditors of £3.20m; an increase in inventory values of £0.19m; offset by higher than planned deferred income of £2.68m due to the under-trade on some commissioner contracts which are paid upfront based on contract values and a slight reduction in the level of debtors. The Trust has been able to reduce previously spiralling levels of Creditors, particular longer term outstanding debts, following the receipt of a Department of Health working capital loan in November.

Investing activities (Capital)

Capital expenditure year to date is £3.53m lower than planned and the resulting cash benefit has offset the pressure on working capital described above and a reduction in Capital creditors due to the payment of EPR related invoices that were accounted for in the 16/17 capital programme.

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 £28.4m of Revenue Support linked to deficit and STF funding requirements and a further £5.70m of working capital support. This is £13.27m more than planned: £11.37m linked to additional deficit funding requirements and working capital support that is £1.91m higher than planned.

3. Use of Resources (UOR) rating and forecast

Against the UOR the Trust stands at level 3 in line with plan in year to date and forecast terms.

The reported forecast is a year-end deficit of £31.34m (excluding £13.91m technical adjustments that are excluded from Control Total), an adverse variance of £15.40m. This variance incorporates two elements: the gap to control total which is forecast to be £8.00m and the loss of Sustainability and Transformation Funding (STF) of £7.40m. The £8.00m gap remains unchanged from the position reported at the end of Quarter 3 and is contingent upon a number of elements:

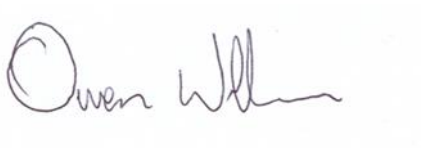
- This forecast position continues to rely upon £1.9m of winter funding (£1.0m of which is contingent upon delivery of the agreed forecast); and £1.0m additional capital expenditure, both of which the Trust has been assured are supported by NHSI.

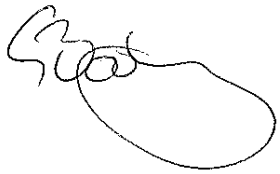
- In addition, the forecast assumes a £1.9m benefit (plus £0.7m associated reduction in technical finance charges) from the set-up of the SPV in-year; and £4.2m from the negotiated settlement with ISS which relies upon finalisation of contract agreements. These benefits are non-recurrent in nature and do not therefore address the underlying deficit position that will be carried forward into the next financial year.

- A year end settlement has been agreed in principle with the two main local commissioners which removes a level of risk around securing CQUIN and winter funding in year.

- The forecast assumes delivery of recovery plans previously identified and the delivery of all forecast CIP and QUIPP schemes.

These internal actions sit alongside a programme of system wide recovery that is being developed in partnership with commissioners with a view to minimising the overall local health system gap to plans. The mobilisation time required to implement a number of these wider health economy plans as well as the transformational internal schemes means that delivery is most likely to span the two year planning timeframe of 2017-2019.





Owen Williams
Chief Executive

Gary Boothby
Executive Director of Finance

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 1st March 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 – minutes of 29.1.18 and verbal update from meeting 26.2.18
Finance and Performance Committee – minutes of 30.1.18 and verbal update from meeting 23.2.18
Workforce Well Led Committee – minutes from meeting 14.2.18
Audit and Risk Committee – minutes from meeting held 24.1.18
Council of Governors - minutes of meeting 23.1.18

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 – minutes of 29.1.18 and verbal update from meeting 26.2.18
Finance and Performance Committee – minutes of 30.1.18 and verbal update from meeting 23.2.18
Workforce Well Led Committee – minutes from meeting 14.2.18
Audit and Risk Committee – minutes from meeting held 24.1.18
Council of Governors - minutes of meeting 23.1.18

Appendix

Attachment:

COMBINED SUB CTTEES MINS AND PAPERS.pdf

QUALITY COMMITTEE

Monday, 29th January 2018
Acre Mill Room 3, Huddersfield Royal Infirmary

019/18 WELCOME AND INTRODUCTIONS

Present

Dr David Anderson **(DA)**	Non-Executive Director **(Chair)**
Helen Barker **(HB)**	Chief Operating Officer
Dr David Birkenhead **(DB)**	Medical Director
Brendan Brown **(BB)**	Chief Nurse
Alistair Graham **(AG)**	Non-Executive Director
Lesley Hill **(LH)**	Director of Planning, Performance, Estates and Facilities
Andrea McCourt **(AMcC)**	Head of Governance and Risk
Lynn Moore **(LM)**	Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In Attendance

Ayesha Marshall **(AM)**	Lead TV Nurse **(for item 023/18a)**
Joanne Middleton **(JM)**	Associate Director of Nursing – Surgery **(for item 023/18c)**
Kristina Rutherford **(KR)**	Director of Operations – Corporate **(for item 026/18)**
Hannah Smith **(HS)**	Community Practitioner – Child Protection **(for item 023/18b)**

020/18 APOLOGIES

Dr Linda Patterson	Non-Executive Director
Juliette Cosgrove	Assistant Director of Quality and Safety
Paul Butterworth	Governor

021/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

022/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 3rd January 2018 were approved as a correct record, with the exception that:

- the following is added to item 006/18 on the Serious Incident Report:

  'The standard of record keeping and communication was also a theme in the analysis of serious case reviews'

- the following is added to item 008/18 within the Health and Safety Report regarding water jugs:

  'Clarification needed that improvement in the process where patients who are 'nil by mouth' are clearly identified by clinical staff, so that it is obvious to all who should not be given jugs of water or food'

OUTCOME: That the minutes of the meeting are approved as a correct record subject to the above amendment.

023/18 ACTION LOG AND MATTERS ARISING

A copy of the action log (appendix B) can be found at the end of the minutes.

(a) Pressure Ulcer Update

AM was in attendance to give an update on pressure ulcers. The report (appendix C), which was previously presented at the Patient Safety Group, summarised incidents reported via Datix in the period of August, September and October 2017.

Reality

- Increasing tissue viability referrals (August – 188; September – 175; October – 192; November - 243) – trying to find cause for increase in November
- Moisture lesions, also known as Incontinence Associated Dermatitis (IAD), which can then evolve into pressure ulcers are increasing, however, under-reporting has been noted. During November, there were 21.
- Pressure Ulcers also increasing, with 99 incidents reported (13 attributes as green no harm incidents, 69 were yellow low harm incidents, 16 were orange moderate harm incidents and one red serious harm incident).
- The highest incidence of pressure ulcers is in the medical division
- Medical device related pressure ulcers were also summarised, with 12 in total.
- There was one serious incident report submitted to commissioners during August to October 2017, the case summary of which was part of the report.

Response

- Improvements made - skin inspection has improved in the Emergency Department, which is being done when patients have been admitted; new Pippa board magnets - a visual reminder for patients who need 2 hourly and 4 hourly intentional rounding have been developed by orthopaedic ward sisters and working well, and all target wards have identified TVLIPS (Tissue Viability Link Practitioners). There have also been no category 3 or 4 pressure ulcers during December 2017.
- Work is ongoing with manual handling advisors around the use of slide sheets that may cause shearing and skin damage, and work is ongoing with Community specialists around the high number of continence lesions that have advanced into pressure ulcers. Investigations are being proposed to see if there is a history of incontinence, looking at risk factors and exploring the effectiveness of safety huddles. Further work is also taking place with local authorities and Clinical Commissioning Groups regarding the safeguarding process.

Discussion ensued on the factual review of pressure ulcers, and it was stated that this programme of education has developed a highly visible team to support frontline colleagues, producing innovative ideas and meaningful information for patients.

OUTCOME: The Quality Committee were assured of the pressure ulcer approach and thanked Ayesha for her update.

(b) Looked after children's service model

HS was in attendance to give an update on the recently agreed proposal to increase the staffing levels of the Children Looked After (CLA) health service in Calderdale (appendix D).

Following CQC inspection in April 2016, the service was identified to be under-resourced, in particular providing care leavers with health summary passports. Agreement has now been reached with commissioners to approve a new service specification to increase the staffing resource within the service. The proposed model shown in the report will provide resources to issue a backlog of care leaver passports over a three-year period commencing from 1st March 2018 and additional agreement for looked after children to be offered services within a 50 mile radius. Discussion ensued on the period that care leavers will be assessed, and it was stated that statutory health assessment means that all factors that will impact on health, from birth, will be captured and monitored in the passport. It was stated that the new service model and improvement to users could not have been done without the resources of partner organisations.

OUTCOME: The Quality Committee noted the improvements and thanked Hannah for her update

(c) Nasogastric tube training

JM was in attendance to give a verbal update on compliance with nasogastric tube training. The training package has been reviewed and compliant with the National Patient Safety Alert (NPSA) guidance. High-use areas for nasogastric tubes are targeted to above 75% with compliance and all areas now above 75% and some at 100%.

Reality

Work is ongoing with an e-learning package which has now been uploaded onto the essential skills framework. The package is aimed at any colleague responsible for initial placement check of nasogastric tubes through to interpretation of x-rays and is one-off training. Monitoring of this and training compliance is reported to the Clinical Outcomes Group.

More recently, patients with nasogastric feeds across more areas than the identified high-use areas are being noted. The knowledge input on low-use areas is also being reviewed, by looking at accessing simulation training as access to patients is limited on those areas.

Discussion ensued on the status of a nasogastric tube related risk on the high-level risk register with a target date for February 2018. It was stated that the risk is to be revised and refreshed for early February.

Response

Discussion also took place on the challenges with junior doctors and how to recognise nasogastric training done at other Trusts. It was stated if training cannot be evidenced, then the procedure should not be taking place, and there was an imperative for training to be completed among the medical workforce and for there to be a cohort of nurses with appropriate skills at ward level. It was recommended that work is done with Sue Burton (Medical Education Manager) regarding the entry competence of new junior doctors, and that a bi-annual update on nasogastric tubes is presented to the Committee. DB confirmed there would need to be a nominated medical lead for this agenda.

OUTCOME: The Quality Committee noted and approved the recommendations and would review progress 6 monthly and consider its future position on risk register and thanked Joanne for her update.

024/18 TERMS OF REFERENCE REVIEW

The terms of reference (appendix E) were reviewed with the following changes made:

- Include Director of Workforce and OD onto membership list
- Include 1 Governor or deputy onto membership list

Discussion ensued on the availability of Divisional Directors to attend these meetings, and it was stated that there needs to be clear consistency for attendance. It was recommended that Divisional Directors should attend 3-monthly and provide input while their division is discussed, but their attendance at the full meeting would not be required.

Discussion also ensued on the templates used for reporting, and it was suggested that one template is used for both the Quality Committee and the Performance Review Meetings.

ACTION: Terms of Reference to return to the next meeting with revisions

025/18 CQC REPORT

KR presented appendix F1 which describes the current activity ahead of inspection and the content of the well-led action plan. The report also summarised the process for the Trust and core service plans, relationship meetings with local inspection teams, which will form part of the inspection reviews and details of well-led reports from other Trusts, under the new inspection regime. These will be reviewed on a regular basis and shared across the organisation.

A well-led action plan (appendix F2) has been developed and progress will be overseen by the CQC Preparation Group and will be included in monthly reports to the Quality Committee, as well as the key areas of risk. Alongside the action plan, there will be a number of opportunities for colleagues to be supported to prepare for the well-led inspection via development days and coaching sessions, and the availability of a learning document (appendix F3) which covers all the actions that the CQC told the Trust it must / should take. This has been developed with action leads and will be shared widely across the Trust.

Discussion ensued on the potential message both pre- and post-Electronic Patient Record (EPR) and the positive changes that can be highlighted in the well-led inspection.

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

026/18 SERIOUS INCIDENT REPORT

AMcC presented appendix G summarising the six new serious incidents and the 10 completed serious incident reports submitted to commissioners in December 2017.

Six new incidents include:
- 1 unplanned transfer to the Specialist Baby Care Unit
- 1 allegation of sexual assault
- 1 failure to act on adverse test result
- 1 infection
- 1 fall and
- 1 pressure ulcer

The report includes case summaries for the 10 completed serious incident reports:

- 2 assessment failures
- 3 appointment/referral delays
- 2 falls
- 1 12-hour breach, and
- 2 medication incidents

Discussion ensued on the root cause for incident 147968, which may need to be revised.
ACTION: AMcC to revisit incident 147968 and feedback to HB outside of the meeting.

AMcC stated that a brief paper will be presented at the next meeting giving assurance that actions from completed serious incident reports have been implemented.

OUTCOME: The Quality Committee received and noted the content of the report and would review the assurance paper regarding actions

027/18 HIGH LEVEL RISK REGISTER

AMcC presented appendix H summarising the high-level risks as at 22nd January 2018.

- 11 top risks scored at 25 or 20 remain since the last report.
- One risk with a reduced score (4783) due to sustained improvements in the mortality reported levels. This will be monitored by the Risk and Compliance Group.

- One new risk (6949) regarding delivery of the blood transfusion service.
- Discussion ensued on risk 7147 relating to Electronic Patient Record (EPR) finance risk within the Medical division. An explanation was sought as to why the risk was discussed at the Risk and Compliance Group and not at the Performance Review Meeting. It was suggested that this is followed up outside the meeting, before submission to the Board of Directors.

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

028/18 HEALTH AND SAFETY COMMITTEE REPORT

LH presented appendix I which summarised key points from the Health and Safety Committee meeting held on 17th January 2018:

- Transporting Patients using Oxygen - The Transportation of Patients policy is under review and will contain details regarding patients being accompanied whilst using Oxygen.
- Datix Incident Reporting - Meeting arranged to promote and raise awareness of incident reporting on Datix, including security issues and abuse issues
- Health & Safety Training - Risk assessment training for Managers and Supervisors will roll out in April 2018. 1-hour training slots will be available, and this will include Reporting injuries, diseases and dangerous occurrences regulations (RIDDOR)

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

029/18 CLINICAL OUTCOMES GROUP AND MORTALITY SURVEILLANCE GROUP REPORTS

DB presented appendices J1 and J2 summarising the Clinical Outcomes Group and Mortality Surveillance Group reports respectively.

- Clinical Outcomes Group meeting held on 18th December 2017 highlighted:
  - Organ Donation update - The Trust is in a positive position for organ donation with three solid organ donors proceeding to donation, resulting in eight patients receiving transplants in the first six months of the financial year.
  - Sepsis – The Sepsis Collaborative Group has reformed and will work through the ABC (achieving behavioural change) sepsis action plan and include improvement work to increase compliance with the sepsis recognition, response and CQUIN measures. It was noted that the Emergency Department (ED) screening has dropped significantly to around 47%. Representatives from ED and Acute Medicine are due to attend the next meeting to give assurance that this is being improved.
  - Surgical Site Infection (SSI) – It was discussed that each surgical speciality should collect data on SSIs as part of the audit programme.

- Mortality Surveillance Group meeting held on 12th January 2018 highlighted:
  - Learning from Death (LfD) – screening review performance is at 27.5%, and there are now eight trained reviewers who have time in job plans to carry out reviews.
  - Stillbirths and perinatal deaths – a quarterly report was presented showing a sustained reduction in stillbirths since 2011.

OUTCOME: The Quality Committee received and noted the content of the report and that Representatives from ED and Acute Medicine will attend the next meeting to give assurance re the Sepsis Action Plan

030/18 QUALITY AND PERFORMANCE REPORT

HB presented appendix K summarising December's performance score which has deteriorated by 8 percentage points to 54%. All domains have deteriorated in-month. The caring domain has dropped significantly due to Friends and Family Test (FFT) inpatient survey 'would recommend' and both Community FFT indicators missing target. The effective domain has moved to amber with a couple of failings in Infection Control plus fractured neck of femur (#NOF) target. The responsive domain is still amber and on a positive note, has maintained its cancer performance across all metrics, however all four stroke targets are now underperforming. Efficiency and finance have improved with Day Cases and Accident and Emergency activity achieving target in-month, however agency expenditure and capital both deteriorated to red in-month. Workforce has deteriorated further with all five mandatory training focus areas missing target and a decline in sickness absence performance.

- Most improved areas – No category four pressure ulcers for six out of the last seven months; all key cancer targets maintained for the second consecutive month and percentage sign and symptom as a primary diagnosis is just above the 9% target.
- Most deteriorated areas – Emergency Care Standard (ECS) 4 hours and stroke patients scanned within one hour of hospital arrival.
- Safe – Work still ongoing to improve the timeliness of investigation reports; % harm free care is running just below the 95% target at 93.45%
- Caring – the performance of percentage of complaints closed within timeframe is expected to be back on track from quarter 4

Discussion ensued on why complaints are not being closed within target timeframe, and whether this could be tracked. It was stated that this could be tracked; however, delays could be due to information being awaited from other trusts. There is an aim to close as many complaints by 6th February 2018.

Discussion also took place around mandatory training. It was stated that a detailed conversation has taken place at Executive Board, and this will be followed up at Performance Review Meetings. Letters will be sent to individuals who have not completed any of the five mandatory training elements, as well as individuals who are non-compliant or due to be non-compliant in one or more of the elements. Mandatory training is being overseen by the Workforce Committee.

As well as reviewing the performance of December 2017, the quality aspects of performance going through to the end of the Quarter were considered to target areas for improvement.

OUTCOME: The Quality Committee received and noted the content of the report and welcomed the focus on quality and forward look on performance.

031/18 RESEARCH AND DEVELOPMENT REPORT

DB presented appendix L which provides a six-month update on research and development activity since the last report in July 2017.

Recruitment activity to the end of quarter 3 was achieved - 1149 against a target of 1473, and a policy on the income distribution model for commercial research as well as a paper on commercial research was ratified by the Weekly Executive Board. The paper outlined a case for supporting the development and increase for greater commercial research within the Trust. A business case for this will be taken forward in the Spring.

Discussion ensued on the reliance of oncology and haematology study trials, and the need for medical Principal Investigators, therapy research and research into midwifery.

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

032/18 INFECTION CONTROL COMMITTEE UPDATE

The minutes of the Infection Control Committee (appendix M) were reviewed and it was stated that the Infection Control Committee are fulfilling their function and managing infection control through this and other meetings. Sharps injuries are to be reviewed in more detail by a new needle stick injury group and concerns were raised regarding the lack of Primary Care Infection Control resources in Calderdale and how the Trust interfaces and manages patients in Calderdale. It was stated that this will be monitored by the Infection Control Committee.

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

033/18 ANY OTHER BUSINESS

There was no other business.

034/18 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Work done on pressure ulcers
- Update given on new model of care for Looked after Children
- Performance Report – how to improve on quality markers to the end of the quarter
- Issue with mandatory training
- Update on CQC preparation and the communications that will be circulated across the Trust.

035/18 EVALUATION OF MEETING

The Quality Committee discussed the effectiveness of the meeting as well chaired.

036/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix N) was accepted.

NEXT MEETING

Monday, 26th February 2018
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

This meeting will include the Q3 reports from the Patient Safety and Quality Board meetings. Representatives from divisions are expected to be in attendance

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Tuesday 30 January, at 9am Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Gary Boothby	Executive 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
Andrew Haigh	Chair of the Trust
Peter Keogh	Head of Performance
Brian Moore	Lead Governor (Observer)
Victoria Pickles	Company Secretary (Minutes)

ITEM

019/18 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

020/18 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Anna Basford, Director of Transformation and Partnerships

021/18 DECLARATIONS OF INTEREST

There were no declarations of interest.

022/18 MINUTES OF THE MEETING HELD 2 JANUARY 2017

The Committee approved the minutes of the meeting held 2 January 2018 as an accurate record.

023/18 MATTERS ARISING AND ACTION LOG

The action log was reviewed all items due for discussion were on the agenda.

02/01/18 It was confirmed that these actions had been completed and that Board had authority to make the decision regarding the Wholly Owned Subsidiary.

024/18 INTEGRATED PERFORMANCE DEEP-DIVE

The Head of Performance gave a presentation on where areas of focus should be to improve overall performance for the Trust.

It was noted that performance in November 2016 was 5 percentage points (32 points) better than in November 2017. The main areas of deterioration were mandatory training, finance and activity. It was noted that mandatory training has quite an impact on the overall score due to its weighting. In year there have been improvements in performance against sickness absence and HSMR. It is likely that

SHMI will also fall below 100 at the next reporting period.
The Head of Performance explained that he had looked at the best case and most likely case for year-end performance. It was noted that there are 110 indicators but that six of these have heavier weighting and could have a significant impact on the overall performance of the Trust.

Discussion took place around this weighting of indicators. The majority of indicators under caring are heavily weighted.

For the responsive section of the report the following areas were discussed:

- Green cross – it was highlighted that this target should be reviewed as a lot of work has been done and the time that patients wait has significantly reduced.
- Stroke – while the Trust performs well for those patients who present with a stroke. The issue is where a patient presents with a neurological disorder and is then diagnosed as stroke which impacts on the achievement of target. There is a process in place for ruling out stroke for these patients early on which should have a real impact on patient experience and achievement of the target.
- 62 day cancer – there will need to be a real focus on this to achieve the target by the year end. It was noted that for some specialties there are small numbers of patients which can have a significant impact on achievement of the target. The Chief Operating officer explained that the Trust was setting up a cancer forum to help with the achievement of all the cancer targets and improved patient experience
- Workforce – Among the mandatory training targets manual handling remains a challenge as there wasn't sufficient capacity to provide the training to all of those who need it. It was noted that mandatory training remains an area of focus at the divisional Performance Review Meetings and a letter had been sent to every member of staff who have not completed their five mandatory training modules. This will be linked to pay progression. Divisions that are not making progress had been asked to present to Workforce Well Led Committee. The Chief Operating Officer highlighted that junior doctors are a particular challenge and this is being picked up with the postgrad department and nationally a junior doctor training passport is being considered.
- Finance – The capital position was discussed and the Executive Director of Finance confirmed that a tracker is in place to ensure all of the committed capital for 2017/18 is spent.
- Activity – The Chief Operating Officer highlighted that there was further work required to consider the metrics for non-elective activity so that it is aligned to the wider system.

The Committee agreed that a number of areas had been discussed which could potentially be changed in the performance reporting for 2018/19. It was agreed to have a wider Board discussion on the targets to be set for 2018/19, using refreshed benchmarking and how this fits with the Trust's underlying financial deficit position.

ACTION: Board time to be allocated to undertaking this work – HB / VP

The Committee welcomed the discussion on performance metrics and **RECEIVED** the deep dive report.

025/18 MONTH 09 FINANCE REPORT

The Deputy Director of Finance reported that year to date at month 9 the Trust has a deficit of £26.3M which is £9.4M away from plan. The reasons for this are being below the planned activity; pressures in pay; and slippage in CIP. It was noted that due to the deficit being away from plan the Trust will lose its STF funding.

Richard Hopkin asked about learning for financial planning in the future. The Executive Director of Finance explained that every year there is learning in relation to budget setting and planning however the challenge is in describing the underlying pressures as some of this is non-recurrent. He added that there needs to be a review of why there have been plans for growth if this is not realistically achievable.

The Deputy Director of Finance reported that the Trust is planning to be £8M away from plan at the year end and that this has been reported to the regulators. The underlying deficit is greater due to non-recurrent benefits recognised in year totalling £11.4M. The forecast deficit relies on recovery actions to be delivered by the year-end including the creation of the wholly-owned estates, facilities and procurement subsidiary; additional support in relation to winter pressures; an increase in allowance for capital to revenue transfer agreed with NHS Improvement; and negotiation with commissioners in relation to CQUIN and the Trust's trading position. It should also be noted that the contract for the soft facilities management has yet to be signed, and it is expected that this would be finalised in February. It was also noted that the remaining CIP would need to be achieved or mitigated.

Discussion took place regarding the allocation of STF. It was explained that the Trust received the payment in the first two quarters of the 17/18 financial year however the bulk of the payment was phased to the last two quarters of the year.

The Chief Operating Officer highlighted that elective activity had been significantly reduced during January following direction from the regulators. The plan was to continue to have some reduction in activity during February to continue to manage patient flow. This would be the subject of discussion with the Commissioners to agree what would be recognised in the final contract position.

The Committee **NOTED** the month 9 financial position.

026/18 DRAFT FINANCIAL RECOVERY PLAN UPDATE

The Executive Director of Finance presented the 2018/19 opening challenge as being a

- Control total of a £13.5M deficit which was agreed as part of the two year annual plan submission
- Less an assumed STF of £10.1M, a recurrent cost improvement plan of £15.4M and a carried forward challenge of £19M

This would leave an underlying deficit of £58M and an efficiency challenge of £34.4 to bring the Trust back to the agreed Full Business Case plan and meet the agreed control total. It was noted that this was based on an assumed control total as the planning guidance had not yet been received.

The Executive Director of Finance clarified that:

- £34m efficiency would equate to recurrent 9.3% challenge
- There was historical delivery nationally of between 2% and 3% efficiency
- There is no opportunity to over trade as the system cannot afford it.
- Gross opportunities would need to be identified of £41m
- The Trust must develop recovery plan (internal and external requirement)
- The Contract form for 2018/19 is yet to be agreed
- The Agreed plan must be realistic and deliverable

There are opportunities to be considered but these will require significant decisions from the Board.

The Chief Executive highlighted the need to be clear about what is and isn't achievable with regulators. He explained that the proposed reconfiguration formed part of the answer to the financial challenge and that the STP has a contribution to make to this. Providers generally are describing fiscal pressures.

Discussion took place on agreeing the 2018/19 contract and defining what the gap will be across the system. It was agreed that the Executive team would talk to NHS Improvement about the options and risks in the planning and contracting arrangements for 2018/19 and what the Trust's control total should be as part of the Quarterly Review Meeting

The Chief Executive highlighted the recent work undertaken with consultant colleagues on job planning and the capacity gap that this had identified. This would lead to conversations about what activity the Trust will do in the future and the impact this would have on nursing and ward configuration.

It was noted that meetings would be held with each of the divisions to review their plans. In addition, cost improvement schemes at gateway 2 would be presented to Turnaround Executive w/c 5 February. This work combined with the planning guidance and discussion with regulators would get the Trust to a position which can be presented to Board for a discussion. The Committee asked for a clear outline of the process to agree the Annual Plan for 2018/19 which would include a discussion on capital.

ACTION: GB

The Committee **NOTED** the challenges faced in developing the financial plan for 201819 and **AGREED** to have a further discussion at the meeting on 23 February 2018.

027/18 CASH FUNDING REQUIREMENTS

Deputy Director of Finance explained that the Trust is not looking for a greater loan funding than previously. The total in-year revenue borrowing requirement is remains at £37.6m based upon the latest forecast deficit position. This is in line with the required Board Resolution to authorise an increased in-year borrowing limit as approved in November 2017.The working capital position will continue to be monitored and managed closely. The level of borrowing matches what the Trust requires however we will not be in a position to pay any of this back in year. A future application is likely to be required for more cash support in 2018/19. Total borrowings at the year-end are just below £100M.

The Chair of the Committee asked for clarification on whether there is sufficient cash if some of the recovery actions don't deliver. The Executive Director of Finance responded that this wouldn't be a risk as a number are not cash backed and a detailed cash profile has been produced to help manage this.

The Committee **NOTED** the cash funding requirements update.

028/18 CIP UPDATE

The Chief Executive gave an overview with the process to develop the Cost Improvement Plan for 2018/19. The Executive Director of Finance explained that the schemes were due to be gateway 2 reviewed within the next two weeks.

029/18 FINANCE DEPARTMENT STRATEGY

The Executive Director of Finance shared the finance department's strategy which outlines a vision for the future of the finance department and wider organisation achievable through short, medium and longer term actions. The Strategy outlines how Finance can support the transformation and improvement of patient care, keep the financial base safe, and develop a financial workforce for the future whilst achieving financial sustainability. He added that the intention was that through delivering the identified actions the finance team will further transform and continue to be a high performing, value adding service function that is at the forefront of the Trust, leading the organisation through financial uncertainties that the NHS currently faces both locally and nationally.

The Committee **RECEIVED** the Strategy and commented that this was a good piece of work.

030/18 MONTH 09 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee received the Month 09 commentary on the financial return which would be submitted to NHS Improvement and which reflected the position discussed at item 7.

The Committee **APPROVED** the month 09 commentary.

031/18 NURSING REVIEW

The Executive Director of Finance highlighted that as a response to the Model Hospital information on Nursing Costs per Weighted Activity Unit, a programme of work has been commissioned by the Chief Nurse and Director of Transformation.

An externally led quality and safety assurance review of the nursing and midwifery staffing levels and the associated governance processes would be taking place on 13 February with colleagues from NHS Improvement and other NHS organisations. The project specification was shared with the Committee. The output of this would be shared with Finance and Performance Committee at a future date.

In addition there would be an internally led review to specifically clarify the reasons for the cost variation. The outputs will make recommendations of any opportunity to reduce costs and generate efficiency savings that do not compromise.

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

032/18 BOARD ASSURANCE FRAMEWORK

The Company Secretary presented the risks on the Board Assurance Framework for which Finance and Performance Committee is the Accountable Committee. Richard Hopkin and Andy Nelson commented on a meeting held previously with the Company Secretary and Head of Risk Management and confirmed that further work was being done to better align the BAF and the high level risk register.

It was noted that the in year financial risk remained at 25 and there had been discussion as to whether this should be classed as a risk or an issue given the likelihood of the year end financial position. The Executive Director of Finance explained that a risk for the 18/19 plan had been drafted and would be brought to a future meeting. The Committee asked that the target for this risk be realistic.

The Committee **RECEIVED and NOTED** the Board Assurance Framework risks.

033/18 MINUTES FROM SUB-COMMITTIES

The Committee received and noted the following sub-committee minutes:
Draft Cash Committee Minutes - 16 January 18
Draft Capital Management Group – 11 January 2018

034/18 WORK PLAN

The Committee noted the work plan and asked that a review be undertaken for the February meeting as there were too many items identified for the meeting.

ACTION: GB/ KA

035/18 MATTERS TO CASCADE TO THE BOARD

The Chair of the Committee highlighted the following for update to the Board:

- Year to date performance, underlying position and risk
- Not requesting any more cash – share the level of total borrowing
- Good conversation on the performance, what is driving the ratings and what we can do to achieve an improved performance. There will be a review of the targets ready for the next financial year and a one page on the actions we are focusing on to the year end will be produced **ACTION – PK / HB**
- Recovery plan and the challenges on this. We need to determine what we think should be our control total for this year.

036/18 REVIEW OF MEETING

In summary it was felt that the meeting was timely, good discussions had taken place covering complex issues allowing good debate and transparency. The deep dive on performance had been helpful.

037/18 ANY OTHER BUSINESS

There were no items to discuss.

DATE AND TIME OF NEXT MEETING

Friday 23 February 2018, 10am
Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Wednesday 14 February 2018, 10.00am – 12 noon, Room 4, 3rd Floor, Acre Mill Outpatients, Huddersfield

PRESENT:

David Anderson	Non-Executive Director
Stephen Baines	Council of Governors
Suzanne Dunkley	Director of Workforce and Organisational Development
Karen Heaton	Non-Executive Director (Chair)
Vicky Pickles	Company Secretary

IN ATTENDANCE:

Rob Aitchison	Director of Operations, Families and Specialist Services (for Helen Barker)
Christine Bouckley	Occupational Health and Wellbeing Lead (for agenda item 25/18)
Mandy Griffin	Managing Director, Digital Health (for agenda item 22/18)
Richard Metcalf/ Andrew Mooraby	Human Resources Business Partner Associate Director of Nursing (for agenda item 22/18)
Ruth Mason	Associate Director of Organisational Development (for agenda items 23/18 and 24/18)
Lindsay Rudge	Deputy Director of Nursing (for Brendan Brown and agenda item 28/18)
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development
Hayley Watts	Human Resources Business Partner (for agenda item 22/18)
Claire Wilson	Assistant Director of Human Resources (for agenda item 29/18)

17/18 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

18/18 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
David Birkenhead, Medical Director
Brendan Brown, Chief Nurse
Jason Eddleston, Director of Workforce and Organisational Development
Alastair Graham, Non-Executive Director

19/18 **DECLARATION OF INTERESTS:**

No declarations of interest were received.

20/18 **MINUTES OF MEETING HELD ON 9 JANUARY 2018:**

The minutes of the meeting held on 9 January 2018 were approved as a correct record.

21/18 **ACTION LOG (items due this month)**

The action log for January 2018 was received. Items due this month were discussed in the meeting.

MAIN AGENDA ITEMS

FOR ASSURANCE

22/18 **MANDATORY TRAINING COMPLIANCE – DIVISIONAL ATTENDANCE**

KB reported that at the Executive Board meeting on 8 February 2018 it was agreed that letters would be sent from the Chair of the Workforce (Well Led) Committee inviting divisional colleagues to provide assurance on actions being taken to improve compliance rates. The Health Informatics Service, Surgery and Anaesthetics Division and Medical Division were invited to attend the Committee meeting.

The Health Informatics Service

MG reported the current overall compliance rate had improved significantly and was now showing 95.59% (green). This had been achieve by:-

- 90 letters sent out to individuals followed by internal meetings.
- Compliance rates tracked weekly
- Mandatory Training is a standing agenda item at business meetings.
- Colleagues who have mandatory training elements due to expire have been identified and will be targeted to ensure compliance.

Surgery & Anaesthetics Division

HW provided the Division's current compliance rates:-

Module	**9 February 2018**
IG	86.82
Fire	87.4
Inf Control	87.23
Manual Handling	79.21
SGAdults	86.08
SGChildren	90.99

HW reported that:-

- 600 letters had been seen to individuals.
- HR Business Partners are working with line managers.
- Compliance rates tracked weekly.
- Mandatory Training is a standing agenda item at business meetings.
- Live Divisional action plan.

HW reported compliance rates had increased particularly in non-medical areas. Junior doctor compliance rates were a challenge for the Division. Junior doctors were advised at their induction session that evidence of previous learning would be accepted. This had received minimal response.

The Committee asked how the Trust could support the junior doctors. HW agreed to follow this up with the junior doctor group.

ACTION: HW to identify what support the junior doctors required to complete their mandatory training.

Medical Division

RMetcalf delivered a presentation outlining the Division's current status and described the activity within the Division:-

- 850 letters were hand delivered to individuals, thus enabling a conversation.

- The Director of Operations had written to each Directorate for assurance on performance management of delivery against target.
- Directorate specific action plans in place
- Compliance rates signifantly increased from 7 February 2018

RMetcalf advised that medical colleague compliance is an issue particularly among junior doctors. There had been poor response to requests for evidence of previous mandatory training. Some junior doctors stated they didn't know what ESR is. The Trust's induction session provided information on mandatory training and how to access ESR.

The Committee discussed the transporting of evidence of mandatory training. RM advised a paper recommending that evidence of mandatory training is accepted by the Trust is to be discussed by the Executive Board on 15 February 2018.

In addition, a further paper for discussion at 15 February 2018 Executive Board recommends that study leave for non-mandatory training will not be approved if mandatory training is non-compliant.

RM also advised the Trust's induction process is being refreshed. A face to face induction is being re-established, which builds in the opportunity to undertake the 5 mandatory training modules.

Concerns were highlighted regarding the pressures of completing mandatory training in Q4. RM agreed to explore ways to level out the training.

ACTION: RM to explore ways to level out mandatory training across the year.
TR to share presentations/action plans with Committee members.

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

23/18 **MANDATORY TRAINING UPDATE**

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

RM advised that a weekly update paper is provided to the Executive Board. RM reported an increase in compliance from the previous week. The letters sent to individuals had seen an impact across the Trust. It was noted the Trust is looking at how it can re-position the purpose of training, for example safety. It was suggested that highlighting the financial cost of consequences of not undertaking mandatory training might see some influence.

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

24/18 **QUALITY OF APPRAISALS**

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

RM reported a successful achievement of 96.26% compliance. To understand the nature and quality of the appraisals undertaken several colleagues were randomly selected to be interviewed about their appraisal. Four standard questions were asked at each interview. The results indicated that most people reported a positive experience. Where appraises rated their experience less positive, managers had not prepared and were unable to refer to records or paperwork from the previous appraisals. The appraisal felt like a tick box exercise leaving the appraisees feeling under-valued.

RM advised actions arising out of the interviews were:-

- No changes to be made to the format of the appraisal paperwork

- Establish appraisal workshops for managers
- Develop a dedicated appraisal section on the intranet
- Audits of completed paperwork to be undertaken

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

25/18 **HEALTH AND WELLBEING UPDATE AND CQUIN**

CB provided a verbal update to the Committee, in addition a paper, including an action plan, had been prepared for the Committee which will be circulated to members following the meeting.

CB outlined the various activities undertaken to progress the health and wellbeing agenda.

A sub group from the Executive Board remains to be established to give a strategic steer to health and wellbeing.

The Occupational Health structure is being reviewed looking at increased medical offer and nurse support. It is anticipated the Occupational Health service will take on the leadership of the moving and handling service. A review of resource is to be prepared with a business plan to deliver key objectives described in the action plan which are as yet unfulfilled.

CQUIN

Part 1a Improvement of health and wellbeing of NHS staff
The staff survey report is currently embargoed until March 2018, however early indication suggests that staff reporting work related stress and musculoskeletal symptoms arising from their work, remains unchanged over the past 2 years, and staff perceptions of the organisation taking interest in their wellbeing appears to be low. Further work is needed across the organisation to understand the drivers behind these indicators and effect change.

Part 1b. Healthy food for NHS staff, visitors and patients
Assurances have been received from our catering providers that they are compliant with the CQUIN standards for this year, and have actions in place to ensure this is maintained into 2018

Part 1c. Improving the uptake of flu vaccinations for frontline clinical staff
Flu vaccine uptake has reached 70.45% and fully meets the CQUIN target of 70% frontline healthcare worker immunisation.

ACTION: TR to circulate the Health and Wellbeing paper.

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

26/18 **IMPLEMENTATION OF ALLOCATE – E-ROSTERING (MEDICAL)**

As part of the Medical Workforce update, PN provided an overview of the current position in relation to the implementation of E-rostering for medical and dental staff.

PN advised there are four 'live' specialties using Allocate; Microbiology, Histopathology, Chemical, Pathology and Paediatrics with other specialties on plan for implementation. The significant benefits of the e-rostering tool were noted by the Committee. PN did advise that a number of implementation issues are being worked through.

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

27/18 **MEDICAL WORKFORCE GROUP**

PN delivered a presentation to provide an update on the Medical Workforce Group key activities:-

- Revision of job descriptions and adverts
- Development of videos for other specialties to personalise each advert
- Working with the British Medical Journal to develop a package for future adverts
- Increased International opportunities
- Medical Training Initiative Doctors
- Physician Associates
- Recruitment and Retention meetings attended by Divisions, Medical HR, Flexible Workforce, Finance, HR
- Pilot site in A&E for Certificate of Equivalence for Specialist Registration (CESR) Programme
- FY3 opportunities
- 2017/2018 CIP

ACTION: TR to share the presentation with Committee members.

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

28/18 **NURSING AND MIDWIFERY WORKFORCE UPDATE**

LR presented an update of the work undertaken by the Nursing and Midwifery workforce Steering Group and its sub-groups. Key activities included:-

- Rebranded recruitment programme
- Social media recruitment programme
- International recruitment programme – 3 nurses in post, 9 more to join the Trust in February 2018. 57 applicants moved to the now recognised OET programme to expedite deployment
- Weekly pay
- Workforce modernisation – upscaling of the Nursing Associate project from Spring 2018
- Exit interviews limited in numbers, but showing a variable picture.
- Enhanced Care Team - National collaborative
- Ward Assurance

ACTION: TR to share the presentation with Committee members.

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

PERFORMANCE

29/18 **WORKFORCE PERFORMANCE REPORT (FEBRUARY 2018)**

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

CW provided an overview of the main highlights from the February 2018 report:-

- Staff in post (headcount and FTE) had increased in January
- Decrease in FTE establishment
- Decrease in vacancies by approximately 31FTE
- YTD sickness increase
- In month sickness saw a decrease from November 2017
- Recording of Return to Work interviews still low (some issues with E-rostering recording which has been escalated to Allocate)

- Mandatory Training compliance – increasing but below target
- Increase in Agency spend from last month - £0.1m, mainly due to capacity – additional wards/some beds not planned for.

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

ITEMS TO RECEIVE AND NOTE

30/18 **ANY OTHER BUSINESS:**

No other business was raised.

31/18 **MATTERS FOR ESCALATION:**

There were no matters for escalation.

DATE AND TIME OF NEXT MEETING:

Friday 16 March 2018, 1.30pm – 3.30pm, Room 4, Acre Mills Outpatients, Huddersfield

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Audit and Risk Committee Meeting held on Wednesday 24 January 2018 in the Boardroom, Calderdale Royal Hospital commencing at 10:30 am

Richard Hopkin	Chair, Non-Executive Director
Phil Oldfield	Non-Executive Director
Andy Nelson	Non-Executive Director - Teleconference

IN ATTENDANCE

Dr Peter Bamber	Council of Governors representative
Gary Boothby	Executive Director of Finance
Leanne Sobratree	Internal Audit Manager
Andrew Haigh	Trust Chair (Observer)
Helen Kemp-Taylor	Head of Internal Audit for Audit Yorkshire
Brian Moore	Council of Governors representative (deputy)
Alastair Newall	External Auditor (KPMG)
Adele Jowett	Local Counter Fraud Specialist
Kathy Bray	Board Secretary (minutes)

Item

1/18 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Brendan Brown, Executive Director of Nursing
Clare Partridge. Engagement Lead, KPMG
Andrea McCourt, Head of Governance and Risk
Victoria Pickles,Company Secretary

The Chair welcomed everyone to the meeting.

2/18 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

3/18 MINUTES OF THE MEETING HELD ON 18 OCTOBER 2017

The minutes were approved as a true record.

4/18 ACTION LOG AND MATTERS ARISING

a. 46/16 PAYROLL UPDATE

It was noted that the update discussed at the last meeting had been circulated to members on the 29 November 2017. It was agreed that this was positive feedback and a brief update on progress was received.

The Executive Director of Finance advised that the service level agreement with Leeds Teaching Hospital who had been helping the Trust implement recommendations was due to end shortly and hopefully arrangements would be made to secure permanent arrangements from Leeds.

It was noted that implementation of EPR had delayed the rollout of ESR for some functions. Brian Moore queried whether the Governors would be submitting expense claims through the electronic system and Gary Boothby agreed to make enquires although the fact that the Governors were not on the payroll may influence this.

ACTION: EXECUTIVE DIRECTOR OF FINANCE

It was noted that the Scheme of Delegation would require review once the details

around the Wholly Owned Subsidiary Proposal had been agreed.

b. 63/17(1) DECLARATION OF INTERESTS

The Board Secretary reported that a draft communications strategy had been prepared in readiness for the launch of the new policy and system, once the arrangements had been finalised regarding the recording system to be used.

Concern was expressed regarding the timescale for the implementation of the new regulations and the fact that no electronic system or training had been put in place to date. The Board Secretary assured the Committee that a manual system was still in operation.

It was noted that an electronic system had been discussed at WEB the previous week and it had been requested that due to costs (approx. £5k) the Company Secretary should make enquiries as to whether the ESR system could be utilised to capture the declarations from Band 7 and above within the Trust without the need to purchase a separate system.

ACTION: VP

c. 67/17(2) INTERNAL AUDIT - CYBER ATTACK DATA

Helen Kemp-Taylor confirmed that she had investigated whether data was available regarding Cyber Attacks/near misses as requested at the last meeting. She reported that information had been received from THIS that there were no reported cases. The Trust was constantly being attacked but systems and controls were in place to stop attacks penetrating.

d. 62/17 RISK MANAGEMENT

As discussed at the last meeting concern was expressed as to value of the Audit and Risk Committee receiving the minutes from the sub-committees and whether seeing the minutes in isolation was sufficient assurance.

The Head of Internal Audit advised that at other Trusts the BAF is used to gain assurance that key risks are being addressed/actioned.

Members present suggested a number of alternative ways of gaining assurance and it was agreed that the Audit Chair and Trust Chair would discuss this with Company Secretary and Head of Risk and Governance and this would be brought to the next meeting.

ACTION: RH/AH/VP/AM – AGENDA ITEM

e. 66/17(2) LOSSES AND SPECIAL PAYMENTS

Discussion had taken place at the last meeting regarding the total claims made and it was agreed that a breakdown of the claims would prepared and circulated to Divisions. The Executive Director of Finance was not aware that this had been undertaken and agreed to follow this up with the Assistant Director of Finance.

ACTION: GB/ZQ

5/18 COMPANY SECRETARY'S BUSINESS

5/18a. BOARD ASSURANCE FRAMEWORK

The updated BAF was presented to the ARC for review and comment.
It was noted that further work was planned with the recently appointed Non-Executive Directors to review the high level risk register and BAF to assess movement and appropriateness of risks. It was noted that prior to the Board meeting on 1 February an additional risk will be included on the BAF relating to the 2018/19 financial position.

ACTION: VP/AMc/RH/AH

Discussion took place regarding the current financial position with the challenges of winter pressures, along with the implications of cancellation of non-urgent inpatient elective care, day case procedures and routine follow-up outpatient appointments during January 2018.
The Chairman reported that information had now been received that permission for 'Hands Off HRI' to seek a judicial review has been refused although an appeal may be likely.

Concern was expressed by Phil Oldfield regarding the timescale and the target for the Trust to return to plan. The Executive Director of Finance advised that the Full Business Case indicated that it would be back to plan by Year 8. It was agreed that realistically achieving this may be challenging and this would be discussed at the next F&P Committee.

ACTION: GB/PO

Andy Nelson raised the EPR risks and it was noted that more work was required on dividing the risks between 'benefits' and 'impact of implementation' and this would be raised at the meeting on 29 January.

Members present discussed and agreed the revised BAF and it was noted that the risk appetite was due to be discussed at the Board of Directors on 1 February 2018.

OUTCOME: The Committee **AGREED** the Board Assurance Framework

5/18b. REVIEW OF STANDING FINANCIAL INSTRUCTIONS
It was noted that the Standing Financial Instructions had been reviewed and there were no amendments to make at this point. It was noted that these will require amendment to reflect any Board decision on the creation of the wholly owned subsidiary for estates and facilities and the proposed amendments will be brought to Audit and Risk Committee in due course.

OUTCOME: The Committee **APPROVED** the Standing Financial Instructions Framework.

5/18c. REVIEW STANDING ORDERS RE CONFLICT OF INTERESTS
A review of the Standing Financial Instructions had been undertaken and apart from amending the reference to Membership Council to Council of Governors, there were no amendments to make. It was noted that any reference to conflicts of interest had not been affected by approval of a new policy.

It was noted that these will require amendment to reflect any Board decision on the creation of the wholly owned subsidiary for estates and facilities and the proposed amendments will be brought to Audit and Risk Committee.

OUTCOME: The Committee **APPROVED** the reviewed of Standing Orders.

5/18d. REVIEW ARC WORKPLAN
All present received and approved the Audit and Risk Committee Workplan for 2018.

The Executive Director of Finance suggested that following the discussions regarding Committee assurance from receipt of minutes from sub-committees, it may be necessary to add 'Sub-Committee Deep-Dives' on to the workplan.

ACTION: VP

OUTCOME: The Committee **APPROVED** the ARC Workplan

5/18e. SELF ASSESSMENT OF COMMITTEE EFFECTIVENESS
As members of the Committee were aware, as part of the strengthened of governance arrangements, the Trust had implemented an annual review of effectiveness.
Each of the Board sub-committees was required to do a self-assessment, the results of which would identify improvement actions, and produce an annual report of the work over the year.

OUTCOME: The Committee **AGREED** to **COMPLETE** and **RETURN** the Self-Assessment questionnaire by close of play on Thursday 1 February 2018 in order that an action plan can be collated and an annual report including all the sub-committees prepared for the next meeting

ACTION: ALL & AGENDA ITEM

6/18 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

6/18a. WAIVING OF STANDING ORDERS
The Executive Director of Finance reported that during the third financial quarter of 2017/2018, 7 orders were placed as a result of standing orders being waived, at a total cost of £205,966.83.

OUTCOME: The Committee **APPROVED** the waivers of standing orders.

6/18b. LOSSES AND SPECIAL PAYMENTS
The Executive Director of Finance reported that losses and special payments over the quarter totalled £45.6k. Overall this was 4% lower than last year.

The losses, with the exception £19.4k, consisted of Pharmacy expired stock, some high value chemotherapy drugs and an increase in all 6 stock holding areas over the quarter. The Committee appreciated that Pharmacy have to manage a balance of keeping drugs that may be infrequently used that may eventually expire against ensuring that medicines are available when they are critically needed. It was noted that expired stock is reported to Pharmacy Management Board each month.

It was noted that the £26.2k for Q3 Public/Employer's liability claims is made up of eleven repayments to NHS Litigation Authority for damages or costs.

OUTCOME: The Committee **NOTED** the losses and special payments report.

6/18c. AGREE FINAL ACCOUNTS PROCESS AND PLANS
The timeline for preparation of the annual accounts process was received and the challenges in the timeline discussed. All presented noted and approved the timeline.

OUTCOME: The Committee **NOTED** the Final Accounts timeline.

7/18 INTERNAL AUDIT
7/18a. INTERNAL AUDIT FOLLOW-UP REPORT
The Head of Internal Audit provided an overview of the outstanding internal audit recommendations. It was noted that the report had been considered by the Executive Team and updated as far as possible.

It was noted that this had deteriorated slightly and a new process had been agreed with internal audit whereby the executive leads would be challenged if required. The Internal Audit Manager reported that a workstream had been established in Audit Yorkshire to look at a new follow-up report and this would be brought to the next Audit

and Risk Committee in April.

ACTION: LS

Specific discussion took place regarding:

- **Medical Devices** – Clarification was requested as to whether this audit related to training of staff or an equipment risk issue. It was agreed that the Exec Director of Nursing and Exec Director of PE&F to report back to ARC and, if necessary would be invited to attend a future ARC meeting to discuss the issues further.
  - **ACTION: KB – AGENDA ITEM**

- **Storage and Transport of Medicines –** Concern was expressed that the recommendation within the Audit suggested more keys be available and ARC questioned whether this would really address the issues. The Internal Audit Manager agreed to obtain further information and feedback to the next ARC Meeting.

ACTION: LS

OUTCOME: The Committee **RECEIVED** the Internal Audit follow-up report and agreed the actions above.

7/18b. Internal Audit Progress Report
The Internal Audit Manager presented the report setting out that since the last Audit and Risk Committee, five reports have been finalised:

CH/03/2018	Hospital Reconfiguration Engagement	✓	Significant
CH/08/2018	THIS – Compliance with ISO Standard 20000	✓	Full
CH/09/2018	Compliance Register	✓	Limited
CH/10/2018	Infection Prevention & Control	✓	Limited
CH/11/2018	E-Rostering and Rostering	✓	Significant

Discussion took place regarding the audits with limited assurance:

- **Compliance Register** – The Internal Audit Manager reported that there had been a breakdown in the central recording system leading to inconsistencies in recording across the Divisions. A new template had been developed and old and new risks had now been incorporated and further work was underway to ensure that this captured the management of External Agency Visits, Inspections and Accreditations. The recommendations within the report were noted.

- **Infection Prevention and Control** – The Internal Audit Manager summarised the feedback from the audit which had audited the Management of Patients with Multi Resistant Organisms. The policy requires all emergency and elective admissions into hospital to have a risk assessment carried out in order to determine Carbapenemase Producing Enterobacteriaceae (CPE) (an infection) status as part of the admission process. The audit found that only 50% of patients admitted to the Trust on the one day tested had an Infection Prevention

and Control Risk Assessment completed and only 17% of patients had the British Stool Chart (BSC) Assessment completed. It was noted that on the EPR system this field is mandatory. Changes were underway to amend the EPR system but this was dependant on discussions with Bradford and therefore work was still underway.

The Committee noted the content of the report and it was noted that the Internal Audit Manager expected that the overall 2017/18 plan would be delivered on time.

OUTCOME: The Committee **RECEIVED** the Internal Audit Progress Report and **NOTED** the limited assurance opinion for Compliance Register and Infection, Prevention and Control.

8/18 LOCAL COUNTER FRAUD SERVICE - PROGRESS REPORT

The Local Counter Fraud Officer presented the LCFS progress report. The report set out the progress against the approved work plan. A brief update on the progress with current investigations was shared with the Committee together with an update on the two specific cases under investigation.

OUTCOME: The Committee **RECEIVED** the progress report.

9/18 EXTERNAL AUDIT

9/18a. TECHNICAL UPDATE

The External Auditor presented the technical update and there were no issues of concern to note.

It was agreed that the Technical Update would be circulated to the remaining Board members for information.

ACTION: KB

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

9/18b. KPMG EXTERNAL AUDIT PLAN 2017-18

The content of the Audit Plan 2017-18 was presented by the External Audit Senior Manager. The contents of the plan were received and it was noted that external audit would be focussing on the following risks/issues:

- Financial Statements Valuation of land and buildings
- Recognition of NHS and non-NHS income
- Electronic Patient Records (EPR) asset valuation
- Estates Special Purpose Vehicle (SPV)
- Financial Sustainability
- Quality Accounts

Discussions had already taken place with CHFT management and visits on site were scheduled from 5 February. It was therefore agreed that it would be timely to feedback on the initial findings at the April ARC Meeting.

ACTION: AGENDA ITEM – APRIL 2018

OUTCOME: The Committee **APPROVED** the External Audit Plan for 2017-18

10/18 REGULATORY COMPLIANCE

There were no regulatory compliance issues to bring to the attention of the Committee.

11/18 INFORMATION TO RECEIVE

The following information was received and noted and as discussed earlier in the meeting under item 62/17 'Risk Management' further discussions would take place regarding the

value of the Audit and Risk Committee receiving these minutes in isolation.

- Quality Committee Minutes – 2.10.17, 30.10.17 and 4.12.17.
- Information Governance & Records Strategy Committee Minutes 16.10.17 8.1.18, 21.8.17
- Risk & Compliance Group Minutes – 17.10.17, 21.11.17 and 19.12.17
- THIS Executive Meeting Summary Notes – 20.9.17, 25.10.17 and 20.11.17.

12/18 ANY OTHER BUSINESS

The Head of Internal Audit for Audit Yorkshire invited all members to an annual Audit Yorkshire event to be held on 5 March 2018 – details of which had previously been circulated.

13/18 MATTERS TO CASCADE TO BOARD

The Committee noted the following items to be brought to the attention of the Board at its next meeting:

- Declaration of Interests Recording System – risks to timeline.
- Year-end Plan – Finance and External Audit reviewed risks to year-end audit
- Internal Audit Reports – limited assurance:
  - Compliance Register
  - Infection, Prevention and Control

DATE AND TIME OF NEXT MEETING

Wednesday 18 April 2018 at 10.30m – Boardroom, Trust Offices, Calderdale Royal Hospital.

REVIEW OF MEETING

All present were content with the issues covered and the depth of discussion.

The Chair closed the meeting at 12.35 pm.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD ON TUESDAY 23 JANUARY 2018 IN THE BOARDROOM, SUB-BASEMENT, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Chair
Rosemary Hedges	Public elected – Constituency 1
Di Wharmby	Public elected – Constituency 1
Annette Bell	Public elected – Constituency 6
Paul Butterworth	Public elected – Constituency 6
Alison Schofield	Public elected – Constituency 7 (+ carer)
Brian Moore	Public elected – Constituency 8 /Lead Governor
Linzi Smith	Staff Elected – Constituency 11
Sian Grbin	Staff-elected – Constituency 13
Megan Swift	Nominated Stakeholder – Calderdale Metropolitan Council
Felicity Astin	Nominated Stakeholder - University of Huddersfield

IN ATTENDANCE:

Helen Barker	Chief Operating Officer
David Birkenhead	Executive Medical Director
Gary Boothby	Executive Director of Finance
Brendan Brown	Executive Director of Nursing/Deputy Chief Executive
Kathy Bray	Board Secretary
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates & Facilities
Victoria Pickles	Company Secretary
David Anderson	Non-Executive Director/SINED

APOLOGIES:

Apologies for absence were received from:

Veronica Maher	Public elected – Constituency 2
Katy Reiter	Public elected – Constituency 2
Dianne Hughes	Public elected – Constituency 3
John Richardson	Public elected – Constituency 3
Kate Wileman	Public elected – Constituency 4 (Reserve Register)
Nasim Banu Esmail	Public elected – Constituency 4
Stephen Baines	Public elected – Constituency 5
Brian Richardson	Public elected – Constituency 5
Lynn Moore	Public elected – Constituency 7
Michelle Rich	Public elected – Constituency 8
Dr Peter Bamber	Staff Elected – Constituency 9
Theodora Nwaeze	Staff-elected – Constituency 12
Charlie Crabtree	Staff-elected – Constituency 13
Chris Reeve	Nominated Stakeholder – Locala
Yasmeen Salma	Nominated Stakeholder – South West Yorkshire Partnership FT
Rory Deighton	Healthwatch Kirklees

The Chairman opened the meeting by thanking everyone for their co-operation when the meeting had been rescheduled from the 17 January to the 23 January due to a combination of sickness and adverse weather conditions. This had resulted in only two public members being available to attend the meeting on the 17 January and therefore due to not being quorate it had been rearranged. The Chair welcomed Felicity Astin the new nominated Stakeholder for the University of Huddersfield. He advised the meeting that discussion had taken place during the private session held prior to this meeting regarding the financial pressures/reforecast, Judical review and issues discussed at recent private meetings of the Board of Directors meetings.

1/17 DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

2/18 EXTERNAL AUDITOR'S PRESENTATION

Alastair Newall, External Auditor from KPMG attended the meeting to give an overview of the role and responsibilities of the external auditors. It was noted that representatives of the Council of Governors had recently been involved in the reappointment of KPMG as the external auditors.

Details were given on the key areas of work which included:

- Financial Statements Audit – resulting in 2 outputs ISA260 and Audit Opinion.
- Use of Resources – value for money
- Review of the Annual Report and Annual Governance Statement – culminating in the preparation of the Annual Report and Accounts
- Quality Report – process for selection of local and mandated indicators and opinion on quality accounts
- Audit timetable
- Attendance at Audit and Risk Committee with regular reports
- Attendance at the Joint Board of Directors/Council of Governors Annual General Meeting to feedback on the audit each year.

Discussion took place regarding the recent instructions received from NHS Improvement for all Trusts to submit a wider range of activity information relating to urgent and emergency care which could be collated to give benchmarking data. Helen Barker advised on the three types of data across the WY patch:
Type 1 – A/E activity
Type 2 – Other access i.e. GP referrals
Type 3 – Walk in Centres

The Chair thanked Alastair for the information given and update received.

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the information presented by the External Auditor

3/18 MINUTES OF THE LAST MEETING – 26 OCTOBER 2017

The minutes of the last meeting held on 26 October 2017 were approved as an accurate record.

4/18 MATTERS ARISING

71/17 – GOVERNORS ATTENDANCE AT FORMAL COUNCIL OF GOVERNOR MEETINGS

The Chairman confirmed that he had now had discussions with Governors who had not attended regular meetings. On the whole it was agreed that the Governors had valid reasons for non-attendance. It was noted that Theodora Nwaez had notified

the Chairman that she would resign from her post at the next elections.

Following discussion Brian Moore asked that nearer the elections the Chairman should contact all Governors who had not attended throughout the year to ask that they reflect on their positions as it was not fair to Trust staff or the public if seats are not represented. All present agreed.

ACTION: CHAIRMAN BEFORE 17.4.18

OUTCOME: The Council of Governors **AGREED** that the Chairman should action before 17.4.18

76/17 – RAISING IT ISSUES

No further information had been received regarding how staff should raise IT issues, although it was noted that at the last meeting the Managing Director – NHS Digital had agreed to investigate this outside the meeting.
It was agreed that the Board Secretary would follow this up.

ACTION: BOARD SECRETARY

5/18 CHAIRMAN'S REPORT

a. UPDATE FROM CHAIRS INFORMATION EXCHANGE MEETING – 13.12.17

The Chairman reported on the minutes from the meeting held on the 13 December 2017 which had been included with the agenda (Appendix B). The next meeting was scheduled to be held on the 26 March 2018.

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the Chairs Information Exchange Minutes – 13.12.17

b. TODMORDEN CAR PARK CHARGES

The Chairman had received a question regarding parking charges at Todmorden. It was noted that the building was managed by the landlord/Todmorden Group Practice and therefore the Trust had no input into deciding the charges.

c. HEALTH AND SAFETY ISSUE – ACCESS TO CRH DURING ROADWORKS

Alison Schofield had asked a question regarding access arrangements for anyone with mobility difficulties crossing Dryclough Lane to access CRH. It was noted that the Trust had been in discussion with Calderdale Council and a new crossing point had been put in place at Dryclough Lane which was slightly higher up than the old one but opposite the path into the hospital. Dropped curbs had been installed on both sides of the crossing.

d. DEALINGS WITH CARILLION

The Chairman confirmed that that the Trust has had no dealings with Carillion.

PERFORMANCE AND STRATEGY

6/18a FINANCIAL POSITION AND FORECAST

The Executive Director of Finance presented the Month 8 finance report, as at 30 November 2017.

The key points were:-

- Reported year to date deficit position of £17.85m, an adverse variance of £3.79m compared with the control total of £14.07m;
- Delivery of CIP is above the planned level at £10.35m against a planned level of £9.97m;

- Capital expenditure is £5.17 below plan due to revised timescales;
- Cash position is £1.99m, just above the planned level;
- A Use of Resources score of level 3, in line with the plan.

It was noted that the Trust continues to report a forecast in line with the Control Total deficit of £15.94m. However the deteriorating position leaves the Trust with the requirement to deliver recovery plans of the magnitude of £11m, to cover the growing underlying gap between the planned deficit and operating position. The size of this gap is unlikely to be resolved quickly enough to achieve the control total over the next 4 months and the Trust is now forecasting an adverse variance from plan during Months 7-11. Sustainability and Transformation Funding of £6.57m for Quarters 3 and 4 remains at risk and will only be made available if the Trust can deliver full financial recovery back to plan.

The Chairman advised that the recovery plan would reference reconfiguration as being part of the solution to address the deficit.

Discussion took place regarding the national drive to improve patient services/safety through consolidation of services and delivering care differently by patients accessing specialist centres. It was felt that this was a way forward for delivering services in the future.

OUTCOME: The Council of Governors **NOTED** the financial position and forecast.

6/18b PERFORMANCE & QUALITY (Including Good News Stories)

The Chief Operating Officer presented the quality and performance report. The key issues from the report included:

- November's Performance Score has improved to 62% for the Trust.
- The SAFE domain is back to AMBER having deteriorated to RED following a reported Never Event last month.
- The EFFECTIVE domain has maintained its GREEN rating for the third month running.
- The RESPONSIVE domain has maintained AMBER with improved performance across the Cancer metrics.
- EFFICIENCY & FINANCE has improved in the Efficiency metrics but remains RED.
- WORKFORCE remains RED with all 5 Mandatory Training focus areas missing target

Discussion took place regarding the winter pressures over the Xmas/New Year period which had affected Trusts nationally. All Governors present wished to thank staff for the work undertaken to address the increased activity levels which continued through January.

Discussion took place regarding concerns around achieving targets for Mandatory Training. It was noted that work was underway within Divisions to address this with support for staff and shared learning. It was agreed that an update on the progress would be fed back to the Governors at the next meeting.

ACTION: HB – AGENDA ITEM

OUTCOME: The Council of Governors **NOTED** the performance and quality data and good news stories.

7/18 STRATEGIC PLAN & QUALITY PRIORITIES UPDATE

7/18a NOTES FROM THE BoD/CoG WORKSHOP HELD ON 15.11.17

The Council of Governors received the notes from the Workshop held on the 15 November 2017 on the Strategy Update which had been brought to the meeting to ensure that all new Governors have sight of the notes.

7/18b QUALITY PRIORITIES FOR QUALITY ACCOUNTS 2017-18 AND 2018-19

The Company Secretary presented the paper prepared by Andrea McCourt, Head of Governance and Risk. She reminded the Governors that the Quality Accounts form part of the Trust Annual Report and Accounts process and provided information for the public on the quality of services the Trust has provided over the previous financial year. The quality accounts detailed the quality achievements during the year and quality performance, details of clinical audit work undertaken, quality priorities for the forthcoming year and feedback from local stakeholders. As had been referenced earlier in the meeting, the Quality Accounts are reviewed by the external auditor.

The quality accounts also contain feedback from our local stakeholders on the quality of services, for example from other local providers and the local authority, as well as statements from the Trust's Chief Executive and the Board.

With regard to the 2017-18 Quality Accounts, as identified in the paper the progress against each of the indicators chosen by the membership was noted:

- sepsis screening for in patients
- discharge planning
- learning from complaints

It was reported that work had also begun to select three quality account priorities for 2018/19, following discussion at the Council of Governors workshop on 7 December 2017.

Six indicators had been chosen, two from each of the following domains:

- safety
- effectiveness
- experience

The list of the proposed 2018/19 quality account priority topics was included within the paper circulated.

It was noted that arrangements were being made for information on the six priorities to be sent to the wider membership during February 2018 and members will be asked to select three of the six as 2018/19 quality account priorities.

As discussed earlier in the meeting, of the 2017/18 quality accounts there are two areas which are nationally mandated for audit by our external auditors and one local indicator for audit that the council of governors selects. We are currently awaiting national guidance which will confirm the two mandated indicators.

The Company Secretary reported that arrangements were being made for the Council of Governors to receive further feedback on the progress of the Quality Reports.

OUTCOME: The Council of Governors **RECEIVED and APPROVED** the strategic plan and quality priorities update.

8/18 RISK REGISTER

The Company Secretary presented the Risk Register paper. It was noted that this information had been presented at the Council of Governors Development Session on the 13 December 2017, but unfortunately only a small number of Governors were able to attend so this has been included on the agenda for information.

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the information provided.

9/18 GOVERNANCE

9/18a COUNCIL OF GOVERNORS REGISTER

The updated register of members as at 1 January 2018 was received for information and the changes were noted. The Chairman reported that no further information had been received from Kirklees Metropolitan Council regarding a nomination to fill this seat despite contact with them.

OUTCOME: The Council of Governors **NOTED** the updated Register.

9/18b REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The Chairman requested that any amendments be notified to the Board Secretary as soon as possible.

OUTCOME: The Council of Governors **APPROVED** the Register of Interests

9/18c REVIEW ANNUAL COUNCIL OF GOVERNORS MEETINGS WORKPLAN

The Company Secretary presented the updated workplan of items for discussion at future Council of Governor meetings. It was requested that any comments be returned to the Board Secretary.

OUTCOME: The Council of Governors **APPROVED** the meetings workplan.

9/18d DRAFT ELECTION TIMETABLE 2018

The Company Secretary presented the draft election timetable for the Council of Governors for 2018. The information was noted and it was requested that any Governor wishing to resign from the Council should make the Board Secretary aware before 16 May 2018.

10/18 UPDATE FROM BOARD SUB COMMITTEES

10/18a QUALITY COMMITTEE

Paul Butterworth highlighted the discussions which had taken place at the last Quality Committee. These included:

- Communications around serious incidents/record keeping
- Nutrition – nil by mouth – risks by being offered fluids – being actioned by Executive Director of Nursing
- Mandatory Training – concern over support for staff in completing this and other personal development

Staff Governors present at the Council of Governors Meeting shared their experience of training on EPR and ESR and the challenges being faced dedicating time to this. The Executive Director of Nursing advised that training needs and support including Mandatory Training was to be raised with the newly appointed Executive Director of Workforce and OD when she commenced on the 1 February 2018 in order that a programme of training can be designed.

10/18b ORGAN DONATION COMMITTEE

In the absence of John Richardson the Chairman updated on the current issues discussed at the Organ Donation Committee which included:

- Training for Anaesthetists
- University of Huddersfield feedback on survey – attitudes and blockers
- Training for staff – handling donation permission with families.
- Promotional activity – advertising on shuttle bus being pursued.

10/18c CHARITABLE FUNDS COMMITTEE

In the absence of Kate Wileman the Chairman updated on the current issues being discussed by the Charitable Funds Committee which included:

- Fund Manager investments
- Performance on funds and spend
- Todmorden – sub committee established with Todmorden Town Council. Charitable Funding being offered for public benches and food bank.

10/19d PATIENT EXPERIENCE AND CARING GROUP

In the absence of Lynn More, unfortunately there were no representatives present who were able to give feedback on the discussions of the Patient Experience and Caring Group.

10/18e NOMINATION AND REMUNERATION COMMITTEE (CoG)

The Chairman reported that the Nominations and Remuneration Committee (COG) had commenced the process for the appointment of Chair and interviews were scheduled for Friday 2 February 2018.

It was noted that the tenures of the Non-Executive Directors had been discussed by the Committee and Dr David Anderson's third and final year was due to end on the 22 September 2018.

OUTCOME: The Council of Governors **RECEIVED** the Sub Committees/Groups updates.

11/18 INFORMATION TO RECEIVE

The following information was received and noted:

a. Updated Council Calendar – updated calendar received and the contents were noted.

b. Extract from Quality Report re Complaints and PALs

The Executive Director of Nursing reported that this information had been supplied to the Council of Governors for information and offered an overall view of the Trust's management of the current position with regard to complaints and PALs contacts. It was noted that discussion regarding the contents of this document had taken place through other forums such as earlier in the meeting within the Performance Report and through Divisional Reference Groups. The Director of Nursing therefore asked Governors to feedback to him how they would like this information presenting in the future to avoid duplication.

ACTION: ALL

Discussion took place regarding capturing compliments as well as complaints and the Executive Director of Nursing advised that work was underway to capture this for the future although it was appreciated that this would not include all compliments received as they are often received informally at ward

level.

12/18 ANY OTHER BUSINESS

There was no other business to note.

13/18 DATE AND TIME OF NEXT MEETING

Wednesday 4 April 2018 commencing at 4.00 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital

The Chair thanked everyone for their contribution and closed the meeting at 6.50 pm.