Calderdale and Huddersfield NHS Foundation Trust

**Meeting of the Board of Directors**
To be held in public
**Thursday 1 February 2018 at 9.00 am**
**Venue**: Large Training Room, Learning Centre, CRH

**AGENDA**

| REF | ITEM | LEAD | PAPER | PURPOSE OF PAPER/ UPDATE | TIMING (INDICATIVE) |
|---|---|---|---|---|---|
| 1 | Welcome and introductions:<br>Di Wharmby, Public Elected Governor<br>Brian Moore, Lead Governor | Chair | **VERBAL** | **Note** | **1 min** |
| 2 | Apologies for absence: | Chair | **VERBAL** | **Note** | **1 min** |
| 3 | Declaration of interests | All | **VERBAL** | **Receive** | **1 min** |
| **Standing items** | | | | | |
| 4 | Minutes of the previous meeting held on 4 January 2018 | Chair | **APP A** | **Approve** | **5 mins** |
| 5 | Action log and matters arising: | Chair | **APP B** | **Review** | **5 mins** |
| 6 | Chairman's Report<br>a. Chair's Recruitment Process Update | Chair | **VERBAL** | **Note** | **5 mins** |
| 7 | Chief Executive's Report:<br>a. Update on Emergency Care Pressures | Chief Executive | **VERBAL** | **Note** | **10 mins** |
| **Keeping the base safe** | | | | | |
| 8 | Patient/Staff Story/Quality Report deep-dive:<br>Patient Flow and Winter Pressures presentation by Helen Barker, Chief Operating Officer | Executive Director of Nursing | **Presentation** | **Note** | **20 mins** |
| 9 | High Level Risk Register | Executive Director of Nursing | **APP C** | **Approve** | **5 mins** |
| 10 | Board Assurance Framework | Company Secretary | **APP D** | **Approve** | **10 mins** |
| 11 | Governance Report<br>a. Council of Governors Election Timetable | Company Secretary | **APP E** | **Approve** | **5 mins** |
| 12 | Freedom to Speak-up/Whistleblowing Annual Report | Dr David Anderson | **APP F** | **Approve** | **10 mins** |
| 13 | Director of Infection, Prevention and Control Quarterly Report | Executive Medical Director | **APP G** | **Note** | **10 mins** |

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| 14 | Equality and Inclusion Annual Report | Company Secretary | **APP H** | **Approve** | **10 mins** |
| 15 | Integrated Performance Report | Chief Operating Officer | **APP I** | **Approve** | **10 mins** |
| **Financial Sustainability** | | | | | |
| 16 | Month 9 – 2017-2018 – Financial Narrative | Executive Director of Finance | **APP J** | **Approve** | **15 mins** |
| **Transforming and improving patient care** | | | | | |
| 17 | Calderdale Cares Moving Forward on Health and Social Care – presentation from Stuart Smith, Director of Adults and Childrens Services , Calderdale Council | Director of Transformation and Partnerships | **Presentation**<br><br>**APP K** | **Approve** | **15 mins** |
| **A workforce for the future – no items** | | | | | |
| | | | | | |
| 18 | **Update from sub-committees and receipt of minutes & papers**<br>▪ Quality Committee – minutes of 3.1.18 and verbal update from meeting 29.1.18<br>▪ Finance and Performance Committee – minutes of 2.1.18 and verbal update from meeting 23.2.18<br>▪ Workforce Well Led Committee – minutes from meeting 9.1.18<br>▪ Audit and Risk Committee – verbal update from meeting held 24.1.18 | | **APP L** | **Receive** | **15 mins** |
| **Date and time of next meeting**<br>Thursday 1 March 2018 commencing at 9.00 am<br>**Venue: Hospital Boardroom, HRI** | | | | | **Approx 168 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**

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## Cover Sheet

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| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 4.1.18 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 4 January 2018 | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>N/A | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 4 January 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 4 January 2018

## Appendix

### Attachment:

APP A - DRAFT - PUBLIC BOD MINS - 4.1.18.pdf

Calderdale and Huddersfield NHS Foundation Trust

# Minutes of the Public Board Meeting held on Thursday 4 January 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 |
| Dr David Birkenhead | Medical Director |
| Gary Boothby | Executive Director of Finance and Procurement |
| 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 |

**IN ATTENDANCE**

| | |
|---|---|
| Anna Basford | Director of Transformation and Partnerships |
| Kathy Bray | Board Secretary (minute taker) |
| Mandy Griffin | Director of The Health Informatics Service |
| Victoria Pickles | Company Secretary |
| Helen McNae | Information Governance & Registration Authority Manager (for item 9) |
| Dr Anu Rajgopal | Guardian of Safe Working (for item 13) |

**OBSERVER**

| | |
|---|---|
| Brian Moore | Publicly Elected Governor – Lead Governor |
| Rosemary Hedges | Staff Elected Governor |

**1/18 WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the meeting.

**2/18 APOLOGIES FOR ABSENCE**

Apologies were received from:
Richard Hopkin, Non-Executive Director
Jason Eddleston, Executive Director of Workforce & OD

Helen Barker, Chief Operating Officer (due to operational pressures)
Brendan Brown, Executive Director of Nursing and Deputy Chief Executive (due to operational pressures)
Dr Peter Bamber, Publicly Elected Governor (due to operational pressures)

**3/18 DECLARATIONS OF INTEREST**

There were no declarations of interest to note.

**4/18 MINUTES OF THE MEETING HELD 7 DECEMBER 2017**

The minutes of the previous meeting were approved as a correct record with the amendment to Page 7 – Month 7 Financial Narrative to read "**Deputy** Director of Finance presented…..".

It was noted that these also included the minutes from the Trustees of the Calderdale and Huddersfield NHS Foundation Trust Charitable Trust Funds held on the 7 December 2017.

**OUTCOME: The minutes of the meeting were APPROVED as a correct record subject to the minor amendment above.**

**5/18 MATTERS ARISING FROM THE MINUTES / ACTION LOG**

**162/17 - SAFER PATIENT PROGRAMME** – It was noted this item had been deferred to the 1 February 2018 Board of Directors Meeting.

**6/18 CHAIRMAN'S REPORT**

The Chairman reported on the extra-ordinary West Yorkshire Association of Acute Trusts Committee in Common meeting held before Christmas and the NHS Improvement telephone conference which discussed financial recovery plans.

**OUTCOME: The Board NOTED the Chairman's report**

**7/18 CHIEF EXECUTIVE'S REPORT**

The Chief Executive updated the Board on the emergency care position locally. It was noted that the position of all NHS Trusts had received national media coverage over the last few days. The Trust had found the previous few days extremely challenging with insufficient beds to meet demands. Although it was noted that many messages had been sent out to colleagues, the Board asked that a formal record be minuted to recognise the efforts of all staff (with direct and non-direct patient contact) for their help and support over this challenging period.

Reference was made to a letter circulated to the Board the previous day from NHS Improvement/NHS England advising that the National Emergency Pressures Panel had asked that Trusts defer all non-urgent inpatient elective care, day case procedures and routine follow-up outpatient appointments until 31 January 2018.

It was noted that staffing was proving difficult. This affected all providers and the response from partners had been good. Locally the position was fast moving and was being monitored on a regular basis. As far as possible senior decision makers were being made available at the front end of the A/E departments to help with patient flow..

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

**8/18 HIGH LEVEL RISK REGISTER**

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

These were:-
6967 (25): Non-delivery of 2017/18 financial plan
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

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

**Risks with reduced scores**
There were no risks with a reduced score.

**New risks**
There are no new risks added to the risk register this month.

**Closed risks**
There were no closed risks during the month.

The Company Secretary advised that discussions were still to take place regarding the review of this document to make it a more dynamic record. This would include changes in the narrative, scores, links with High Level Risk Register and Board Assurance Framework and strategic risks.

Karen Heaton raised the fact that deferring patient appointments during January will obviously have an impact on staff and suggested that this might need to be included in the next High Level Risk Register update.

Mandy Griffin reported that work was still in progress regarding data quality and EPR, although the position was improving in some areas, work still continued.

Discussion took place regarding the resuscitation area and ventilation work required. The Executive Director of Planning, Estates and Facilities advised that a decision on whether a full upgrade or ventilation upgrade only was required would be made at the end of February 2018.

The Chief Executive raised the item of "Emergency Preparedness, Resilience and Response Statement" which had previously been discussed at the Board of Directors. It was noted that following the submission of the Trust's statement further work had been undertaken and an update had been provided to the Executive Board on the progress.

The Chief Executive suggested that any interested NEDs be invited to attend relevant meetings to gain assurance on the underlying processes within the Trust to review risks. The Board appreciated that items on the High Level Risk Register should be viewed through the lens of the regulator.

**ACTION: NEDS/COMPANY SECRETARY**

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

**9/18 PREPARATION FOR THE GENERAL DATA PROTECTION REGULATIONS (GDPR)**

Helen McNae, Information Governance and Registration Authority Manager attended the meeting to update the Board on the preparation for the new General Data Protection Regulations which would be fully implemented by the 25 May 2018.

The presentation gave the Board an overview of the work undertaken by the Trust since May 2016 in preparation for the regulations and provided assurance on the steps taken and planned to ensure compliance. It was noted that monthly updates on the progress would be taken to the Executive Board.

Helen explained that the changes brought in by the GDPR in 2018 are substantial and ambitious and that the Regulation is one of the most wide-ranging pieces of legislation passed by the EU in recent years. It includes the introduction of a Data Protection Officer, data portability, data breach notification, identifying data flows, reviewing contracts, IT systems, procurement processes and privacy by design.

The Board noted that understanding and embedding the GDPR throughout the Trust was important and non-compliance could result in enforcement action by the Information Commissioner's Office, damage to public Trust and reputational damage. Discussion took place regarding the timeline and it was noted that some actions would run past the May 2018 deadline but assurance was given that this would not affect the Trust's compliance with the regulations.

The commercial aspects of this issue for THIS were discussed and these would be included in the THIS Strategic Plan.

It was agreed that progress against plan would be monitored by the Executive Board and Audit and Risk CommitteeClear governance arrangements would be provided thought this route and an update brought to the Board in May 2018.

The Board thanked Helen McNae for her informative presentation and assurances on the process within the Trust to prepare for the new General Data Protection Regulations and approved the 12 step plan within the report. The Board discussed and agreed the appointment of a Data Protection Officer, subject to no additional costs being incurred by the Trust.

**ACTION: BOD AGENDA ITEM – MAY 2018**

**OUTCOME: The Board RECEIVED and APPROVED the work around the implementation of the new GDPR and agreed the appointment of a Data Protection Officer, subject to no additional costs being incurred by the Trust.**

**10/18 GOVERNANCE REPORT – RISK MANAGEMENT STRATEGY**

The Company Secretary presented the Governance Report which included the reviewed Risk Management Strategy. It was noted that the Board of Directors had approved the Risk Management Strategy in January 2017 and set a one year review date.

Audit and Risk Committee and the Risk and Compliance Group had reviewed the Strategy and the proposed changes which had been tracked on the document within the papers. Discussion took place and subject to amendments this was approved:

- Governance Structure – Workforce Well-led Committee – monthly meetings
- Reference to Membership Council to be amended to Board of Governors
- Finance and Performance Committee to look at Risk on a quarterly basis
- Freedom to Speak Up 'Guardian' to be inserted.

**OUTCOME: The Board APPROVED the revised Risk Management Strategy subject to the above amendments.**

**11/17 INTEGRATED PERFORMANCE REPORT**

In the absence of the Chief Operating Officer the Chief Executive highlighted the key points of operational performance for November 2017. 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:-

- 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 seen 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.

Phil Oldfield reported that Finance and Performance Committee had agreed to take a deep-dive review of the IPR and performance trends at the next meeting in February.

Discussion took place regarding Action Cards. Their purpose and process was discussed

agreed that the Chief Operating Officer would be asked to circulate a brief to the Non-Executive Directors to explain the process around the use of these cards.

**ACTION: CHIEF OPERATING OFFICER**

David Anderson enquired about the current position regarding Green Cross Patients following the Xmas period. It was agreed that the Chief Operating Officer would be asked to circulate an update to the Board.

**ACTION: CHIEF OPERATING OFFICER**

Rosemary Hedges asked for information regarding the recent ward moves (cardiology, respiratory and elderly medicine). It was noted that these had all now been completed and the impact of the moves, including staff impacts were being reviewed by the Quality Committee. The Chief Executive reported that on the whole the ward moves had been implemented without any large adverse effects and the patient safety benefits were being realised.

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

**12/18 MONTH 8 – 2017-2018 FINANCIAL NARRATIVE**

The Executive Director of Finance presented the Month 8 Financial Narrative which had been submitted to NHS Improvement and had been discussed in detail at the last Finance and Performance Committee.

It was reported that the Month 8 position is a deficit of £23.41m on a control total basis, a £3.80m adverse variance from the planned deficit of £19.61m. This excludes year to date Sustainability and Transformation funding (STF) of £2.70m.

The final planning submission made to NHSI on 30th March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had a number of 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 initially assessed at £8m plus any subsequent loss of STF funding.

As was discussed with NHSI in the Financial Recovery meeting with the Trust on 4 December, 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 £13.4m 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 Month 7 and 8 the Trust had been unable to deliver the financial plan reporting an adverse variance of £3.80m of which £1.30m related to Month 8. 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 £7m 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 group; cost pressures linked to the requirement to open additional beds and

unidentified CIP of £1.8m. The Trust has undertaken a detailed forecast both activity and income which indicates that activity levels are unlikely to recover to planned levels during this financial year.

A recovery action plan has been implemented which aims to tackle: the recovery of clinical income at risk due to issues with capture and coding in EPR; the development of Divisional financial recovery plans; a Trust wide establishment review; further tightening of budgetary controls and the consideration of a number of technical recovery options. In addition, an EPR stabilisation plan has been put into action to regain activity performance levels to the maximum achievable. This in itself drives additional cost requirements. Every effort will be made to deliver the financial plan, including pursuing innovative technical accounting benefits, but in this context full recovery is unlikely to be possible. Delivery of the financial plan remains the highest risk on the Trust risk register scoring the maximum of 25. The Board noted the Financial recovery plans which were being implemented and highlighted in the report.

It was noted that discussion had taken place at the Finance and Performance Committee on the 2 January 2018, when they had agreed that a financial strategy and plan should be produced to outline the Trust's move away from the forecast position. This was also to be discussed with the Regulator at a meeting on Monday 8 January 2018.

The Board discussed the impact of the deferred patient activity during January which would impact on the Trust's already challenging position and it was noted that no advice had been received from the Regulators regarding the fiscal issues within the letter referred to in the Chief Executives update earlier in the meeting. It was felt that the impacts of this action could continue for some time, even years to come.

**OUTCOME: The Board NOTED the contents of the report.**

**13/18 GUARDIAN OF SAFE WORKING ANNUAL REPORT**

Dr Anu Rajgopal, Guardian of Safe Working within the Trust attended the meeting to present the Annual Report which provided assurance to the Board that doctors in training (junior doctors) under the new terms and conditions of service are working safe hours and to highlight any areas of concern.

In summary it was noted that all doctors in training at CHFT are now on the 2016 contract. In the past 12 months, there has been considerable variation in the number of exception reports but consistently the vast majority of these are from FY1s in general surgery seemingly due to a heavier workload in these specialities. Four fines have been issued by the previous Guardian of Safe Working Hours (GOSWH) on the general/urology/vascular surgery F1 rota in Q2 and further fines will be imposed on the surgical division for the same rota due to breeches in Q3. There is a reasonable awareness among Educational and Clinical supervisors about exception reporting and the 2016 contract however there are a small number that need further support and training around the software for Allocate.

There has been a decrease in the unfilled shifts in the latter half of this last year with an increased use of bank staff to fill these. This should lead to improved junior doctor wellbeing. Combined data around specific junior doctor rota gaps and how these have been covered is not currently available from a single source and this would improve with e-rostering which is currently being rolled out within CHFT.

The regional Guardians' forum of Health Education England working across Yorkshire and the Humber has suggested that 1 WTE administrator is needed to support the Guardian from August 2017. Dr Rajopal commented that the lack of dedicated administrative support is hampering the ability of the Guardian to undertake their role and may prevent us from being able to effectively monitor breeches particularly those arising in relation to the 48-hour average working week. 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

from within the organisation to assist the Guardian of Safe Working.

There was a concern about the poor attendance at the quarterly junior doctor forums and an action plan has been drafted by the Guardian with support from medical education and human resources.

**ACTION: EXECUTIVE MEDICAL DIRECTOR**

**OUTCOME: The Board APPROVED the Guardian of Safe Working Annual Report**

**14/18 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES**

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

**a. Quality Committee**

Dr Linda Patterson, Chair of the Quality Committee reported on the items discussed at the meeting held on 3 January 2018 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- **HSMR/SHMI** – HSMR rates reducing. The latest data on SHMI is awaited.
- **Fall Initiative** – presentation received – good results to date
- **CQC Group** – update on work of the group received
- **Documentation** – discussion re poor documentation issues continues – on going issue – EPR implementation should help but multifactorial issues involved.
- **Whistleblowing** – It was noted that the last minutes had made reference to a team from Chesterfield visiting the Trust. Discussion took place regarding the collation of whistleblowing/freedom to speak up process in the Trust.

**OUTCOME: The Board RECEIVED the minutes from the meeting held on 4 December 2017 and the verbal update of the meeting held on 3 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 2 January 2018 which had not been previously covered on the Board's agenda.

The main areas discussed included:

- **Month 8 Financial Narrative** - Issues as discussed earlier in the meeting
- **2018-2019 Trajectory** – paper to next meeting to look at hard choices
- **Cancelled Activity** – position changed since F&P Committee
- **Update on STP 5 Year Plan** – increase from £11m to £16m due to system issue.
- **Deep-dive in Performance** – deferred to next meeting
- **CNST** – premium reduced due to reduced negligence claims within the Trust but no benefit as control total will be adjusted.

**OUTCOME: The Board RECEIVED the minutes from the meeting held on 28 November 2017 and verbal update from 2 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 13 December 2017. The key items discussed at the meeting included:

- **Staff Survey Update** – was received. Final report will be available late February/early March 2018
- **Mandatory Training** – assured that work within Divisions had been undertaken to develop actions plans to meet compliance
- **Effectiveness Template** – Committee to review its work using the CQC template.
- **Investors in People** – overview of report received. A final assessment will take place in mid-2018

**OUTCOME: The Board RECEIVED the minutes from the meeting held on the 13 December 2017.**

**DATE AND TIME OF NEXT MEETING**
The next meeting was confirmed as Thursday 1 February 2018 commencing at 9.00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair thanked everyone for their contribution and closed the public meeting at 11.30 am.

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

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|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>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 February 2018 | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>N/A | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 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 Action Log for the Public Board of Directors Meeting as at 1 February 2018

## Appendix

### Attachment:

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

# ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2018/ APP



| Red | Amber | Green | Blue |
|---|---|---|---|
| Overdue | Due this month | Closed | Going Forward |

| Date discussed at BOD Meeting | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | DUE DATE | RAG RATING | DATE ACTIONED & CLOSED |
|---|---|---|---|---|---|---|
| 7.12.17<br>183/17 | **PATIENT STORY**<br>It was agreed to discuss how EPR can support the serious incident investigation and information capture. | OW / JC | | Feb 2018 | | |
| 7.12.17<br>186/17 | **CHAIRMAN'S REPORT**<br>The slides from NHS Providers would be shared with the Board | AH | | | | Email circ'd 3.1.18 |
| 7.12.17<br>187/17 | **CHIEF EXECUTIVE'S REPORT**<br>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 | | March 2018 | | |
| 7.12.17<br>188/17 | **QUARTERLY QUALITY REPORT**<br>The Quality Committee will undertake a deep dive on sepsis and will report back to the Board | Chair of Quality Committee / DB | | March 2018 | | |
| 7.12.17<br>190/17 | **HIGH LEVEL RISK REGISTER**<br>The narrative for the risk register will be reviewed to ensure issues are not stagnant and are properly explained | BB / VP | | Feb 2018 | | |
| 7.9.17<br>141/17 | **HIGH LEVEL RISK REGISTER**<br>The Executive Director of Nursing reported that work was on going to broaden the number of investigators available to undertake SI investigations. It was agreed that a deep-dive report would be brought to the December 2017 BOD Meeting. | BB/JC | **4.1.18**<br>The Company Secretary advised that discussions were still to take place regarding the review of this document to make it a more dynamic record. This would include changes in narrative, scores, links with High Level Risk Register and Board Assurance Framework and strategic risks.<br><br>The Chief Executive suggested that any interested | 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 |
|---|---|---|---|---|---|---|
| | | | NEDs be invited to attend relevant meetings to gain assurance on the underlying processes within the Trust to review risks. | | | |
| 7.12.17 191/17 | **GOVERNANCE REPORT** All Board members to complete their self-assessment and return to the Board Secretary | ALL | | March 2018 | | |
| 7.12.17 193/17 | **INTEGRATED PERFORMANCE REPORT** It was agreed that a narrative would be included within the report to outline the areas of change and their impact over the last 6 months. | HB | | Feb 2018 | | |
| 7.12.17 194/17 | **MONTHLY FINANCIAL NARRATIVE** It was agreed that the Board needed to be more sighted on a timeline when the EPR and activity levels would return to expected levels and this would be discussed in detail at the next Finance and Performance Committee. | MG / HB | | Feb 2018 | | |
| 7.12.17 197/17 | **UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES** The Chief Executive advised that a piece of work was underway looking at staff experience of appraisals would be brought to a future BOD meeting | JE | | TBC | | |
| 2.11.17 174/17a | **BOARD ASSURANCE FRAMEWORK** Updated BAF received. MD-Digital Health and Co-Sec undertaking work around identifying IMT dependency/resilience and this would be included | VP | **7.12.17** It was agreed that the next update would be brought to the February 2018 Meeting. | Feb 2018 | | |

| Red | Amber | Green | Blue |
|---|---|---|---|
| Overdue | Due this month | Closed | Going Forward |

| Date discussed at BOD Meeting | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | DUE DATE | RAG RATING | DATE ACTIONED & CLOSED |
|---|---|---|---|---|---|---|
| | when the BAF was next updated in February 2018. | | | | | |
| 7.9.17<br>141/17 | **HIGH LEVEL RISK REGISTER**<br>The Executive Director of Nursing reported that work was on going to broaden the number of investigators available to undertake SI investigations. It was agreed that a deep-dive report would be brought to the December 2017 BOD Meeting. | BB/JC | **4.1.18**<br>The Company Secretary advised that discussions were still to take place regarding the review of this document to make it a more dynamic record. This would include changes in narrative, scores, links with High Level Risk Register and Board Assurance Framework and strategic risks.<br><br>The Chief Executive suggested that any interested NEDs be invited to attend relevant meetings to gain assurance on the underlying processes within the Trust to review risks. | TBC | | |
| 5.10.17<br>162/17 | **IPR – GREEN X PATIENTS**<br>The Board agreed that the IPR did not accurately record the number of Green X Patients to reflect the improvement journey. The Chief Operating Officer agreed to review this at the December 2017 Board Meeting. | HB | **7.12.17**<br>It was noted that this item would be reported in more detail within the Feb 2018 meeting report.<br>**4.1.18**<br>David Anderson enquired on the position on Green X Patients following the Xmas period. It was agreed that the COO would be asked to circulate an update to the Board. | Feb 2018 | | |
| 5.10.17<br>162/17 | **IPR – SAFER PATIENT PROGRAMME**<br>Arrangements had been made for 'Discharge Lounge' to be included on the Council of Governors agenda in October. It was noted that | HB | | 1.2.18 | | |

| 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 |
|---|---|---|---|---|---|---|
| | the Safer Patient Programme would be brought to the Board in January 2018. | | | | | |
| 2.11.17<br>147/17a. | **ESTATES – CAP FUNDING REDUCTION**<br>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 | | TBC | | |
| 5.10.17<br>160/17 | **EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRRR) & CORE STANDARDS ANNUAL SUBMISSION**<br>The Board requested that further work be undertaken on the submission to ensure an audit trail before submission to the Yorkshire and Humber Local Health Resilience Partnership. | LH | **2.11.17**<br>It was noted that amendments had been made to the submission and it was agreed that this would be circulated to the Board.<br>**7.12.17**<br>It was noted that amendments had been circulated to the Board outside the meeting. | | | 7.12.17 |
| 4.1.18<br>9/18 | **PREPARATION FOR THE GENERAL DATA PROTECTION REGULATIONS (GDPR)**<br>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 | | |

# ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 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<br>11/17 | **IPR – ACTION CARDS**<br>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 | | TBC | | |
| 1.4.18<br>13/18 | **GUARDIAN OF SAFE WORKING**<br>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 | | TBC | | |
| 1.6.17<br>87/17 | **HOSPITAL PHARMACY SPECIALS (HPS) ANNUAL REPORT**<br>The Annual Report was received and production development noted.<br>The DoF reported that in order for the service to undertake large scale products, significant investment was required and a Business Strategy would be brought to the Board later in the summer. | GB | | Early in New Year 2018 | | To private BOD Agenda Feb 2018 |

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

| |
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| |

## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Andrea McCourt, Head of Governance and Risk |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Brendan Brown, Executive Director of Nursing |
| **Title and brief summary:**<br>High Level Risk Register - To present the high level risks on the Trust Risk Register as at 22 January 2018 | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>Risk and Compliance Group 15 January 2018 | |
| **Governance Requirements:**<br>Keeping the Base Safe | |
| **Sustainability Implications:**<br>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 22 January 2018.

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

iii. Two new risks added to the high level risk register during January 2018; risk 7147, EPR financial risk within the medical division scored at 20 and risk 6949 regarding the Blood Transfusion service scored at 15.

iv The risk relating to mortality levels falling below national standards, risk 4783 has been reduced from a score of 16 to 12 following sustained improvements in reported mortality levels. The risk will continue to be monitored via the Clinical Outcomes Group.

### Next Steps:

Financial risks for 2018/19 are being developed and will be considered by the Finance and Performance Committee on 30 January 2018. These will be reviewed at the Risk And Compliance Group on 13 February 2018 and reported to the Board of Directors at its meeting on 12 March 2018.

### 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:

# HIGH LEVEL RISK REGISTER SUMMARY OF CHANGES

**Risks as at 22 January 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
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 Medical

The Trust risk appetite is included below.

## RISKS WITH INCREASED SCORE

None

## RISKS WITH REDUCED SCORE

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. See agenda for new risks identified by divisions for discussion as potential risks.

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

## CLOSED RISKS

None

## JANUARY 2018 – BOARD - SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK AS AT 22.1.18

| BAF ref | Risk ref | Strategic Objective | Risk | Executive Lead | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 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 | =15 | ↑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 (JE) | =16 | =16 | =16 | =16 | =16 | =16 |
| 014 | 6977 | Keeping the base safe | Mandatory training 2017/18 | Director of Workforce and OD (JE) | =16 | =16 | =16 | =16 | =16 | =16 |
| 011 | 6903 | Keeping the base safe | ICU/Estates joint risk | Director of Estates and Performance (LH) | =20 | =20 | =20 | =20 | =20 | =20 |
| 007 | 6924 | Keeping the base safe | Misplaced naso gastric tube for feeding | Director of Nursing (BB) | =15 | =15 | =15 | =15 | =15 | =15 |
| 007 | 6715 | Keeping the base safe | Poor quality / incomplete documentation | Director of Nursing (BB) | =15 | =15 | =15 | =15 | =15 | =15 |
| 007 | 6971 | Keeping the base safe | Endoscopy provision | Associate Director of Nursing, Surgery and Anaesthetics (JM) | =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 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Finance Risks** | | | | | | | | | | |
| 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 |
| 021 | 6441 | 2017/18 income | Divisional income surgery and anaesthetics | Associate Director of Nursing, Surgery and Anaesthetics (JM) | | !16 | ↑20 | =20 | =20 | =20 |
| 021 | 7147 | 2018/ 18 income | Divisional income medical | Associate Director of Nursing, Medical Division | | | | | | !20 |
| **Performance and Regulation Risks** | | | | | | | | | | |
| 007 | 6658 | Keeping the base safe | Inefficient patient flow | Director of Nursing (BB) | =16 | ↑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 22/1/2018

**KEY:** = Same score as last period ↓ decreased score since last period
! New risk since last period ↑ increased score since last period

| LIKELIHOOD (frequency) | CONSEQUENCE (impact/severity) | | | | |
|---|---|---|---|---|---|
| | **Insignificant** | **Minor** | **Moderate (3)** | **Major (4)** | **Extreme (5)** |
| **Highly Likely (5)** | | | = 6715 Poor quality / incomplete documentation | = 6345 Nurse Staffing<br>= 7049 Financial risk arising from EPR<br>= 6658 Inefficient patient flow<br>= 7078 Medical Staffing | = 6967 Not delivering 2017/18 financial plan |
| **Likely (4)** | | | | = 6300 CQC improvement actions<br>= 6596 Serious Incident investigations<br>= 6598 Essential Skills Training Data<br>! 5862 Falls risk<br>= 6990 CQUIN sepsis<br>= 6977 mandatory training<br>= 7046 EPR quality and safety risks<br>= 7047 EPR Performance /regulatory/KPI risk arisisng from EPR | = 2827 Over reliance on locum middle grade doctors in A&E<br>= 5806 Urgent estate work not completed<br>= 6903 ICU/ resus estates risk<br>= 7062 Capital programme 2018/19<br>=6441 Divisional income 2017/18 surgery and anaesthetics<br>! 7147 Divisional income 2017/18 medical |
| **Possible (3)** | | | | | = 6829 Pharmacy Aseptic Unit<br>= 6924 Misplaced naso gastric tube<br>= 6971 Endoscopy provision<br>= 6011 Blood transfusion process<br>= 5747 Vascular /interventional radiology service<br>! 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.<br><br>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** |

# High Level Risk Register

## Risks 15+

01-Feb-18

| Risk No | Div | Opened | Status | Objective | Risk Description plus Impact | Existing Controls | Gaps In Controls | Initail | Current | Target | Further Actions | Review | Target | RC | Exec Dir | Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6967 | Trustwide | Apr-2017 | Active | 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:<br>- £20m (5.3% efficiency) Cost Improvement Plan challenge is not fully delivered<br>- loss of productivity during EPR implementation phase and unplanned revenue costs<br>- inability to reduce costs should commissioner QIPP plans deliver as per their 17/18 plans<br>- income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets<br>- Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance<br>- expenditure in excess of budgeted levels<br>- agency expenditure and premium in excess of planned and NHS Improvement ceiling level | Standing Financial Instructions set spending limits<br>Project Management Office in place to support the identification of CIP<br>Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action<br>Accurate activity, income and expenditure forecasting<br>Finance and Performance Committee in place to monitor performance and steer necessary actions<br>Executive review of divisional business meetings<br>Budget reviews hold budget holders to account<br>Realistic budget set through divisionally led bottom up approach<br>Financial recovery actions were agreed by Turnaround Executive on 13th June.<br>Controls around use of agency staffing have been strengthened.<br>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, | Lack of direct consequence to budget holders for poor budgetary management.<br>Difficulty in identifying EPR benefits to offset additional committed resource.<br>Nursing Agency spend above planned level.<br>Not all Agency shifts booked through flexible workforce team. | 20 5 x 4 | 25 5 x 5 | 15 5 x 3 | 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 £18.03m 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 9 the Trust reported a position that is £5.55m 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. | Feb-2018 | Mar-2018 | FPC | Gary Boothby | Philippa Russell |
| 6903 | Estates & Facilities | Dec-2016 | Active | 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:<br><br>ICU - Air Handling Unit (AHU)<br>RESUS - Ventilation<br>RESUS – Electrical Resilience<br>ICU & RESUS - Flooring<br>ICU & RESUS - Electrical Infrastructure<br>RESUS - Plumbing infrastructure<br>ICU & RESUS - Life Support Beams/Pendant<br>ICU - Building Fabric<br>ICU - Nurse Call System<br>RESUS - Medical Engineering Risk - 4 Dameca Anaesthetic Machines<br>RESUS - Operational Safety f<br>RESUS – Compliance / Statute Law<br><br>All of the above does not meet the minimum requirement as stipulated in the Health Technical Memorandums (HTM) and Health | 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 | November 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Estates have re-developed the old plaster room into a Rapid Assessment Area.<br><br>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.<br><br>**January 17 Update**<br>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. | Feb-2018 | Dec-2018 | RC | Lesley Hilll / David McGarrigan | Chris Davies |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7049 | Trustwide | Aug-2017 | Active | Financial sustainability | EPR Financial risk with increased costs and decreased income.<br>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.<br>Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff<br>Increased costs to ensure timely and appropriate response to clinical & operational risks. | Developing financial recovery plans.<br>Weekly activity and income meeting chaired by Director of Transformation and partnership, weekly Theatre scheduling now attended by an Executive. systems to capture activity.<br>Weekly performance monitoring.<br>Targeted improvement for those in greatest need.<br>Activity coding issues being addressed.<br>Continuing to shadow monitor activity using existing systems.<br>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.<br>Stabilisation plan developed. | Adequate system build<br>BAU Team capacity.<br>Staff training. | 20<br>4 x<br>5 | 20<br>4 x<br>5 | 0 0<br>x 0 | Identification of staff training needs.<br>Specialty delivery of recovery plans.<br>System build changes identified and prioritised, BAU team capacity review.<br>Education and training for clinical staff.<br>Placing Coders in clinical areas<br><br>December Update<br>Weekly data quality meeting reviews data capture and system issues with Divisional, Finance and THIS representation - ongoing. Divisional financial recovery plans to address activity maximisation. Negotiations with commissioners have concluded to secure estimated income which had been at risk in Months 1-6. Additional costs incurred being monitored with approvals to be taken through Commercial Investment Strategy Group and monthly financial monitoring. Discussions taking place with regulators, NHSI with regards to the exceptional financial pressure incurred as a result of EPR implementation in-year and the potential impact on achievement of control total.<br><br>**January 2018**<br>No update | Feb-18 | Mar-20 | FC | Gary Bo nby | Kirsty A er |
| 7147 | Medical | Dec-2017 | Proposed for Acceptance | Financial sustainability | EPR Financial risk with increased costs and decreased income.<br>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.<br>Loss of income relating to the recording of fewer diagnosis and more signs and symptoms which produces a lower tariff<br>Increased costs to ensure timely and appropriate response to clinical & operational risks.<br><br>See High level risk 7049 | Developing financial recovery plans.<br>Weekly activity and income meeting chaired by Director of Transformation and partnership.<br>Weekly performance monitoring.<br>Targeted improvement for those in greatest need.<br>Activity coding issues being addressed.<br>Continuing to shadow monitor activity using existing systems.<br>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.<br>Stabilisation plan developed. | Adequate system build<br>BAU Team capacity.<br>Staff training. | 20<br>4 x<br>5 | 20<br>4 x<br>5 | 0 0<br>x 0 | Identification of staff training needs.<br>Specialty delivery of recovery plans.<br>System build changes identified and prioritised, BAU team capacity review.<br>Education and training for clinical staff.<br><br>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..<br><br>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.<br>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.<br><br>Contract income is impacted upon as a by-product of these actions<br><br>**January 2017**<br>Discussions with commissioners on year end position are in train**.** | Feb-18 | Mar-2018 | DB | Ashwin Verma | Andrew Gee |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7062 | Trustwide | Sep-2017 | Proposed for Acceptance | Finance 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.<br><br>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<br><br>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 | Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling.<br><br>On-going dialogue with regulators for additional support to reflect the unique CHFT and in particular HRI circumstances. | Limited Contingency available.<br>Potential for slippage of 17/18 schemes in next financial year.<br>Uncertainty regarding long term capital planning while FBC is awaiting approval. | 20<br>5 x<br>4 | 20<br>5 x<br>4 | 12<br>4 x<br>3 | 18/19 Capital Plan has been developed but is currently in excess of internally generated capital funds. To be reviewed by Commercial Investment Strategy Committee on the 25th of January 2018.<br>Trust is exploring alternative methods of increasing Capital Delegated Limits | Feb-2018 | Jun-20 | FPC | Gary B nby | Philipp ussell |
| 7078 | Corporate | Oct-2017 | Active | Keeping the base safe | Medical Staffing Risk (see also 6345 nurse staffing and 7077 therapy staffing)<br>Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to:<br>- difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology<br>- dual site working and impact on medical staffing rotas<br><br>resulting in:<br>- increase in clinical risk to patient safety due to reduced level of service / less specialist input<br>- negative impact on staff morale, motivation, health and well-being and ultimately patient experience<br>- negative impact on sickness and absence<br>- negative impact on staff mandatory training and appraisal<br>- cost pressures due to increased costs of interim staffing<br>- delay in implementation of key strategic objectives (eg Electronic Patient Record) | Medical Staffing<br>Medical Workforce Group chaired by the Medical Director.<br>Active recruitment activity including international recruitment at Specialty Doctor level<br>- new electronic recruitment system implemented (TRAC)<br>-HR resource to manage medical workforce issues.<br>-Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements | Medical Staffing<br>Lack of:<br>- job plans to be inputted into electronic system<br>- dedicated resource to implement e-rostering system<br>- centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team<br>- measure to quantify how staffing gaps increase clinical risk for patients | 20<br>4 x<br>5 | 20<br>4 x<br>5 | 9 3<br>x 3 | August 2017<br>Work has been undertaken to promote the role of Physician Associates (PAs) within the Trust, and 13 offers were made on the 10 June for posts within Medicine and Surgery. 10 are due to start on the 2 October 2017, 1 has withdrawn and 2 are still going through pre-employment checks.<br><br>September 2017<br>The number of vacancies within the Medical and Dental staff group has reduced 16 FTE in the last month<br>- All trainee doctors due to commence on the 2016 Contract in July,August and September are all now in post. The new trainees due to commence in October have been sent their work schedules and pre-employment checks are underway to ensure that they commence in post as planned. From October 2017 all doctors in training at CHFT will have been migrated to the new terms and conditions of the 2016 Junior Doctor Contract.<br>- 6 new Consultant commenced in post as planned in August 2017. Work is underway with with the BMJ and divisional colleagues for another Trust wide advert at Consultant level in September 2017. The previous full page colour adverts, whilst a cost to the organisation, have produced positive results. The campaign in November 2016 resulted in 8 appointments at Consultant level (1 of which is a Fixed term employee) and the March 2017 advert resulted in 9 offers at Consultant Level (3 as Fixed Term Employees). | Feb-18 | Jan-2018 | WF | David Birkenhead | Pauline North |

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| 2827 | Medic | Apr-20 | Active | Develo 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.<br>Risks:<br>1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents<br>2. Risk to the emergency care standard due to risk above and increased length of stay<br>3. Risk of shifts remaining unfilled by flexible workforce department<br>4. Risk to financial situation due to agency costs<br><br>***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<br>Middle Grade Doctors moved within sites to respond to pressures<br>Part-time MG doctors appointed<br>Where necessary other medical staff re-located to ED<br>Consultants act down into middle grade roles to fill gaps temporarily<br>4 weeks worth of rota's requested in advance from flexible workforce department<br>Development of CESR programme<br>ACP development<br>Continued recruitment drive for Consultant and Middle Grade doctors<br>Weekly meeting attended by flexible workforce department, finance, CD for ED and GM | Difficulty in recruiting Consultants, Middle Grade and longer term locums<br>Relatively high sickness levels amongst locum staff.<br>Flexible Workforce not able to fill gaps<br>ACP development will take 5 yrs from starting to achieve competence to support the middle grade level<br>CESR training will extended time to reach Consultant level with no guarantee of retention | 20<br>4 x<br>5 | 20<br>5 x<br>4 | 12<br>4 x<br>3 | Nov 2017<br>CESR applications being progressed. 2 MTI doctors recruited.. applications being progressed.<br>Currently aware of significant shortfalls in night provision for Christmas week. Alternative strategies being explored<br><br>Dec 2017<br>Some improvement in fill rates for Christmas week, but likely requirement for on-call Consultant cover overnight.<br><br>**Jan 2018**<br>No significant change from last month | Mar-2018 | Aug-20 | WEB | David E enhead | Dr Mari avies/Mrs Caroline Smith |
| 6345 | Corporate | Jul-2015 | Active | Keeping the base safe | Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077)<br>Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to:<br>- 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)<br>- Inability to adequately staff flexible capacity ward areas<br><br>resulting in:<br>- increase in clinical risk to patient safety due to reduced level of service / less specialist input<br>- negative impact on staff morale, motivation, health and well-being and ultimately patient experience<br>- negative impact on sickness and absence<br>- negative impact on staff mandatory training and appraisal<br>- cost pressures due to increased costs of interim staffing<br>- delay in implementation of key strategic objectives (eg Electronic Patient Record) | Nurse Staffing<br>To ensure safety across 24 hour period:<br>- use of electronic duty roster for nursing staffing, approved by Matrons<br>- risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing<br>- staff redeployment where possible<br>-nursing retention strategy<br>- flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream<br>Active recruitment activity, including international recruitment | | 16<br>4 x<br>4 | 20<br>4 x<br>5 | 9 3<br>x 3 | **January 2018**<br>Applicants from International recruitment trip to the Philippines are progressing. 119 offers were made in country, since March 2017; 11 candidates have withdrawn, 105 are completing their training for the International English Language Test System (IELTS) including 7 with their IELTS exam booked before the end January. The Trust is offering the remaining students the opportunity to change onto the Occupation English Test (OET) following the announcement from the NMC that the OET will be accepted as an alternative to IELTS. This is being offered to 57 applicants who meet the criteria to move over from IELTS. The OET process has a turnaround of 4 - 6 weeks for students currently averaging 6 in their IELTS so there is potential these applicants could be in post by April 2018. In addition to those in training we have 9 candidates who have passed their IELTS and are progressing with their NMC application, 2 are currently going through the visa application process and 3 nurses started with the Trust on 4 December 2017.<br><br>The split generic advertising approach for staff nurses, 1 for Medical division and the other 1 for Surgical division has continued following the success of applications received in previous months. The current adverts are due to close 22 January and have so far attracted 7 applicants.<br><br>A further Physician Associates (PAs) vacancy for 2 additional PAs in Medicine is currently at offer stage with 2 candidate's completing pre employment checks. | Jan-2018 | Jan-2018 | WF | Brendan Brown, Jason Eddleston | Rachael Pierce |

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| 6441 | Surgery & Anaesthetics | May-2017 | Active | Finance & 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 | November 2017 update<br>Risk score remains at 20 with Division forecast remaining as per month 5 re forecast. Weekly Theatre scheduling meeting has been reviewed and agenda and approach amended to incorporate additional KPI's in order to drive out the in efficiencies. Month 7 reported financial position is inline with reforecast plan.<br><br>December 2017 update<br>Risk score remains at 20. The underlying forecast remains in the region of £9m adverse to plan. Although improvements to expenditure and activity, income are forecast for the last quarter these are being off set with risks associated with the CRH theatre refurbishment and high risk CIP schemes. Change control notices are being developed in relation to the CIP schemes with a stop moment planned for the CRH theatre refurbishment plan as discussed at the Surgery PRM 4.12.17.<br><br>**January 2018 update**<br>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. | Feb-18 | Mar-20 | DB | Julie Jordan | Joanne Hurdcastle |

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| 6658 | Corpo[illegible] | Mar-2[illegible] | Active | Keepi[illegible] the base safe | There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and [illegible]. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties | 1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures.<br>2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement<br>.3 Daily reporting to ensure timely awareness of risks.<br>4 4 Hourly position reports to ensure timely awareness of risks<br>5 Surge and escalation plan to ensure rapid response.<br>6 Discharge Team to focus on long stay patients and complex discharges facilitating flow.<br>7 Active participation in systems forums relating to Urgent Care.<br>8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow.<br>9 Weekly emergency care standard recovery meeting to identify immediate improvement actions<br>10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation.<br>11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB.<br>12. Single transfer of care list with agency partners | 1. Capacity and capability gaps in patient flow team<br><br>2. Very limited pull from social care to support timely discharge<br><br>3. Limited used of ambulatory care to support admission avoidance<br><br>4. Tolerance of pathway delays internally with inconsistency in documented medical plans<br><br>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<br><br>6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision.<br><br>7. Lack of system resilience funding and a risk that previously agreed funding | 20 | 4 x 5 | 20 | 4 x 5 | 9 | 3 x 3 | October 2017<br>Delay in the additional cubicle space being created - should be in place by November<br>Introduction of Urgent Care Action Cards- to aid good flow, prevent exit block- work on-going with the divisions to embed.<br>Discharge Improvement week took place in September.<br>Introduction of a whole system partner working group to improve transfer of care (medically fit patients waiting for discharge)<br>November 2017<br>Work initiated to meet the discharge CQUIN will have a positive impact on this risk by reducing the LOS for complex patients, improve clinical pathway management.<br>Implementation of the SAFER Bundle across the clinical divisions starts this month.<br><br>December 2017<br>Winter Plan in place and being implemented, within the plan are specific actions to reduce 'exit block' and improve flow.<br>Internal Silver Tactical Command in Place<br>Winter monies available to support increased medical staff, weekend discharges and tracking clinical pathways.<br><br>**January 2018**<br>Winter Plan remains in place.Tactical Command will be in place until the end of January 2018.<br>Winter initiates being reviewed. | Feb-18 | Jan-20[illegible] | BOD | COO H[illegible]n Barker | Bev We[illegible]r |
| 5806 | Estates & Facilities | May-2015 | Active | Keeping the base safe | There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure.<br><br>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.<br><br>The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan.<br>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<br>and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities.<br><br>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.<br><br>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 | November 17 Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Estates have re-developed the old plaster room into a Rapid Assessment Area.<br><br>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.<br><br>**January 18 Update**<br>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. | Feb-2018 | Mar-2018 | RC | Lesley Hill / David McGarrigan | Paul Gilling / Chris Davies |

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| 5862 | Medic | Aug-2 3 | Active | Keepi 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;<br>Vulnerable adult risk assessment and care plan.<br>Falls monitors,falls beds/chairs, staff visibility on the wards,<br>Cohort patients and 1:1 care for patients deemed at high risk.<br>Falls collaborative work on wards deemed as high risk;<br>Staff education.<br>All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings.<br>Focussed work in the acute medical directorate as the area with the highest number of falls.<br>Butterfly scheme.<br>Delirium assessment | Insufficient uptake of education and training of nursing staff, particularly in equipment.<br><br>Staffing levels due to vacancies and sickness.<br><br>Inconsistent full multifactorial clinical assessment of patients at risk of falls.<br><br>Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners.<br><br>Environmental challenges in some areas due to layout of wards. . | 12<br>4 x 3 | 16<br>4 x 4 | 9 3<br>x 3 | November update<br>Work continues as plan however further engagement is required for implementing consistently safety huddles on clinical areas .<br>Falls incidents are reducing in numbers in the last 2 months (N=137).<br>ESR falls prevention now available as mandatory clinical training.<br><br>December update<br>Results of National Audit of Inpatient Falls audit report 2017is now available,with CHFT practice below 50% compliance in the target interventions of visual screening, lying and standing blood pressure, access to mobility aids and medication review.<br>These will influence further improvement work through the Collaborative work.<br>Falls incidents increased in total for Nov -155 with an increase noted in OPD and CHFT community areas in month.One harm fall in month.<br><br>**January 2018 update.**<br>Decembers number of falls have increased in number 172 with 2 harm falls.<br>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.<br>ESR trajectory set to improve Falls prevention training. Reported compliance in Dec -57%.<br>Falls policy revised in line with EPR introduction and includes the post falls management flow chart.<br>Post falls safety huddle tool (FISH)now available on datix documents for capture immediate information and patient experience.<br>Ward assurance tool to be used consistently to audit falls assessment and interventions for centralised compliance and actions for individual ward | Feb-2018 | Feb-20 | PSQB | Brenda rown | Janette- ckroft |

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| 6300 | Trustwide | May-2015 | Active | Keeping the base safe | As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services.<br><br>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<br>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<br>Action plans progressed for all must and should do actions<br>Separate action plans in place for each core service<br>Reports to the Trust Board on those core services requiring improvement<br>CQC compliance reported in Divisional Board reports to the Quality Committee<br>Mock inspections for core services<br>System for regular assessment of Divisional and Corporate compliance<br>Routine policies and procedures<br>Quality Governance Assurance structure<br>The Risk and Compliance Group has oversight of areas outstanding actions not completed<br><br>Well Led Inspection<br>A mock PIR for the Well Led domain is taking place to identify further areas for improvement<br>Each division is restarting CQC groups to oversee pre inspection activity<br>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.<br><br>We do not know the date of the next inspection<br><br>We do not yet have the Insight Report from the CQC which details the data that they hold regarding our services.<br><br>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 | November 2017: Trust wide CQC group reviewing responses from the self assessments commenced with well led domain, next will be safe domain. Populating plan with issues identified. Trust wide Regional Leadership Event delivered by Ted Baker, Chief Inspector of Hospitals<br><br>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.<br><br>**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 | Feb-18 | Apr-2018 | WEB | Brenda Brown | Juliette Cosgrove |
| 6596 | Corporate | Jan-2016 | Active | 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.<br>- Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs<br>- Patient Safety Quality Boards review of serious incidents, progress and sharing of learning<br>- Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports<br>- Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements.<br>- Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs<br>- Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans<br>- Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for | 1. Lack of capacity to undertake investigations in a timely way<br><br>2. Need to improve sharing learning from incidents within and across Divisions<br><br>3. Training of investigators to increase Trust capacity and capability for investigation | 16 | 4 x 4 | 16 | 4 x 4 | 8 | 4 x 2 | November 2017<br>Continued focus on meeting with appointed investigators to support completion of report and / or timely investigation and scheduling within divisional panels prior to SI panel.<br><br>December 2017<br>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.<br><br>**January 2018**<br>Development of investigators pack to support investigators.<br>Revised serious incident report template to improve level of analysis within serious incident reports.<br>Effective investigations course being held 10 January 2018, with 20 staff booked to attend. | Feb-18 | Mar-2018 | QC | Director of Nursing, Brendan Brown | Juliette Cosgrove |

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| 6598 | Corpo | Jan-2( | Active | Keepi | There is a risk of reporting low compliance against many of the agreed essential skills, therefore the organisation cannot be assured [illegible] ant 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.<br>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.<br>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.<br>Compliance reports are produced monthly and deviation compared to the previous month to track improvement and build on successes.<br>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.<br>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.<br>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.<br>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.<br>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.<br>5/ recent focus on mandatory training and appraisal has had an impact on staff completing essential skills training.<br>6/ A small number of maternity essential skills are set in ESR but the actual learning takes place on an externally hosted e- | 16 | 16 | 12 | December 2017<br>As all but 1 of the essential skills now has a target audience set and are live in ESR, the description of this risk has been changed. The risk is no longer that we are unable to compliance report against the essential skills, instead it is that we are at risk of reporting low levels of compliance. The details have therefore been amended to reflect this change.<br>A communications strategy has now been agreed and applied to the latest essential skill to go live - IV therapies. The remaining outstanding essential skill not yet set is Food Hygiene level 1. Issues with the e-learning assessment allowing a pass with 0 correct answers and a late change to the target audience have created delays. This is linked to a recent SI for which there is a datix action of training to be rolled out by March 2018. We are on schedule to achieve this.<br>A plan is in place to engage SMEs and HR BPs to help drive up compliance across the range of essential skills with progress reviewed on a fortnightly basis in the short term. BI colleagues will support the necessary reporting process. All essential skills compliance rates have now been RAG rated and targets set for improvements in compliance for each.<br><br>**January 2018**<br>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.<br>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. | Feb-2018 | Mar-20 | WF | Jason E leston | Ruth M n |

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| 6977 | Corpo[illegible]a | May-2[illegible]7 | Active | Develo[illegible]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 2017) 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.<br>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.<br>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.<br>WEB IPR monitoring of compliance data. Quality Committee assurance check<br>Well Led oversight of compliance data identifying 'hot-spot' areas for action<br>Divisional PRM meetings focus on performance and compliance.<br>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.<br>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 | November 17<br>A 'deep dive' into the reasons for non-compliance is being undertaken by the mandatory training lead. Areas of high levels of non-compliance are being contacted to discover what the reasons are and to offer support in achieving compliance. This is an on-going action as colleagues can drop out of compliance for any of the 5 key subjects at any point in the year, this is dependent on when their previous learning expires.<br>December 17<br>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.<br><br>**January 18**<br>Weekly compliance reports are produced for the Weekly Executive Board with actions to improve compliance before end of March 2018.<br>A mandatory training summit is being held with key stakeholders from WOD on 22 January. | Feb-18 | Mar-20 | WF | Jason Fo[illegible]leston | Ruth M[illegible]on |
| 6990 | Corporate | Jun-2017 | Proposed for Acceptance | Transforming and improving patient care | CQUIN target at risk of not being met for 2017/18 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non - compliance with NICE guidelines for sepsis.<br><br>This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues.<br><br>The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also | Awareness and new controls for ward areas<br>Divisional plan, medical leads identified in all divisions<br><br>-improvement action plan in place, improvements seen in data for 2016/17<br>-stop added to nerve centre to prompt screening<br>-new screening tool and sepsis 6 campaign was launched introducing the BUFALO system<br>-matrons promoting the and challenging for screening in the 9-11 time on wards<br>-sepsis prompt in EPR | Lack of engagement with processes<br>Lack of clear process for ward staff to follow<br>Lack of communication and joined up working between nursing and medical colleagues<br>Information on patients not receiving the sepsis bundle in a timely manner.<br>Clarity on use of EPR prompts required | 16 | 4 x 4 | 16 | 4 x 4 | 4 | 4 x 1 | November update<br>In-depth analysis of sepsis prompts being undertaken to prepare guidance for staff.<br>Policy review underway<br>Focussed work with ED teams to take place over the coming weeks<br><br>December update<br>Continuing analysis of sepsis prompts with plan to develop Standard Operating Procedure to guide staff<br>Policy review continues<br>No significant change in trigger compliance<br><br>**January 2018 update**<br>In depth review of screening completed and will show increased compliance with screening following the implementation of EPR | Feb-2018 | Mar-2018 | SC | David Birkenhead | Juliette Cosgrove |

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| 7046 | Trustw | Aug-2 7 | Active | 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;<br>access issues for several members of staff resulting in delays.<br>RTT build issue which does not place patients correctly onto the pathway.<br>Electronic Discharge summary process not adhered to resulting in delayed information to GP.<br>Lack of understanding on use of 'Encounters' leading to activity being connected with the incorrect episode.<br>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.<br>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.<br>Stabilisation plan.<br>Issues log populated by specialties, clinical and non-clinical staff to ensure all issues, risk, concerns were known and prioritised.<br>All Divisions have own risk register and included in PSQB & Digital Modernisation Boards; high risks and risk changes reviewed at PRMs.<br>Two weekly Operations Board with clear process for escalation.<br>Datix reporting encouraged and all Red Datix received by Medical Director, Chief Nurse & Chief Operating Officer.<br>Clinical Risk Panel established and Stabilisation plan in place<br>SWAT team deployed to undertake Deep Dives/RCAs.<br>DT meeting undertaken as required<br>Visible leadership and feedback.<br>Manual workarounds.<br>Targeted support and training.<br>On going training requirements identified and developed.<br>Additional expert support deployed for Junior Doctor Change.<br>Training & Access process for new and agency staff agreed.<br>Access rights provided for all staff to undertake role as delivered pre-EPR | Response of external partner slow leading to delayed resolution.<br>BAU team capacity & focus on BTHFT readiness<br>Thematic review of incidents complaints, PALs etc.<br>Adequate system build<br>Training<br>Review of access right.<br>Robust audit of end to end pathways and documentation. | 16 4 x 4 | 16 4 x 4 | 0 0 x 0 | November Update<br>EPR risk panel reviewing risks derived from EPR clinical hazards log.<br><br>Each specialty to meet with EPR Team and a Director to ensure all concerns identified and plans agreed.<br>Quality Directorate to attend each Digitial Modernisation Board for assurance of appropriate escalation and mitigations.<br>BAU team capacity and operational capability being reviewed.<br>Change Board TORs reviewed to ensure operational/clinical led prioritisation.<br>Further formal escalation to EPR partner regarding speed of resolution.<br>Introduce thematic review of incidents, complaints, PALS etc.<br>Submit change requests for system build.<br>Formal review of roles and development of these on EPR to refine access rights.<br>Identify training needs.<br>Work with clinical leads to develop information and support tools.<br><br>December Update<br>Cerner are visiting the Trust to understand and assist to resolve issues on the 5th and 6th December<br>Some SOPs have been updated and will be shared with the Ops Group early December<br><br>**January Update**<br>SOP process has been revised<br>There is no longer a resource to undertake the access/roles, discussion being had CEO regarding the risk associated with this<br>Project team contracts will end this month<br>The action plan agreed with Cerner is being worked through | Feb-18 | Mar-20 | QC | David E enhead | Alistair rris |

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| 7047 | Trustwide | Aug-2017 | Active | Keeping the base safe | EPR Performance risk of failed regulatory standards, contractual key performance indicators or other patient/staff focussed performance due to:<br>Issues with data migration impacting on RTT pathways.<br>Build/Configuration impacting on reporting data and pathway tracking.<br>Delayed access for patient as a result of migration, build and staff familiarity.<br>Patient satisfaction and reputational issues due to the perceived impact of the system as staff familiarise themselves.<br>Staff satisfaction as they learn the new system or there are delays in resolving issues pertaining to patient care, flow and efficiency.<br>Data Quality issues, duplications, incorrect pathways, coding all impacting on ability to report.<br>Management capacity & capability to resolve issues with the new system and maintain sufficient focus on all KPIs.<br>Management reports inaccurate and requiring additional validation before deployed delaying responsiveness.<br>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.<br>Modelling of data to identify potential performance risks.<br>Recruitment of additional staff into AED & Booking office.<br>Shadow monitoring of activity using existing systems.<br>Task and finish groups to address activity dips.<br>Investigating areas of most concern.<br>Manual recovery where poor recording is identified.<br>Micromanagement of pathways.<br>Working with IT to design appropriate reports.<br>Use of Cymbio reports.<br>Manual recording and collection of data.<br>Stabilisation plan developed.<br>Management capacity increases prioritised.<br>All regulatory bodies kept informed proactively | Adequate system build.<br>Availability of additional management capacity with correct skill set.<br>Vacancies remain across all staff groups<br>BAU capacity to support resolution of outstanding issues.<br>Partner responsiveness & ability to find solutions.<br>Several very large scale priorities to be managed.<br>Communication and engagement | 16 4 x 4 | 16 4 x 4 | 0 0 x 0 | **January 2018 Update**<br><br>3 of 4 scope types contained in DM01 data validation complete and external return for December will again be made. Regular data quality reports and performance reports now issued weekly to service for these areas.<br>Cystoscopy validation delayed due to extra work required on other 3 scopes for December return. First draft position expected end of January with fully validated to be ready end of February 2018.<br><br>Key reporting issues impacting on Trust Income and Patient safety worked through with Cerner at two day session w/c - 4/12/17. Action Plan received – Steve Fincher (Cerner) meeting Information colleagues 17th and 18th January.<br><br>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.<br><br>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.<br><br>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 | Feb-18 | Mar-20 | QC | Helen Fincher | Divisional Directors |

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| 6924 | Corpo[illegible]a | Feb-2[illegible]7 | Active | Keepi[illegible] 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<br>Task and finish group established by director of nursing to address elements of NPSA alert 22.7.16 on nasogastric tube misplacement<br><br>Training package available<br>Nursing staff have been encouraged to undertake self assessment and declaration of competency<br>Check X rays are performed where aspirate is not obtained, or greater than pH5.5<br>Radiology team flag when sighted if tube is in the lung following xray<br>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<br>Daily process for checking is dependent on individuals competency to be performed accurately<br>Training data base is only available through medical device data base and is not monitored for compliance<br>No assurance that all medical and nursing staff who are inserting and managing NG tubes have the competency required to do this<br>No policy in place at CHFT to support guidelines | 15 | 15 | 8 | October Update<br>Meetings re-established for the Trust-wide CQC group with an initial focus on reviewing outputs from the mock well led PIR and core service self-assessments. Plan being established for key lines of enquiries (KLOEs) identified.<br><br>November 2017 Update<br>Training package sourced by essential skills team from Preston and is currently being reviewed to ensure content suitable for target audience. When this has been done Dr Uka will work through Comms plan and THIS will lease with Preston team to transfer onto CHFT e learning. 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.<br>Class room sessions continue for nursing staff. Uptake remains variable as not mandatory however Comms plan has been rolled out regarding ' No training , No touching ' in terms of access of NG tubes. High use areas all have a key trainer identified who is responsible for ensuring that nursing staff are trained as per NPSA guidelines.<br>2 further areas have been identified as increased use since original areas were identified – these are ward 10 and 15. Nursing staff booking onto training however areas have been asked to identify key trainers.<br><br>**January 2018**<br>No update | Feb-18 | Feb-18 | QC | Brenda [illegible]rown, | Jo Midd[illegible]on |
| | | | | | | | | 5 x 3 | 5 x 3 | x 2 | | | | | |

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| 6971 | Surgery & Anaesthetics | Apr-20 | Active | Keeping the base safe | Business continuity risk relating to reduced endoscopy provision / capacity and hysteroscopy capacity (risk 6993) due to increased demand on the Automatic Endoscope Reprocessing (AER's) machines at HRI following fire in endoscopy at CRH and additional workload for AER machines at HRI, which increases the risk of machine failure and potentially fire resulting in further reduction in capacity / service delivery if machines need to be turned off.<br><br>The risk of a complete equipment failure would result in a seizure of endoscopy services at CHFT due to individual AER failures reducing service delivery and disruption of the service. This would adversely impact the Trust's ability to achieve all access targets, list down time, reputational damage, complaints/litigation associated with poor patient experience/delayed diagnosis, delayed / cancelled procedures may cause distress to patients, extended waiting time in the Endoscopy Department for procedures and additional cost in resource and repairs could result in escalation of costs and further cancellation of procedure.<br><br>Patient safety risk due to impact of reduced endoscopy provision and an increasing back log of patient's awaiting flexible sigmoidoscopy under the bowel cancer screening programme (BCSP) , diagnostic cystoscopy's, fast track haematuria's and gastro intestinal activity. Due to data quality it is impossible to assess a accurate back log position this is impacting on the ability to outsource patients to identified providers.<br><br>There is currently a risk to patient receiving timely care due to reduced hysteroscopy | Machines checked and monitored daily by endoscopy technicians whilst in use and all cycles are now conducted under physical supervision.<br><br>The trust fire officer has ensured that there is adequate fire fighting equipment and decontamination staff are compliant in their use.<br><br>Increased estates support and improved access to gettinge (HRI) Cantel (CRH) (maintenance contractor) technicians in place for all AER's<br><br>A full downtime 36 hour period for maintenance schedules to be completed and all relevant tests to ensure all compliance is met.<br><br>In sourced provider (medinet) is continuing to support service delivery through 2 CRH theatres on Saturdays, meetings with providers with a view to out source patient back log have commenced (Living Care/Yorkshire Clinic) these providers have offered capacity that will clear the back log by November. Continued support through medinet and in house weekend support will enable 3 theatres at CRH to deliver service lists and reduce the current back log. Discussions (meeting 29/09/17) with Living Care for the delivery of BoSs lists that run parallel to in house delivery increasing to a potential 9 lists per week.<br><br>CRH decontamination now have replacement AER's in place, commissioned and operational<br><br>For the next 9 weeks we will be running additional hysteroscopy weekend sessions (mixture or consultant and nurse-led sessions) which will start to reduce the waiting list (the first of these is this coming Saturday)<br>Now the women's health unit is up and running we are planning to run additional sessions during the week the limiting factor here is staff to run additional lists but we're working to resolve this. | Data Quality | 20<br>5 x<br>4 | 15<br>5 x<br>3 | 4 4<br>x 1 | Update November 2017<br><br>Plan in place for unit manager<br>Increased Medinet use will have back log cleared by Dec 17 (plan with Chief Operating Officer).<br><br>To replace all AER's as part of the endoscopy decontamination replacement scheme, by expediting the scheme the risk will be mitigated.<br><br>December Update<br><br>Dedicated developmental Matron appointed start date 02/01/18 to mitigate current leadership issues<br><br>All un-appointed patients now have a TCI date or received a procedure regaining endoscopy 6 week diagnostic target, fast track position maintained<br><br>Plan for Jan to deliver services through CRH for planned patients weekend 13/14th Jan<br><br>Both units have regained all access targets plan for Jan to run additional capacity through HRI on weekends and repatriate Saturdays into week day capacity gained by removal of Hysterocopy<br><br>**January 2018**<br>No update | Feb-2018 | Mar-20 | DB | TBC | Jason F-<br>hby |

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| 5747 | Family & Specialist Services | Mar-2013 | Active | Keeping the base safe | Service Delivery Risk<br><br>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<br>Part-time short term Locums supporting the service | Failure to appoint to vacant post substantively due to limited availability.<br>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;<br>2. Continue to try to recruit to the vacant post;<br>3. Progressing a regional approach to attract candidates to work regionally;<br>4. Progressing approach to further contingency using regional-wide approach.<br><br>December 2017 update -<br><br>Advert currently out for joint post (regional initiative in collaboration with Leeds and Bradford).<br>Service still being supported by part time locum cover - continuing to seek long term locum cover.<br><br>**January 2018 update:**<br><br>Advert for joint post with Bradford closed on Friday 12 January 2018, with no applicants. | Feb-2018 | Apr-2018 | DB | Rob Aitchison | Sarah Clinton |
| 6011 | Family & Specialist Services | May-2014 | Active | 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.<br>- Quality Control systems in the laboratory so that samples with missing, incorrect or discrepant patient ID details are rejected.<br>- Training for relevant staff (Junior Doctors supported with additional targeted training as they enter the Trust). | Lack of electronic systems<br>Lack of duplicate sampling<br>Training compliance not at 100% | 15 | 5 x 3 | 15 | 5 x 3 | 3 | 3 x 1 | November 2017<br>Apex upgrade postponed - will not impact on planned go-live of phase 1 of project (April 18). Overall project progressing to timescales.<br><br>December 2017<br>we have accepted delivery of some of the Haemonetics equipment over the past week and is currently being installed, however no progress will be made with this risk until implementation of stage 2 (HLB)<br><br>Apex upgrade has been delayed until next spring as this isn't required until stage 3 (HLB)<br><br>**January 2018**<br>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)<br><br>Apex upgrade has been delayed until next spring as this isn't required until stage 3 (HLB) | Feb-2018 | Mar-2019 | PSQB | Julie O'Riordan | Sarah Ramsden |

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| 6715 | Corpo[illegible] | Apr-20[illegible] | Active | Keepi[illegible] the base safe | There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation.<br><br>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.<br><br>Training and education around documentation within EPR.<br><br>Monthly assurance audit on nursing documentation.<br><br>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<br><br>Establish a joint CHFT / BTHFT clinical documentation group.- lead Jackie Murphy and Alistair Morris timescale December 2017.<br><br>Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. | 20 | 4 x 5 | 15 | 3 x 5 | 6 | 3 x 2 | Establish clinical documentation group<br>Nov 2017<br>No change to existing controls<br><br>December 2017<br>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.<br><br>**January 2018**<br>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. | Dec-2018 | Dec-20[illegible] | WEB | Brenda [illegible]rown | Jackie [illegible]phy |
| 6829 | Family & Specialist Services | Aug-2016 | Active | Keeping the base safe | The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately 50,000 pa ready to administer injectable medicines with short expiry dates for direct patient care.<br><br>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 | Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products.<br>Self-audits of the unit<br>External Audits of the HRI unit will be undertaken by the Quality Control Service on behalf of NHSE every 6 months.<br>Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance.<br>The capacity plan of the HRI unit will not be exceeded.<br>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<br>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.<br>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<br>Dec 17 - discussions ongoin re solution - meeting with HPS Fri 15th Dec to hopefully bring a resolution<br><br>**January 2018** - still discussing options for the business case - preferred option still to locate at CRH and extend the current facilities | Feb-2018 | Feb-2018 | DB | Brendan Brown | Fiona Smith |

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| 6949 | Family Specialist Services | Mar-2( 7 | Propo d for Acceptance | Keepir the base safe | The inability to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain sufficient number 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.<br><br>2. Staff rotas changed to a block pattern for night shifts.<br><br>3. All substantive vacancies are being advertised and gaps backfilled with locum staffing.<br><br>4. Staff development plan in place for training Biomedical Scientists<br><br>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.<br><br>3. Delay in recruiting locums due to impact of Flexible workforce procedures.<br><br>4. Staff development plan for trainees is compromised and time scale lengthened, due to reduced levels of trainers present during core hours as a result of additional shift commitments. | 10 | 5 x 2 | 15 | 5 x 3 | 5 | 5 x 1 | 3. Understand blockers to the recruitment process and determine options to expedite the process.<br><br>5. Organise a test for Business continuity plan with relevant stakeholders. Update 12/1/2018- BCP test planning meeting arranged for 15th Jan<br><br>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 | Feb-2018 | Jul-201 | DB | Rob Aitk son | Hayley ker |

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

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| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>BOARD ASSURANCE FRAMEWORK - The Board is asked to receive and comment on the Board Assurance Framework | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>Audit and Risk Committee - 24.1.18; Finance and Performance Committee 30.1.18 | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The updated BAF is presented to the Board for review and approval.
Further work is 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 should be noted that an additional risk is to be included on the BAF relating to the 2018/19 financial position

## Main Body

### Purpose:

Please see attached

### Background/Overview:

Please see attached

### The Issue:

Please see attached

### Next Steps:

Please see attached

### Recommendations:

The Board is asked to receive and comment on the Board Assurance Framework

## Appendix

### Attachment:

BAF - MASTER - latest update January 2018.pdf

Latest update for Board January 2018

Calderdale and Huddersfield NHS Foundation Trust

# BOARD ASSURANCE FRAMEWORK 2017/18

Contents:



compassionate care

**BOARD RISK APPETITE STATEMENT - APPROVED OCTOBER 2016**

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

| REF | RISK DESCRIPTION | Current score | Lead | Link to RR | Risk Appetite |
|---|---|---|---|---|---|
| **Transforming and improving patient care** | | | | | |
| 01/17 | Risk that the Trust will not secure agreement to implement the proposals set out in the Full Business Case resulting in poor quality of care and impacting on workforce resilience. | **20 =** | AB | | Seek / Significant |
| 02/17 | Risk of non-delivery of the WYAAT programme as part of the wider West Yorkshire STP due to internal focus, lack of partnership working and capacity resulting in enforcement action and inability to achieve a rating of 'advanced'. | **12** | OW | | Seek / Significant |
| 03/17 | Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care. | **10** | DB | | Cautious / Moderate |
| 04/17 | Risk that the Trust does not involve and engage patients and the public in the delivery and improvement of services due to lack of clear processes, capacity and capability resulting in poor patient experience, poor quality of care and challenge to service change decisions | **12** | BB | | Cautious / Moderate |
| 05/17 | Risk that the Trust will not realise the safety, quality and financial benefits from the implementation of the Trust's EPR due to lack of optimisation of the system. | **15 =** | MG | | Seek / Significant |
| **Keeping the base safe** | | | | | |
| 06/17 | Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. | **15 =** | BB | | Minimal / Low |
| 07/17 | Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement resulting in enforcement action | **15 =** | OW | | Cautious / Moderate |
| 08/17 | Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action. | **20 =** | HB | | Cautious / Moderate |
| 09/17 | Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement. | **20 =** | LH | | Minimal / Low |
| **A workforce fit for the future** | | | | | |
| 10/17 | Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. | **20 =** | BB / DB | | Minimal / Low |
| 11/17 | Risk of not having colleagues who are confident and competent to provide clinical and managerial leadership due to a lack of clear strategy and focus on development for current and aspiring leaders resulting in an inability to deliver the Trust's objectives and sustainable services for the future | **12 =** | JE | | Seek / Significant |
| 12/17 | Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the culture of the organisation due to a lack of robust engagement mechanisms | **12 =** | JE | | Seek / Significant |
| **Financial sustainability** | | | | | |
| 13/17 | Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention | **25 =** | GB | | Open / High |
| 14/17 | Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. | 20 | GB | | Open / High |

| LIKELIHOOD (frequency) | CONSEQUENCE (impact / severity) | | | | |
|---|---|---|---|---|---|
| | Insignificant (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
| Highly likely (5) | | 3. Seven day services = | | 9. Estate fit for purpose = | 13. Financial delivery = |
| Likely (4) | | | | | 1. Full Business Case =<br>8. National and local targets =<br>10. Staffing levels =<br>14. Capital = |
| Possible (3) | | | | 4. Public involvement<br>12. Staff engagement =<br>11. Clinical leadership = | 5. EPR<br>6. Compliance with quality standards =<br>7. Compliance with NHS Improvement = |
| Unlikely (2) | | | | | 2. WYAAT |
| Rare (1) | | | | | |

Assessment is Likelihood x Consequence

| TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee Exec Lead | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| 1.17 | Board of Directors | Director of Transformation and Partnerships | **Risk**<br>Risk that the Trust will not secure agreement to implement the proposals set out in the Business Case resulting in poor quality of care and impacting on workforce resilience.<br><br>**Impact**<br>- Delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance; Compliance with Paediatric Standards; Compliance with Critical Care Standards; Speciality level review in Medicine<br>- Unable to meeting 7 day standards<br>- Inabilty to recruit and retain workforce in particular medical workforce (increased reliance on Middle Grades and Locums)<br>- Potential loss of service to other areas | • Participation in Hospital Services Board by key senior staff. 20/1/16 CCGs made the decision to commence public consultation on the future configuration of hospital services.<br>• CCGs and NHS England representatives included in roundtable discussion with NHS I<br>• There is an agreed consensus between the CCGs and the Trust on the preferred clinical model.This has been reviewed and endorsed by Yorkshire and Humber Clinical Senate.<br>• NHS I support for development of Business Case and timetable for decision making received from NHS I.<br>• ED business continuity plan developed<br>• Additional consultant posts agreed for ED<br>• Interim actions to mitigate known clinical risks<br>• Nurse led service managing Paediatrics<br>• Critical care still being managed on both sites<br>• Frequent hospital to hospital transfers to ensure access to correct specialties | First line<br>Vanguard work in Calderdale showing an impact<br><br>Second line<br>Full Business Case approved by the Board August 2017<br><br>Third line<br>CCG support for Full Business Case at Governing Bodies in October 2017<br>QRM meeting with NHS I and roundtable meeting tracks progress<br>Reconfiguration included within WYSTP | • Difficulty in recruiting Consultants, Middle Grade and longer term locums<br>• Estate limitations inhibit the present way of working<br>• Consultant rotas cannot always be filled to sustain services on both sites<br>• High use of locums | • Referral made to Secretary of State and awaiting clarity on timescale for decision<br>• Letter before claim received and responded to and awaiting a decision from the Court as to whether the Judicial Review will proceed.<br>• Lack of capital funding availability | **Initial**<br>5x5 = 25 | **Current**<br>4x5 = 20 | **Target**<br>3x5 = 15 |
| **Action** | | | | | **Timescales** | | | **Lead** | | |
| Clarification responses to be sent to NHS I | | | | | COMPLETE | | | AB | | |
| **Links to risk register:**<br>Risk 6131 - large scale service change | | | | | | | | | | |

| TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee Exec Lead | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| | | | | | | | | **Initial** | **Current** | **Target** |
| 2.17 | Board of Directors | Chief Executive | **Risk**<br>Risk of non-delivery of the WYAAT programme as part of the wider West Yorkshire STP due to internal focus, lack of partnership working and capacity resulting in enforcement action and inability to achieve a rating of 'advanced'.<br><br>**Impact**<br>- Reputational impact<br>- Inability to realise benefits of partnership working<br>- Regulatory impact related to single oversight framework requirements<br>- Potential loss of services | • Full participation in WYAAT - Chair post currently held by CHFT<br>• CHFT lead on two big programmes of work - Estates and Facilities and IM&T<br>• Estates business case considered by Trust Board and initial agreement made across WYAAT<br>• Key senior individuals engaged in programmes of work and leading on aspects of support work including governance and communications .<br>• Joint EPR implementation with Bradford Teaching Hospitals Trust | First line<br>WYAAT minutes and programmes of work reported to Board<br>WYAAT Programme Director attendance at WEB<br><br>Second line<br>Governance arrangements approved by the Board<br><br>Third line<br>Reconfiguration included within WYSTP | • Programme of work and reporting timescales still to be finalised<br>• Programme Director's report to be developed and routinely received by Trust Board | • Competing priorities within the Trust impacting on ability to fully engage. | **2x5 = 10** | **2x5 = 10** | **1x5 = 5** |

| **Action** | **Timescales** | **Lead** |
|---|---|---|
| Estates business case to come to Board - revised version to come to March Board | March 2018 | LH |

**Links to risk register:**
Risk 6131 - large scale service change

| TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| | | | | | | | | **Initial** | **Current** | **Target** |
| 3.17 | Quality Committee | Executive Medical Director | **Risk**<br>Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care<br><br>**Impact**<br>- Reduced quality of care<br>- Increased length of stay<br>- Increased HSMR / SHMI<br>- Delayed discharges | • Working group set up and workshop held with senior colleagues to develop plan<br>• Perfect week learning shared<br>• Governance systems and performance indicators in place<br>• Part of the West Yorkshire early implementers | First line<br>Improvement in performance against some key indicators including pre 12 o'clock discharge and reduction in outliers<br><br>Second line<br>Integrated Board report<br>Benchmarked against four key Keogh standards<br>Paper received at WEB<br><br>Third line<br>Independent review of mortality cases by Professor Mohammed<br>Visit from NHS Improvement Medical Director gave positive feedback | • Latest benchmarking report to be reviewed to identify gaps and appropriate actions<br>• National consultant contract negotiations outcomes awaited<br>• Capacity to deliver 7 day service action plan | • Included within new Single Oversight Framework. Need to understand metric measured and impact on Trust<br>• Scope for futher implementation limited without service reconfiguration or additional investment | 5x3 = 15 | 5x2= 10 | 2x3 = 6 |
| **Action** | | | | | **Timescales** | | | **Lead** | | |
| Benchmarking report to be reviewed and actions to be agreed | | | | | December | | | SU | | |
| **Links to risk register:**<br>No corporate (>15) risks | | | | | | | | | | |

| TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| | | | | | | | | **Initial** | **Current** | **Target** |
| **4.17** | Quality Committee | Executive Director of Nursing | **Risk**<br>Risk that the Trust does not involve and engage patients and the public in the delivery and improvement of services due to lack of clear processes, capacity and capability resulting in poor patient experience, poor quality of care and challenge to service change decisions<br><br>**Impact**<br>- Non delivery of improvements in services<br>- Risk of legal challenge<br>- Reputational impact | • Public engagement plan in place<br>• Joint working with CCGs<br>• Working with HealthWatch on key areas of interest / concern<br>• Patient Experience Group in place<br>• Engagement champions in place across the Trust<br>• Engagement toolkit been developed<br>• Go see planned to examplar Trust | First line<br>Public involvement and engagement included in Patient Experience Group<br>Areas of good practice identified within the Trust<br><br>Second line<br>Governor included in Patient Experience Group<br>Patient Experience Group reporting to Quality Committee<br>Engagement work completed in relation to proposed Medical Service reconfiguration<br><br>Third line<br>Annual reporting to CCGs | • Engagement plan to be refreshed | • Formal reporting arrangements not fully embedded. | **3x4 = 12** | **3x4= 12 NEW** | **1x4 = 8** |
| **Action** | | | | | | | | **Lead** | | |
| Revised public engagement and involvement plan to be approved | | | | | February | | | VP | | |
| **Links to risk register:**<br>No risks on the risk register >15 | | | | | | | | | | |

| TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| | | | | | | | | **Initial** | **Current** | **Target** |
| **5.17** | Finance and Performance Committee | Managing Director of Digital Health | **Risk**<br>Risk that the Trust will not realise the safety, quality and financial benefits from the implementation of the Trust's EPR due to lack of optimisation of the system.<br><br>**Impact**<br>- Non delivery of improvements in clinical outcomes<br>- inability to realise return on investment or financial value for money | • Modernisation Programme Management and Governance structure to manage the ongoing implementation EPR system within the Trust-wide IT Modernisation Programme.<br>• Operational Delivery Board in place with cross divisional representation<br>• Business as Usual structure in place<br>• Transformation Board reporting<br>• Operational Delivery Board in place with cross divisional representation | First line<br>Operational Board reporting<br><br>Second line<br>Joint Transformation Board with BTHT meets on a monthly basis chaired at Chief Executive level. Assurance Board that includes Non-Executive directors.<br>Report to Finance and Performance Committee<br><br>Third line<br>Improvement as part of QRM reporting arrangements | • Number of issues following implementation still to be addressed<br>• Business as usual structure doesn't include development structure<br>• Training plan for new starters and follow-up training to be agreed and implemented<br>• Governance and process around benefits realisation for the trust now the system is operational to be confirmed. | • Lack of capital funding for developments | 3x5 = 15 | 3x5 = 15 | 2x5 = 5 |

| **Action** | **Timescales** | **Lead** |
|---|---|---|
| Further work require with Bradford post go-live to agree priorities for benefits implementation | ONGOING | MG |
| Agreed list of actions to be circulated | End of January | MG |

**Links to risk register:**
Risk 7049 - EPR Financial risk

**TRUST GOAL: 2 KEEPING THE BASE SAFE**

| Ref | OWNER Board committee | OWNER Exec Lead | RISK DESCRIPTION *(What is the risk?)* | KEY CONTROLS *(How are we managing the risk?)* | POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)* | GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)* | GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)* | RATING Initial | RATING Current | RATING Target |
|---|---|---|---|---|---|---|---|---|---|---|
| 6.17 | Quality Committee | Executive Director of Nursing / Executive Medical Director | **Risk**<br>Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.<br><br>**Impact**<br>- Quality and safety of patient care and Trust's ability to deliver some services.<br>- Enforcement notices with regulators<br>- Ability to deliver national targets and CQUINS.<br>- Increased risk of litigation and negative publicity.<br>- poor staff morale | • Quality governance arrangements revised and strengthened<br>• Revised SI investigation and escalation process in place<br>• Strengthened risk management arrangements<br>• Risk and Compliance Group overseeing implementation of actions and preparation plans for well led inspection<br>• Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures and introduction of ward assurance tool.<br>• Board to ward programme in place<br>• Process in place for policy reviw and approval<br>• Process tightened around review and compliance with NICE guidance<br>• New inspector of hospitals attending the Trust 3.11.17 | <u>First line</u><br>Staffing levels reported to WEB<br>Clinical audit plan reviewed<br>Assessment of compliance with NICE guidance<br>Improvement in HSMR & SHMI<br>Vacancy and agency use reporting<br>Improvement in staff sickness absence<br><br><u>Second line</u><br>Quarterly Quality Report to Quality Committee and Board<br>6 monthly Hard Truths report to Board<br>KPIs in Integrated Board Report.<br>PSQB reports to Quality Committee<br>DIPC report to Board<br><br><u>Third line</u><br>CQC report showed requires improvement; no inadequate areas in line with Trust's self-assessment<br>Quality Account reviewed by External Auditors and stakeholder bodies<br>Well Led Governance review<br>Independent assurance on clinical audit strategy<br>Ongoing relationship with arms length regulatory bodies<br>Independent Service Reviews and accreditations | • Consistent mandatory training compliance<br>• Operational and financial priorities impacting on capacity and ability to maintain consistent quality of care - winter pressures particularly impacting on capacity and staffing<br>• Standard of serious incident investigations needs further improvement<br>• Estate issues identified<br>• Scale of change and pace impacting on staff morale and engagement<br>• New inspection process being implemented including Use of Resources inspection. Have submitted documents and expecting inspections to commence March. Lack of clarity on process for UoR inspection. | • CQC assessed the Trust as requires improvement<br>• National Clinical Advisory Team recommendations not fully addressed<br>• Staff FFT response to recommendation as a place to work and place to be cared for declining<br>• Essentials skills monitoring<br>• Medical and therapy staffing monitoring arrangements | 3x5 = 15 | 3x5 = 15 | 2x5 = 10 |

| Action | Timescales | Lead |
|---|---|---|
| Inspector of Hospitals visit | COMPLETE | BB |
| Self assessments taking place | COMPLETE | BB |
| Preparation for CQC inspection to address identified areas for action | February | BB |

**Links to risk register:**
Risk 6345 - Staffing risk, nursing and medical
Risk 6658

| TRUST GOAL: 2. KEEPING THE BASE SAFE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee | Exec Lead | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** Initial | Current | Target |
| 7.17 | Board of Directors | Chief Executive | **Risk**<br>The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement<br><br>**Impact**<br>- Risk of further regulatory action<br>- Reputation damage<br>- Financial sustainability | • QRM meeting with NHS I<br>• Corporate compliance register in place<br>• Review of monthly NHS I bulletins to assess any required actions<br>• PMO in place with Turnaround Executive governance around CIP<br>• 5 Year strategic plan completed and formally adopted by the CCGs as part of the pre-consultation business case<br>• Well Led Governance review completed | First line<br>Clear PMO reporting from Divisions<br><br>Second line<br>Integrated Board report showing CIP delivery<br>CIP report to Finance and Performance Committee<br>Well Led Governance review report to Board<br>Board approval of 5 Year Strategic Plan<br><br>Third line<br>Quarterly PRM with NHS Improvement<br>Round table meetings being held with CCGs, NHS England and NHS Improvement<br>CCG acceptance of 5 Year Strategic Plan | • Performance against STF standards<br>• Achievement of year end financial position remains challenging | • Performance against key targets<br>Lack of clarity on approval process for FBC<br>Lack of clarity on Use of Resources inspection requirements | 5x5 = 25 | 3x5 = 15 | 2x5 = 10 |
| **Action** | | | | | **Timescales** | | | **Lead** | | |
| Clarity to be sought on external approval process<br>New single oversight framework awaited | | | | | AWAITED<br>RECEIVED and reported to Board | | | AB<br>VP | | |
| **Links to risk register:**<br>Risk 4706 - Financial plans<br>Risk 6693 - Agency cap | | | | | | | | | | |

| TRUST GOAL: 2. KEEPING THE BASE SAFE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee Exec Lead | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| | | | | | | | | Initial | Current | Target |
| 8.17 | Finance and Performance Committee | Chief Operating Officer | **Risk**<br>Risk of failure to achieve local and national performance targets and levels required for STF<br><br>**Impact**<br>- Poor quality of care and treatment<br>- Poor patient experience<br>- Regulatory action<br>- Reputational damage with stakeholders<br>- STF withheld and financial issues | • Strengthened performance monitoring and management arrangements<br>• Bed modelling work and additional investment made in to bed capacity<br>• New patient flow programme<br>• CQUINS compliance monitored by Quality directorate<br>• Bronze, silver and gold command arrangements and escalation process<br>• System-wide gold commanders meeting in place<br>• Regular forum in place between Operations and THIS to strengthen information flows and reporting<br>• Head of Performance in place<br>• Assistant Director for SAFER appointed | First line<br>Weekly performance review with divisions.<br>Divisional board and PSQB reviews of performance with executive attendance<br>Activity reporting discussed at WEB Intergrated Board report focus of one WEB each month for detailed scrutiny wtih wider representation from divisions<br>'Deep dive' discussions into areas of under performance<br>Appointment slot issues action plan has resulted in reduced ASIs<br>Work begun to develop more intuitive dashboard<br><br>Second line<br>Enhanced Integrated Board Report discussed at Quality Committee and Board<br>Finance and Performance Committee monthly report on activity<br>Report on compliance with best practice tariff<br><br>Third line<br>Urgent Care and Planned Care Boards and System Resilience group | • System responsiveness<br>• Appointment slot issues backlog still to be addressed<br>• Winter pressures impacting on delivery of key targets and elective activity<br>• Achievement of 4 hour emergency care standard requires micro-management.<br>• Inability to retain enough middle grades<br>• Impact of IR 35 resulting in service gaps | • New EPR system impacting on reporting accuracy | 4x4 = 16 | 4x5 = 20 | 2x5 = 10 |

| **Action** | **Timescales** | **Lead** |
|---|---|---|
| Review impact of EPR implementation | Ongoing | HB |

**Links to risk register:**
Risk 6658 - Patient flow

| TRUST GOAL: 2. KEEPING THE BASE SAFE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee Exec Lead | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| | | | | | | | | **Initial** | **Current** | **Target** |
| 9.17 | Quality Committee | Executive Director of Planning, Performance, Estates and Facilities | **Risk**<br>Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care<br><br>**Impact**<br>- Poor quality of care and treatment<br>- Poor patient experience<br>- Poor staff experience and negative impact on their health and wellbeing<br>- Regulatory action<br>- Inability to implement service change<br>- Reputational damage with stakeholders | • System for regular assessment of Divisional and Corporate compliance<br>• Policies and procedures in place<br>• Quality Governance assurance structure revised<br>• Estates element included in development of 5 Year Strategic plan<br>• Close management of service contracts to ensure planned maintenance activity has been performed<br>• Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance<br>• Development of Planned Preventive Maintenance (PPM) Programme<br>• Audit of medical devices by independent assessor to identify any further actions needed<br>• Health Technical Memorandum (HTM) structure in place including external Authorsing Engineers (AE's) who independantly audit Estates against statutory guidance.<br>• Authorising engineer for fire<br>• Partnership agreement with fire authorities | First line<br>CQC compliance reported in Quarterly Quality and Divisional Board reports<br>Weekly strategic CQC meetings<br><br>Second line<br>Health and Safety Committee monitors medical devices action plan to address recruitment issues, database, risk analysis of devices<br>Monitor review of PFI arrangements<br>Assurance provided by AE's following audits against Estates statutory requirements<br>Delivery of recommendations from Internal Audit report<br>Third line<br>PLACE assessments<br>CQC Compliance report<br>Assurance received from Environment Agency regarding healthcare waste implementation plans<br>Progress made on DoH Premises Assurance Model (PAMs) to illustrate to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe.<br>HSE review of water management<br>Assessment by local operational Fire and Rescue teams | • Capital funding significantly scaled back which has impacted on ability to deliver estates schemes<br><br>• Medical Device database needs to be reviewed to ensure accurate formation on medical devices needing maintenance. | • Internal Audit report on medical devices has a small number of outstanding actions<br>• Mandatory training figures remain below plan for health and safety | 4x4 = 16 | 5x4= 20 | 2x4 = 8 |

| **Action** | **Timescales** | **Lead** |
|---|---|---|
| Continue to review urgent estate work in line with capital programme | Ongoing | LH |

**Links to risk register:**
Risk 6903 - Estates / ICU risk, HRI
Tisk 5806 - Urgent estate schemes not undertaken

**TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE**

| Ref & Date added | OWNER Board committee | Exec Lead | RISK DESCRIPTION *(What is the risk?)* | KEY CONTROLS *(How are we managing the risk?)* | POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)* | GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)* | GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)* | RATING |
|---|---|---|---|---|---|---|---|---|
| 10.17 | Quality Committee | Executive Director of Nursing / Executive Medical Director | **Risk**<br>Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce.<br><br>**Impact**<br>- Quality and safety of patient care and Trust's ability to deliver some services.<br>- Ability to deliver national targets and CQUINS.<br>- Increased risk of litigation and negative publicity.<br>- poor staff morale<br>- Increased sickness absence<br>- Continued financial pressure due to use of locums / agency staff | • Weekly nurse staffing escalation reports<br>• Ongoing multifacted recruitment programme in place, including international recruitment;<br>• Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure<br>• ED business continuity plan in place;<br>• Vacancy Control Panel in place;<br>• E-roster system in place.<br>•Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place.<br>• Risk assessments in place<br>• Nursing recruitment and retention strategy in place | First line<br>Staffing levels, training and education compliance and development reported to WEB<br>Divisional business meetings and PSQBs consider staffing levels as part of standard agenda<br>IBR shows slight decrease in sickness levels, and reduction in agency spend<br>Bi-annual review of ward nursing levels<br>Weekly meeting on agency spend<br>Number of PA posts recruited to<br><br>Second line<br>Quarterly Quality Report to Quality Committee and Board<br>6 monthly Hard Truths report to Board<br>KPIs embedded in Integrated Board Report.<br>PSQB reports to Quality Committee<br>Workforce Strategy approved by the Board<br>Third Line<br>Plans discussed with NHS I<br>Assurance process with CQC colleagues | Current hotspots are: Emergency Care; Radiology; ; opthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; therapies;<br><br>Recruitment and retention strategy for medical and therapy staffing required<br><br>Continued spend on locums and agency remains above the NHS I cap leading to financial pressures in year.<br><br>Multi-professional e-roster yet to be rolled out | • Not yet clear of the impact of agency figures on the new Single Oversight Framework assessment<br>• Need to embed workforce plan<br>• Impact of IR35 | Initial: 4x4 = 16<br>Current: 4x5 = 20<br>Target: 3x3 = 9 |

| Action | Timescales | Lead |
|---|---|---|
| Workforce strategy for medical staff to be developed | December - timescales awaited | DB |
| New allocate system to be fully implemented | March | CP |

**Links to risk register:**
Risk 6345 - overall staffing risk
Risk 2827 - Over reliance on middle grade doctors in A&E

| TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee Exec Lead | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| | | | | | | | | **Initial** | **Current** | **Target** |
| 11.17 | Quality Committee | Executive Medical Director | **Risk**<br>Risk of not having colleagues who are confident and competent to provide clinical and managerial leadership due to a lack of clear strategy and focus on development for current and aspiring leaders resulting in an inability to deliver the Trust's objectives and sustainable services for the future<br><br>**Impact**<br>- Ability to deliver transformational change compromised.<br>- Potential to affect the quality of patient care.<br>- Low staff morale.<br>- Non–achievement of key Trust priorities | • Devolved clinical structure<br>• Work together get results programme in place<br>• Positive feedback from Junior doctors on medical training<br>• Performance appraisal based around behaviours<br>• Coaching circles process<br>• All CIP schemes have clinical lead<br>• Development of new roles across professional groups<br>• Good revalidation compliance<br>• Performance Management Framework agreed including job description for clinical leads.<br>• Development of medical director's office<br>• Development programme being rolled out - first cohorts completed | <u>First line</u><br>Established escalation framework to prioritise action to address week areas<br>Clinicians leading of transformation programmes e.g. cardio /respiratory<br>Engaged leaders toolkit in place<br>Clinical lead particpation in star chamber approach<br>Job planning framework approved<br>Recruitment to key roles across the Trust<br><br><u>Second line</u><br>Integrated Board Report<br>Revalidation report to board<br><br><u>Third line</u><br>IIP Accreditation<br>Feedback from Royal Colleges<br>Junior doctor GMC questionnaire feedback | • OD plan for medical workforce to be developed | • Acquire independent assessment of clinical leadership arrangements<br>• Staff FFT / Survey results deteriorating | 4x4 = 16 | 3x4 =12 | 3x3 = 9 |

| **Action** | **Timescales** | **Lead** |
|---|---|---|
| OD plan for medical workforce to be developed | December - clarity requred on timescale | JE |
| Continue implementation of CLIP | March | JE |

**Links to risk register:**
No corporate (>15) risks

| TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee | Exec Lead | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| 12.17 | Well Led Workforce Committee | Executive Director of Workforce and Organisational Development | **Risk**<br>Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the culture of the organisation due to a lack of robust engagement mechanisms.<br><br>**Impact**<br>- Ability to deliver transformational change compromised.<br>- Potential to affect the quality of patient care.<br>- Low staff morale.<br>- Non–achievement of key Trust priorities<br>- Poor response to staff survey / staff FFT | • Leadership visibility increasing and impact of EPR work<br>• Quarterly staff FFT in place<br>• Work together get results programme in place<br>• 'Ask Owen' being responded to<br>• Good evidence of colleague engagement in OBC / FBC development<br>• Celebrating success annual awards<br>• Staff survey action plan<br>• Health and wellbeing strategy<br>• Implemented star award recognition scheme<br>• Board to ward programme in place<br>• Board to ward programme in place<br>• BME network in place and well attended | First line<br>Divisional leadership approach<br>CQC preparation for self assessment shows some areas reporting GOOD in well led domain<br>Significant number of actions delivered against action plan<br><br>Second line<br>Integrated Board report shows sickness absence slightly improved<br>CQC Mock inspection feedback from focus groups<br><br>Third line<br>Staff FFT / staff survey provides some positive feedback<br>IIP accrediation - Bronze award | • Cultural barometer indicators to be developed<br>• Continued difficulty in engaging clinical staff<br>• Outstanding actions on WRES action plan<br>• Go engage programme to be delivered | • Staff FFT response rate deteriorating along with number of staff who would recommend the Trust as a place to work<br>• Still a number of well led indicators on the IBR showing red<br>• Number of areas in CQC assessment showing requires improvement | **Initial** | **Current** | **Target** |
| | | | | | | | | **3x4 = 12** | **3x4 = 12** | **1x4 = 4** |
| **Action** | | | | | **Timescales** | | | **Lead** | | |
| Colleague engagement plan being rolled out. | | | | | November - clarity required on timescale | | | JE | | |
| **Links to risk register:**<br>No corporate (>15) risks | | | | | | | | | | |

**TRUST GOAL: 4. FINANCIAL SUSTAINABILITY**

| Ref & Date added | OWNER Board committee | OWNER Exec Lead | RISK DESCRIPTION *(What is the risk?)* | KEY CONTROLS *(How are we managing the risk?)* | POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)* | GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)* | GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)* | RATING Initial | RATING Current | RATING Target |
|---|---|---|---|---|---|---|---|---|---|---|
| 13.17 | Finance and Performance Committee | Executive Director of Finance | **Risk**<br>Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention.<br><br>**Impact**<br>- financial sustainability<br>- loss of STF<br>- increased regultory scrutiny<br>- insufficient cash to meet revenue obligation<br>- inability to invest in patient care or estate | • Financial recovery and cost improvement programme plan in place<br>• PMO tracking of delivery against CIP plan<br>• Budgetary control process<br>• Detailed income and activity contract monitoring<br>• Bottom-up forecasting process<br>• Star chamber process to support CIP schemes off track<br>• Quality directorate overview of progress against delivery of CQUIN<br>• Authorisation processes for agency spend<br>• Standing Financial Instructions set authorisation limits<br>• Detailed recovery plan in place including non-pay review, tightening of vacancy control panel process, controls around additional hours. | First line<br>Divisional Board performance reports<br><br>Second line<br>Turnaround Executive Reports<br>NHS I scrutiny at Finance and Performance Committee and Board<br>Integrated Board report including CQUIN delivery reporting<br><br>Third line<br>Monthly return to NHS I<br>QRM meeting with NHS I<br>Well Led Governance Review<br>Internal Audit Report on divisional performance management arrangements<br>NHS I review of CIP arrangements | • Temporary staffing remains a cost pressure<br>• Remain gap between activity and agreed contract<br>• Activity recording challenge due to EPR<br>• Unidentified CIP<br>• Additional cost pressures resulting from the winter challenges | • Spending levels still high<br>• CIP remains unidentified | 4x4 = 16 | 5x5=25 | 1x4=4 |

| Action | Timescales | Lead |
|---|---|---|
| Ongoing monitoring of financial position through F&P and Board | Ongoing | GB |
| Reporting to Turnaround Exective on progress with CIP | ongoing | AB |
| Clear communications plan for financial pressures | January / February | VP |

**Links to risk register:**
Risk 6967 - Non-delivery of financial plan
Risk 7049 - EPR Financial risk

| TRUST GOAL: 4. FINANCIAL SUSTAINABILITY | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ref & Date added** | **OWNER** Board committee | | **RISK DESCRIPTION** *(What is the risk?)* | **KEY CONTROLS** *(How are we managing the risk?)* | **POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)* | **GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)* | **GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)* | **RATING** | | |
| | | | | | | | | **Initial** | **Current** | **Target** |
| 14.17 | Finance and Performance Committee | Executive Director of Finance | **Risk**<br>Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.<br><br>**Impact**<br>- financial sustainability<br>- inability to provide safe high quality services<br>- inability to invest in patient care or estate | Agreed £8m capital loan from Independent Trust Financing Facility (ITFF) to support capital programme, specifically the Electronic Patient Record (EPR) investment.<br>Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling.<br>Prioritised capital programme.<br>Small contingency remains in place to cover any further changes. | First line<br>Reporting through WEB on capital prioritisation<br><br>Second line<br>Turnaround Executive Reports<br>Scrutiny at Finance and Performance Committee and Board<br>Capital Management Group reports<br><br>Third line<br>Monthly return to NHS I<br>QRM meeting with NHS I | The planned capital expenditure for 17/18 is £14.40m. All capital expenditure, including any slippage on the EPR programme, must be contained within available internally generated capital funding, supplemented in 17/18 by the remaining £8m of our pre-approved capital loan facility. | • Not meeting regulatory requirement in relation to capital | 4x5 = 20 | 4x5 = 20 | 3x4=12 |

| **Action** | **Timescales** | **Lead** |
|---|---|---|
| Ongoing monitoring of financial position through F&P and Board | Ongoing | GB |

**Links to risk register:**
Risk 7062 - Capital programme

**ACRONYM LIST**

| | |
|---|---|
| **BAF** | Board Assurance Framework |
| **BTHT** | Bradford Teaching Hospitals NHS Foundation Trust |
| **CCG** | Clinical Commissioning Group |
| **CIP** | Cost Improvement Plan |
| **CQC** | Care Quality Commission |
| **CQUIN** | Commissioning for Quality indictor |
| **CSU** | Commisisoning Support Unit |
| **ED** | Emergency Department |
| **EPAU** | Early Pregnancy Assessment Unit |
| **EPR** | Electronic Patient Record |
| **F&P** | Finance and Performance Committee |
| **FBC** | Full Business Case |
| **FFT** | Friends and Family Test |
| **HSMR** | Hospital Standardised Mortality Ratio |
| **IBR** | Integrated Board Report |
| **IIP** | Investor In People |
| **ITFF** | Independent Trust Financing Facility |
| **KPI** | Key performance indicators |
| **NHS E** | NHS England |
| **NHS I** | NHS Improvement |
| **OBC** | Outline Business Care |
| **OSC** | Overview and Scrutiny Committee |
| **PFI** | Private Finance Initiative |
| **PMO** | Programme Management Office |
| **PMU** | Pharmacy manufacturing unit |
| **PPI** | Patient and public involvement |
| **PRM** | Progress review meeting (with NHS Improvement) |
| **PSQB** | Patient Safety and Quality Board |
| **SI** | Serious incident |
| **SHMI** | Summary hospital-level mortality indicator |
| **SOC** | Strategic Outline Case |
| **WEB** | Weekly Executive Board |
| **WYAAT** | West Yorkshire Association of Acute Trusts |
| WYSTP | West Yorkshire Sustainability and Transformation Plan |

**INITIALS LIST**

| | |
|---|---|
| **AB** | Anna Basford, Director of Transformation and Partnerships |
| **BB** | Brendan Brown, Director of Nursing |
| **DB** | David Birkenhead, Executive Medical Director |
| **GB** | Gary Boothby, Director of Finance |
| **HB** | Helen Barker, Associate Director of Operations |
| **JC** | Juliette Cosgrove, Assistant Director of Quality |
| **MG** | Mandy Griffin, Managing Director of Digital Health |
| **LH** | Lesley Hill, Executive Director of Planning, Estates and Facilities |
| **RM** | Ruth Mason, Associate Director of Engagement and Inclusion |
| **VP** | Victoria Pickles, Company Secretary |
| **CP** | Cornelle Parker, Deputy Medical Director |
| **SU** | Sal Uka, Consultant Paediatrician and 7 day services clinical lead |
| **OW** | Owen Williams, Chief Executive |
| **ALL** | All board members |

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>COUNCIL OF GOVERNORS - ELECTION TIMETABLE 2018 - The Board is asked to receive and note the draft Council of Governors Election Timetable 2018. | |
| **Action required:**<br>Note | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>Council of Governors Meeting - 17.1.18 | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The Board is asked to receive and note the draft Council of Governors Election Timetable 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 receive and note the draft Council of Governors Election Timetable 2018.

## Appendix

### Attachment:

DRAFT ELECTION TIMETABLE 2018 (3).pdf

NHS
Calderdale and Huddersfield
NHS Foundation Trust

# PROPOSED ANNUAL ELECTION TIMETABLE – 2018 as at 22.1.18

| DAY | DATE | ACTION |
|---|---|---|
| Thursday | 19 July 2018 | Trust & Members Annual General Meeting – Formal Election Announcement |
| Wednesday | 4 July 2018 | Issue of Results to Trust |
| Tuesday | 3 July 2018 | Close of Ballot |
| Friday | 8 June 2018 | Voting packs despatched by ERS to members |
| Thursday | 7 June 2018 | Notice of Poll Published by ERS provided to Trust |
| Thursday | 24 May 2018 | Electoral data to be provided by Trust. Uncontested report provided to Trust |
| Monday | 21 May 2018 | Final date for Candidate withdrawal |
| Thursday | 17 May 2018 | ERS & CHFT publish summary of nominated candidates upon validation |
| Wednesday | 16 May 2018 | Deadline for receipt of nominations |
| Tuesday | 17 April 2018 | ERS/CHFT issue the Notice of Election. Nomination forms to be made available to CHFT |
| Tuesday | 10 April 2018<br>(6.00 – 7.00 pm) | Briefing Sessions for prospective Council Members – Boardroom, Sub Basement, Huddersfield Royal Infirmary |
| Thursday | 12 April 2018<br>(6.00 – 7.00 pm) | Briefing Sessions for prospective Council Members – Large Training Room, Learning Centre, Calderdale Royal Hospital |

| BRIEFING SESSIONS FOR PROSPECTIVE CANDIDATES | | |
|---|---|---|
| **Tuesday** | **10 April 2018 (6.00 – 7.00 pm)** | **Boardroom, Sub-basement, Huddersfield Royal Infirmary** |
| **Thursday** | **12 April 2018 (6.00 – 7.00 pm)** | **Large Training Room, Learning Centre, Calderdale Royal Hospital** |

| VACANT POSITIONS AND CANDIDATES ELIGIBLE FOR RE-ELECTION* | |
|---|---|
| **NAME** | **CONSTITUTENCY** |
| **PUBLIC** | |
| Rosemary Hedges* | 1 - Calder Valley, Luddenden Foot, Todmorden, Ryburn |
| Di Wharmby* | 1 - Calder Valley, Luddenden Foot, Todmorden, Ryburn |
| Kate Wileman (Reserve Register) | 4 - Batley East, Batley West, Birstall & Birkenshaw, Cleckheaton, Dewsbury East, Dewsbury West, Heckmondwike, Mirfield, Spenborough, Thornhill |
| Annette Bell* | 6 - Bingley Rural, Clayton, Great Horton, Hipperholme, Lightcliffe, Northowram, Shelf, Odsal, Queensbury, Thornton, Tong, Wibsey, Wyke |
| Brian Moore* | 8 – Colne Valley West, Golcar, Holme Valley North, South and Lindley |
| Vacant Seat | 10 – AHPs/HCs/Pharmacists |
| Vacant Seat (from 4.2.18) | 13 - Nurses and Midwives |

* = Eligible for Re-election

/KB/MC-ELECTION2018

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>FREEDOM TO SPEAK-UP - WHISTLEBLOWING ANNUAL REPORT - The Board is asked to receive and approve the Whistleblowing Annual Report | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>- | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The national NHS Whistleblowing Policy includes a reference to Board oversight and an annual whistleblowing report. To this end this report contains a review of the Trust's approach to Raising Concerns during 2017 together with an updated work plan for 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 receive and approve the Whistleblowing Annual Report

## Appendix

### Attachment:

Whistleblowing Annual Report February 2018.pdf

**BOARD OF DIRECTORS 1 FEBRUARY 2018**

**FREEDOM TO SPEAK UP: RAISING CONCERNS (WHISTLEBLOWING) ANNUAL REPORT**

## 1. Introduction

The Trust's Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy introduced in June 2017 was modelled closely on the national whistleblowing policy for the NHS which was introduced by NHS Improvement in 2016. The policy requires that "the Board of Directors will receive an annual report on concerns raised by staff and what has been done to address them. The Board of Directors will also review the effectiveness of the policy and will ensure the outcome is published." The first annual report was considered by the Board at its meeting on 2 February 2017.

NHS England has published the National Variation to the terms and conditions of the NHS Standard Contract, which includes the need for NHS providers to comply with the requirements of the National Guardian's Office. This will take effect from **1 February 2018**.

These requirements include the need for:

- NHS providers to appoint one or more Freedom to Speak Up Guardians to fulfil the role set out and otherwise comply with the requirements of National Guardian's Office guidance.
- NHS providers to ensure that the National Guardian's Office is kept informed at all times of the person or persons holding this position.

The Trust meets these requirements.

## 2. Details of concerns raised

No concerns have been logged on the Trusts Raising Concerns log to date, nor have staff utilised the Freedom to Speak Up Guardian or Head of Governance and Risk to progress concerns. Two queries were raised as potential whistleblowing concerns during 2017, but these did not progress to be formally logged as Concerns under the Raising Concerns Policy.

External to the Freedom to Speak Up process, concerns are being managed in business as usual by line managers, and by Executive Directors in response to concerns raised via portals such as "Ask Owen" and when reported to external bodies.

Since "Ask Owen" was introduced in September 2015, almost 200 questions have been responded to. They have come from all divisions and most staff groups, from consultants to HCAs. The topics have been wide-ranging; covering both national and local health economy topics including reconfiguration proposals, as well as CHFT specific topics. A number have been complex or personal which were considered to be colleagues exercising their freedom to speak up. In these cases, senior team members have personally contacted colleagues to discuss their experience/issue/suggestion. Key themes include: Working environment, car parking, staff recognition, our use of agency and secondments. This has led to a number of improvements being made.

An annual summary of the key themes from "Ask Owen" will be produced.

The Trust was notified by the CQC of two anonymous concerns that had been raised with them in 2017.

The first in January related to nurse staffing levels in the Acute Medical Unit at Huddersfield Royal Infirmary, and the potential impact a shortfall in staffing levels would have on patient care. Actions taken were as follows:

- Review of staffing model on AMU, which included short term increases to the workforce and leadership model.
- Fast track recruitment to vacant nursing posts.
- A Director led engagement event with all Ward Managers (at both HRI and CRH) to discuss nurse staffing levels, and confirm the Trust's position in regards to recruitment, retention, escalation and use of temporary staffing.

A second anonymous concern was raised with CQC colleagues about (maternity) Theatres at Calderdale Royal Hospital. These included concerns about high staff turnover rates and the reasons behind these, and adherence to compliance in safety measures. Actions taken were as follows:

- Review of leadership model to enable additional support to Theatres at CRH. This included dedicating the Divisions Head Nurse position to review, support and refresh the leadership and safety culture in Theatres at CRH for a dedicated period of three months.
- Coaching and Mentoring support for the leadership team.
- Director led Exit Interviews for staff.

**3. <u>Review of action taken in 2017, together with a review of the effectiveness of the policy</u>**

| Date | Activity | Outcome |
|---|---|---|
| January 2017 | Consider recommendations of Internal Audit review of the Trusts whistleblowing processes. | Internal audit report concluded that there was "significant assurance" for the Trust's arrangements. The report recommended that Datix be used to record concerns but this was not considered appropriate as Datix cannot facilitate anonymous concerns. |
| 18 January 2017 | Report on progress considered by the Audit and Risk Committee. | Progress noted. |
| January 2017 onwards | Work undertaken to revise the existing policy to be known as Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy. | Approval by the Executive Board 1 June 2017. |
| March 2017 | Analysis of 3 years' worth of data on responses to local whistleblowing questions in annual staff surveys 2014 -16 inclusive. | Key findings noted. Those requiring action are as follows:-<br>• Still work to do on publicising the policy<br>• Still work to do on how the Trust handles concerns<br>• Still work to do to ensure there are no negative repercussions when raising concerns<br>• Still work to do on ensuring staff receive feedback. |

| | | |
|---|---|---|
| 7 June 2017 | Guidance for named contacts in the policy to be given. | Letter from Chief Executive to all named contacts alerting them to their role. |
| Throughout 2017 | Preparation for CQC visit, with particular focus on "well-led" issues including whistleblowing. | Development of repository of information on activity for CQC inspectors. Further publicity for FTSUG |
| 8 June 2017 | Update on progress for the Workforce Well Led Committee. | Progress noted. |
| 12 June 2017 | Communicate the revised policy to Trust staff. | All Trust email from Chief Executive. |
| Throughout 2017 | Development of working relationship with the National Guardians Office. | Regular reporting of Trust Whistleblowing data to National Guardians Office. |
| 24 August 2017 | Inclusion of FTSUG in CHFT Weekly "Hello my name is" feature. | Enhanced publicity for FTSUG and understanding of role. |
| Late 2017 and ongoing | Programme of attendance of FTSUG at various team meetings (e.g. Matrons). | Enhanced publicity for FTSUG and understanding of role. |
| Throughout 2017 | Continued participation in various national and regional networks e.g. NHS Employers 'Share and Learn', National Guardians Office Workshops, and Regional Guardians Network meetings. | Enhanced knowledge base. |
| 12 October 2017 | First meeting with THIS staff to look at improving recording and reporting arrangements. | Work commissioned to develop an on-line reporting system. |
| 9 November 2007 | Meeting with FTSUG at Mid Yorkshire Hospitals Trust (recent award winner) to discuss her approach. | Enhanced knowledge base. |
| December 2017 | Work commenced on developing a network of champions and ambassadors in line with National Guardians Office recommendation. | Work still ongoing. |
| 15 December 2017 | Discussion at BAME network on linkage between Talk in Confidence Champions and FTSU network. | Encouragement given to BME staff to volunteer for Champion/Ambassador roles. |

Whilst there is no doubt that the revised policy was widely publicised during 2017 there is little evidence of the policy actually being used by Trust staff to raise concerns. This may have been due in part to the absence of an effective tool for reporting and recording concerns and this will be addressed in 2018.

**4. Work programme for 2018**

| Activity | Planned outcome | Timescale | Lead |
|---|---|---|---|
| Ensure concerns raised through other sources are captured on the Raising Concerns log. | All concerns raised are channelled through the Trusts Raising Concerns Policy so they can be included on National Guardians Office returns. | Ongoing | FTSU Guardian |
| Finalise work on proposals for Champions/Ambassadors network and launch within the Trust. | Establishment of network across both sites to support the work of the FTSUG. | By 1 April 2018 | Senior HR Adviser |
| Develop and launch on-line reporting tool for recording and reporting concerns. | Much needed improvement to current system. Staff will be able to register their concerns direct to FTSUG. | By 1 April 2018 | • FTSUG<br>• Senior HR Adviser<br>• THIS staff |
| Review policy to incorporate on-line reporting tool and publicise widely. | Updated policy and more user-friendly reporting tool. | By 30 June 2018 | Senior HR Adviser |
| Continue work to publicise role of FTSUG. | Enhanced understanding of role and increased visibility within the Trust. | Ongoing | • Senior HR Adviser<br>• Communications Team<br>• FTSUG |
| Work with Communications Team to refresh Intranet pages on Raising Concerns. | More user-friendly intranet site with better content. | Ongoing | • Senior HR Adviser<br>• Communications Team<br>• FTSUG |
| Continue attendance at National /Regional Raising Concerns meetings. | Enhanced knowledge base. | Ongoing | • FTSUG<br>• Senior HR Adviser |
| Improve reporting of concerns to capture issues from BME staff. | Better take up from BME staff to raise concerns. | Ongoing | • FTSUG<br>• Senior HR Adviser |
| Continue input of HR Adviser Hella Monroy-Dominguez to support this work. | Development opportunity and more support for work of FTSUG | Ongoing | Senior HR Adviser |
| Continue work on implementing actions from staff survey results 2014 – | Improved use of policy and better treatment of staff who raise concerns. | Ongoing | • Senior HR Adviser<br>• FTSUG |

| | | | |
|---|---|---|---|
| 16 and also 2017 survey when the data is available. | | | |
| Consider options for replacing FTSUG when term of office expires in September 2018. | New FTSUG | By June 2018 | Director of Workforce and Organisational Development |

The work programme for 2018 is, inter alia, designed to improve the effectiveness of the Trust's policy and also enhance the profile of the FTSU Guardian role. This will also be boosted by the Champions/Ambassadors network.

**5. <u>Conclusion</u>**

Whilst it is clear that a substantial amount of work has been undertaken to develop an open and transparent culture within the Trust there are still areas for improvement and these will be addressed during 2018. The Board of Directors is asked to note the content of this report.

Dr David Anderson
FTSU Guardian
11 January 2018

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Shelley Adrian, PA to Medical Director |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>David Birkenhead, Medical Director |
| **Title and brief summary:**<br>Director of Infection, Prevention and Control Quarterly Report - The Board are asked to receive the report on the position of healthcare associated infections. | |
| **Action required:**<br>Note | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>- | |
| **Governance Requirements:**<br>- | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

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

## 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:

DIPC Report - 24.01.18.pdf

Calderdale and Huddersfield NHS Foundation Trust

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

## Performance targets

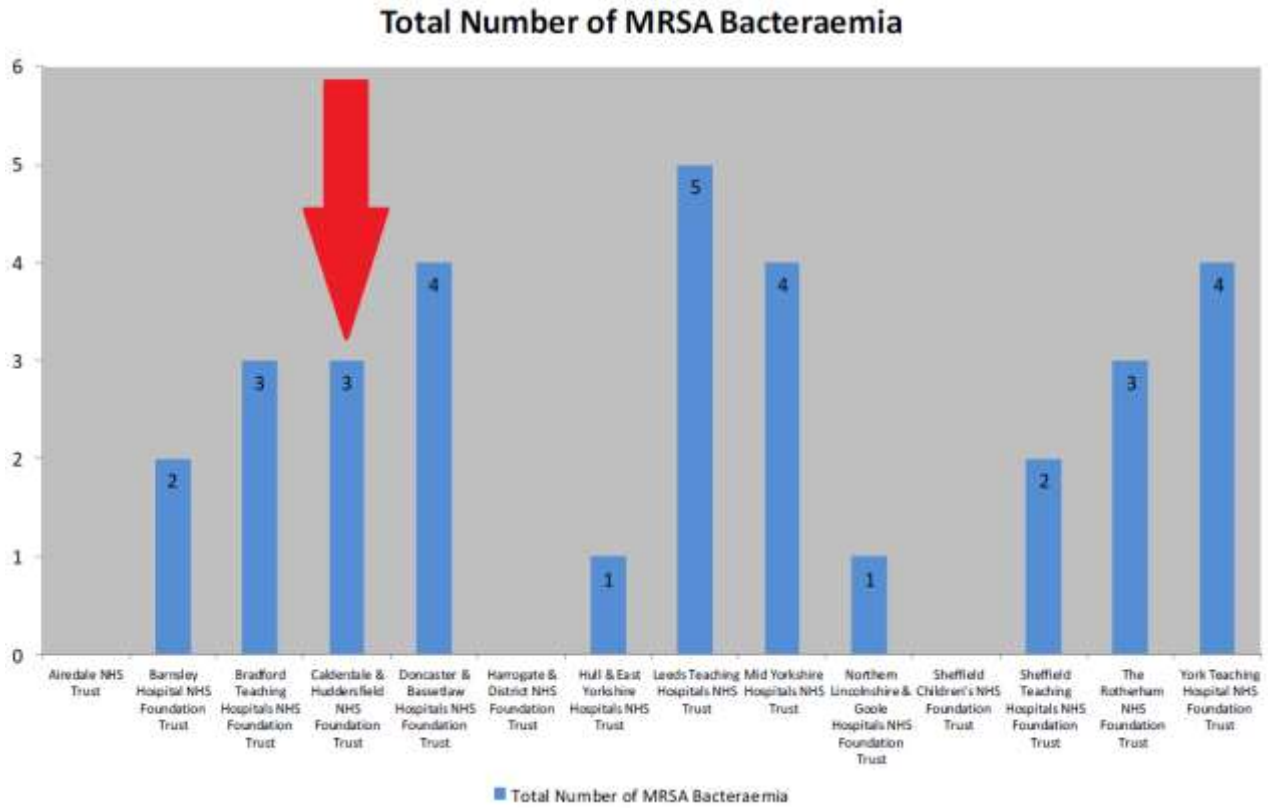
| Indicator | End of year ceiling | YTD performance | Actions/Comments |
|---|---|---|---|
| MRSA bacteraemia (trust assigned) | 0 | **3** | 1 post case<br>2 pre cases attributed to the organisation. |
| C.difficile (trust assigned) | 21 | **23** | 14 Non Preventable<br>7 Preventable<br>2 Pending Post-Infection Review |
| MSSA bacteraemia (post admission) | 9 | **18** | Local ceiling – 15/16 outturn |
| E.coli bacteraemia (post admission) | 43 | **32** | Local ceiling – 15/16 outturn |
| MRSA screening (electives) | 95% | 69.7% | Please note there have been issues validating data since EPR – a meeting has been arranged to find a workaround |
| Central line associated blood stream infections (Rate per 1000 cvc days) | 1 | 0.44 | Rolling 12 months |
| ANTT Competency assessments (doctors) | 90% | 73% | Only a 4% improvement in compliance has been achieved since August. Divisions have been tasked with improving compliance by the end of 2017/18. |
| ANTT Competency assessments (nursing and AHP) | 90% | 90% | Well done to our nursing colleagues |
| Hand hygiene | 95% | 98.6% | |

## Quality Indicators

| Indicator | Year-end agreed target | YTD performance | Comments |
|---|---|---|---|
| MRSA screening (emergency) | **95%** | **66.4%** | Please note there have been some issues validating data since EPR – a meeting has been arranged to find a workaround |
| Isolation breaches | **Non set** | 248 | Compared to 195 for same time period last year. |
| Cleanliness | **Non set** | 97% | |

**MRSA bacteraemia:**
There have been 3 MRSA cases attributed to the organisation; 1 post case and 2 pre cases. All have been subject to a post-infection review which are presented at the Infection Prevention and Control Performance Board. Action plan completion is monitored through the Infection Control Committee.

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




**MSSA bacteraemia:**
There have been 18 post-admission MSSA bacteraemia cases at the end of quarter 2, against the internal objective of 9. A review of cases has been presented at the Infection Prevention and Performance Board. There is no strong common theme, although Hospital Acquired Pneumonia is an area for future focus and is incorporated in the HCAI Action Plan.

No comparative data is available with other Trusts.

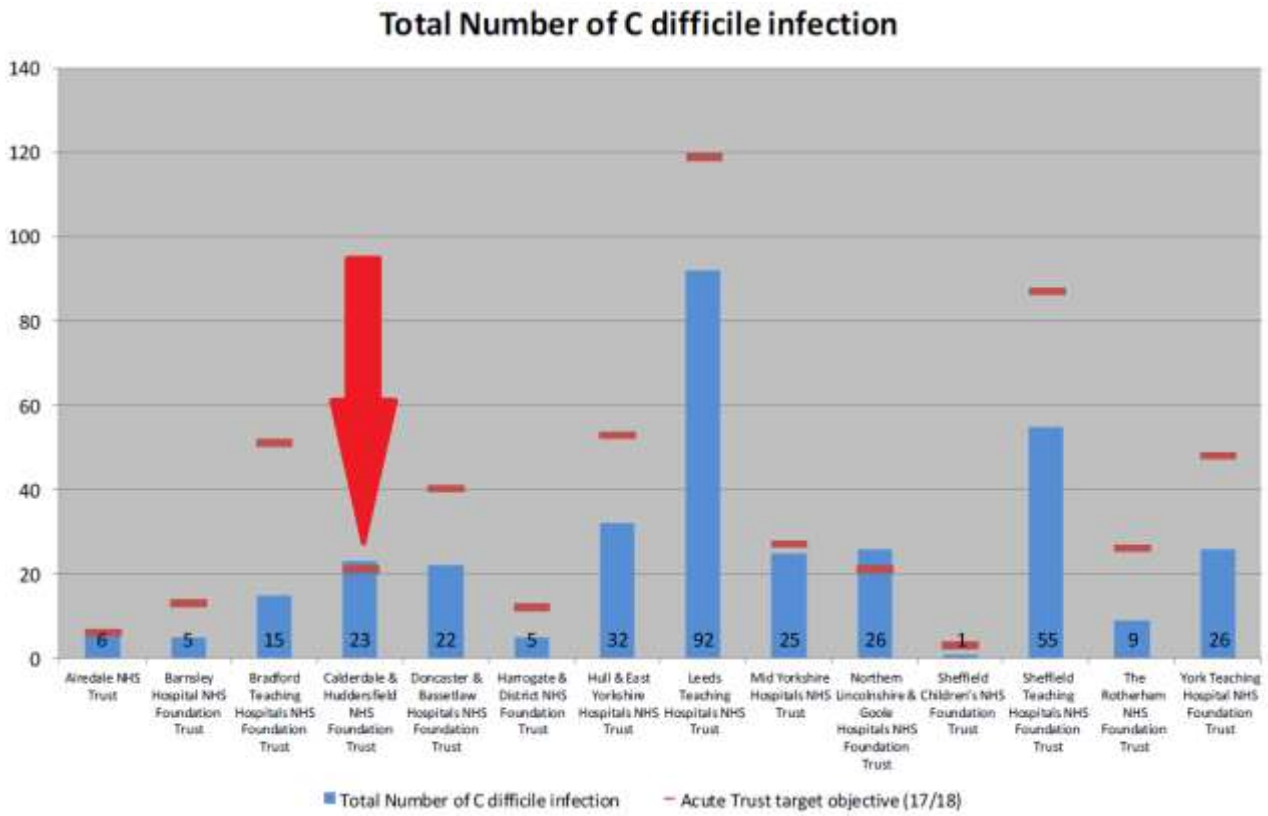
**Clostridium difficile:**
The ceiling for 2016/17 is for no more than 21 post-admission cases. As of 31st December there have been 23 cases which is the same number as this time last year.

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

- Completion of the Bristol Stool Chart and assessing patient bowel habits. Compliance with this reduced since the introduction of EPR. Work is ongoing to improve access to, and use, of the Bristol Stool Chart within EPR.
- Delay in isolation – wards awaiting specimen results before isolation as opposed to isolating patients at the time of sampling.
- Antibiotic prescribing is generally in line with policy, although inappropriate antibiotic prescribing including extended courses of antibiotics has been highlighted in a couple of cases.
- All cases are of a sporadic in nature with no dominant strain being identified – all C. difficile isolates are typed to ensure there is no outbreak emerging. There is no evidence of an outbreak of C. difficile.

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

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



**E. coli bacteraemia:**
There have been 32 post-admission E-coli bacteraemia cases against the internal objective of 43; There is both a Trust and health economy wide reduction plan which has been developed and will be monitored through the Infection Control Committee and the HCAI Health Economy Meeting.

**Outbreaks & Incidents:** We are starting to see norovirus within the local health economy with a number of care homes already affected.

| WARDS CLOSED & BED DAYS LOST FIGURES | | | | | |
|---|---|---|---|---|---|
| **MONTH** | **HOSPITAL SITE** | **WARD** | **DAYS CLOSED** | **BAY/S CLOSED** | **BED DAYS LOST** |
| April | HRI | 0 | 0 | 0 | 0 |
| | CRH | C5B | 8 | - | 0 |
| | | C5C | 3 | - | 7 |
| | | C5A | 14 | - | 47 |
| | | C5C | 2 | - | 0 |
| | | C5D | 6 | - | 4 |
| December | HRI | 1 | 3 | - | 18 |
| | CRH | 8 | 6 | - | 15 |

- = Ward not closed
√ = Bay closed only

**Central Vascular Access Device related bacteraemia**
The internally set target for CVAD related bacteraemia is 1 per 1000 CVAD line days, the current rate is 0.44%

**Isolation Breaches**
There have been 248 isolation breaches since 1st April 2017 compared to 195 breaches for the previous year. The majority of breaches are patients with a previous history of MRSA colonisation at the time of admission to MAU, or patients being transferred and their infection status not being handed over, although this information is all clearly visible within the EPR.
The IPCT will continue to monitor isolation breaches; actions to reduce breaches have been included in the HCAI annual action plan, this includes ongoing work with the medical division where the majority of breaches occur.

**Audits:**
40 Quality improvement environmental audits have been carried out since the beginning 1st April 2017 to 31st December.
Compliance scores: <75% = red rating; 76% - 90% = amber rating; 91%+ = green rating.

- 18 of the areas achieved a green rating.
- 20 of the areas achieved an amber rating; actions plans are produced by the ward/department following the audit in order to address any issues or concerns identified.
- 2 areas were deemed as a Red rating; one September which was re-audited and achieved an amber scoring and one at the end of November which is to be re-audited asap– Actions plans are produced and completed and will be re-audited within the next month.

**IPCT:**

A band 7 member of the team retired in December; this post was recruited to internally and a replacement band 6 has been appointed and will start in post in March.

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

| |
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| |

## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>EQUALITY AND INCLUSION ANNUAL REPORT - The Board is asked to approve the Equality and Inclusion Annual Report | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>- | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

This equality report is to show the progress Calderdale and Huddersfield NHS Foundation Trust (CHFT) has made during 2017 in meeting its equality duties under:

• Section 149 of the Equality Act 2010 (the public sector equality duty) and
• The Equality Act 2010 (Specific Duties) Regulations 2011

## Main Body

### Purpose:

This report provides assurance to the Board on how the Trust is meeting the requirements of the Public Sector Equality Duty. The report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the General Equality Duty. The report also contains the Equality in our Workforce Report

### Background/Overview:

CHFT strives to provide the highest quality of service to all of its patients. Equality and diversity considerations are part of the Trust's work to improve the experience and health outcomes for everyone in its care.

### The Issue:

This report highlights our approach and work to address any additional needs of those patients who identify with a range of protected characteristics. The report gives examples of work/initiatives going on at CHFT to do this. It should be noted that this is only a sample of the work going on overall to improve services for patients and colleagues from protected groups.

### Next Steps:

Once approved by the Board, the Report will be formally published on the Trust's website.
As part of its compliance with the Equality Delivery System 2, progress with two of the equality objectives will be presented to a public panel in March and will take action from the feedback we receive.
The Trust is also in the process of reviewing its "Putting Patients First – a strategy for involvement and equality". This wider strategy identifies actions to enhance the patient experience, and to address specific needs of those with a protected characteristic. These in turn will also address the mandatory requirements of the EDS2 and the WRES.

### Recommendations:

The Board is asked to approve the Equality and Inclusion Annual Report

## Appendix

### Attachment:

PSED Report 2017_CHFT.pdf

Calderdale and Huddersfield
NHS Foundation Trust

# CHFT Public Sector Equality Duty Annual Report 2017

# CONTENTS

## 1 Executive Summary

This equality report is to show the progress Calderdale and Huddersfield NHS Foundation Trust (CHFT) has made during 2017 in meeting its equality duties under:

- Section 149 of the Equality Act 2010 (the public sector equality duty) and
- The Equality Act 2010 (Specific Duties) Regulations 2011

This report provides assurance to the Board on how the Trust is meeting the requirements of the Public Sector Equality Duty. The report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the General Equality Duty. The report also contains the Equality in our Workforce Report, at Appendix 1.

CHFT strives to provide the highest quality of service to all of its patients. Equality and diversity considerations are part of the Trust's work to improve the experience and health outcomes for everyone in its care. This report highlights our approach and work to address any additional needs of those patients who identify with a range of protected characteristics. The report gives examples of work/initiatives going on at CHFT to do this. It should be noted that this is only a sample of the work going on overall to improve services for patients and colleagues from protected groups.

This report received the support of the Trust's Board of Directors at its meeting on 1 February 2018.

## 2 The Legal and Compliance Framework

### 2.1 Equality Act 2010

The Equality Act came into force from October 2010 providing a modern, single, legal framework with clear, streamlined law to more effectively tackle disadvantage and discrimination. On 5 April 2011, the public sector equality duty came into force. The equality duty was created under the Equality Act 2010.

The Act applies to service users and Trust employees who identify with the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy or maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The equality duty consists of a general equality duty, with three main aims (set out in section 149 of the Equality Act 2010) and specific duties for public sector organisations. The Equality Act requires public bodies like CHFT to publish relevant information to demonstrate their compliance with the duty.

The duty has two parts – the general duty and the specific duties. The **general equality duty** means that the Trust must have due regard to the need to:

- Eliminate unfair discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups; and
- Foster good relationships between different groups

By:

- Removing or minimising disadvantages suffered by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The **specific duties** are legal requirements designed to help the Trust meet the general equality duty. These require the publication of:

- Annual information to demonstrate our compliance with the general equality duty published on our website by 31 January each year;

- Equality Objectives (which are specific and measurable) published for the first time by 5 April 2014, reviewed annually and re-published at least every four years.

2.2 Care Quality Commission Requirements

The Care Quality Commission (CQC) expects to find evidence that the Trust is actively promoting equality and human rights across all its services and functions. Equality and diversity considerations are specifically addressed as part of its key line of enquiry around a Trust's responsiveness to patient needs. The CQC asks "Are services planned and delivered to meet the needs of people?" and "Do services take account of needs of different people, including those in vulnerable circumstances?"

The Trust had a full CQC inspection in March 2016 and is expecting a further visit early in 2018.

2.3 Mandatory Requirements – the Equality Delivery System 2 (EDS2) and the Workforce Race Equality Standard (WRES)

The Equality Delivery System 2 (EDS2) is a generic framework designed for both NHS commissioners and NHS providers. The framework helps NHS organisations to review and improve their performance for people with protected characteristics, and through it, to deliver on the Public Sector Equality Duty. It emphasises engagement with stakeholders and users, and encourages local adaptation to focus on local issues.

The EDS2 comprises 18 outcomes focused on the achievement of four goals and under the framework, we are required, in conjunction with local stakeholders, to analyse our equality and diversity performance, taking account of each relevant protected group. In order to achieve this, the Trust is working collaboratively with its Clinical Commissioning Groups (CCGs) and other providers in the local area (see section 3.1 for more detail).

The Workforce Race Equality Standard (WRES) is now part of standard NHS contracting arrangements and requires providers to address the low levels of Black and Minority Ethnic (BME) employees within their workforce and specifically at board level.

Work in this area is reported on in the Equality in our Workforce Report for 2017 (see Appendix 1).

## 3 Our progress in 2017

### 3.1 Embedding equality and diversity

The outcomes of the NHS' Equality Delivery System 2 (EDS2) help us to focus our work around equality and diversity, and to decide on our equality objectives.

We identified our priority outcomes for 2016 to 2020 as:

1.2 Individual people's health needs are assessed and met in appropriate and effective ways.

2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.

4.2 Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed.

Some examples of what we have done in 2017 to achieve these outcomes are shown below:

| Protected Group | What we have done | EDS2 Outcome |
|---|---|---|
| All | At the start of 2017 we launched an electronic equality impact assessment process. The process includes a mechanism to ensure that assessments are completed before proposals to introduce new policies or service changes are submitted to the Board or other major committees. During 2017, there were 113 completed assessments. | 4.2 |
| | During 2017 the Trust has started the procurement process for a new patient correspondence system and has included a section within the tender documentation which asks how the successful bidder will ensure full compliance with the Accessible Information Standard. | 2.1 |
| Age (older people) | In 2017 the Trust purchased dementia friendly crockery for wards that typically care for dementia patients on the Huddersfield site. The crockery has been tested by the Food for Life partnership and is considered to be the best product available for this group of patients. Patient and carer feedback on the crockery to date has been very positive. Our PFI partners are also hoping to introduce the crockery on the Calderdale site. | 1.2 |
| | The Trust has purchased a RemPod - unique pop-up reminiscent scenes provided with authentic furniture, replica TVs, record players, or cinema screens, and | 1.2 |

| Protected Group | What we have done | EDS2 Outcome |
|---|---|---|
| | nostalgic accessories and games. They transform clinical environments into therapeutic and reminiscent spaces, helping to change the quality of life for people living with dementia. This is being trialled for working with our dementia patients.  | |
| | The appropriateness of the environment for dementia patients is assessed as part of the annual PLACE (patient led assessment of the care environment) inspections. In 2017 HRI scored 84.3% (1.6% above the national average) and CRH scored 81.4% (representing an increase of 5.9% compared with 2016 performance). | 1.2 |
| | The role of the Engagement Support workers continues to develop. During 2017 they have been working with fractured neck of femur patients who have dementia who are admitted from residential and nursing homes. They liaise with the homes to identify the patients' likes and dislikes, patterns of behaviour, routines, family details etc. This has proved extremely beneficial for these patients, who are less likely to develop delirium. | 1.2 |
| Disability (visual impairment) | Feedback from patients/carers has shown that the introduction of dementia friendly crockery at HRI has also had a positive impact for patients with a visual impairment due to its colour. | 1.2 |
| Age (younger people) | We have opened a dedicated room for young people to socialise and relax (the Teenage Room) on our Children's Ward.  | 1.2 |
| | When attending Ophthalmology outpatient appointments, children are seen within an adult setting. We have introduced a new child friendly waiting area to ensure that | 1.2 |

| Protected Group | What we have done | EDS2 Outcome |
|---|---|---|
| | the needs of our younger patients can be met appropriately.<br>  | |
| Disability (hearing impairment) | In 2016, in order to improve the quality of BSL services for our deaf patients, we changed our service provider to a small, local company. The service has been reviewed on two occasions during 2017, and we are satisfied that the service provided continues to be of high quality and that patient experience has improved. | 2.1 |
| Disability (physical) | The plans to upgrade the public toilets in the main entrance at the HRI site during 2017/18 include an upgrade of the accessible toilets. | 2.1 |
| | The appropriateness of the environment for patients with a physical disability is assessed as part of the annual PLACE (patient led assessment of the care environment) inspections. In 2017 HRI scored 89.4% and CRH scored 88.9%. These scores were broadly in line with the national average. | 2.1 |
| Race | It is known that patient outcomes and the patient experience is improved when those staff providing care who have a protected characteristic feel valued and respected by the organisation. To address this, since 2016 the Trust's Chief Executive has led on a programme of focus groups for BME colleagues.<br>  <br>This has resulted in a strategy and action plan and the group has continued to meet on a quarterly basis throughout 2017 to progress this work. | 3.4 |
| Sexual Orientation | In November 2017 the Trust hosted a regional event to raise awareness of the experiences of LGBT patients | 1.2, 2.1 & 3.4 |

| Protected Group | What we have done | EDS2 Outcome |
|---|---|---|
| | receiving care in the NHS and the experiences of LGBT staff working for the NHS:<br>  <br>The event was well received and we are planning to host a similar engagement event in the community in 2018. | |
| Disability (mental health) | Our Emergency Nurse Consultant represents the Trust on the Kirklees Suicide Prevention Strategy Group. In 2017 the Trust has been supporting the distribution of contact details for local groups and support services, particularly those responding to the highest risk groups (e.g. 'Andy's Man Club', 'Men in Sheds' etc).<br>The Trust will continue to actively support this vital multi-agency strategy. | 1.2 |
| Sexual orientation | During 2017 managers within the Radiology Department have been working on a process to address the sensitivity around the requirement, when undertaking examinations that involve ionising radiation, to ask transgender patients about the possibility of them being pregnant. This work will be ongoing in 2018, in conjunction with a local expert. | 1.2 |
| Religion/ belief | Together with colleagues from Overgate Hospice and Calderdale Council, Trust staff have been shortlisted for an Accolade Award for their work with Calderdale Council of Mosques centred on the South Asian community in West Halifax.<br>A partnership has been formed, the Horizon Group, to establish a programme of education, explaining concepts of palliation and strategies of care to the South Asian community:<br>  <br>This also gives Trust colleagues the opportunity to hear of | 1.2 & 2.1 |

| Protected Group | What we have done | EDS2 Outcome |
|---|---|---|
| | possible ethical, cultural and religious misgivings that members of the community may have. | |
| | Inter-faith relations and co-operation has continued to be an important part of the work of our Chaplaincy Department. This has included a visit to the Fartown Sikh Temple:<br>  <br>and a Sikh Day of Prayer in the HRI Hope Centre:<br>  | 1.2 & 2.1 |
| Pregnancy/ Maternity | Privacy and dignity concerns raised by our patients highlighted a need to work closely with our junior doctors prior to them working in maternity services at CHFT. A session has therefore been incorporated into the junior doctors' induction course, the focus of which is 'walking in the woman's shoes'. This involves scripting and role playing women's stories and specific areas covered include informed consent, privacy and dignity. | 1.2 |
| Disability (learning) & Pregnancy/ Maternity | The Lead Matron for Learning disabilities at CHFT has agreed to create a bespoke training session for maternity staff about caring for pregnant ladies with a learning disability and plans to invite a previous user of the service to contribute to the session | 1.2 |

3.2 EDS2 Grading and Feedback

As part of its collaborative approach to the EDS2, early in 2017 staff from CHFT attended two grading panels (made up of members of third sector organisations) in Kirklees and Calderdale. They presented the progress the Trust had made on two initiatives linked to its four priority goals.

Both initiatives were graded as 'developing' and the feedback from the panels was that the Trust should focus on having more inclusive engagement activities, using different approaches for different groups rather than having a "one size fits all" approach. The following section describes some of the engagement activities the Trust has undertaken, some of which were in direct response to the grading panels' feedback.

3.3 Engagement activities

There is awareness across the Trust of the importance of listening to, and responding to, patient feedback. This is championed through the representatives on the Trust's Patient Experience and Caring Group. More innovative approaches are being introduced to gather feedback and create opportunities to listen, through a range of feedback options that sit alongside the more formal methods of feeding back such as through the Friends and Family test, complaints, PALs and surveys.

The Friends and Family test has been implemented across the Trust in line with national guidance; this is the main opportunity for service users to provide their feedback. A range of methods is used to engage patients with this initiative: postcards, text messaging and web-based solutions. Easy read cards are also available for patients with a learning disability.

The Trust is working with the Yorkshire & Humber Improvement Academy to conduct face to face interviews with patients. These surveys, known as PRASE (Patient Reporting and Action for a Safe Environment) are conducted by trained volunteers at ward level, and following completion of a minimum of 20 surveys a report is generated and shared with representatives from the ward team. To date surveys have been undertaken on the surgical wards, and are now being rolled out to other areas - initially the medical and paediatric wards.

Wards and departments use a variety of other methods to encourage patient feedback, including direct contact through rounding by the ward managers and Matrons, debriefs, guest books and graffiti boards.

During 2017, colleagues in Maternity services worked with HealthWatch to better understand how to engage with service users about their experiences. This enabled a critical review of ways in which staff listened to users and learned from experience – with previous methods tending to be linear and quantitative data based, rather than personalised.

The service is now focussing on experienced based co-design to capture intelligence regarding some of the work streams from 'Better Births', which in the first instance will highlight the experience of women with complex needs.

This refreshed approach to engagement in Maternity Services is shown in diagrammatic form at Appendix 2.

Some examples of action we have taken as a result of feedback from patients from protected groups in 2017 include:

- On the Paediatric wards a fruit and milkshake round has been set up as a way of engaging informally with children and their families.

- Across Children's and Maternity Services graffiti boards have been introduced to capture “what word captures your experience today”. This has enabled staff to gather real time evidence of what the ward or department is like from a patient’s perspective.

- Following feedback from families in Children's Outpatients the layout of the chairs and toys has been altered to facilitate a more private discussion at the reception area.

- The colours used on the walls on Ward 5abcd at CRH have been reviewed based on feedback from patients/carers on the ward to ensure they are less bright but still meets the needs of dementia patients.

Children’s Services have also refreshed their approach to engagement – this is shown in diagrammatic form at Appendix 3.

As a Foundation Trust, CHFT has a council of governors, which is actively engaged through divisional reference groups and corporate sub-groups with members and service users about quality improvement and service change.

In addition, governors attend familiarisation tours around clinical areas where they can observe services first hand and talk directly to staff and patients.

It is also Trust practice to involve governors and public members in recruitment panels for the appointment of hospital consultants, senior nursing staff and other senior staff.

The Trust has a large membership which is compared with its local population to ensure that we are engaging with the diverse communities that we serve. The data (see Appendix 4) shows that we continue to have under representation in three different sectors of our communities, namely younger people, males and those with an ethnic group of Asian/Asian British. These groups will be given special focus during recruitment activities in 2018.

In 2018 we plan to introduce a new method of recruiting members whereby patients receiving a new outpatient appointment letter will also receive a membership application form to encourage them to join the Trust. This has proved to be an effective method of recruitment in other organisations, and will ensure that the most relevant people (i.e. prospective patients) are targeted.

## 4 Strengthening Equality & Diversity

### 4.1 Equality & Diversity Training

CHFT is committed to ensuring that it provides a high quality service for all of its patients and is an employer of choice in the local area. It also has a legal obligation under the Equality Act 2010 to provide services and employment in a manner that eliminates discrimination, advances equality and fosters good relationships between protected groups.

As a result, in 2015, the Trust made equality and diversity training mandatory for all employees. Compliance rates are monitored by the Equality & Diversity function and statistics show that as at 1 December 2015, 63.3% of colleagues had undertaken their training. As at 1 December 2016, the compliance rate for the Trust stood at 88%. By 1 December 2017 the figure had risen to 94.5%, which is an increase in compliance of over 30% over a two-year period.

Colleagues are required to repeat their equality and diversity training every three years.

## 5 Conclusions

The Trust is in the process of reviewing its "Putting Patients First – a strategy for involvement and equality". This wider strategy identifies actions to enhance the patient experience, and to address specific needs of those with a protected characteristic. These in turn will also address the mandatory requirements of the EDS2 and the WRES.

Ultimately the Trust is striving to help colleagues feel confident and competent when caring for or dealing with people with any of the protected characteristics, and to ensure that equality and diversity considerations are an everyday, intrinsic part of being a valued Trust colleague and of delivering excellent, compassionate care.

## 6 Contacts and Enquiries

If you have any questions or comments on this report, or would like to receive it in alternative formats, e.g. large print, braille, languages other than English, please contact our Membership and Engagement Manager on 01484 347342 or e-mail equalityanddiversity@cht.nhs.uk

## APPENDIX 1

## EQUALITY IN OUR WORKFORCE REPORT

### 1. Introduction

Equality and diversity related to the workforce is led by the Director of Workforce and Organisational Development. This report provides information about equality in the Trust's workforce. It is based on data that is held about the workforce as at 30 November 2017. In accordance with the Equality Act 2010, we have a duty to "publish information relating to persons who share a relevant protected characteristic who are its employees."

The Trust published its Workforce Race Equality Standard (WRES) on 1 July 2017. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES became operational from 1 April 2015. The standard has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for BAME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

### 2. Staff profile

The staff profile shown in the graphs below are based on a 'snapshot' of all the staff working for the Trust as at 30 November 2017 against the same date in the previous four financial years.

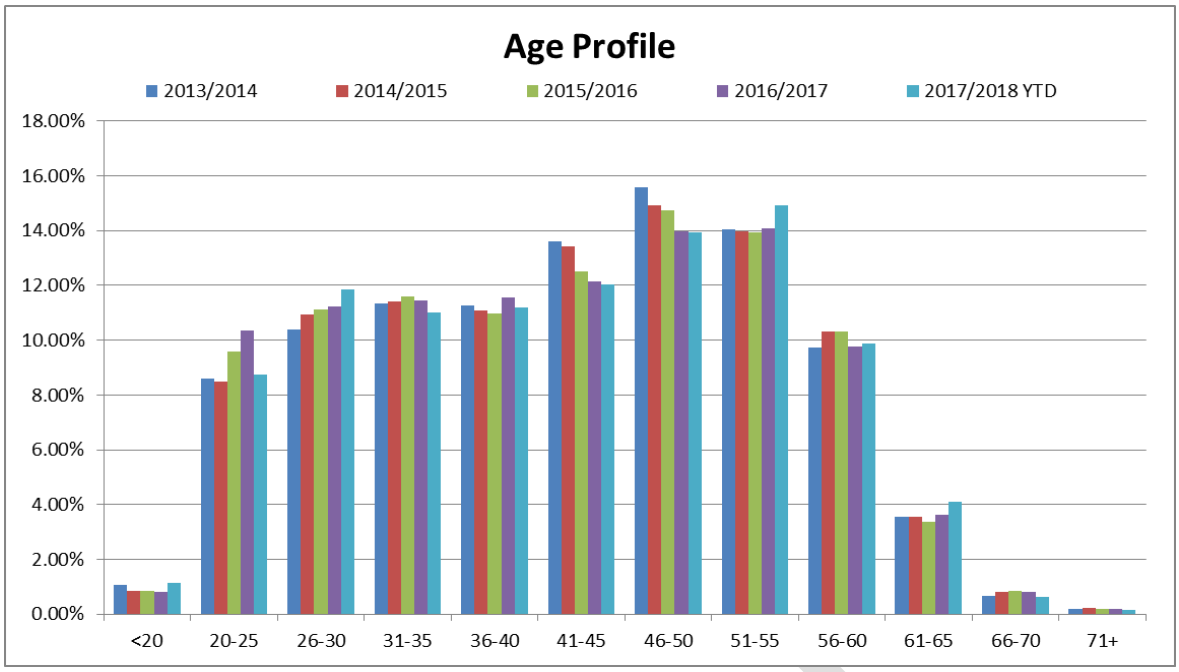
Following good practice in data protection and to ensure personal privacy, some categories have been combined. This helps to protect the anonymity of staff.

We have analysed the Trust's workforce information from the last four years using key equality and diversity indicators to try and identify any significant trends in the data. The categories used are:

- Age
- Disability
- Ethnicity
- Gender
- Religious Belief
- Sexual Orientation

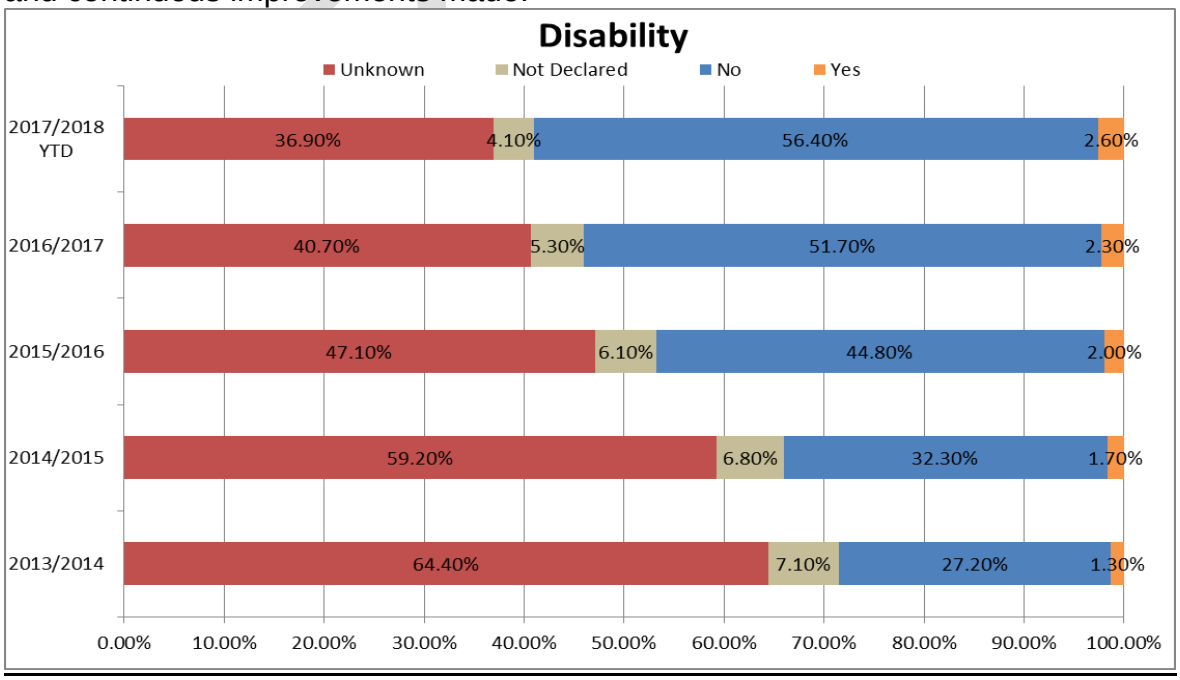
Age Profile

The highest proportion of Trust employees are in the age bracket 51-55.



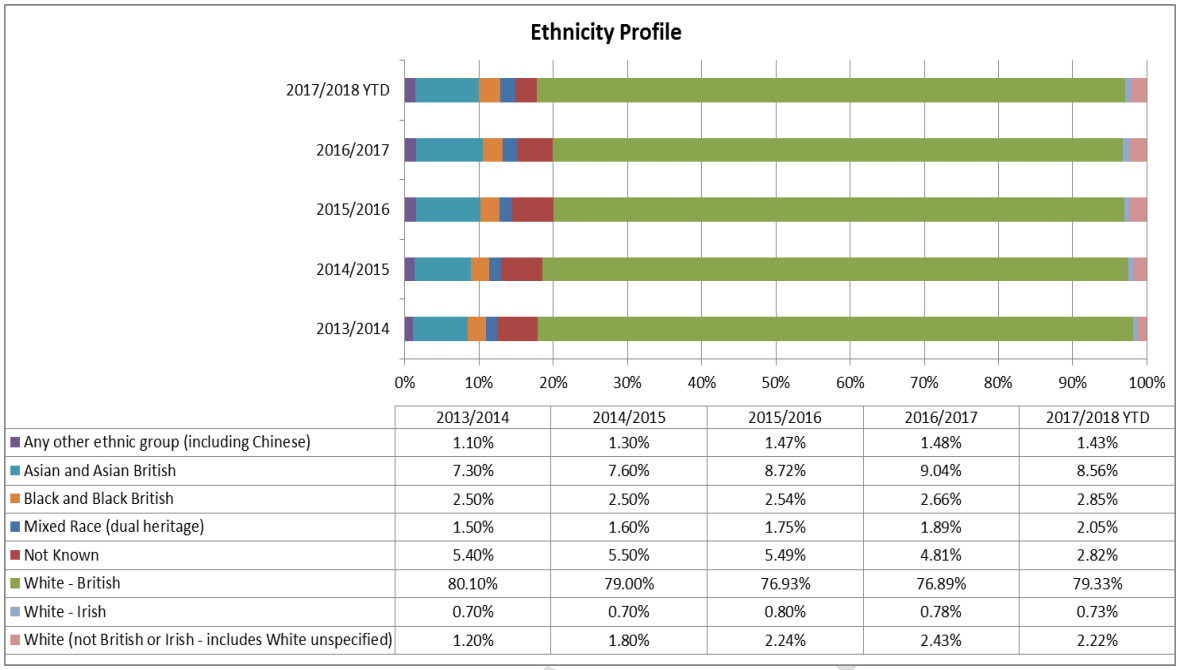

Disability

Information on the profile of the Trust's workforce in terms of disability is not sufficient to provide a valid analysis of the data. Data quality has improved over the last 5 years; however there is still 36.9% of the workforce where information around disability is unknown. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



## Ethnicity Profile

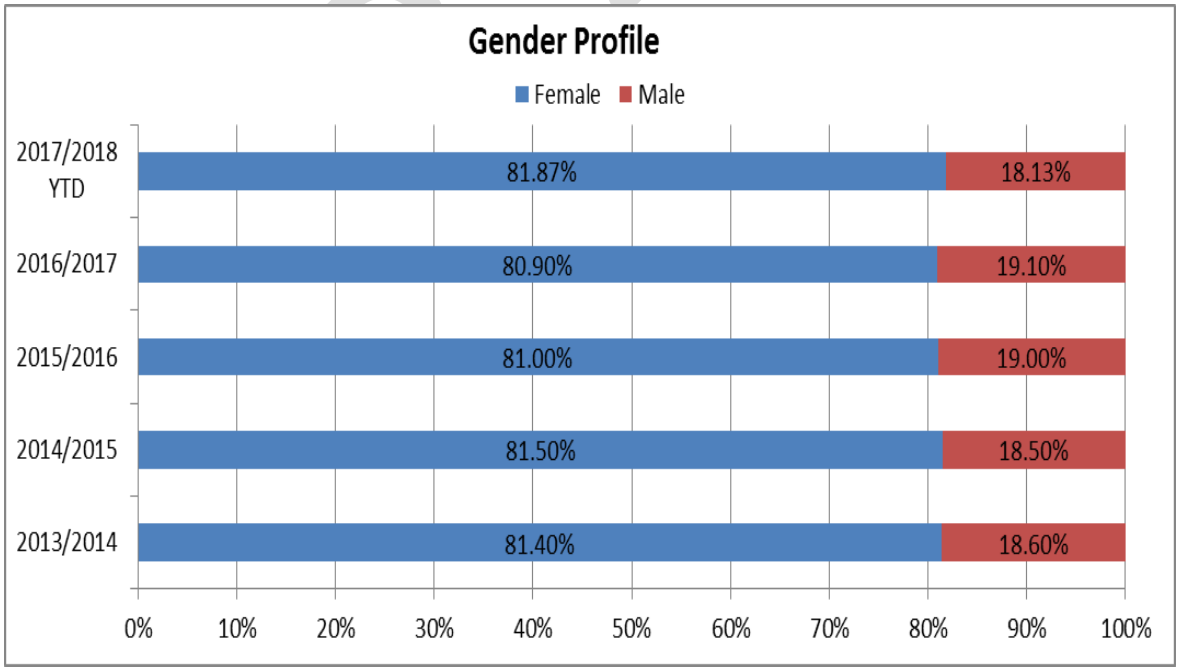
The ethnicity profile of the Trust has not shown much change over the last 4 years, the biggest profile remain white British (79.33%)




| | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 YTD |
|---|---|---|---|---|---|
| Any other ethnic group (including Chinese) | 1.10% | 1.30% | 1.47% | 1.48% | 1.43% |
| Asian and Asian British | 7.30% | 7.60% | 8.72% | 9.04% | 8.56% |
| Black and Black British | 2.50% | 2.50% | 2.54% | 2.66% | 2.85% |
| Mixed Race (dual heritage) | 1.50% | 1.60% | 1.75% | 1.89% | 2.05% |
| Not Known | 5.40% | 5.50% | 5.49% | 4.81% | 2.82% |
| White - British | 80.10% | 79.00% | 76.93% | 76.89% | 79.33% |
| White - Irish | 0.70% | 0.70% | 0.80% | 0.78% | 0.73% |
| White (not British or Irish - includes White unspecified) | 1.20% | 1.80% | 2.24% | 2.43% | 2.22% |

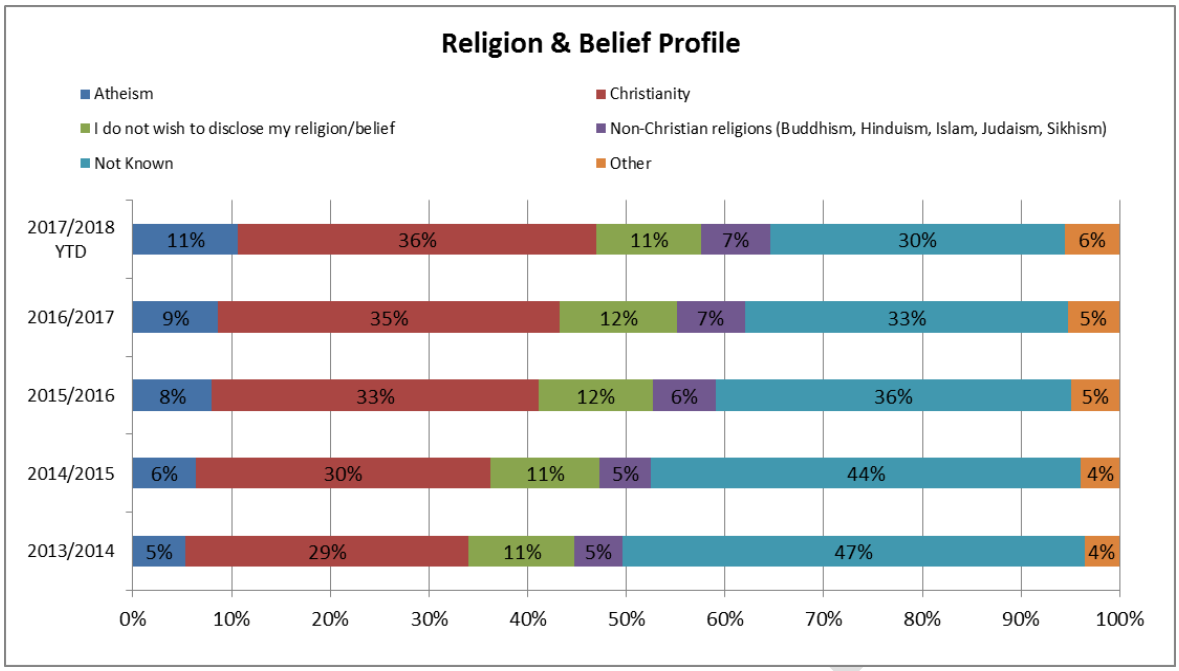
## Gender Profile

The proportion of men working for the Trust is significantly lower than the national workforce. However, the health and social care sector traditionally employs more women than men.



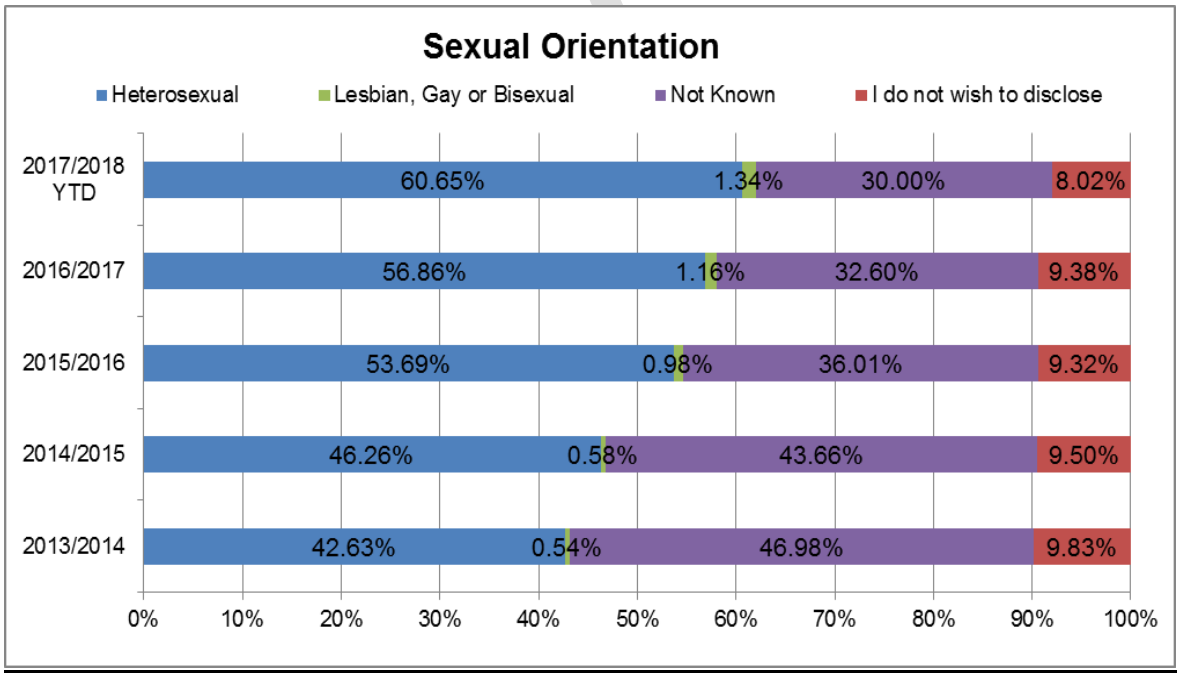
Religion & Belief

Data quality has continued to improve; however there is still 30% of the workforce where information around religious belief is unknown.




Sexual orientation

Data quality has continued to improve; however there is still 30% of the workforce where information around sexual orientation is unknown.



## 3. Staff joining the Trust

This section shows demographic data for the recruitment of staff and has been broken down using equality and diversity indicators. All information in this section is sourced from Trac, an online recruitment tool used by Calderdale and Huddersfield NHS Foundation Trust.

The charts below reflect all recruitment activity for the period 1 December 2016 to 30 November 2017, and provide a breakdown (%) of applicants, applicants shortlisted and applicants recruited.

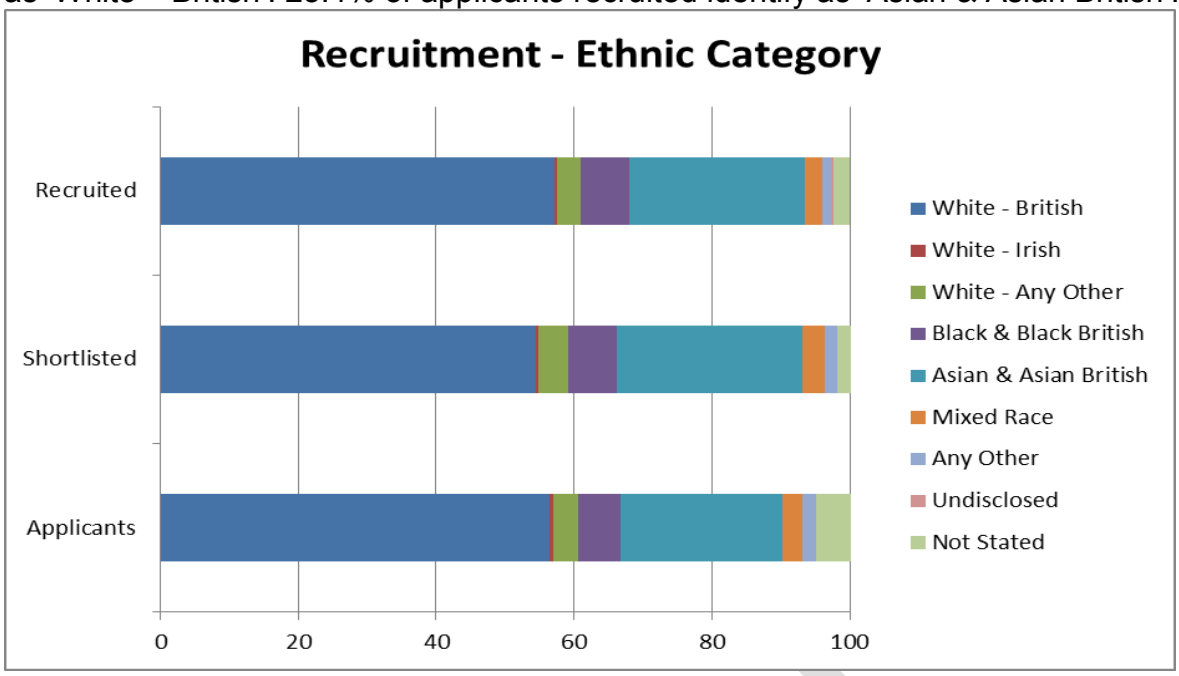
Age Profile

22.1% of all applications are from the 25-29 age group. The 20-24 age group has the highest number of applicants shortlisted at 23.2%. The majority of the applicants recruited come from the 25-29 age group at 27.2%.

| Age | Applications | % | Shortlisted | % | Recruited | % |
|---|---|---|---|---|---|---|
| Under 20 | 362 | 3.6 | 221 | 3.3 | 30 | 4.3 |
| 20 - 24 | 2111 | 21 | 1534 | 23.2 | 121 | 17.4 |
| 25 - 29 | 2225 | 22.1 | 1475 | 22.3 | 189 | 27.2 |
| 30 - 34 | 1315 | 13.1 | 867 | 13.1 | 96 | 13.8 |
| 35 - 39 | 928 | 9.2 | 569 | 8.6 | 72 | 10.4 |
| 40 - 44 | 858 | 8.5 | 546 | 8.3 | 46 | 6.6 |
| 45 - 49 | 813 | 8.1 | 487 | 7.4 | 53 | 7.6 |
| 50 - 54 | 737 | 7.3 | 461 | 7 | 47 | 6.8 |
| 55 - 59 | 463 | 4.6 | 291 | 4.4 | 25 | 3.6 |
| 60 - 64 | 200 | 2 | 134 | 2 | 13 | 1.9 |
| 65+ | 25 | 0.2 | 11 | 0.2 | 2 | 0.3 |
| Not stated | 24 | 0.2 | 5 | 0.1 | 0 | 0 |
| **Total** | **10061** | **100** | **6601** | **100** | **694** | **100** |

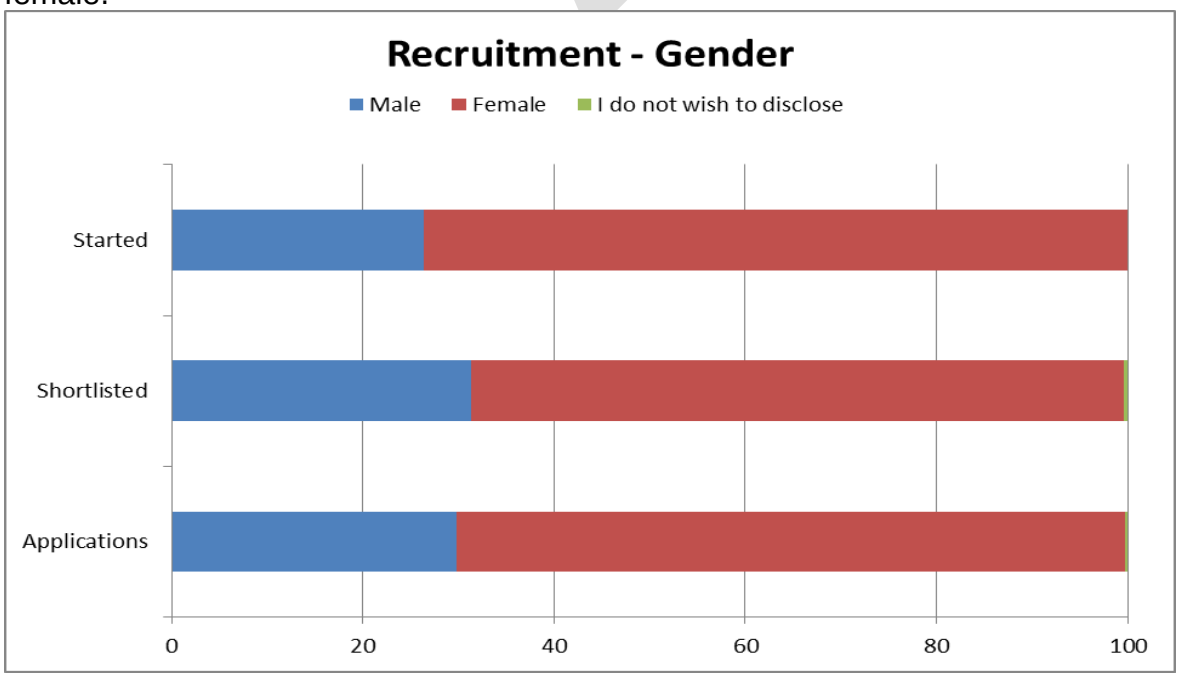
Ethnic Category

Over 50% of all applications, applicants shortlisted and applicants recruited identify as 'White – British'. 25.4% of applicants recruited identify as 'Asian & Asian British'.



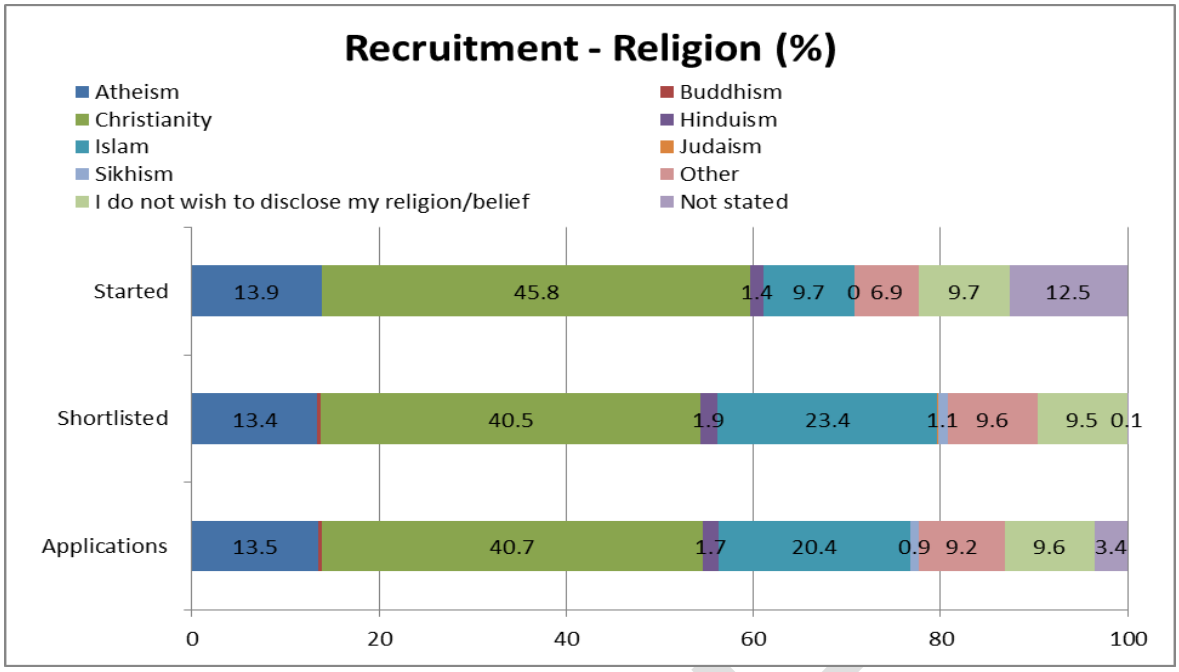

Gender

The majority of applications, applicants shortlisted and applicants recruited are female.



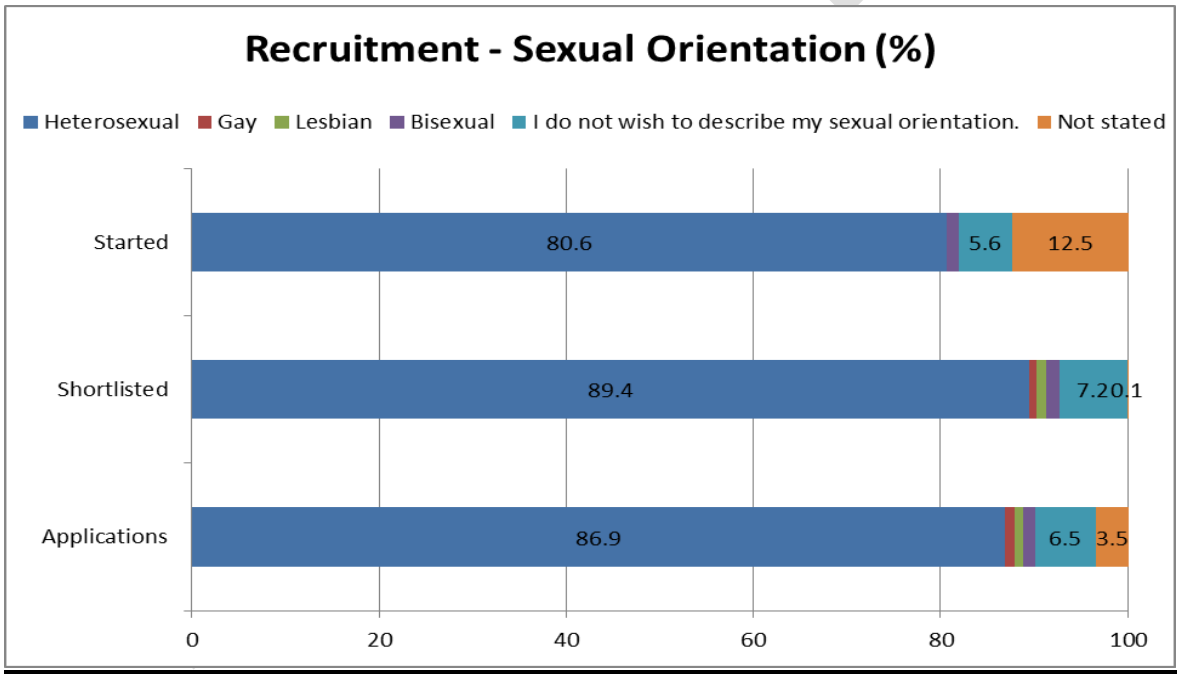

Religion

Over 40% of all applicants, applicants shortlisted and applicants recruited identify as Christians.




Sexual Orientation

The majority of applications, applicants shortlisted and applicants recruited identify as heterosexual.

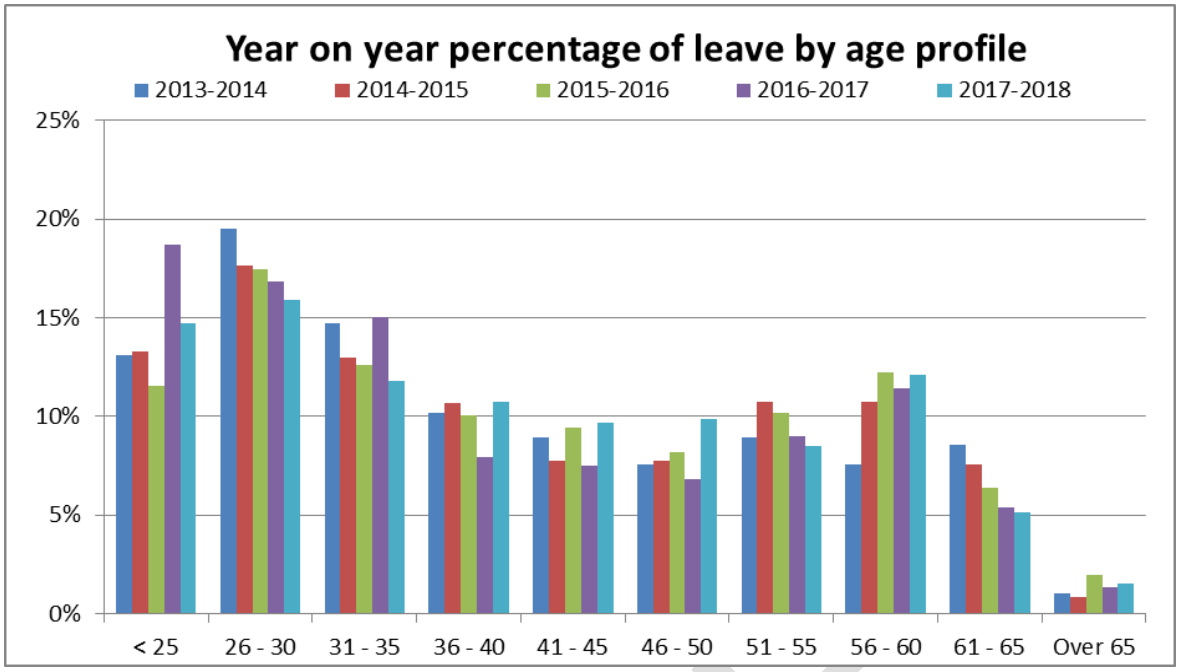



## 4. Staff leaving the Trust

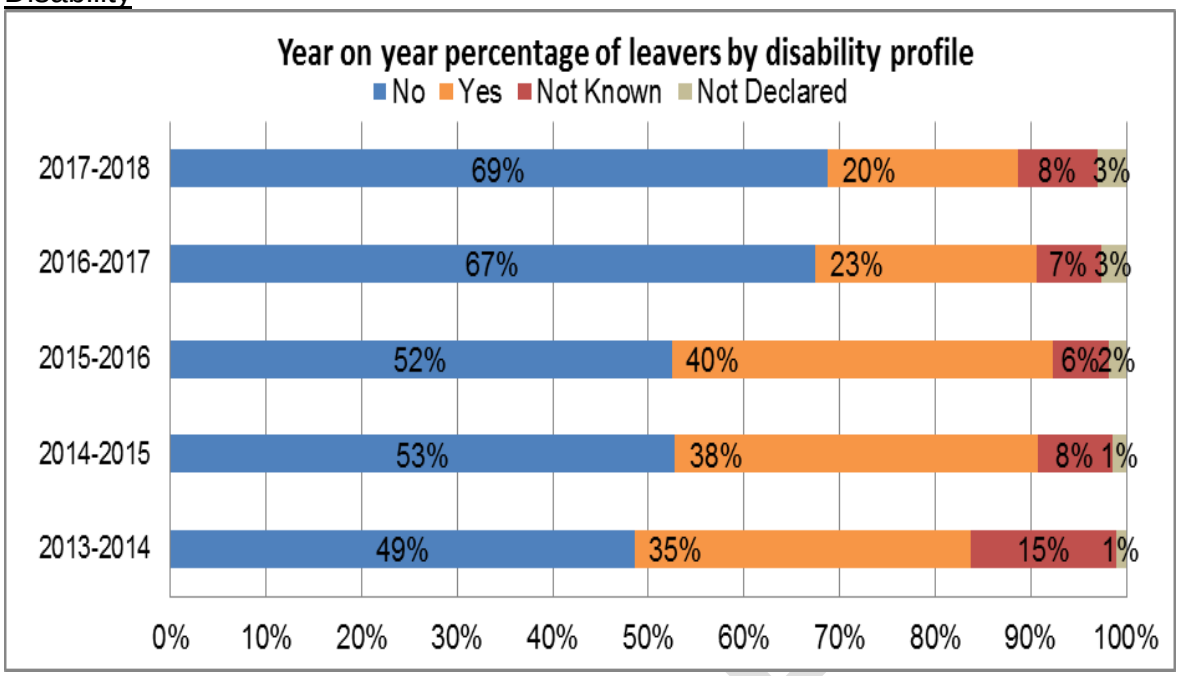
This section shows data regarding staff that left the Trust between 1 April 2012 and 30 November 2017; broken down using the equality and diversity indicators.

Age

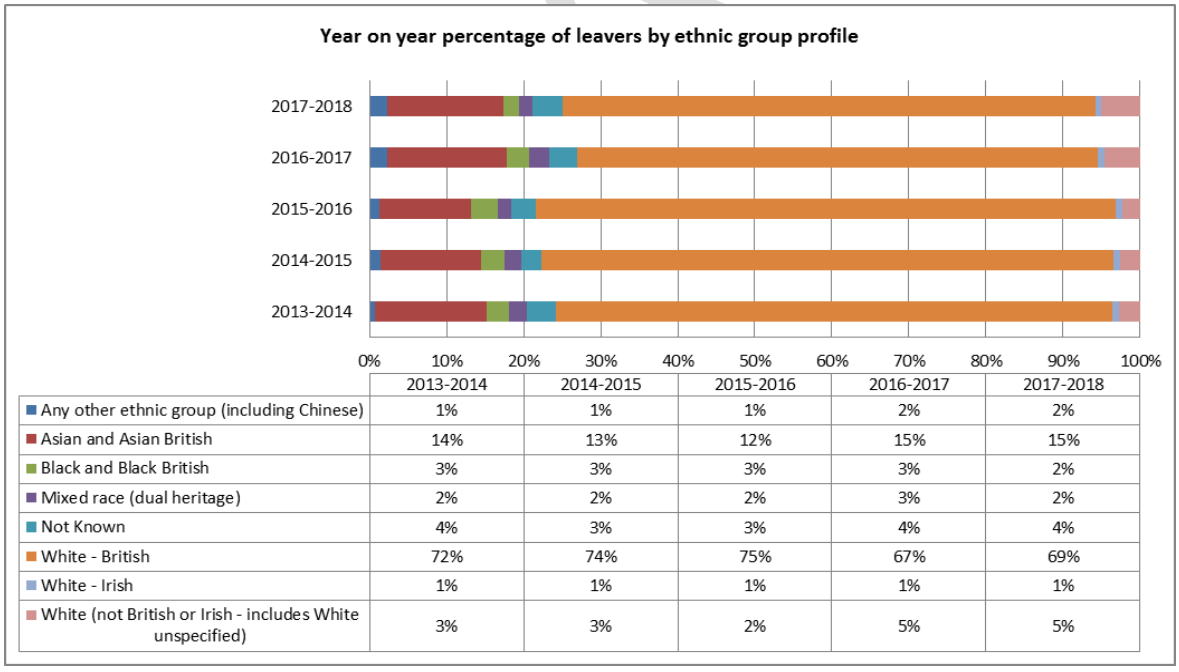
During the current year to date, turnover is highest amongst staff aged 26-30 (16%).


Year on year percentage of leave by age profile
2013-2014
2014-2015
2015-2016
2016-2017
2017-2018
25%
20%
15%
10%
5%
0%
< 25
26 - 30
31 - 35
36 - 40
41 - 45
46 - 50
51 - 55
56 - 60
61 - 65
Over 65

## Disability



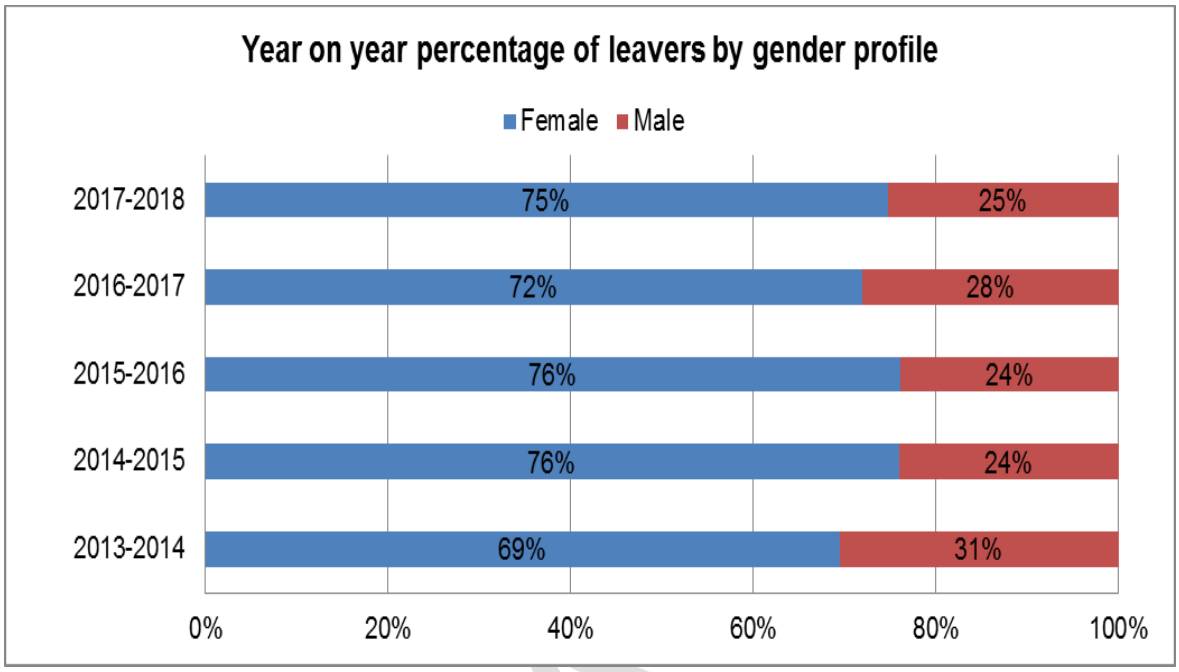

## Ethnicity Profile




| | 2013-2014 | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 |
|---|---|---|---|---|---|
| Any other ethnic group (including Chinese) | 1% | 1% | 1% | 2% | 2% |
| Asian and Asian British | 14% | 13% | 12% | 15% | 15% |
| Black and Black British | 3% | 3% | 3% | 3% | 2% |
| Mixed race (dual heritage) | 2% | 2% | 2% | 3% | 2% |
| Not Known | 4% | 3% | 3% | 4% | 4% |
| White - British | 72% | 74% | 75% | 67% | 69% |
| White - Irish | 1% | 1% | 1% | 1% | 1% |
| White (not British or Irish - includes White unspecified) | 3% | 3% | 2% | 5% | 5% |

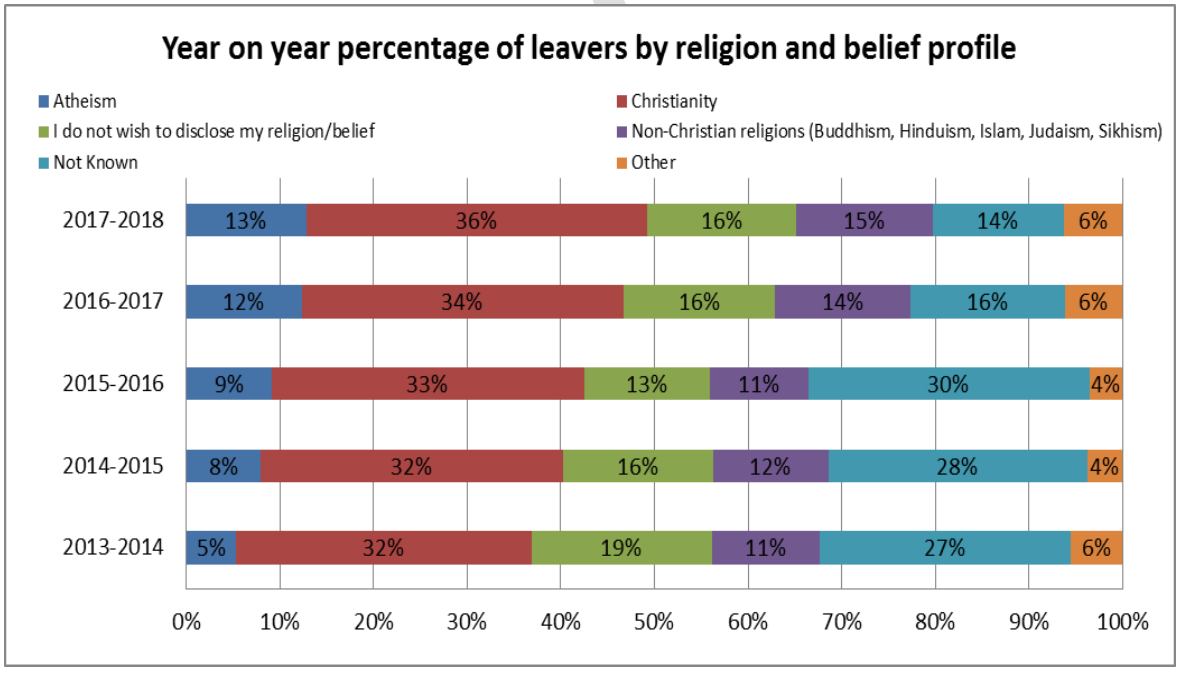
Gender

Again turnover is higher amongst female employees (75%) with the Trust employing a significantly higher amount of female employees to male. Therefore, this is expected.



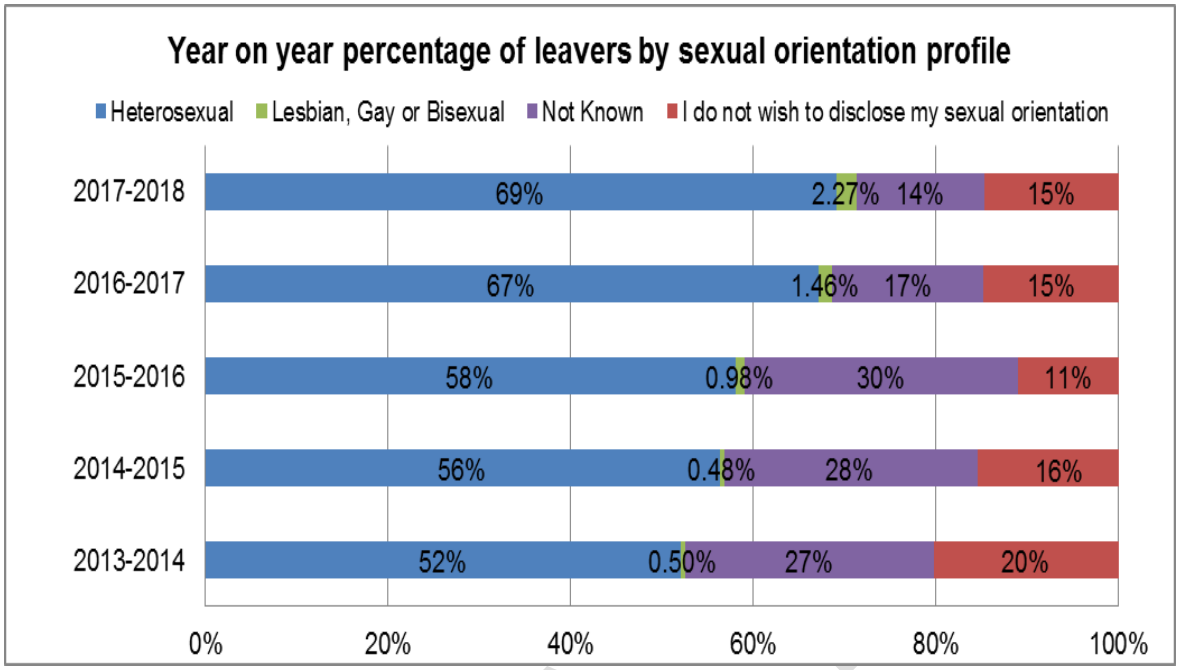

Religion & Belief

As with 2016-17, the majority of leavers are Christians (36%),



Sexual Orientation

The majority of leavers in 2017-18 are Heterosexual. The percentage of 'Not Known' sexual orientation has improved from 17% to 14%.




## 5. Staff profile by pay

The data below is a 'snapshot view' of the pay levels for all Trust employees as at 30 November 2017. This section looks at the organisation pay and measures this against the key equality and workforce indicators.

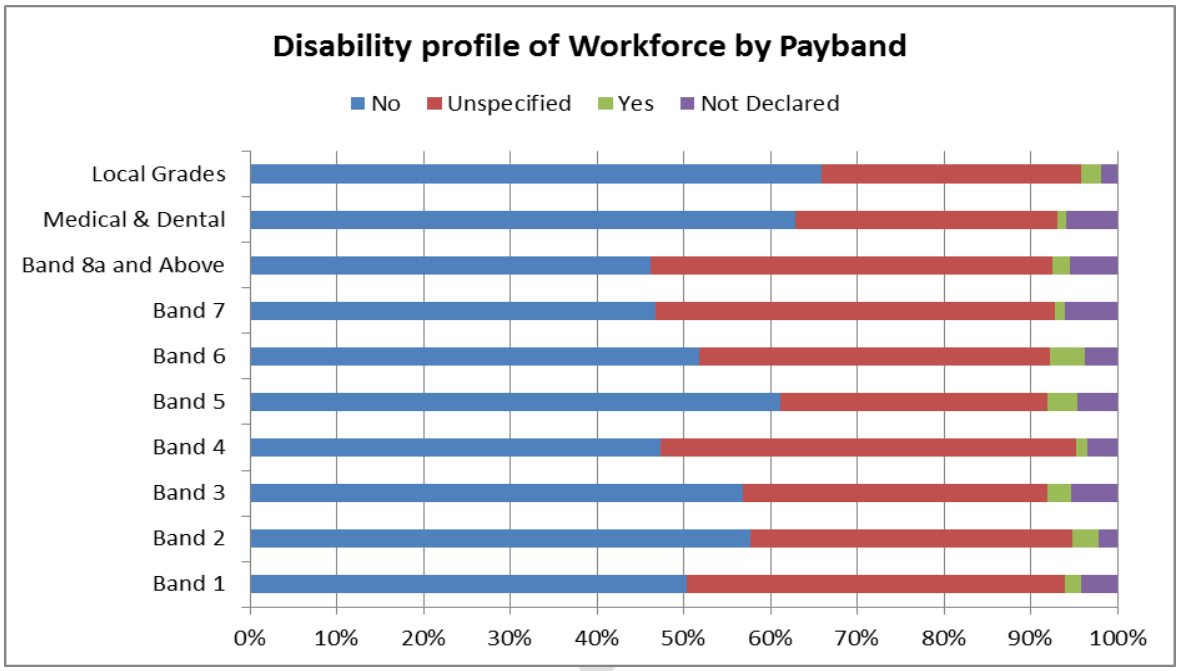
Age

The most common pay band in the Trust is Agenda for Change band 5. 13.98% of people on this band are 25 or under.

| Age Band | Band 1 | Band 2 | Band 3 | Band 4 | Band 5 | Band 6 | Band 7 | Band 8a And above | Local Grades | Medical and Dental |
|---|---|---|---|---|---|---|---|---|---|---|
| <25 | 8.79% | 13.40% | 7.47% | 7.01% | 13.98% | 2.98% | 1.40% | 0.00% | 27.10% | 10.56% |
| 26 - 30 | 5.76% | 11.70% | 11.62% | 8.89% | 15.37% | 12.13% | 6.28% | 2.74% | 5.61% | 18.21% |
| 31 - 35 | 4.55% | 9.60% | 8.92% | 7.28% | 13.14% | 15.33% | 10.70% | 10.96% | 8.41% | 11.84% |
| 36 - 40 | 7.88% | 8.47% | 9.34% | 10.24% | 11.39% | 15.44% | 14.19% | 9.59% | 7.01% | 14.57% |
| 41 - 45 | 7.88% | 10.25% | 13.28% | 12.67% | 11.46% | 13.67% | 14.42% | 16.44% | 9.35% | 14.75% |
| 46 - 50 | 14.55% | 11.78% | 13.90% | 19.68% | 10.76% | 15.66% | 20.47% | 22.60% | 19.63% | 11.29% |
| 51 - 55 | 19.39% | 13.96% | 15.56% | 19.68% | 12.51% | 14.99% | 20.70% | 22.60% | 15.42% | 10.56% |
| 56 - 60 | 18.79% | 12.99% | 14.11% | 10.78% | 8.46% | 7.17% | 8.84% | 9.59% | 4.67% | 4.19% |
| 61 - 65 | 10.30% | 6.78% | 5.19% | 3.50% | 2.59% | 1.87% | 2.79% | 4.79% | 2.34% | 2.73% |
| Over 65 | 2.12% | 1.05% | 0.62% | 0.27% | 0.35% | 0.77% | 0.23% | 0.68% | 0.47% | 1.28% |

## Disability

Information on the profile of the Trust's workforce in terms of disability is not sufficient to provide a valid analysis of the data. Data quality has improved over the last 2 years; however there is still 36.9% of the workforce where information around disability is unknown. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



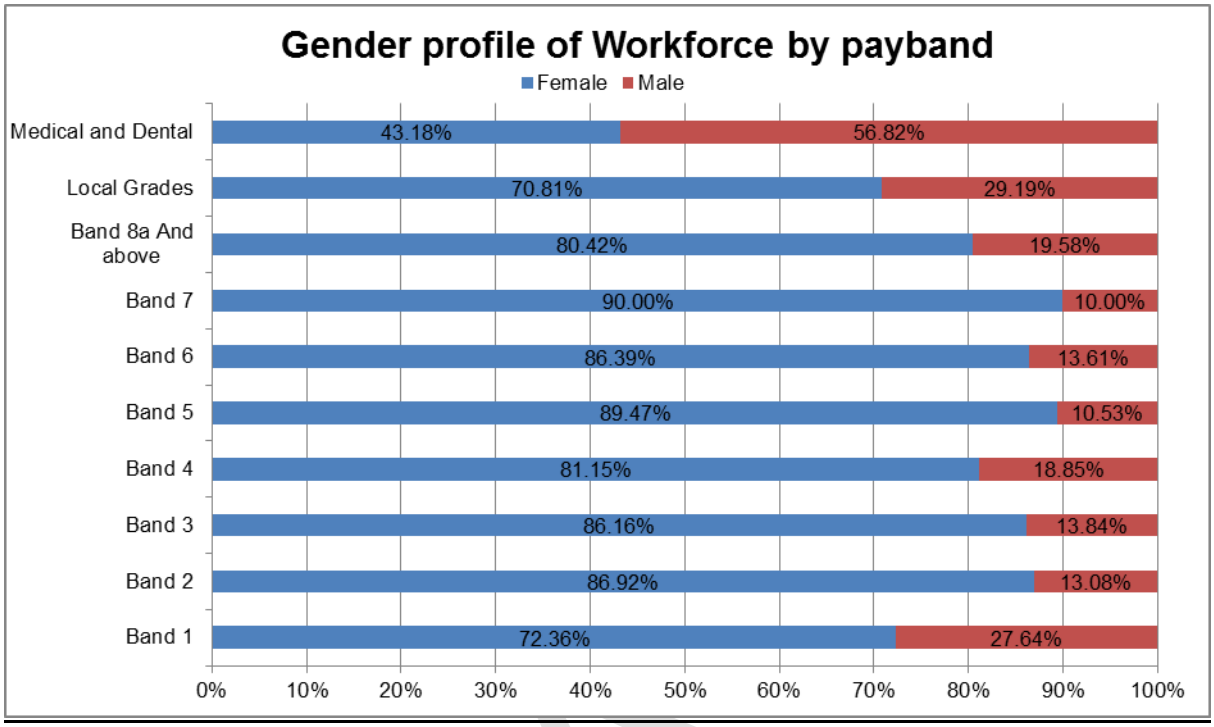

## Ethnicity

Overall the Agenda for Change pay scales, the majority of staff were White British. While Medical and Dental have a more even split between White and other ethnic backgrounds, with a large proportion of those being Asian/Asian British.

| Ethnicity | Band 1 | Band 2 | Band 3 | Band 4 | Band 5 | Band 6 | Band 7 | Band 8a And above | Local Grades | Medical and Dental |
|---|---|---|---|---|---|---|---|---|---|---|
| Any other ethnic group (including Chinese) | 0.00% | 0.74% | 0.21% | 0.55% | 1.42% | 1.35% | 0.48% | 0.70% | 0.00% | 6.58% |
| Asian and Asian British | 3.42% | 7.46% | 5.04% | 4.11% | 7.93% | 4.28% | 4.52% | 0.70% | 2.87% | 36.65% |
| Black and Black British | 8.39% | 3.77% | 1.26% | 2.47% | 3.05% | 1.35% | 0.95% | 0.00% | 3.35% | 3.01% |
| Mixed race (dual heritage) | 3.42% | 2.70% | 1.89% | 1.64% | 1.98% | 0.23% | 2.62% | 1.40% | 2.87% | 3.20% |
| Not Known | 3.73% | 1.97% | 2.10% | 2.74% | 1.91% | 1.24% | 2.86% | 3.50% | 0.48% | 6.95% |
| White - British | 76.40% | 81.23% | 88.03% | 86.85% | 80.03% | 88.85% | 88.10% | 93.71% | 88.04% | 37.03% |
| White - Irish | 0.62% | 0.82% | 0.63% | 0.27% | 0.78% | 1.46% | 0.24% | 0.00% | 1.44% | 0.00% |
| White (not British or Irish - includes White unspecified) | 4.04% | 1.31% | 0.84% | 1.37% | 2.90% | 1.24% | 0.24% | 0.00% | 0.96% | 6.58% |

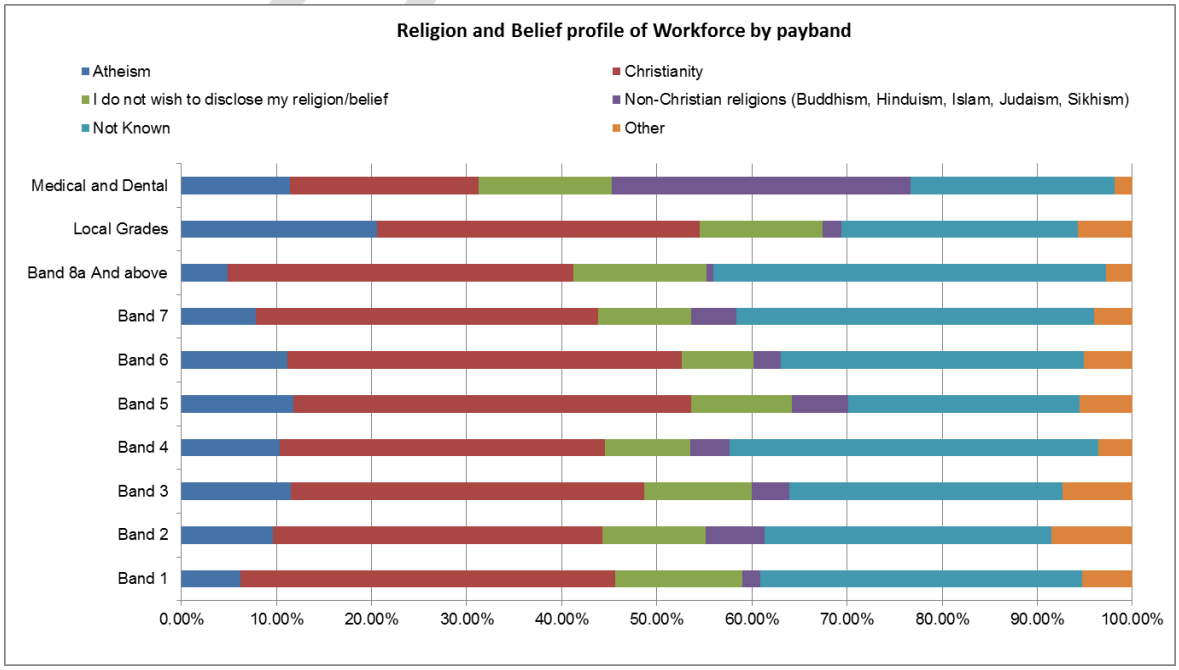
Gender

Men are over-represented in the Medical and Dental pay band (56.82%) compared with the workforce profile as a whole.



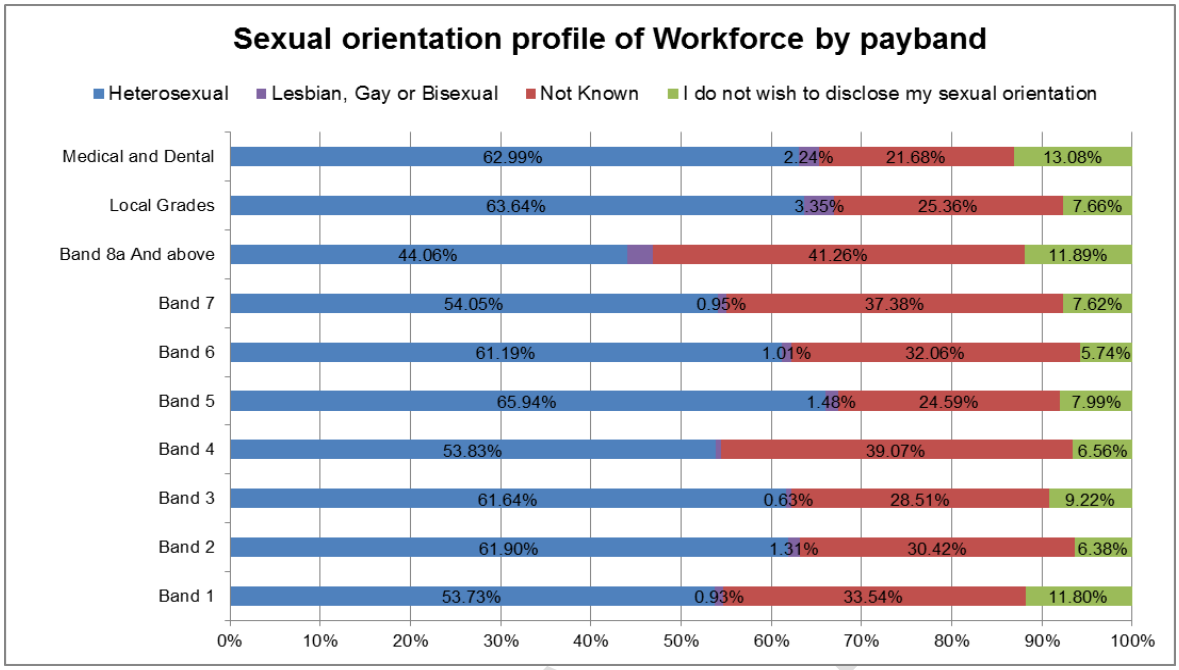

Religion and belief

Progress is been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



Sexual orientation

Not known information is predominant in all pay bands with the most significant being in Band 8 and above.



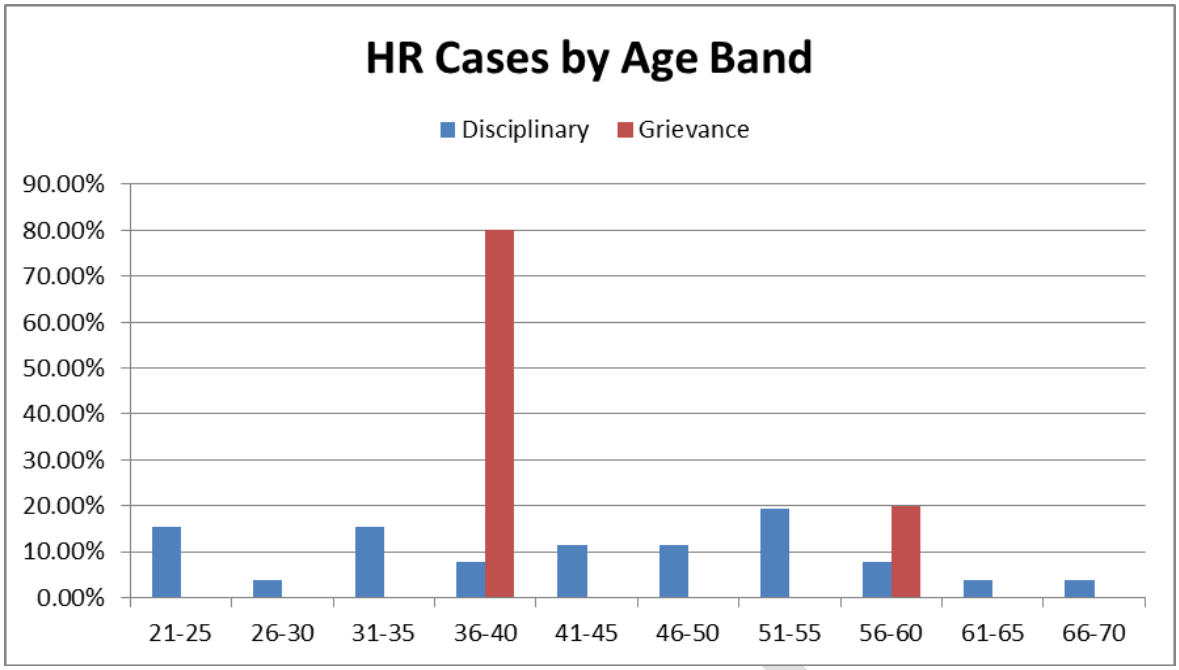

## 6. Disciplinary, grievance and bullying and harassment

Overall, between December 2016 and November 2017 there were:

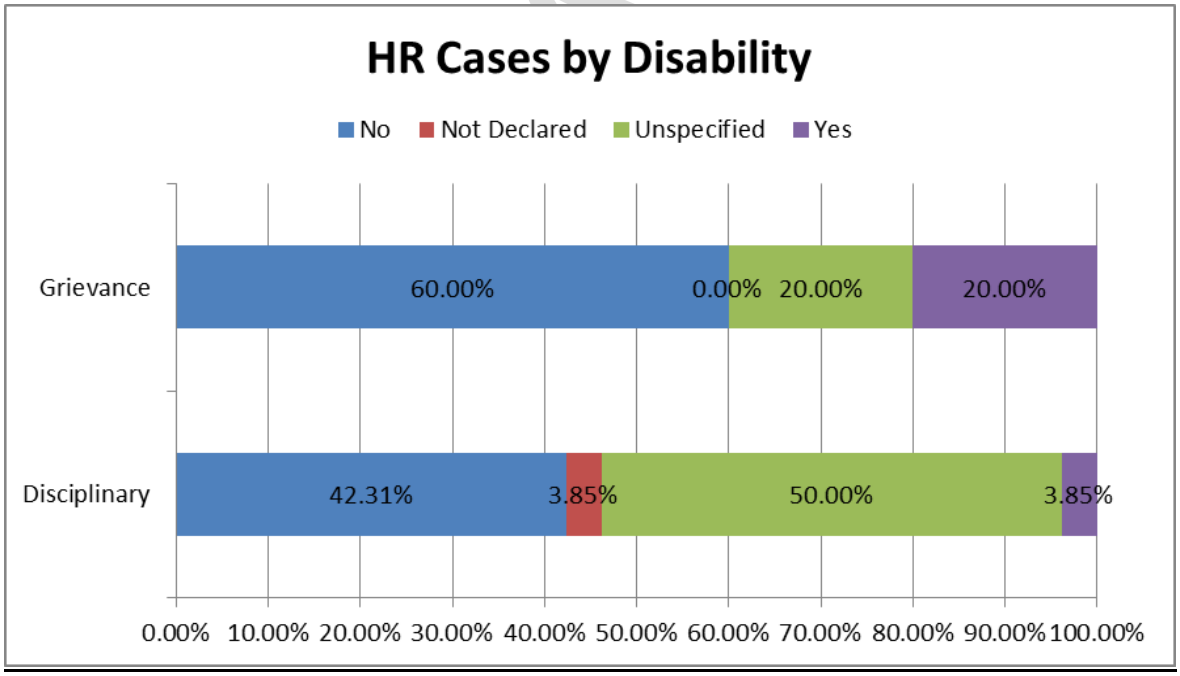
- 26 disciplinary investigations.
- 3 grievance investigations
- 2 bullying and harassment investigations

To protect the anonymity of the data we have merged the bullying and grievance cases together. This section looks at the number employee relation cases and measures this against the key equality and workforce indicators.

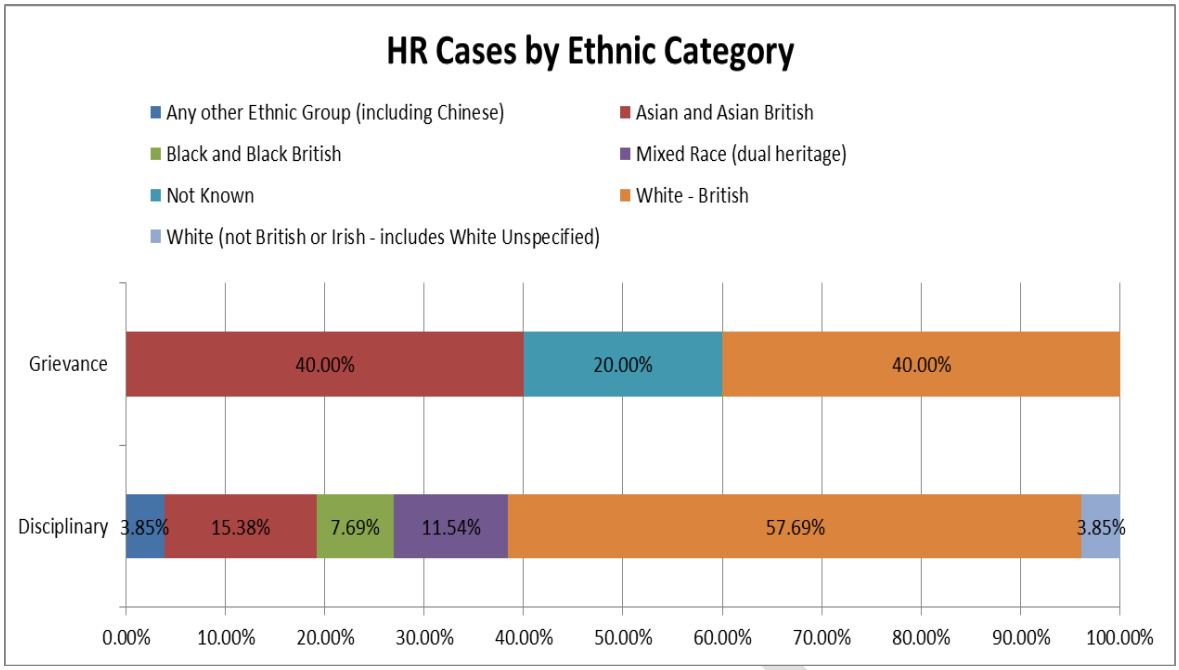
Age Profile



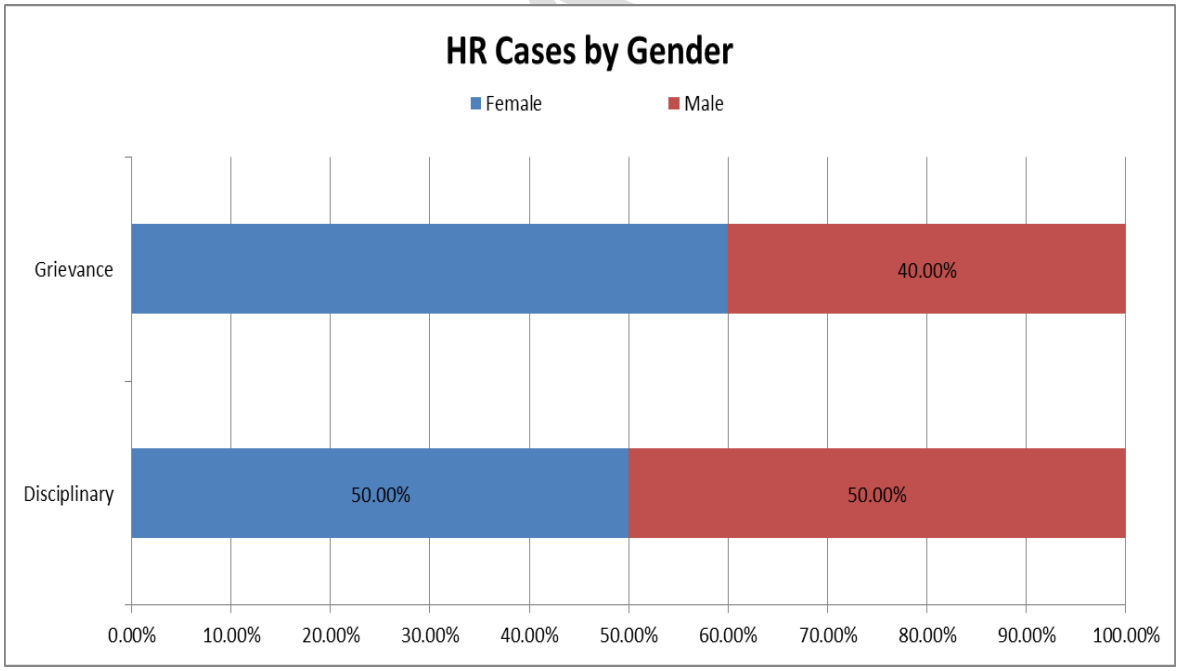

Disability



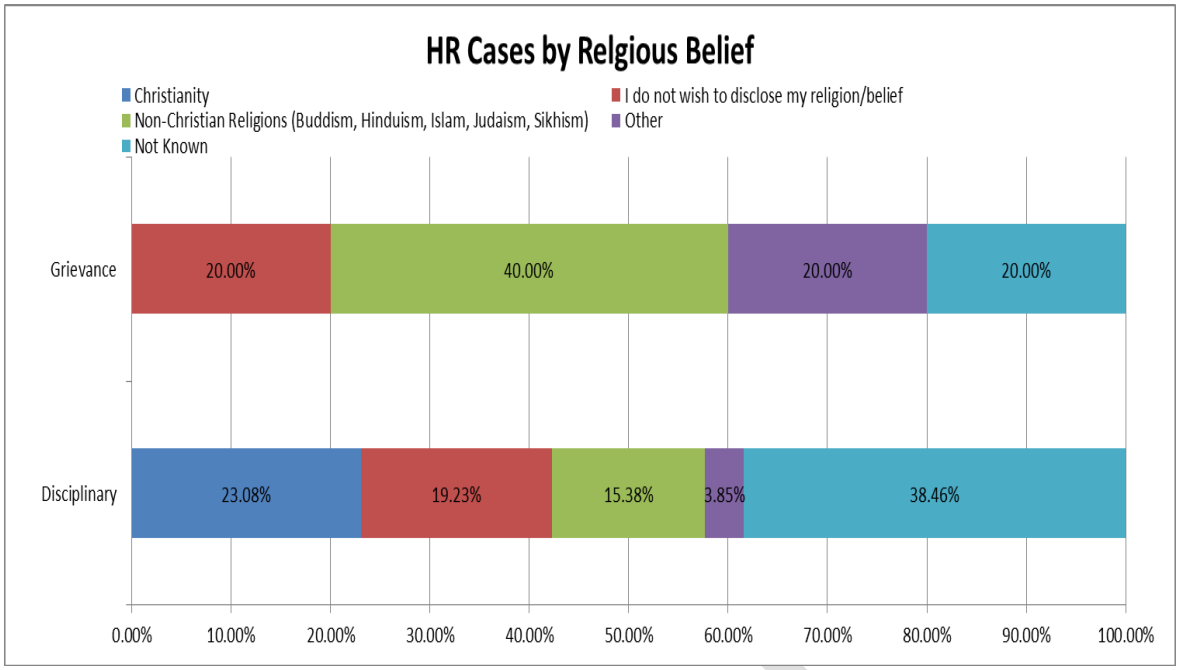
## Ethnicity



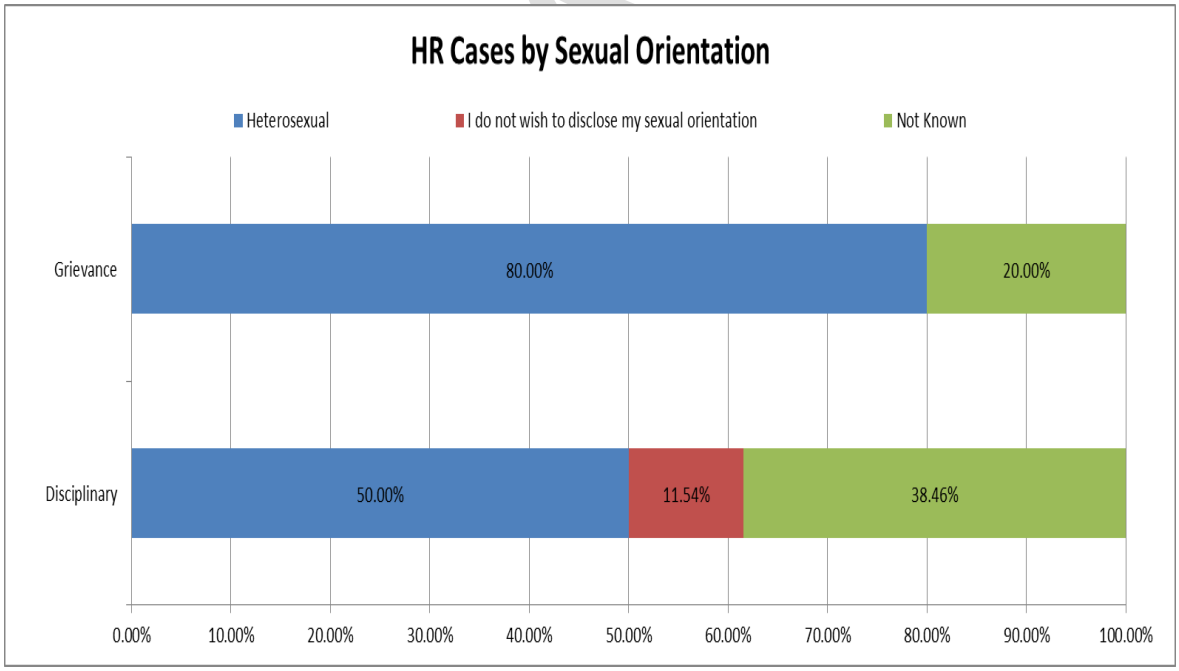

## Gender



## Religious Belief




## Sexual Orientation



## 7. Policies and programmes in place to address equality issues

The Trust continually reviews its policy framework in order to ensure that it is meeting its legal obligations and providing a supportive workplace environment for all of its employees. The Trust policies apply to all employees regardless of gender, ethnicity, disability and sexual orientation.

The introduction of the revised electronic equality impact assessment process from January 2017 ensures that all policies are assessed for their impact on patients/colleagues with a protected characteristic. No policies are given executive approval without having first gone through this important process.

The disability `two tick' symbol was replaced with the new Disability Confident scheme in November 2016. The new scheme offers every employer the opportunity to progress from being Disability Confident Committed (Level 1) to being a Disability Confident Employer (Level 2), then going on to be a Disability Confident Leader (Level 3). The Trust was assessed against the new scheme by the Employment Service in August 2017 and was recognised as being a Disability Confident Employer (Level 2). The Trust demonstrates its commitment to promoting a disability confident culture in the workplace and that it will work towards becoming a Disability Confident Leader (Level 3).

The Trust is committed to interviewing all applicants with a disability who meet the minimum criteria for a job vacancy and considering them on their abilities; to ensuring there is a mechanism in place to discuss the development of disabled employees; to making every effort when employees become disabled to make sure they stay in employment and to taking action to ensure that all employees develop the appropriate level of disability awareness needed.

In March 2017 the Trust's Calderdale Royal Hospital was identified as a suitable place due to the Trusts strong corporate values and strategic equality aims to work in partnership with the Calderdale Project SEARCH programme. This is a nine month long school/college-to-work internship for students with disabilities that will take place entirely on site at Calderdale Royal Hospital. Total workplace immersion facilitates a seamless combination of classroom instruction, career exploration, and on-the-job training and support. The goal for each student is competitive employment somewhere in the community using the skills they have acquired at the Trust. The internship provides real-life work experience combined with training in employability and independent living skills to help youths with disabilities make successful transition from school/college to productive adult life.

This opportunity enables the Trust to have a positive long term impact on outcomes for young people with special educational needs and disabilities, enabling them to live independent lives and contribute successfully to society. The commitment required from the Trust includes the need to provide an area for training, working with the Project SEARCH Team at creating/identifying internships, help identify a mentor for each internship and assist with disability awareness training for colleagues of the intern. The Trust is supporting 12 students during 2017/2018

through the programme and include placements in estates and facilities, administrative and clerical, portering and IT roles.

The Trust successfully introduced the apprenticeship scheme for all posts at Agenda for Change pay bands 1 and 2, and continues to recruit to posts through the scheme. The Trust initially recruited to healthcare assistant roles, administrative and clerical using the scheme but has expanded the types of roles year on year to include: therapy assistants, phlebotomists and radiography assistants, assistant theatre practitioners for the clinical apprenticeships and finance and procurement for non-clinical. Whilst the Trust recruits to all roles a key success has been through the cohort recruitment approach for clinical apprentices. The first cohort of 14 employees commenced in July 2013 with 16 further cohorts recruited as at November 2017. 11 cohorts have successfully completed their training and have been recruited into substantive posts or moved onto to further training. The cohort approach is now being applied to admin and clerical roles as we have seen a significant increase in the number of apprenticeship vacancies for these roles.

The Care Certificate has been incorporated into the apprenticeship programme for all new healthcare assistant roles ensuring we deliver to the standards. The Trust is looking to widening participation through ensuring the scheme continues to support people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation in to the employment market. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting health and wellbeing.

The Trust's colleague engagement strategy adopts a consistent approach to change management with colleague engagement at its core. The strategy focuses on four behaviours that set out the Trust's values for employees, which the Trust expects to be demonstrated by all employees.

The Trust's Occupational Health Department is fully accredited to Safe Effective Quality Occupational Health Standards (SEQOHS). The Standards measure that the Occupational Health Department meets minimum requirements, reflecting existing ethical and professional guidance and consensus and helps them achieve uniform good practice. The Occupational Health Department has a strong focus on the health and well-being of staff and will focus on initiatives like becoming a smoke free Trust and pathways to support staff and managers on mental health pathways and reducing the impact of musculoskeletal conditions.

The Trust published its annual Workforce Race Equality Standard (WRES) in July 2017. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The standard has nine indicators and has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for Black, Asian and Minority Ethnic (BAME) staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust's WRES has identified a number of areas where improvement is required and these relate to recruitment, career progression and bullying and harassment. In September 2016, the Trust's Chief Executive together with BAME colleagues established a BAME Network. The Network is now well established and meets quarterly. One of the areas of focus of the Network is to oversee the delivery of the WRES action plan.

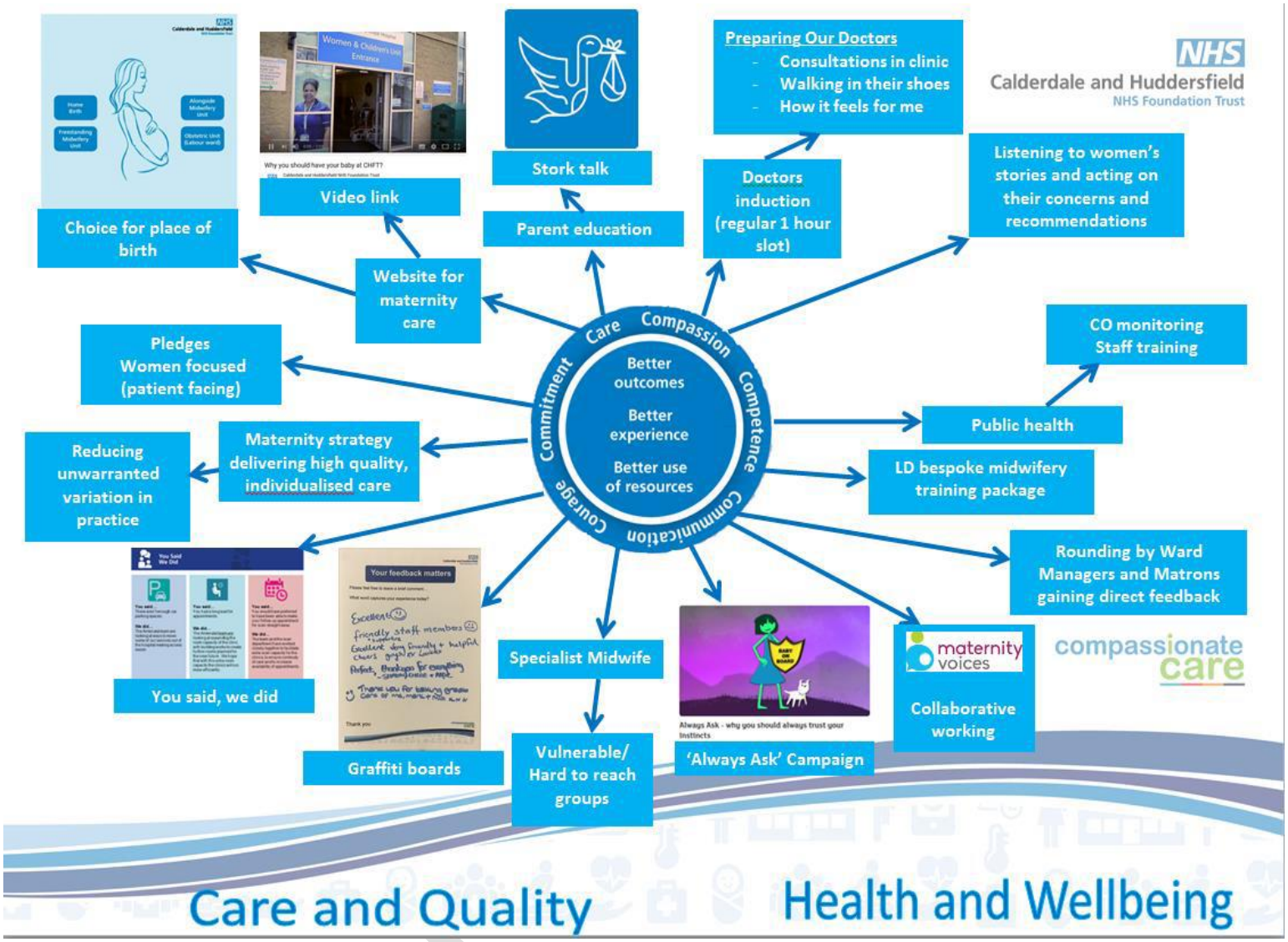
The Trust conducts a leavers survey where employees leaving the organisation are given an opportunity the complete the survey. The response rate is 39.6%. The top three reasons for leaving the Trust are better career opportunity, end of fixed term contract and retirement.

## 8. Improving workforce equality data

In 2017, we have:

- Improved the quality of data stored within the Electronic Staff Record (ESR) around ethnicity, sexual and religious.
- Introduced ESR employee self-service to all colleagues which means that employees can update their personal data including protected characteristics on ESR which will improve accuracy.
- The Trust continued to support and recruit staff using the apprenticeship scheme.
- Published the Workforce Race Equality Standard (WRES) in July 2017

## APPENDIX 2


Choice for place of birth
Video link
Stork talk
Parent education
Preparing Our Doctors
- Consultations in clinic
- Walking in their shoes
- How it feels for me
Doctors induction (regular 1 hour slot)
Listening to women's stories and acting on their concerns and recommendations
Website for maternity care
Pledges Women focused (patient facing)
Care
Compassion
Competence
Communication
Courage
Commitment
Better outcomes
Better experience
Better use of resources
CO monitoring Staff training
Public health
LD bespoke midwifery training package
Maternity strategy delivering high quality, individualised care
Reducing unwarranted variation in practice
Rounding by Ward Managers and Matrons gaining direct feedback
You said, we did
Graffiti boards
Specialist Midwife
Vulnerable/ Hard to reach groups
'Always Ask' Campaign
maternity voices
Collaborative working
compassionate care
Care and Quality
Health and Wellbeing

**APPENDIX 3**


Children's Services- Working together with families to support the delivery of the Nursing and Midwifery Strategy
NHS
Calderdale and Huddersfield
NHS Foundation Trust
Screens (clinical areas)
Calendar of celebratory events – e.g. National play day
Education with schools e.g diabetes
Diabetes wellbeing day- e.g rock climbing
Website
Promotional video- how we value feedback
Public health
OPD
Calm room (parents)
Jake's room
NICU
Environment improvements
Staff fundraising
Ball
PROUD SUPPORTER OF
TOUGH MUDDER
10 steps to theatre
Less waiting for children's blood tests
Responding to feedback
Bring me food/fruit
Ward/department pledges
Care
Compassion
Competence
Communication
Courage
Commitment
Better outcomes
Better experience
Better use of resources
Staff learning from other hospitals
PEN
Patient Experience Network
Recruitment- involving service users
'It's ok to ask'- that's why we are here
When you enter this building
You are the reason we are here
Website
Fruit round-rounding by Clinical Managers & Health Care Assistants
You said, we did
Twitter
Surveys
Teenagers, Children's OPD & Inpatients
Diabetes Team- Rufus the Bear @CHFT_PaedsDiab
PRASE
Children's Ward @CHFT_Child
Patient Reporting and Action for a Safe Environment
We Welcome your Feedback & Comments
Feedback boards for parents
Teenager designed room
Graffiti boards
Care, Quality, Health and Wellbeing for Children and Young People
compassionate care

## APPENDIX 4

## MEMBERSHIP DATA

### Membership Representation as at December 2017 by Age, Ethnicity & Gender

| | Members | % of total members | Eligible membership* | % of eligible membership |
|---|---|---|---|---|
| **Age (years)** | | | | |
| 17-21 | 193 | 2.3% | 52215 | 8.2% |
| 22+ | 8159 | 97.7% | 573203 | 90.2% |
| | | | | |
| **Ethnicity** | | | | |
| White | 7203 | 86.2% | 529668 | 83.3% |
| Mixed | 162 | 1.9% | 9659 | 1.5% |
| Asian or Asian British | 723 | 8.7% | 79829 | 12.6% |
| Black or Black British | 227 | 2.7% | 10162 | 1.6% |
| Other | 37 | 0.4% | 3935 | 0.6% |
| | | | | |
| **Gender** | | | | |
| Male | 2940 | 35.2% | 309248 | 48.6% |
| Female | 5411 | 64.8% | 326568 | 51.4% |
| Transgender | 1 | 0.0% | Not available | - |

* 2011 Census Data

Please note these totals are approximate as not all Trust members declare their age or ethnicity.

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

| |
|---|
| |

## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Sue Laycock, PA to Chief Operating Officer |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Helen Barker, Chief Operating Officer |
| **Title and brief summary:**<br>Integrated Performance Report - The Board is asked to note the overall performance score for December 2017 | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>Weekly Executive Board (25/1/18) | |
| **Governance Requirements:**<br>Keeping the Base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

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 with a couple of failings in Infection Control plus #NoF target. The RESPONSIVE domain is still AMBER and, on a positive note, has maintained its cancer performance across all metrics. However, all 4 Stroke targets are now underperforming. 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 5 Mandatory Training focus areas missing target and a decline in sickness absence performance.

## 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 December 2017.

## Appendix

### Attachment:

Short Version final Board Report - Dec 2017.pdf

Calderdale and Huddersfield NHS Foundation Trust

# Quality and Performance Report

December 2017

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

# Contents



| RAG Key | |
|---|---|
| Not achieving target or threshold | |
| Achieving target | |
| Between target and threshold | |

# Performance Summary

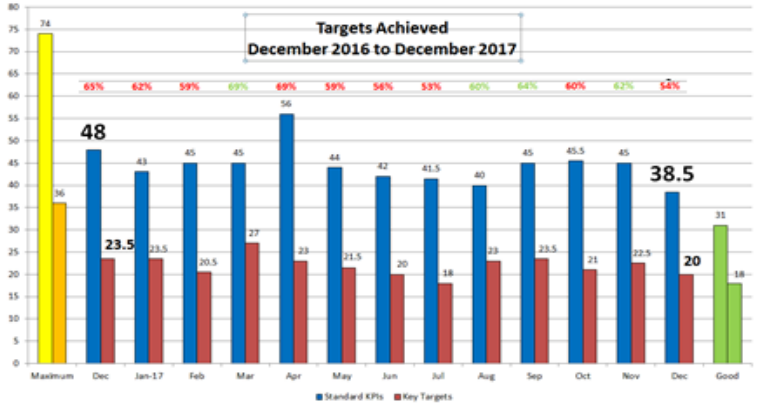
**To Note**

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 **December's** performance the 2 Emergency Readmission indicators in the Effective domain have been discounted as part of the Performance Score in line with the recent update to the Single Oversight Framework. This has resulted mostly in minor improvements in previous months by up to 0.5%.

**Comparing December 2016 performance to December 2017 performance**

**December 2016** performance **(65%)** was **11 percentage points (80 points)** better than **December 2017 (54%)**. The main areas of deterioration are **Mandatory Training (48 points),** FFT (24 points) and Finance (12 points). On the contrary we had an MRSA in December 2016 plus SHMI and HSMR were worse. Graph shows deterioration in total number of targets achieved.




**Comparing 9 months' cumulative performance to December with same period in 2016**

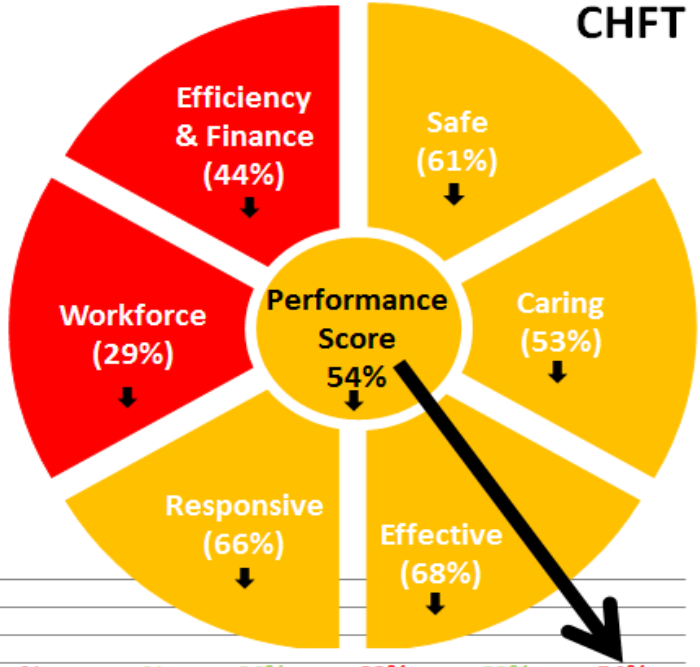
**Period to December 2017's** performance **(59.4%)** was **3 percentage points worse** than **period to December 2016 (62.5%)**. Again the main area of deterioration was **Mandatory Training**, this is only compensated by an equivalent improvement in **Sickness Absence**. Other contributory areas are **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.

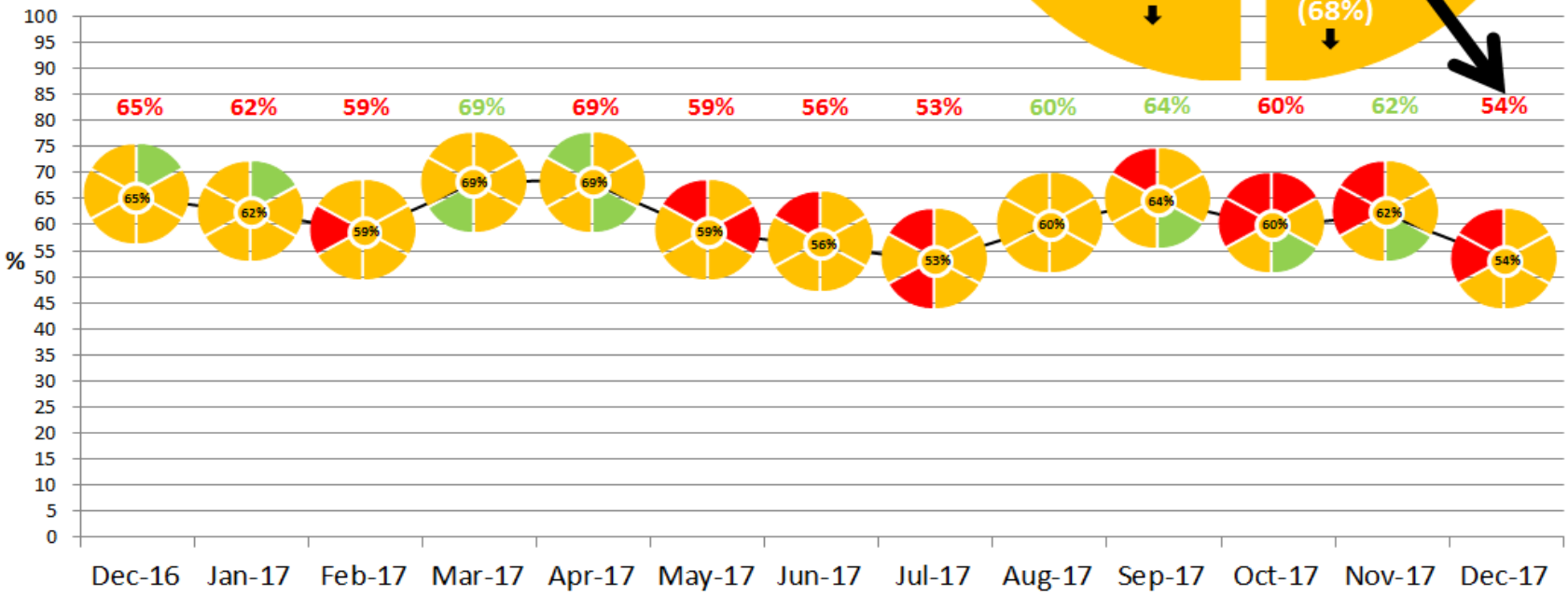
# Performance Summary

## December

**RAG Movement**

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 with a couple of failings in Infection Control plus #NoF target. The RESPONSIVE domain is still AMBER and on a positive note has maintained its cancer performance across all metrics however all 4 Stroke targets are now underperforming. 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 5 Mandatory Training focus areas missing target and a decline in sickness absence performance.




**SINGLE OVERSIGHT FRAMEWORK**

| | |
|---|---|
| SAFE | |
| VTE Assessments | Never Events |
| CARING | FFT A&E<br>FFT IP |
| FFT OP<br>FFT Community | FFT Maternity |
| 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 |

| | | Current Month Score | Previous Month | Trend | Target |
|---|---|---|---|---|---|
| CARING | Friends & Family Test (IP Survey) - % would recommend the Service | 96.2% | 96.8% | ↓ | 96.3% |
| | Inpatient Complaints per 1000 bed days | 1.9 | 2.4 | ↑ | TBC |
| EFFECTIVE | Average Length of Stay - Overall | 4.47 | 4.23 | ↓ | 5.17 |
| | Delayed Transfers of Care | 3.40% | 2.01% | ↓ | 3.5% |
| | Green Cross Patients (Snapshot at month end) | 100 | 119 | ↑ | 40 |
| | Hospital Standardised Mortality Rate (1 yr Rolling Data) | 89.86 | 91.47 | ↑ | 100 |
| | Theatre Utilisation (TT) - Trust | 80.6% | 83.5% | ↓ | 92.5% |
| RESPONSIVE | % Last Minute Cancellations to Elective Surgery | 0.54% | 0.69% | ↑ | 0.6% |
| | Emergency Care Standard 4 hours | 88.03% | 90.96% | ↓ | 95% |
| | % Incomplete Pathways <18 Weeks | 92.61% | 92.45% | ↑ | 92% |
| | 62 Day GP Referral to Treatment | 87.7% | 88.8% | ↓ | 85% |
| SAFE | % Harm Free Care | 93.45% | 93.41% | ↑ | 95.0% |
| | Number of Outliers (Bed Days) | 991 | 627 | ↓ | 495 |
| | Number of Serious Incidents | 6 | 4 | ↓ | 0 |
| | Never Events | 0 | 0 | ↔ | 0 |

**MOST IMPROVED**

No Category 4 pressure ulcers for 6 out of the last 7 months.

All key cancer targets maintained for the 2nd consecutive month.

% Sign and Symptom as a Primary Diagnosis just above the 9% target but achieving lowest rate since EPR go-live back in April.

**MOST DETERIORATED**

Emergency Care Standard 4 hours at 88% (89.8% including types 2 and 3) which is lowest performance since May 17, however still 11 percentage points above the England average. There was an unprecedented surge in demand throughout December with acuity increased. With limited flow out of the Trust through the 2 bank holidays exit block from AED was a regular occurance. Additional beds were opened to support flow impacting on agency spend and gaps in medical staffing in AED specifically over the Christmas and New Year period contributed to the position.

% Stroke patients scanned within 1 hour of hospital arrival - at 30% lowest rate since December 2016.

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

**ACTIONS**

The ECS recovery and sustainability Plan actions continue to be worked through and implemented. New processes have been brought in to reduce pressures on the department including nursing staff now turning patients round at the front door and if appropriate booking GP appointments during daytime hours. Significant actions implemented from 2nd January and will be detailed in the January IPR.

Stroke Assessment Area
Investigation into performance suggests that the establishment of an assessment facility to allow the Stroke team to receive stroke and other neurological presentations would confirm strokes quickly and establish diagnostics and bed requirements early impacting on time to scan and time spent in a stroke bed. Work has commenced to identify an assessment location.

**Arrow direction count** ↔ 2 ↑ 6 ↓ 11

| PEOPLE, MANAGEMENT & CULTURE: WELL-LED | Current Month Score | Previous Month | Trend | Target |
|---|---|---|---|---|
| Doctors Hours per Patient Day | | | | |
| Care Hours per Patient Day | 7.5 | 7.5 | ↔ | |
| Sickness Absence Rate | 4.65% | 4.17% | ↓ | 4.0% |
| Turnover rate (%) (Rolling 12m) | 13.05% | 12.81% | ↓ | 12.3% |
| Vacancy | 359.05 | 318.08 | ↓ | 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) | -£11.98 | -£9.95 | |
| Expenditure vs Plan var (£m) | £2.67 | £3.42 | |
| Liquidity (Days) | -16.96 | -22.00 | |
| I&E: Surplus / (Deficit) var - Control Total basis (£m) | -£5.55 | -£3.79 | |
| CIP var (£m) | £0.13 | £0.38 | |
| UOR | 3 | 3 | |
| Temporary Staffing as a % of Trust Pay Bill | 14.25% | 13.02% | |

# Executive Summary

The report covers the period from December 2016 to allow comparison with historic performance. However the key messages and targets relate to December 2017 for the financial year 2017/18.

| Area | Domain |
|---|---|
| **Safe** | • **% Harm Free Care** - Performance maintained in-month at 93.5%. Within the Medical division a number of initiatives continue to be strengthened (changes to the format of the pressure ulcer panel, progress with the falls action plan) to impact on improving the position. No additional actions are to be put in place in light of the ongoing pressure ulcer improvement collaborative which is already engaged with Community and Trust colleagues.<br>• **% PPH ≥ 1500ml - all deliveries** - 4.2% is highest rate since March 2017. All PPH >1500mls are measured against the ARREST care bundle and th data reflects good compliance with risk assessement and treatment at the time of the PPH. |
| **Caring** | • **Complaints closed within timeframe** - Of the 79 complaints closed in December, 38% of these were closed within target timeframe. Given recent pressures CHFT still aims to have backlog of complaints closed by February with complaint panels and aid from corporate staff aiming to close 15 complaints per week. 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.<br>• **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance is still not achieving target although 90% is best performance since April 2017. The team continues to work across divisions, especially with the Matron for FSS addressing how we can work together to improve response rate and address feedback. A review of Q3 comments is going to be undertaken in January with the performance lead and the division's patient experience lead to ensure that interventions are being targeted in the right place.<br>• **Friends and Family Test A & E Survey -** Response Rate has slipped to 10% in-month whilst % would recommend is still just below target. Both targets have been challenging this month which is due to the unprecedented surge in demand we have seen in the month of December. It is hoped that moving the ACPs to the medical rota will reduce waiting times for patients out of hours which in turn should lead to an increase in patient satisfaction and the would recommend rate.<br>• **Friends and Family Test Community -** Response Rate has dropped below target at 2.7% whilst % would recommend is back below target following 2 months of achievement. 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 focussed day a month). |
| **Effective** | • **Clostridium Difficile Cases** - There were a further 4 cases in-month following the 6 in November. 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.<br>• **E.Coli - Post 48 Hours** - There were 6 cases in-month. 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.<br>• **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.<br>• **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours** - Performance has reduced to 68% following successful achievement in November. 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 was busy in December with acuity increasing and impacting on LOS. There was a national challenge on local DTOC targets for Calderdale which required significant collective actions to secure iBCF funding release. This will have positive outcomes for patients through Q4 and 18/19.

Medicine continued with the reconfiguration of Cardiology, Respiratory and Elderly services with the last ward move taking place 11th December. The implementation of the move was a success with operational issues resolved as and when they arose. A broader review and monitoring of the reconfiguration will be ongoing, culminating in a large scale review in 3 months' time which will include a comprehensive review of the KPIs attached to the business case.

The other significant challenge during December was planning for Christmas, New Year and the January pressures. Whilst there were plans in place to navigate the winter period CHFT was faced with an unprecedented surge in demand for non-elective care for the back end of December and early January which required the Trust to operate fully in silver command and control mode with an OPEL 3 (bordering on OPEL 4) status for both sites.

There was an increase in sickness absence rates in November with total sickness absence increasing to 4.65% which was the highest rate since December 2016. There was an increase in 'Gastrointestinal Problems' and 'Cold/Cough/Flu – Influenza' which contributed to performance.

From the outset in planning for 2017/18 the Trust expressed concerns at the scale of the challenge to deliver £15.9m control total deficit. 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

At Month 9, the Trust has formally declared to NHSI that it 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; exceptional winter cost pressures linked to the requirement to open additional beds and remaining unidentified CIP of £2.0m.

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).

# Executive Summary

The report covers the period from December 2016 to allow comparison with historic performance. However the key messages and targets relate to December 2017 for the financial year 2017/18.

| Area | Domain |
|---|---|
| **Responsive** | • **Emergency Care Standard 4 hours** deteriorated to 88% in November, lowest performance in the last few years - There were also issues with doctor staffing specifically over the Christmas and New Year period. The ECS recovery and sustainability Plan actions continue to be worked through and implemented. New processes have been brought in to reduce pressures on the department including nursing staff now turning patients round at the front door and if appropriate booking GP appointments during daytime hours.<br>• **All 4 Stroke indicators -** missed target in December with % scanned within 1 hour of arrival at 30% lowest performance since December last year. Stroke Assessment Area - Investigation into performance suggests that the establishment of an assessment facility to allow the Stroke team to receive stroke and other neurological presentations would confirm strokes quickly and establish diagnostics and bed requirements early impacting on time to scan and time spent in a stroke bed. Work has commenced to identify an assessment location.<br>• **% Diagnostic Waiting List Within 6 Weeks** - Last batch of the hospital initiated ECHO referrals via additional capacity still being worked through. As of 20th January all the patients that were due to breach have been seen and no further breaches are anticipated for the remainder of January and February although the ECHO team is still struggling with recruitment which could impact on future breaches due to current reliance on locum capacity.<br>• **38 Day Referral to Tertiary** - maintained 56% which it has been for 3 out of the last 4 months. This is being addressed at the weekly escalation meeting. |
| **Workforce** | • **Overall Sickness absence** increased again in November with total sickness absence increasing to 4.65% which was the highest rate since December 2016. Monthly attendance management sessions supporting line managers are scheduled until March 2018.<br>• **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 £26.34m, on a control total basis (excluding the impact of loss of Sustainability and Transformation funding (STF)) the reported year to date deficit position is £22.42m an adverse variance of £5.55m compared with the control total of £16.87m;<br>• Delivery of CIP is above the planned level at £11.96m against a planned level of £11.83m;<br>• Capital expenditure is £4.63m below plan due to revised timescales;<br>• Cash position is £3.34m, above the planned level;<br>• A Use of Resources score of level 3, in line with the plan.<br>In the year to date to Month 9 the adverse variance to the control total deficit is £5.55m. This is the level of financial improvement that the Trust required in order to be eligible for Q3 STF. To date £3.86m of STF has been lost based on Quarters 1 & 2 A&E performance and financial performance in Quarter 3. This is driving a total variance from control total of £9.41m, (excluding technical items excluded for control total purposes). However it should be noted that 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. This position has been discussed with the regulator NHSI and is reliant upon delivery of a number of recovery actions. |

**Background Context**

FSS has been supporting the pressures experienced within the Trust:
- Radiology teams have created additional inpatient scanning and reporting capacity to support speedy response
- Phlebotomy teams have been providing additional PM sessions to support inpatient areas
- Clinical teams within Paediatrics and Obstetrics and Gynaecology have been providing 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.

December saw some weather related challenges and sickness across the Community teams with increased demand towards the end of the month.

The Frailty team continued 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.

Due to Surgery's urgency to recover its performance and financial position it has prioritised the following areas: Supporting ECS, Cancer, Complaints, #NoF, IP/OP workforce capacity and its utilisation, Endoscopy recovery plan and JAG accreditation, Large Value off Track CIPs and Data Quality.

In recognition of the capacity required to complete this the Division have appointed 2 Operational Managers to support Head and Neck and General Surgery who commenced in post 2nd January. In addition to this Surgery has appointed to a Patient Experience post (commenced mid-December) who will assist the Division with overdue complaint resolution and then work on improving the Divisional complaint processes and performance in conjunction with

# Safe, Effective, Caring, Responsive - Community Key messages

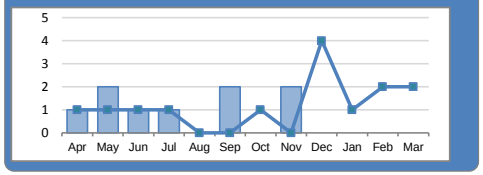
| Area | Reality | Response | Result |
|---|---|---|---|
| **Safe** | **Grade 3/4 pressure ulcers**<br>We are maintaining a low prevalence of grade 3/4 pressure ulcers with two grade 3 reported in November.<br>**Falls**<br>We are maintaining a low prevalence of harm falls with 0 harm falls reported in November. | **Grade 3/4 pressure ulcers**<br>Continued work is progressing with tissue viability. We have released one senior nurse to focus more dedicated time on wound care and pressure ulcers. Orange panel continues to review all grade 3 and 4 pressure ulcers.<br>**Falls**<br>We are looking to spread the Falls Improvement work from Intermediate Care beds into Community Place as there are a number of no harm falls occurring here. | **Grade 3/4 pressure ulcers**<br>Continue to maintain and improve performance in this area.<br>**Falls**<br>Reduce the number of no harm falls in Community Place<br><br>**By when: Review March 2018** |
| **Effective** | **Admission Avoidance**<br>The number of patients reported to have had an admission avoided has reduced again in December. We recognise that community teams need to be able to support patients in their own homes and we need to be able to report effectively when we have avoided an admission. | **Admission Avoidance**<br>We have agreed at divisional board to develop guidance so that we have a consistent approach to reporting admission avoidance. This includes weekly reporting to teams their level of admission avoidance - and reporting this into organisational weekly performance report. | **Admission Avoidance**<br>We will have an accurate report on numbers of admissions avoided and be able to benchmark our teams against this consistent methodology.<br><br>**By when: March 2018**<br>**Accountable: ADN** |
| **Caring** | **FFT**<br>We have had a disappointing result in FFT in December in both response rate (2%) and result (91%).<br>We have reviewed all of the comments received and there are no themes that emerge to help us to change services. We are therefore focussing on improving response rates through January and February with some targeted actions in the division. | **FFT**<br>We have set up a piece of focussed 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 focussed day a month).<br>We are sending the comments to teams and have recognised services where good comments have been received. | **FFT**<br>We will continue to monitor the response rate and would recommend and drill down into comments so we can develop responses for improvement.<br><br>**By when: Review March 2018**<br>**Accountable: Director of Operations** |
| **Responsiveness** | **Waiting Time for Children's services**<br>This area continues to be highlighted as a high risk on our risk register. The main challenges are in Speech and Language therapies with 146 children waiting at Huddersfield and 233 at Calderdale. | **Waiting Time for Children's services**<br>The service are undertaking a review to determine what it would take to reduce the waiting time to 8 weeks - we will then determine whether this is possible to implement and how quickly the waiting list would reduce with these remedial actions in place. Discussions are set up with the CCG once the review has taken place. | **Waiting Time for Children's services**<br>We will continue to monitor the waiting times and prioritise new patient clinics to reduce waiting times.<br><br>**By when: March 2018** |

# Dashboard - Community

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

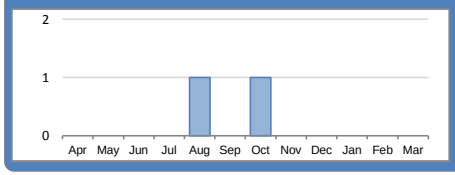
## Safe

### Community acquired grade 3 or 4 pressure ulcers



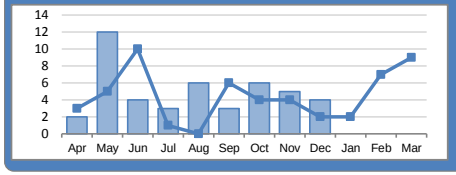

One month in arrears

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

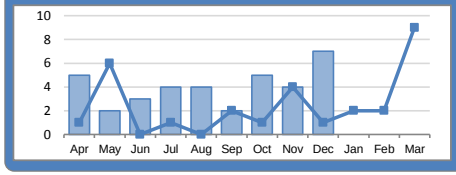



One month in arrears

### Incidents - New Harms

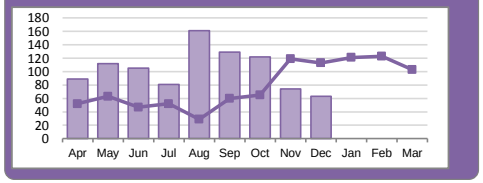



### Medication Incidents

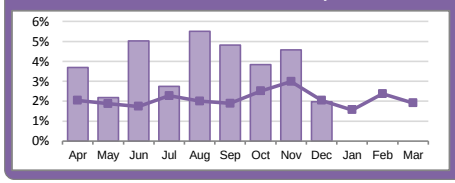



## Effective

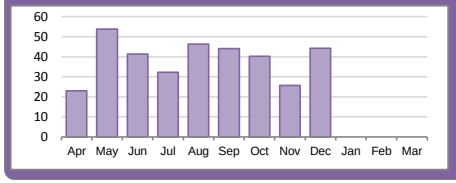
### Number of Hospital admissions avoided by Community Nursing services



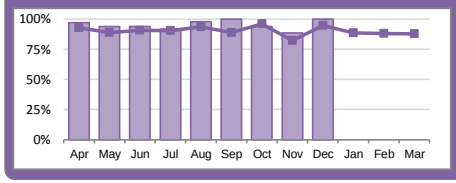

### Patients who attended A&E while on a Community Matron Caseload, who readmitted within 30 days




### Intermediate Care Bed base (Average Days)

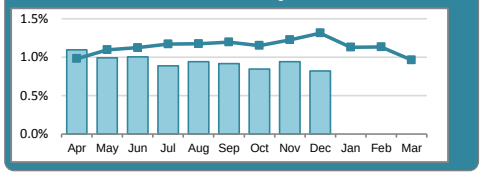



### House Bound leg ulcers healed within 12 weeks

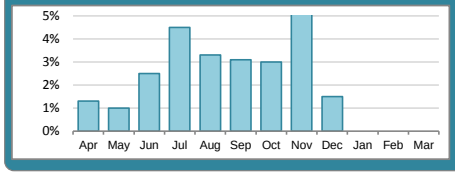



## Caring

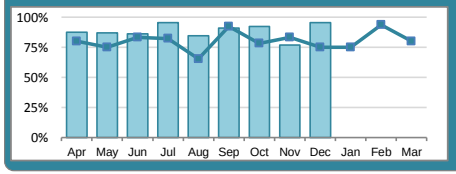
### Community No Access Visits Adult Nursing



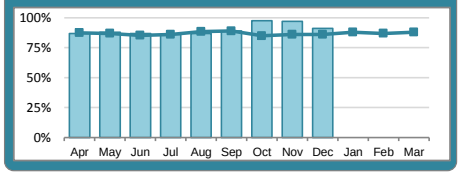

### Intermediate Care Readmission rate




### End of life patient died in preferred place of death

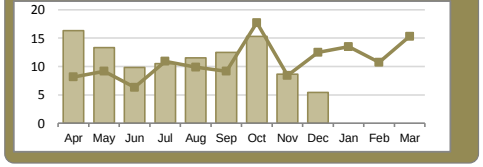



### Friends and Family Test- Likely to recommend

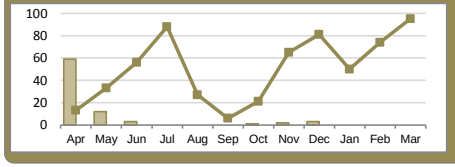



## Responsive

### Average time to start of reablement (days)

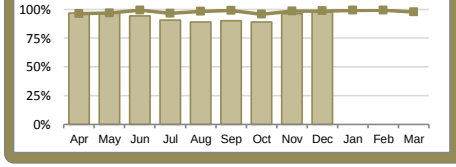



### Appointment Slot Issues for MSK & Podiatry

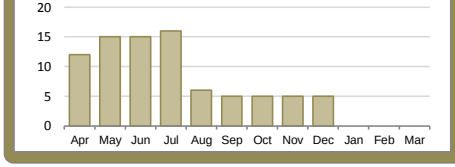



MSK Podiatry

### Waiting Times - 18 week RTT

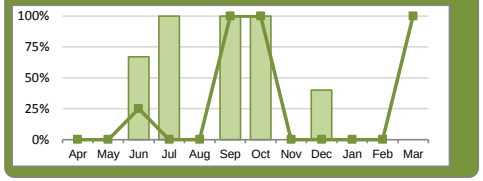



### Waiting Times - Physiotherapy Routine (Weeks)

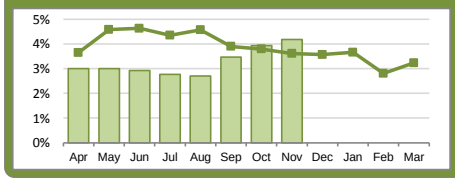



## Well Led

### % Complaints closed within target timeframe

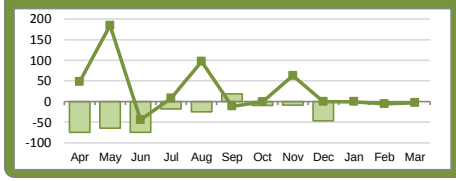



### Staff sickness rate

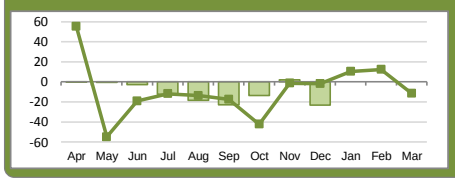



One month in arrears

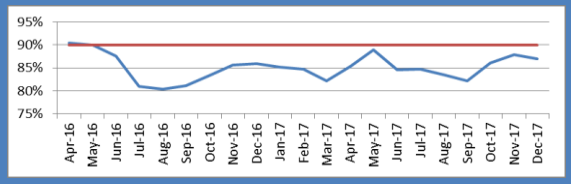
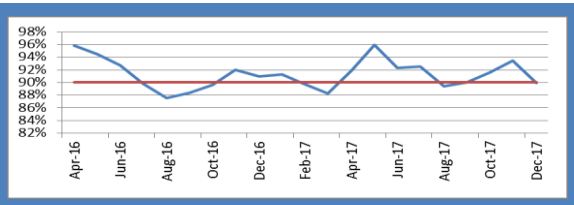
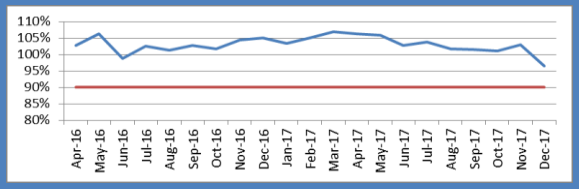
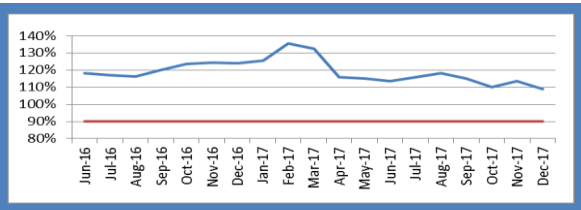
### Finance - Planned variance against actual (£'000)




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



# Hard Truths: Safe Staffing Levels

| | Description | Aggregate Position | Trend | Variation | Result |
|---|---|---|---|---|---|
| **Registered Staff Day Time** | Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only. | 86.89% of expected Registered Nurse hours were achieved for day shifts. |  | Staffing levels at day <75%<br>- 8a/b 69.0% | 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 rates reported in December on ward 8a/b is due to the flexible staffing model in place to support the "variable" bed base |
| **Registered Staff Night Time** | Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only. | 89.88% of expected Registered Nurse hours were achieved for night shifts. |  | Staffing levels at night <75%<br>- ward 12 72%<br>8a/b 61.3%<br>8D 69.4%<br>ward 10 66.7%<br>ward 11 72.3% | 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 embedding new WFM to support re-configuration of medical services. |
| **Clinical Support Worker Day Time** | Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only. | 96.41% of expected Care Support Worker hours were achieved for Day shifts. |  | Staffing levels at day <75%<br>ward 15 68.3%<br>8a/d 61.5%<br>LDRP 71.5%<br>NICU 44.5%<br>ward 18 72.2% | The low HCA fill rates in December 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 vacent 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. | 108.78% 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 December on either site. Fill rate in excess of 100% can be attributed to supporting 1-1 requirments 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 | | MSSA (post cases) | MRSA Bacteraemia (post cases) | Pressure Ulcer (Month Behind) | Falls | Total RN vacancies | Total HCA vacancies |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Registered Nurses | | Care Staff | | Average Fill Rate - Registed Nurses (%) | Average Fill Rate - Care Staff (%) | Registered Nurses | | Care Staff | | Average Fill Rate - Registed Nurses(%) | Average Fill Rate - Care Staff (%) | Total PLANNED CHPPD | Total ACTUAL CHPPD | | | | | | |
| | Expected | Actual | Expected | Actual | | | Expected | Actual | Expected | Actual | | | | | | | | | | |
| CRH ACUTE FLOOR | 2802 | 2455.1 | 2343 | 1874.5 | 87.6% | 80.0% | 2288 | 2211 | 1716 | 1529 | 96.6% | 89.1% | 14.7 | 14.5 | 1 | | 2 | 18 | 9.55 | 6.83 |
| HRI MAU | 1980 | 1762 | 2070 | 1775 | 89.0% | 85.7% | 1705 | 1574.5 | 1364 | 1375 | 92.3% | 100.8% | 12.5 | 12.3 | | | 1 | 12 | 0 | 0 |
| HRI Ward 5 (previously ward 4) | 1674 | 1501.5 | 1209 | 1242.9 | 89.7% | 102.8% | 1023 | 1023 | 1023 | 1273.5 | 100.0% | 124.5% | 5.7 | 6.2 | | | 1 | 10 | 2 | 0 |
| WARD 15 | 2046 | 1586.45 | 2046 | 1396.5 | 77.5% | 68.3% | 1364 | 1172 | 1364 | 1079 | 85.9% | 79.1% | 6.3 | 6.2 | | | 1 | 4 | 11.74 | 4 |
| WARD 5C | 1069.5 | 1021 | 837 | 801 | 95.5% | 95.7% | 682 | 682 | 341 | 341 | 100.0% | 100.0% | 5.6 | 5.5 | | | 1 | 3 | 3.28 | 0 |
| WARD 6 | 1674 | 1637.5 | 1209 | 1254 | 97.8% | 103.7% | 1023 | 1078 | 682 | 828 | 105.4% | 121.4% | 7.0 | 6.8 | | | | 4 | 2.4 | 2.3 |
| WARD 6BC | 1674 | 1628.5 | 1209 | 1193 | 97.3% | 98.7% | 1364 | 1342 | 682 | 737 | 98.4% | 108.1% | 5.0 | 5.0 | | | 1 | 5 | 0 | 0 |
| WARD 5B | 2076 | 1567.5 | 1099.5 | 1134 | 75.5% | 103.1% | 1320 | 1001 | 660 | 638 | 75.8% | 96.7% | 5.5 | 6.0 | | | | 2 | 4.74 | 0 |
| WARD 6A | 976.5 | 806.5 | 976.5 | 918 | 82.6% | 94.0% | 682 | 682 | 341 | 429 | 100.0% | 125.8% | 6.0 | 5.2 | | | | 5 | 2.2 | 1 |
| WARD CCU | 1674 | 1359 | 372 | 396 | 81.2% | 106.5% | 1023 | 1020 | 0 | 55 | 99.7% | - | 18.1 | 18.0 | | | | | 0 | 0 |
| WARD 7AD | 1674 | 1340.5 | 1581 | 1787 | 80.1% | 113.0% | 1023 | 1012 | 1023 | 1012 | 98.9% | 98.9% | 7.3 | 7.2 | | | 1 | 10 | 2.99 | 0 |
| WARD 7B | 837 | 925.5 | 837 | 1140 | 110.6% | 136.2% | 682 | 682 | 341 | 385 | 100.0% | 112.9% | 7.5 | 8.8 | | | | 2 | 4.92 | 0 |
| WARD 7C | 1674 | 1313 | 837 | 924 | 78.4% | 110.4% | 1364 | 1111 | 341 | 597.5 | 81.5% | 175.2% | 11.7 | 10.7 | | | 2 | 1 | 3.04 | 0 |
| WARD 8 | 1441.5 | 1223.9 | 1209 | 1996 | 84.9% | 165.1% | 1023 | 979 | 1023 | 1607 | 95.7% | 157.1% | 5.6 | 6.9 | | | 2 | 16 | 7.11 | 1 |
| WARD 12 | 1674 | 1282.5 | 837 | 1013 | 76.6% | 121.0% | 1023 | 737 | 341 | 627 | 72.0% | 183.9% | 6.4 | 6.3 | | | | 2 | 2.88 | 2 |
| WARD 17 | 2046 | 1575 | 1209 | 1180 | 77.0% | 97.6% | 1023 | 1027 | 682 | 671 | 100.4% | 98.4% | 5.9 | 5.3 | | | 1 | 6 | 1.19 | 0 |
| WARD 8C | 837 | 810.8 | 837 | 1092.5 | 96.9% | 130.5% | 682 | 682 | 341 | 693 | 100.0% | 203.2% | 8.5 | 8.5 | | | 2 | 3 | 5.57 | 1 |
| WARD 20 | 2046 | 1553 | 2046 | 1752 | 75.9% | 85.6% | 1364 | 1364.5 | 1364 | 1355.5 | 100.0% | 99.4% | 6.0 | 5.6 | | | 1 | 16 | 0 | 0 |
| WARD 21 | 1534.5 | 1450 | 1534.5 | 1482.9 | 94.5% | 96.6% | 1069.5 | 1000.5 | 1069.5 | 1046.5 | 93.5% | 97.8% | 9.8 | 9.3 | | | 3 | 3 | 7.15 | 4 |
| ICU | 4030 | 3385.5 | 821.5 | 656 | 84.0% | 79.9% | 4278 | 3367 | 0 | 46 | 78.7% | - | 47.0 | 39.7 | | | 3 | | 3.41 | 0 |
| WARD 3 | 945.5 | 946 | 746.5 | 732.5 | 100.1% | 98.1% | 713 | 713 | 356.5 | 356.5 | 100.0% | 100.0% | 6.6 | 6.6 | | | | 6 | 0.46 | 2.59 |
| WARD 8AB | 954.5 | 659 | 862 | 530 | 69.0% | 61.5% | 862.5 | 529 | 218.5 | 241.5 | 61.3% | 110.5% | 9.2 | 7.6 | | | | 1 | 2.57 | 0 |
| WARD 8D | 821.5 | 777 | 821.5 | 697 | 94.6% | 84.8% | 713 | 494.5 | 0 | 218.5 | 69.4% | - | 8.2 | 7.9 | | | | | 1.87 | 0 |
| WARD 10 | 1302 | 1080.5 | 746.5 | 899 | 83.0% | 120.4% | 1069.5 | 713 | 356.5 | 713 | 66.7% | 200.0% | 6.6 | 6.6 | | | | 2 | 7.81 | 0 |
| WARD 11 | 1551 | 1204 | 1152 | 1016.5 | 77.6% | 88.2% | 1146 | 828 | 837.5 | 638 | 72.3% | 76.2% | 5.7 | 6.0 | 1 | | 1 | 1 | 2.66 | 0 |
| WARD 19 | 1643 | 1465 | 1178 | 1511.5 | 89.2% | 128.3% | 1069.5 | 1035 | 1069.5 | 1146 | 96.8% | 107.2% | 7.5 | 7.7 | | | 1 | 5 | 0.93 | 0 |
| WARD 22 | 1178 | 1152.05 | 1178 | 1165 | 97.8% | 98.9% | 713 | 759 | 713 | 761 | 106.5% | 106.7% | 5.9 | 5.6 | | | 1 | | 1.55 | 2 |
| SAU HRI | 1891 | 1574.8 | 954.5 | 994 | 83.3% | 104.1% | 1426 | 1386 | 356.5 | 345 | 97.2% | 96.8% | 9.2 | 8.2 | | | | 1 | 4.36 | 0 |
| WARD LDRP | 4278 | 3694 | 945.5 | 676.5 | 86.3% | 71.5% | 4278 | 3452.5 | 713 | 644.5 | 80.7% | 90.4% | 19.1 | 15.9 | | | | | 0 | 5.48 |
| WARD NICU | 2247.5 | 1919 | 930 | 414 | 85.4% | 44.5% | 2139 | 1810.5 | 713 | 621 | 84.6% | 87.1% | 11.2 | 9.2 | | | | | 0.86 | 1.42 |
| WARD 1D | 1227 | 1123.5 | 356.5 | 364 | 91.6% | 102.1% | 713 | 693 | 356.5 | 333.5 | 97.2% | 93.5% | 4.4 | 4.4 | | | | | 1.72 | 0 |
| WARD 3ABCD | 3103 | 2964 | 1215.5 | 1040 | 95.5% | 85.6% | 2495.5 | 2656.5 | 356.5 | 404 | 106.5% | 113.3% | 7.2 | 7.1 | | | 1 | | 0 | 2.33 |
| WARD 4C | 713 | 701.5 | 465 | 380 | 98.4% | 81.7% | 713 | 701.5 | 356.5 | 299.5 | 98.4% | 84.0% | 7.2 | 7.0 | | | | 1 | 3 | 3.46 |
| WARD 9 | 1069.5 | 980.9 | 356.5 | 310.5 | 91.7% | 87.1% | 713 | 713 | 356.5 | 333.5 | 100.0% | 93.5% | 5.1 | 4.9 | | | | | 2.14 | 0.57 |
| WARD 18 | 786.5 | 701.5 | 126 | 91 | 89.2% | 72.2% | 713 | 633 | 0 | 23 | 88.8% | - | 19.1 | 18.0 | | | | 1 | 0 | 0 |
| Trust | 59151 | 51127.5 | 37154 | 35829.8 | 86.44% | 96.44% | 45482.5 | 40865 | 21458.5 | 23403.5 | 89.85% | 109.06% | 7.9 | 7.6 | | | | | | |

# Hard Truths: Safe Staffing Levels (3)

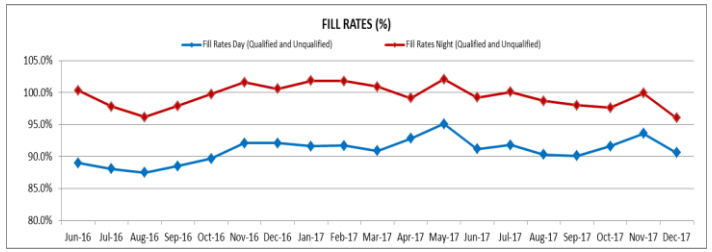
Care Hours per Patient Day

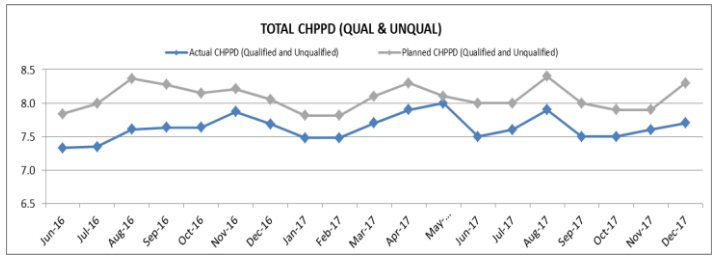
## STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

| | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|
| Fill Rates Day (Qualified and Unqualified) | 91.60% | 93.60% | 90.61% |
| Fill Rates Night (Qualified and Unqualified) | 97.60% | 99.90% | 96.04% |

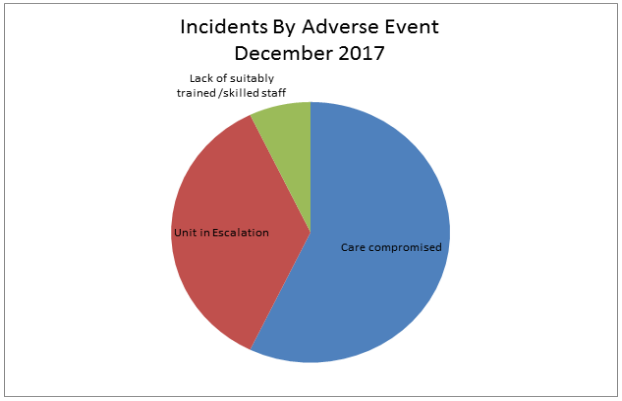
| | | | |
|---|---|---|---|
| Planned CHPPD (Qualified and Unqualified) | 7.9 | 7.9 | 8.3 |
| Actual CHPPD (Qualified and Unqualified) | 7.5 | 7.6 | 7.7 |

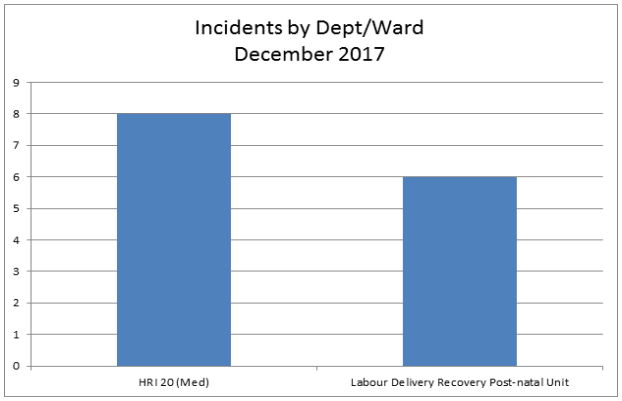
A review of December CHPPD data indicates that the combined (RN and carer staff) metric resulted in 25 clinical areas of the 37 reviewed had CHPPD less than planned. 5 areas reported CHPPD as planned. 7 areas reported CHPPD slightly in excess of those planned. Areas with CHPPD more than planned was due 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 **14 Trust Wide Red shifts** declared in **December**. The 8 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 additt ional 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 model of working are embedded and to review the quality impact - weekley touch point with the senior corporate and divisional nursing teams have been faciitated. HCA Posts generated as a result of reconfiguration of services have now been recruited to and going forword the s taffing position should improve.

There have been 4 level 1, unit in esculation datex repots raised in the reporting period from the FSS division. These have been managed through the esculation 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 forword 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 recruitement projects are progressing well and the first 3 nurses have arrived in Trust, with a further 9 planned for deployment in January 2018

4. A review of the English language requirments to gain entry onto the register has been compleated following announcments 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 and retention of the graduate workforce. This is being further enhanced by the development of a year long graduate programme to support and 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 workfore.

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:**<br>Board of Directors | **Report Author:**<br>Philippa Russell, Senior Finance Manager |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Gary Boothby, Executive Director of Finance |
| **Title and brief summary:**<br>Financial Commentary for NHS Improvement - Month 9 - Financial Commentary for NHS Improvement - Month 9 - The attached commentary was submitted to NHS Improvement on the 23rd of Jan 2018 alongside the Month 9 Monthly Monitoring financial return. | |
| **Action required:**<br>Note | |
| **Strategic Direction area supported by this paper:**<br>Financial Sustainability | |
| **Forums where this paper has previously been considered:**<br>Finance and Performance Committee | |
| **Governance Requirements:**<br>Financial Sustainability | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

**Summary:**

For information - see attached

## Main Body

**Purpose:**

See attached

**Background/Overview:**

See attached

**The Issue:**

-

**Next Steps:**

-

**Recommendations:**

To note

## Appendix

**Attachment:**

NHSI Financial Commentary Month 9 final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

**MONTH 9 DECEMBER 2017, NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN**

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

The report is structured into three sections to describe:

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

## 1. Key Messages

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, 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, 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 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. Financial recovery plans are being implemented details of which are shown below in section 4.

**Month 9, December 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 | 279.24 | 267.25 | (11.98) |
| Expenditure | (277.26) | (274.59) | 2.67 |
| **EBITDA** | **1.98** | **(7.34)** | **(9.32)** |
| Non-operating items | (32.78) | (19.00) | 13.78 |
| **Surplus / (Deficit)** | **(30.80)** | **(26.34)** | **4.46** |
| Less: Items excluded from Control Total | 13.93 | 0.05 | (13.87) |
| Less: Loss of STF funding | 0.00 | 3.86 | 3.86 |
| **Surplus / (Deficit) Control Total basis** | **(16.87)** | **(22.42)** | **(5.55)** |

- Delivery of CIP of £11.96m against the planned level of £11.83m.
- Contingency reserves of £2.00m have been released against pressures.
- Capital expenditure of £8.32m, this is below the planned level of £12.95m.
- Cash balance of £3.34m against a plan of £1.91m.
- Use of Resources score of level 3, in line with the plan.

## 2. Detailed Commentary for the Reporting Period

**Statement of Comprehensive Income (SOCI)**

**Operating Income**

Operating Income is £11.98m below plan year to date.

***NHS Clinical Income***

The year to date NHS Clinical income position is £235.92m, £13.00m below the planned level.

The Clinical Contract income position for Month 9 is £8.08m 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. An agreement has been reached with Commissioners to secure the Month 1-6 income position and discussions are ongoing with a view to secure both the year to date and forecast income positions.

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 £4.7m 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 £0.9m year to date and beyond the control of the Trust.

Maternity pathway, Adult Critical Care and NICU income which naturally fluctuate are all below plan with a combined impact of £0.60m 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. Delays in the delivery of a CIP / QIPP scheme to reduce inpatient capacity which was planned to result in a reduction in both cost and income is also contributing to higher than planned Non Elective income of around £0.90m.

In addition, there is an adverse variance of £4.93m on NHS Clinical income that is outside of contract, of which £3.86m 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 £1.7m (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 £3.02m Quarter 3 planned STF funding 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. Performance in Quarter 3 remained below trajectory at 92.50%.

***Other income***

Overall other income is above plan by £1.02m year to date. Increased sales activity within our commercial operations, in particular the Pharmacy Manufacturing Unit (£1.0m) and Health Informatics Service (£0.24m), and assumed income for the Endoscopy fire insurance claim, have been offset to some extent by slippage in recovery of the Apprentice Levy of £0.3m compared to plan and lower than planned Car Parking income of £0.6m.

**Operating expenditure**

There is a cumulative £2.67m favourable variance from plan within operating expenditure across the following areas:

| | |
|---|---|
| Pay costs | £1.22m adverse variance |
| Drugs costs | £0.07m favourable variance |
| Clinical supply and other costs | £3.82m 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 £1.22m 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 £3.30m. There are a number of cost drivers including £1.0m due to the impact on Nursing pay of opening additional unplanned capacity and emerging winter pressures, £0.7m due to 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 £12.78m year to date, with total Agency expenditure of £11.80m.

***Drug costs***

Expenditure year to date on drugs is £0.07m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £2.11m below plan, offset by additional costs of £1.49m 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 £0.55m.

***Clinical supply and other costs***

Clinical Support costs are £2.76m lower than planned. This underspend reflects an activity related underspend in clinical supplies of £1.94m, as well as a non-recurrent benefit of £0.82m relating to prior year creditors as described above.

Other costs are £1.06m 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 £1.95m 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 the Board believes is extremely challenging.

£11.96m of CIP has been delivered this year against a plan of £11.83m, an over performance of £0.13m. This position includes non-recurrent CIP of £3.5m relating to the refund of PFI facilities management costs mentioned above. The Trust has now identified £18.03m 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 £18.03m will be delivered, but this remains challenging with a number of schemes currently flagged as high risk.
It is also worth flagging 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 December 2017 the Trust had a cash balance of £3.34m, £1.39m above the planned level.

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 | 4.46 |
| | Non cash flows in operating deficit | (13.62) |
| | Other working capital movements | (4.06) |
| | **Sub Total** | **(13.22)** |
| **Investing activities** | Capital expenditure | 4.66 |
| | Movement in capital creditors / Other | (2.13) |
| | **Sub Total** | **2.52** |
| **Financing activities** | Net drawdown of external DoH cash support | 12.88 |
| | Other financing activities | (0.79) |
| | **Sub Total** | **12.08** |
| | **Grand Total** | **1.39** |

***Operating activities***

Operating activities show an adverse £13.22m variance against the plan. The impact of the I&E variance of £5.55m and loss of £3.86m STF funding, (Quarter 1 &2 A&E 4 hour performance and all of Quarter 3's allocation), plus the adverse cash impact of £4.06m working capital variances less the cash benefit of higher than planned Depreciation charges of £0.27m. 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 £4.29m; an increase in inventory values of £0.16m; offset by higher than planned deferred income of £0.43m, due to the under-trade on some commissioner contracts which are paid upfront based on contract values. 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 £4.66m lower than planned and the resulting cash benefit has offset some of the pressure on working capital described above. However, this cash benefit has been partially offset by 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 £27.7m of Revenue Support linked to deficit and STF funding requirements and a further £5.70m of working capital support. This is £12.88m more than planned: £5.56m linked to additional deficit funding requirements, £2.25m due to the timing of STF payments and working capital support that is £5.07m 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.

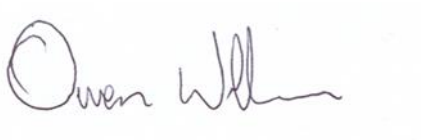
The reported forecast is a year-end deficit of £31.34m (excluding £13.91m technical adjustments that are excluded from Control Total) an adverse variance of £15.40m. This variance incorporates two elements: the gap to control total which is forecast to be £8.00m and the loss of Sustainability and Transformation Funding (STF) of £7.40m. The £8.00m gap compares favourably with the forecast position of £8.60m discussed with NHS Improvement at Month 8, however:

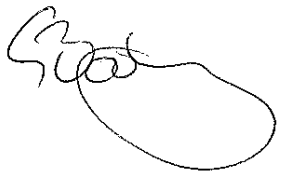
• The movement belies an underlying worsening which can be attributed to £0.4m relating to an agreed change in job plans for surgical consultants and £2.0m relating to additional operational pressure relating to dealing with winter.
• The £2.0m winter pressure is net of anticipated receipt of £0.9m central winter funding. The total £2.9m is made up of £1.3m income loss and £1.6m additional costs.
• Further benefits to offset these new pressures are anticipated to come from £1m further winter funding, £1m additional capital in support of revenue, both of which the Trust has been assured are supported by NHSI and £1m commissioner income.
• The forecast assumes delivery of recovery plans previously identified and shown below. A number of recovery plans have been identified, although the majority are non-recurrent in nature and do not therefore address the underlying deficit position that will be carried forward into the next financial year.

The latest view of the recovery plans is shown in summary below:

| **Recovery Actions** | **Assumed in forecast** £'000 |
|---|---|
| **Recovery Actions previously discussed with NHS I** | |
| Enhanced Vacancy Control | 250 |
| Discretionary Spend: Hospitality etc (£75k included in forecast position) | 25 |
| Course Fees outside of Apprentice Levy (£75k included in forecast position) | 75 |
| Multi-professional staffing model review | 40 |
| **Sub Total:** | **390** |
| **Further recovery Actions** | |
| Supplier Discounts | 150 |
| Depreciation reduced due to SPV / asset lives | 500 |
| PDC reduced due to SPV | 200 |
| Further in year benefit from ISS | 700 |
| CCG Funding property rent increases (Yr2) | 202 |
| **Sub Total:** | **1,752** |
| **Technical accounting recovery opportunities** | |
| **Sub Total:** | **300** |
| **Grand Total: Recovery actions** | **2,442** |

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**

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## Cover Sheet

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|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>CALDERDALE CARES MOVING FORWARD ON HEALTH AND SOCIAL CARE - The Board is asked to receive the presentation from Calderdale Council representatives, provide comment on and approve in principle the Memorandum of Understanding. | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Transforming and Improving Patient Care | |
| **Forums where this paper has previously been considered:**<br>Calderdale Leaders Group | |
| **Governance Requirements:**<br>Transforming and Improving Patient Care | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

This paper proposes a position on delivering “place-based” health and social care integration by 2020, through the Single Plan for Calderdale - a sustainable health & care system for the people of Calderdale that delivers improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care.

## Main Body

### Purpose:

This paper proposes a position on delivering “place-based” health and social care integration by 2020, through the Single Plan for Calderdale.

**Background:**

1. The government wants to see the integration of health and social care, in every area of England, by 2020 . In response, a range of contracting and organisational forms are emerging across England that enables the delivery of joined up GP, Hospital, Mental Health and Community Care Services.

2. This paper proposes a position on delivering “place-based” health and social care integration by 2020, through the Single Plan for Calderdale; the Health and Wellbeing Board’s collective vision of a sustainable health & care system for the people of Calderdale that delivers improved health outcomes, reduced health inequalities, greater independence and a lower need for bed-based care.

3. The Kings Fund Place-Based systems of care report argues that providers of services should work together to improve health and care for populations they serve through collaboration of common resources. The report outlines a set of key design principles (See Appendix 1).

4. Shared and integrated services should improve services for the local population through seamless health and social care pathways that shift demand from more acute services to early intervention and preventative services based in the community. For the people of Calderdale, this could mean:
Easier and faster access to a wider range of joined-up pathways of care where people tell their story once.
Better outcomes based on what is important to people.
Fewer trips to hospital as more services will be available in the community.
More advice and guidance to help people make the right choices and manage their own health.
Better access to local voluntary and community groups.
More involvement in the design of care services near where people live.
Support from community and voluntary services when people need them.

Meanwhile, for our organisations, this could mean:
• Being part of developing new services that better meet the needs of local people.
• Improved communication between services.
• More time to support people who need professionals’ specific expertise.
• Access to people who understand the diverse community and voluntary sector services to help signpost people to the right services.
• A health and care system that has the skills and knowledge to look at the whole person and recognises the power of a strong community.

6. Joint commissioning should reduce perverse incentives inherent in the existing system; improve resource allocation to the areas that need it most; encourage shared objectives across organisations; and produce better health outcomes for the wider population.

7. The Health and Wellbeing Board is currently working to reimagine the health and wellbeing system through its Single Plan for Calderdale; promoting personalisation, supporting healthy decisions, enabling physical activity and encouraging self-care.

## The Issue:

To respond to both of these, a fundamental realignment of community health services, primary care, public health and social care services for children and adults called Calderdale Cares is proposed. Calderdale Cares will represent a place-based approach to the delivery of Health and Social Care that will see the collaboration of a range of organisations that shares common resources and delivers shared population health outcomes.

## Next Steps:

This paper will be discussed at the Cabinet, Board or Governing Body of the other health and social care partners over the next month. A project plan and governance arrangements will be developed to take forward this wok.

The Board is asked to receive the presentation from Calderdale Council representatives, provide comment on and:

1. To endorse, in principle, the approach to delivering a place-based integrated health and social care system.
2. To endorse, in principle, the alignment of in-scope service budgets with a view to pooling budgets.
3. To endorse the intention to begin a pilot project based in North Halifax and Todmorden as a testbed for joint commissioning and further integration.

## Appendix

### Attachment:

Calderdale Cares.pdf

**Health and Social Care Leadership Approach and Calderdale Cares**

**By**

**Robin Tuddenham**

**Chief Executive**

**Calderdale Council**

**12.12.17**

Given the present context of intense fiscal challenge, and increasing demand on the Health and Social Care system, there is renewed impetus to establish a clear trajectory for integration of health and social care in every area of England, at each level (Health and Care Partnership, district) by 2020. In response, a range of contracting and organisational forms are emerging that enables the delivery of joined up GP, Hospital, Mental Health and Community Care Services. These include regional approaches, alignment of NHS commissioning and provision, and integration of CCG functions into a local authority as seen in a number of authorities in Greater Manchester and other Councils like North East Lincolnshire.

In Calderdale, there is a strong desire to move towards a place based approach to health and social care, harnessing the contribution of both the statutory and community sectors, ensuring effective governance both clinical and democratically accountable, and defining better the role of the primary and acute system. There is a real opportunity to harness what I describe as the 'collaboration imperative' to develop new relationships, a parity of esteem across the system and a strong sense of place utilising the role of community anchors in early prevention and supporting wider agendas such as inclusive growth. There are important principles which are important to reaffirm; sustaining the NHS as free at the point of delivery, and commitment to what is being described as 'left shift' into the community with a strong focus on the social and wider determinants of health.

This shift seeks to deliver improved access to primary care, effective delivery of services in the community and to support people in their own homes, improved access to mental health oriented around patients' needs, and the ongoing development of evidence based emergency and acute services.

Calderdale Council has produced the paper ***Health and Social Care Leadership Approach and Calderdale Cares***. This reflects a range of discussions within the Council, with Health and Social Care leaders and with local providers. Although not a fixed blueprint, the paper presents a rationale for change, a potential approach to delivering an integrated health and social care system, and highlights the scope of local authority involvement within an integrated system. It also makes recommendations for the Council to consider moving toward integrated Health and Social Care by 2020. The paper has some clear principles such as defining an agreed approach to neighbourhoods (localities) across the system, more integrated commissioning through the Integrated Commissioning Executive, and clarity of providers at local level through a potential alliance model in future years.

There are many challenges to overcome, a sense of seeing it before, leadership and workforce capacity, economic and political uncertainty, and fiscal pressures leading to a risk

of a retreat back to silo working. All of these risks can be overcome. They do not prevent our potential to realise the opportunity for the Calderdale system to write its own script, rooted in communities, within tight resources and with the best chance to create a health and social care system as sustainable as it can possibly be.

**Progress so far:**

- Discussions have recently taken place at Calderdale Council
- Health and Social Care Leaders have considered the paper in response to the discussion at the last Health and Wellbeing Board with external facilitation. This has sought to consider options both locally and in response to the developing work at a West Yorkshire and Harrogate Health and Care Partnership level.
- The paper was recently presented at Vanguard Board where it was received positively with all partners demonstrating a commitment to move forward, once there is greater clarity on next steps and the position of the Council and partners.
- The Health and Wellbeing Board meeting will enable further discussion on next steps.

**Calderdale Cares: Moving Forward on Health and Social Care**

# 1. Calderdale Cares Proposal

1. This paper proposes a fundamental realignment of community health services, primary care, public health and social care services for children and adults called Calderdale Cares.
2. Calderdale Cares will represent a place-based approach to the delivery of Health and Social Care that will see the collaboration of a range of organisations that shares common resources and delivers shared population health outcomes.
3. To achieve this we need to develop new forms of care to specific cohorts of our population through new organisational forms, such as an alliance model, that are incentivised by new forms of commissioning and aligned with the outcomes defined by the Single Plan for Calderdale (See Appendix 1 -5). Meanwhile, emphasis upon prevention and self-management and technological care should be visible all future service design.
4. A core part of integrated care concerns that focus on changing population needs and a move toward prevention is the interface between acute hospitals and community based services and is therefore vital that there are close effective working relationships between acute secondary care hospitals and community based services.
5. Through a structured process, we should progress to identifying services to be initially aligned, be prepared to start a pilot in two areas of the Borough and adjust our joint governance arrangements to oversee this project within agreed timescales.
6. Consideration should also be given to the development of an integrated Wellness Service model as a holistic approach to addressing the wider determinants of health. Meanwhile, parity of esteem for physical and mental health conditions should be visible across the system.
7. Upon conclusion, the pilots will be assessed and rolled out across to-be-determined localities, budgets will be aligned across the Borough and a wide range of services will be jointly commissioned through Calderdale Cares.
8. This paper sets out the stages that are needed to reach this position.
9. If agreed, the Calderdale Cares proposals will be discussed with the CCG and CHFT senior leaders in November. The Chief Executives of these three bodies will put a joint proposal to the meeting of the Health and Wellbeing Board to be held on 21 December 2017 on proposed models of delivery in support of delivering the Single Plan for Calderdale

## 2. Strategy

### Stage 1

1. We will agree via the Single Plan for Calderdale; joint strategic outcomes and values, with our partners that will shape delivery of *Calderdale Cares* and inform values, behaviours, and measures for quality, cost, and performance. These strategic aims will reflect a whole system approach to developing *Calderdale Cares*, whilst ensuring that the council is at the forefront of a 'place based' narrative that emphasises a shift toward preventative service provision.
2. All partners will recognise the potential risks and challenges posed by the process including recognition that the CHFT will require standardised operating procedures across Calderdale and Greater Huddersfield.
3. A scoping exercise will identify Council services for alignment with the Calderdale Cares "Pilot", with risks identified within the proposal and resolved accordingly.
4. A to-be-determined localities model will be adopted across the health and social care system as a basis for locality working. These areas should cover populations of roughly 50,000. However, a piece of work is necessary to understand how the boundaries connect with existing social care footprints and GP localities.
5. The Calderdale Cares "pilot" project will be designed to provide aligned primary care, community health, and social care services from two locations. It is suggested that these locations could be North Halifax and Todmorden and we will work with NHS colleagues on taking this forward. Todmorden, in particular, will be able to build upon learning from the Vanguard project. From this, an estimate of a budget that is spent in these areas on the services covered by the Council and by the NHS should be available.
6. The pilot will aim to implement a person-centred population-outcome approach, ensuring that our children have the best start in life and that Calderdale people live well and age well. This will be achieved through the integration of health and social care provision based around GP practices and the proposed development of Integrated Wellness Service that focuses upon wellbeing, healthy lifestyles, welfare and work/learning skills (See Appendix 3 and 4). The pilot will also test how individual partner organisations can retain their statutory responsibilities (e.g. duty of care) while working in partnership.
7. Joint commissioning by the Council and the CCG will be extended through the Integrated Commissioning Executive, with an option for elected Members to be included on the board. This wider focus enable the continued shift to a primary care/prevention service, as well reducing duplication and ensure best value for each £ spent.

**Stage 2**

8. Calderdale Cares will be established as the mechanism for delivering integrated community health, primary care and social care services with defined outcomes and accountabilities. A proposed alliance model could include a board with representative membership from across the partners, including an opportunity for elected member involvement.
9. In-scope services will be delivered through the agreed localities, all of which will have identified budgets to meet the health needs of their population.
10. Governance arrangements for joint commissioning and overseeing service provision will be fully established with continued strategic oversight by the Health and Wellbeing Board, with clear accountabilities for each aspect of delivery.
11. The Integrated Commissioning Executive will play a pivotal role to drive this integration process and should be in a position to commission the proposed alliance of providers to manage a whole-population budget and plan to deliver services to meet agreed outcomes.

## 3. Operational

**Stage 1**

1. Delivery of a common vision for change that will guide the way we will operate, shape our values and behaviors and inform integrated decision making that remains engaged with wider conversations across the West Yorkshire footprint.
2. Delivery of a pilot that will test delivery of a person-centered approach to Health and Social Care against defined whole-population health outcomes, promoting people to live well and age well across the whole of Calderdale.
3. Development of effective measures of cost, quality, public satisfaction that link to the Single Plan for Calderdale and are fully deployed for the Calderdale Cares Pilot.
4. Delivery of a strategy for supporting employees about how their day-to-day work will change and that encourage individuals and groups to take ownership for their new roles and responsibilities for delivery of an effective preventative/early intervention/self-management service that engenders a culture based on a shared vision and shared principles and lived out in the behaviours of leaders at all levels.
5. Delivery of a concrete plan for how to measure whether or not the change is a success and follow-up plans for both successful and unsuccessful results.

**Stage 2**

6. Apply learning from the pilot to begin to implement Calderdale Cares across defined localities.

7. Develop organisational structures for the full implementation of Calderdale Cares.
8. Begin to develop effective measurement of key quality, finance and performance outcomes.

## 4. Governance

### Stage 1

1. The Integrated Commissioning Executive will be undertaking a broader more strategic commissioning role. Its membership will include one Council Cabinet Member.
2. The Single Plan for Calderdale Officer Group will oversee the implementation of decisions of the HWB and the Leadership Group and report to each meeting of the HWB.
3. The Leadership Group (Council Leader and chief executives of Council, CCG, CHFT, SWYPFT) will meet to provide strategic leadership and to ensure productive partnership working.
4. Governance will be reviewed and proposals prepared to make sure the right governance can be introduced to take forward the next stages of *Calderdale Cares*.
5. The Governance structure should clearly show how organisations are accountable for each aspect of delivery.

### Stage 2

6. Implementation of recommendations for governance structure that reflects the path to delivering integrated services should be completed. New Governance structures will be fully operational and will include provision for commissioning of services under Calderdale Cares.

## 5. Finance

### Stage 1

1. The Council, the CCG and CHFT will immediately begin working together to adopt a shared approach to addressing the budget deficit across the whole system.
2. Work will begin to identify spend of social care, primary care services and community health with a view to aligning budgets.

### Stage 2

3. Budgets will be pooled and transferred via ICE to deliver shared health and population outcomes through Calderdale Cares.

## 6. Next Steps

- Discuss the Cabinet position with the CCG and other health colleagues ensuring linkage with West Yorkshire HWB Chairs' discussions from HWB's Chair meetings and STP footprint.
- Develop a joint strategic outcomes agreement based on the "triple aim" of improved population health, quality of care and financial efficiency.
- Develop a value and behaviours statement to guide the work and as a basis for engaging with staff.
- Review governance arrangements to ensure effective delivery of integrated services.
- Create a project plan for the delivery of the pilot that details agreed timescales.
- Identify in-scope LA services for implementation in pilot project.

PB and MB
13/12/17

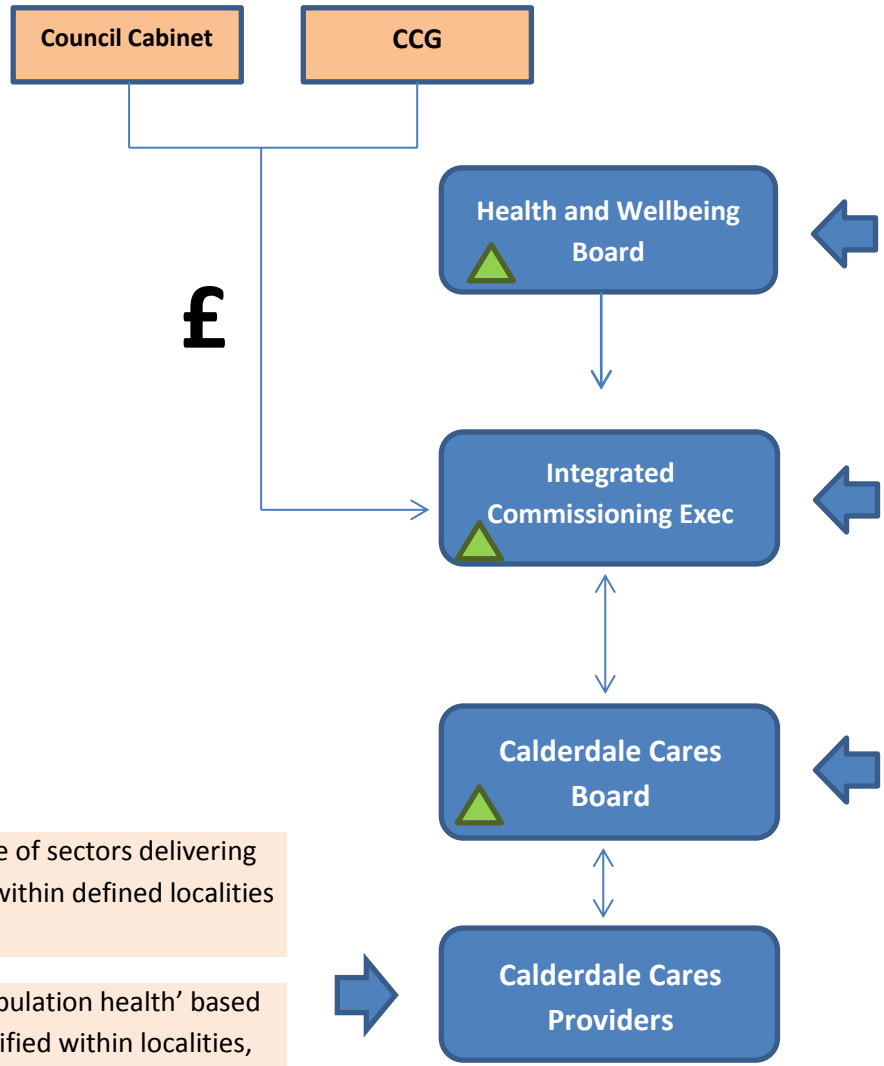
## Appendix 1. King's Fund Place-based systems of care design principles.

- Define the population group and the system's boundaries
- Identify the right partners and services
- Develop a shared vision and objectives
- Develop an appropriate governance structure
- Identify the right leaders and develop a new form of leadership
- Agree how conflicts will be resolved
- Develop a sustainable financing model
- Create a dedicated team
- Develop a single set of measures

Source: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf

# Appendix 2 Moving forward on Health and Social Care Proposed Structure

**KEY:**
Proposed Elected Member Position = ▲
Pooled Budget = £




Committee of key partners led by the Council (Chair) – joint strategic needs assessment and place based outcomes strategy for wellbeing system based on defined locality/data. Potential council delegated powers around commissioning/ visible commitment to public engagement.

A joint CMBC/CCG commissioning team with pooled budget rooted in place commissions and monitors Calderdale Cares .

Alliance Board with members' representation.

Chair is agreed through voting structure. Overarching governance contract between all parties' sets out governance arrangements, risk, and performance regime.

Meetings are held in public – with elected member on the board.

It is responsible for whole population budget and *works to contractual terms set via Integrated Commissioning Exec working within a localities model, delivering targeted services.*

*Localities of approximately 50k population*

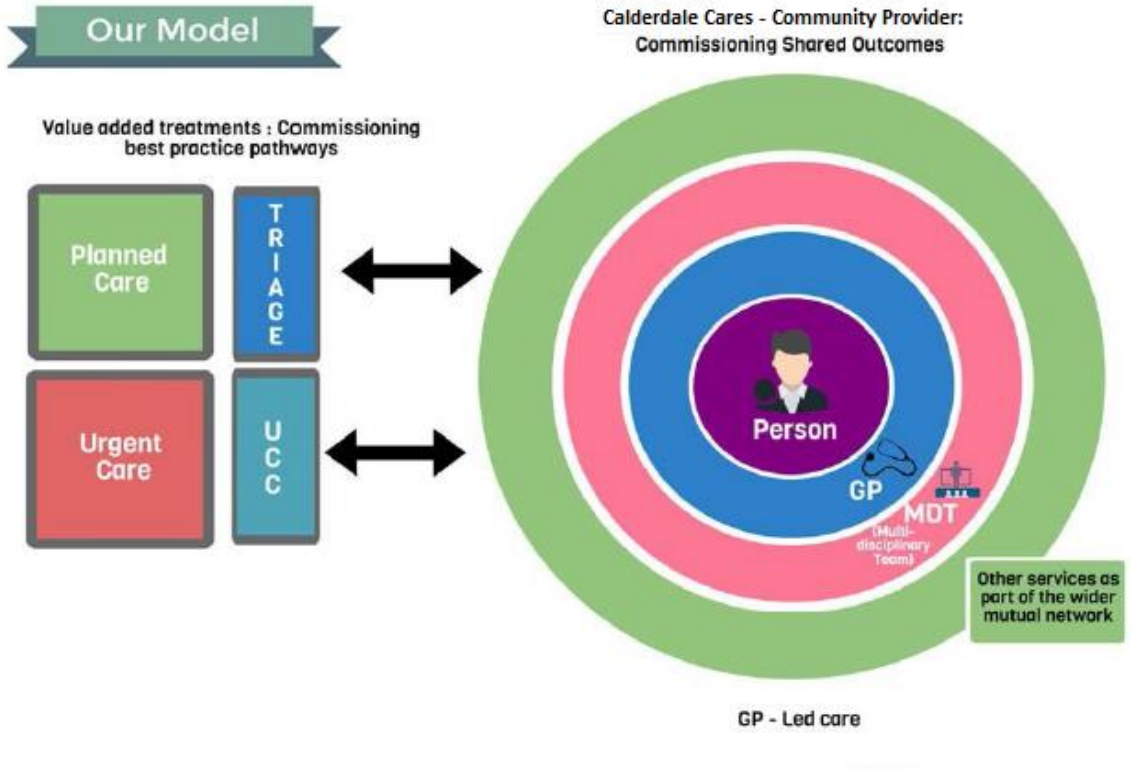
Alliance of providers from range of sectors delivering joined up locality hub services within defined localities model.

Budget allocated through a 'population health' based approach targeting needs identified within localities, delivering services focused on prevention and wellbeing.

# Appendix 3 Example of a potential Calderdale Cares Model and Patient Pathway

A population with multiple chronic conditions requires care to be provided in an integrated manner as opposed to supplying the predominantly episodic interventions of our fragmented system at present. This potential Calderdale Cares delivery model addresses these imbalances and General Practice takes overall responsibility for the care provided by other services.

Patients can access services via their local GP, a single point of access which ties into a multi-disciplinary team of professionals and services that are able to address needs quickly and efficiently.



The services are summarised below that strive to improve access, continuity and coordination underpinned by more generic population health improvements, system and staff benefits and the empowerment of Calderdale communities.

ii.***Rapid Access Services*** largely delivered on a locality basis and designed to respond to urgent care needs whilst identifying proactively potential onset or exacerbation of illness and ensuring an integrated approach to patient management within a community setting;

iii.***On-going Care Services*** delivered at a GP level predominantly through multi-disciplinary teams (MDTs). These are delivered at scale on a locality through Local Access Hubs effectively forming a mutual network of care with a wider network of community based and voluntary sector services.

iv.***High Care Need Services*** that operate as a 'step up' mechanism for the more vulnerable, complex care patients or patients with increasing acuity that require more enhanced condition management to prevent an admission to hospital and 'stepping down' to On-going Care Services.

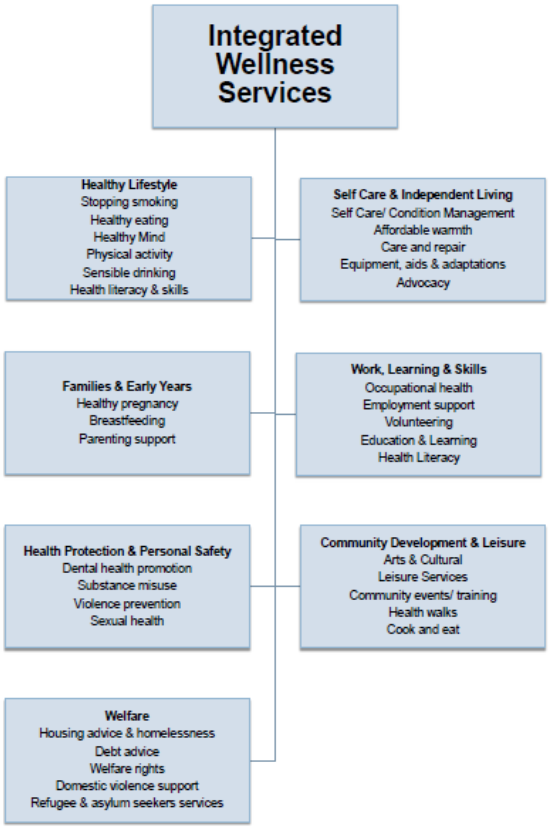
*v.* ***Integrated Wellness Services*** which is predominantly focused on prevention and population health management would wrap around this model providing a range of services that address the wider determinants of health. **(See Appendix 3).**

**(This model is based on the Dudley alliance approach).**

# Appendix 4 Integrated Wellness Service

An Integrated Wellness Service is defined as *providing support to people to live well, by addressing the factors that influence their health and wellbeing and building their capability to be independent, resilient and maintain good wellbeing for themselves and those around them (Knowsley Council) .*

It moves beyond focussing on single issues and takes a holistic and person-centred approach, addressing the psychosocial determinants of health behaviour. **Source: Knowsley MBC**




**Knowsley Integrated Wellness Service: A Whole System Approach**

- Single point of access 'hub'.
- Holistic assessment of individuals.
- Hub triages clients based upon need and provides on-going support.
- Service supports community development and builds upon community assets.

# Appendix 5. Potential Alliance Organisation Model

A review of the literature highlights a range of MCP models that could be explored – this paper presents a proposed alliance model based on the overview below:

**Contractual Alliance Overview**

• The four Providers remain separate legal entities, continue to directly employ their own staff but are bound together by an alliance agreement. In this option, the alliance would overlay existing contracts

• The Joint Commissioners and Providers come together in a contractual alliance to deliver MCP services under their existing contracts with the commissioners

• Decision making by the four Providers is delegated from each provider to their member(s) who sit on an Alliance Board and bind their organisation

• An overarching robust alliance arrangement which deals with risk and reward sharing is put in place

• Services are delivered by the individual members under their existing contracts

• The joint commissioners (Calderdale MBC/CCG) act as system integrators

**Appendix B Ten lessons to support the development and implementation of new care models**


**1. Start by focusing on a specific population**
Focusing first on a specific cohort of the population gives teams experience of co-designing services with patients and using data to understand need.

**2. Involve primary care from the start**
Primary care plays an essential role in delivering coordinated care for patients, families and communities. General practitioners can offer significant insight into the needs of populations and where services can be developed.

**3. Go where the energy is**
Identifying individuals and teams who already have ideas for and commitment to change can help gain momentum locally.

**4. Spend time developing a shared understanding of problems**
Ensuring there is a shared understanding of the problems to be solved is a crucial factor in

cross-team improvement work and requires that people are bought together at the beginning of any change initiative.

**5. Work through and thoroughly test assumptions about how activities will achieve intended results**
Developing logic models can help teams think through and articulate links between planned activities and outputs without rushing to implementation.

**6. Find opportunities to learn from others and assess suitability of interventions**
When looking at learning from elsewhere bring staff together to work through how to adapt the interventions for the local area.

**7. Set up an 'engine room' for change**
In the absence of formal organisational structures, it is important to put in place a central project team that includes project management, data analysis, communication and administrative expertise. This should include staff who have already worked in the local area to create confidence among stakeholders.

**8. Distribute decision making roles**
Ensure decision making roles are allocated across organisations and professional groups – not just at the most senior level.

**9. Invest in workforce development at all levels**
With the creation of new cross-organisational services, investment in developing people is crucial. This is necessary at all levels of the local system and requires a focus on individual skills, team development and training for those in leadership roles.

**10. Test, evaluate and adapt for continuous improvement**
Giving teams licence to experiment is crucial in order to understand the impact of changes and to help shape plans as they progress. It's important to make sure the people and teams involved are given feedback and supported to alter plans when changes do not go as intended.

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

| |
|---|
| |

## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st February 2018 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from the sub-committees. | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>As appropriate | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The Board is asked to receive the updates and minutes from the sub-committees:
Quality Committee – minutes of 3.1.18 and verbal update from meeting 29.1.18
Finance and Performance Committee – minutes of 2.1.18 and verbal update from meeting 23.2.18
Workforce Well Led Committee – minutes from meeting 9.1.18
Audit and Risk Committee – verbal update from meeting held 24.1.18

## 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 3.1.18 and verbal update from meeting 29.1.18
Finance and Performance Committee – minutes of 2.1.18 and verbal update from meeting 23.2.18
Workforce Well Led Committee – minutes from meeting 9.1.18
Audit and Risk Committee – verbal update from meeting held 24.1.18

## Appendix

### Attachment:

COMBINED SUB CTTEES MINS.pdf

# QUALITY COMMITTEE

## Wednesday, 3rd January 2018
## Acre Mill Room 3, Huddersfield Royal Infirmary

**PRESENT**

| | |
|---|---|
| Dr Linda Patterson **(LP)** | Non-Executive Director **(Chair)** |
| Dr David Anderson **(DA)** | Non-Executive Director |
| Dr David Birkenhead **(DB)** | Medical Director |
| Paul Butterworth **(PB)** | Governor |
| Juliette Cosgrove **(JC)** | Assistant Director of Quality and Safety |
| Alistair Graham **(AG)** | Non-Executive Director |
| Andrew Hardy **(AH)** | Consultant – Acute Medicine |
| Lesley Hill **(LH)** | Director of Planning, Performance and Estates and Facilities |
| Angie Legge **(AL)** | Senior Risk Manager |
| Lynn Moore **(LM)** | Governor |
| Michelle Augustine **(MA)** | Governance Administrator **(Minutes)** |

### 001/18 WELCOME AND INTRODUCTIONS

The Chair welcomed members to the meeting.

### 002/18 APOLOGIES

| | |
|---|---|
| Helen Barker | Chief Operating Officer |
| Brendan Brown | Executive Director of Nursing – Corporate |
| Andrea McCourt | Head of Governance and Risk |
| Lindsay Rudge | Deputy Director of Nursing |

### 003/18 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

### 004/18 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 4th December 2017 were approved as a correct record.

### 005/18 ACTION LOG AND MATTERS ARISING

- Families and Specialist Services Division Q2 Patient Safety and Quality Board Report

  It was reported that the paper has not yet been signed off by the division.

  **ACTION**: That the report is deferred to the next PSQB reporting meeting on Monday, 26th February 2018

- Falls Update

  Dr Andrew Hardy, Consultant in Acute Medicine and chair of the Falls Collaborative, was in attendance to provide an update on falls.

  There has been a 15% reduction in falls since September 2016, and there has been an overall reduction in falls across the Trust. The Falls Collaborative has an action plan structured around five themes: Prevention (risk assessments, medicine review), Individualised (care plans, toileting, visual assessment and footwear assessment), Integrated (community in-reach/outreach, discharge planning), learning from incidents and culture of safety (huddles, notice boards, awareness week, celebrating success).

The medical division are ensuring that action plans are being implemented and will be looking to engage with the surgical division. Work also takes place with external bodies through the Improvement Academy and Haelo to focus on improving quality improvement in a team. Awareness work has been taking place during summer.

Discussion ensued on the good examples of clinical leadership and improvements made with falls in a challenging environment. It was stated that improvements are made over summer in order to see if the system can cope with the pressures of winter. It was asked whether these principles can be used in care homes, and it was stated that it could be used in care homes, in the community as well as different settings. It was also stated that this has contributed to care given to patients and also affects Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio, both of which are also reducing.

Congratulations were conveyed on the great work done by the Falls team.

**ACTION**: Update to be received from the Collaborative in six months' time – July 2018

Further discussion took place on communication, not just within falls but in other areas. It was stated that there tends to be gaps in communication and getting documentation completed, however, clinical teams are working on this. There is now better visibility with the Electronic Patient Record (EPR). Discussion also took place on how colleagues can be supported to complete documentation.

## 006/18 SERIOUS INCIDENT REPORT

AL presented the above report (appendix E) summarising 10 new serious incidents and five completed serious incident reports submitted to commissioners during October and November 2017. A further category 3 pressure ulcer serious incident had been declared but de-logged after a patient's family came forward with information which showed that the pressure ulcer had been present on admission to the Trust.

The Committee reviewed the incidents and discussion ensued on whether there were any assurances that the recommendations within the reports are implemented and actioned. It was stated that there is a policy in place (Incident reporting, management and investigation policy – incorporating the Serious Incident process), as well as a clear process where all actions from serious incidents are monitored on the Datix system. Once actions are completed, the incident is closed. The Committee requested a short paper giving assurance that recommendations have been implemented to ensure that patients have not come to harm.

**ACTION**: Brief paper to be presented to meeting on 26th February 2018 giving assurance that actions from completed serious incident reports have been implemented.

## 007/18 HIGH LEVEL RISK REGISTER

AL presented the above report (appendix F) summarising the high level risks as at 22nd December 2017.

There were no changes in the risks or the scores since the last report. There were also no risks with an increased or reduced score, and no new or closed risks.

LH gave an update on the risk regarding ventilation in resuscitation, and stated that a plan will be in place by March 2018 to mitigate any future risk of closure.

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

LH presented the above report (appendix G) which summarised key points from the Health and Safety Committee meeting held on 20th December 2017:

- Health and Safety Executive (HSE) – a copy of the HSE report following a routine inspection in microbiology at CRH has been requested.
- Fire wardens – Divisions to ensure there is one fire warden on duty between two wards at all times
- Bed storage – beds found to be stored on corridors for a certain period of time will be disposed of.
- Ventilation audit carried out – Theatres HRI is compliant, however, resuscitation at CRH requires forced ventilation adding to the capital plan.
- Water jugs – LH to raise issue with the Executive Director of Nursing relating to the filling of water jugs for patients at the start of the day.
- Nasogastric tube training – poor attendance being noted due to colleagues being unable to leave clinical area to attend training. Looking into different ways for training to be carried out, for example, trainers going to ward areas to carry out training.

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

## 009/18 PATIENT SAFETY GROUP REPORT

JC presented the above report (appendix H) which summarised key points from two Patient Safety Group meetings held on 2nd November and 7th December 2017:

- Radiation Protection Board – update received from meeting held in July 2017, which included discussion on attendance at the meeting and the chair of the Board stepping down;
- Pressure Ulcer Incidents – update received on pressure ulcers reported during period of August to September 2017, as well as increasing tissue viability referrals
- Venous Thromboembolism (VTE) – update received from Thrombosis Committee on risk assessments, VTE compliance, hospital acquired thrombosis data and attendance at Thrombosis Committee meetings
- Falls Update – update received from Falls Collaborative (see item 005/18)
- Review of sub-group – results received from a 12-month review of the Patient Safety Group's sub-group effectiveness. A summary of the results were reviewed, which identified that some groups are more effective than others. An action for the Chair of the Patient Safety Group is to meet with the sub-group chairs. An assurance report will be provided to the Quality Committee on this work in the next quarter.

Discussion ensued on the reasons behind the increase in pressure ulcers and this was partly due to an increase in reporting, however, expected improvements are not yet being seen. It was asked whether the Pressure Ulcer Collaborative could learn anything from the Falls Collaborative, and it was stated that the Pressure Ulcer Collaborative is currently being re-focussed, and some of the methodologies from the Falls Collaborative are being reviewed.

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

## 010/18 MORTALITY SURVEILLANCE GROUP AND CLINICAL OUTCOMES GROUP REPORTS

DB presented the above reports (appendices I1 and I2) which summarise key points from two Mortality Surveillance Group meetings held on 11th November and 8th December 2017 and the Clinical Outcomes Group meeting held on 20th November 2017:

- Hospital Standardised Mortality Ratio (HSMR) – Slight improvement, score now 91.08

- Patients with Learning Disabilities – report received on 9 deaths in patients with learning disabilities, all of which are subject to an internal review
- Learning from death (LfD) - Initial screening reviews (ISR) are currently averaging 25% of all deaths being reviewed. Screening reviews have been allocated on a weekly basis since September and are being done in a timelier manner. From the beginning of December reviews were allocated to consultants.
- Documentation - Concerns have been raised regarding gaps in documentation including timeliness of observations, Sepsis and Delirium screening. An overarching group has been agreed to look at improvement methodology for EPR documentation.

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

## 011/18 PATIENT EXPERIENCE AND CARING GROUP REPORT

JC presented the above report (appendix J) which identified the following items from two Patient Experience and Caring Group meetings held in September and November 2017:

- Dementia Update – dementia screening and initiating of care plans on the Electronic Patient Record (EPR) has been identified as a concern. This has been added to the risk register, and work has been done with ward staff to improve this; the dementia strategy has been refreshed with further work to establish objectives and a three year plan.
- Learning Disabilities Improvement Work - feedback from the annual survey of patients / relatives were positive
- Findings from Morecambe Bay 'go see' - Two areas being developed locally in response to this visit - the involvement of services users to improve the 'empathy' within complaint responses and the use of a 'fresh eyes' approach involving cross-divisional reviews of past complaint responses and learning. Complaint workshops are being planned in order to show colleagues how they can resolve low-level complaints at the time they occur to avoid a formal complaint being made.

Discussion ensued on whether patients are involved in investigations, and this was stated as being done as part of the duty of candour.

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

## 012/18 QUALITY AND PERFORMANCE REPORT

November's Quality and Performance Report was circulated (appendix K). Brief discussion took place on the improvements made within the report.

The report is due to be discussed in full at the Board of Director's meeting on Thursday.

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

## 013/18 CQC REPORT

JC presented the above report (appendix L). The report summarised the current position following the CQC inspection in March 2016, activity undertaken as part of the subsequent inspection, key concerns identified throughout the planning phase and the next steps, including the role of the Quality Committee.

Current areas of ongoing challenges which arose from the inspection in March were discussed, and activity is underway to continue to address the issues and mitigate the risk where change will be achieved following mitigation.

Planning for the next inspection has four phases – monitoring, pre-inspection, core services

ection. The well-led inspection is expected at the beginning of April this is not confirmed as yet. The unannounced inspection can take place at any time.

The Trust CQC action plan and divisional plans are in development; the CQC planning group will assure the Quality Committee through monthly reports on progress against delivery and any emerging risks and engagement activities are scheduled with the local inspection team from January onwards building on activities since the last inspection. It was also stated that external reviews may be commissioned to provide additional insight into areas of concern.

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

## 014/18 ANY OTHER BUSINESS

Reconfiguration

The chair enquired about the reconfiguration of the cardiology, respiratory and elderly medicine hospital services, and it was stated that this had gone well. Walkrounds had taken place, with no issues reported and no indication of patients arriving on incorrect sites for clinical services. It was also asked whether the reconfiguration has helped with patient flow, however, this is difficult to judge due to the Christmas period.

## 015/18 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Falls Update
- SHMI and HSMR improvements
- Communication regarding staff training
- Assurance regarding learning being shared with colleagues
- CQC update

## 016/18 EVALUATION OF MEETING

The Quality Committee discussed the effectiveness of the meeting:

- Good discussions taken place, a lot of information covered
- Meeting finished on time
- Would have been better if there was more clinical engagement

## 017/18 QUALITY COMMITTEE ANNUAL WORK PLAN

The Quality Committee work plan (appendix M) was circulated and accepted.

## 018/18 QUALITY COMMITTEE MEETING DATES 2018

The Quality Committee meeting dates for 2018 (appendix N) were circulated for information.

## NEXT MEETING

Monday, 29th January 2018
3:00 – 5:30 pm
Acre Mill Room 3, **HRI**

Calderdale and Huddersfield NHS Foundation Trust

APP A

# Minutes of the Finance & Performance Committee held on Tuesday 2 January, 12.30pm – 3.30pm Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary

**PRESENT**

| | |
|---|---|
| Anna Basford | Director of Transformation & Partnerships |
| Gary Boothby | Director of Finance |
| Phil Oldfield | Non-Executive Director (Chair) |
| Owen Williams | Chief Executive |
| Andy Nelson | Non-Executive Director |

**IN ATTENDANCE**

| | |
|---|---|
| Stuart Baron | Associate Director of Finance |
| Andrew Haigh | Chair of the Trust |
| Betty Sewell | PA (Minutes) |

**ITEM**

**001/18 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**002/18 APOLOGIES FOR ABSENCE**

Apologies for absence were received from: Kirsty Archer, Helen Barker, Richard Hopkins and Brian Moore.

**003/18 DECLARATIONS OF INTEREST**

There were no declarations of interest.

**004/18 MINUTES OF THE MEETING HELD 31 OCTOBER 2017**

The Minutes of the meeting held 28 November 2017 were approved as an accurate record subject to the change of wording for Item 187/17 as follows:-

*The Director of Finance advised the Committee that we continue to forecast on plan but in month were £2.5m away from the original plan, and £5m away from or internal re-forecast plan. It was noted that an agreement of the Month 6 income has been reached with Commissioners removing that risk. It was also noted that CIP is now forecast at £17m which was agreed last month, however, this position includes the non-recurrent benefit relating to the Soft FM. We continue to have a number of cash challenges with 7,000 invoices approved for payment which have not been paid.*

*It was also noted that our previously reported year to date performance on STF had changed and this has impacted upon cash. The payment of STF is influenced by system performance and it is this element that has been reported differently between periods by regulators. The change has resulted in lost income from STF.*

**005/18 MATTERS ARISING AND ACTION LOG**

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

**006/18 INTEGRATED PERFORMANCE DEEP-DIVE**

It was noted that the Chair had agreed that this item should be deferred until the 30 January 2018 meeting.

**007/18 MONTH 8 FINANCE REPORT**

The Director of Finance reported the following headlines:-

- The Trust reported a deficit of £17.85m on a control total basis, an adverse variance to plan of £3.8m year to date.
- In month, we reported a £1.3m adverse variance, in month slightly better than forecast.
- The YTD challenges were identified and summarised within the report.
- The Trust continues to report a forecast in line with the Control Total deficit, however, the deteriorating position leaves the Trust with the requirement to deliver recovery plans of £11.1m.
- CIP was re-assessed before Christmas and following Turnaround Executive discussions today, £800k was still identified as risk. Actions were agreed at TE for clarification to be sought this week to ensure an accurate forecast.

With regard to the £800k CIP risk, it was noted that this will have an effect on the year-end forecast. There also remains additional risks within the forecast which have been discussed with NHSI, namely, Theatre Productivity and Job Planning.

Discussions turned to the latest SPV position, the Director of Finance reported that there are a number of reports being provided from external advisors which, subject to Board approval, should be sufficient for our Auditors, it was confirmed that meetings have taken place with KPMG where this project has previously been raised and discussed.

In terms of the re-forecast, in depth discussions took place covering the timing of our decision to re-forecast, the FBC position and our focus on recovery plans. In summary it was recognised that further work by Executives needs to take place to develop a recovery plan and a strategic narrative, it was acknowledged that the FBC needs to form part of that plan.

It was agreed a decision would be taken at the Board of Directors on Thursday 4 January 2018 with regard to the re-forecast and for the next Finance & Performance Committee (30/1/18) a detailed report was requested which describes the unpalatable/(unpleasant) decisions which will then be discussed at the Board of Directors on the 1 February 2018.

The following actions came out of discussions:-

**ACTION:** To provide Board members with a 'set of words' for consideration prior to the Board meeting to clarify what is being asked of them with regard to the SPV – **GB/SB, prior to Board 4 January 2018**

**ACTION:** To also have clarity with regard to the Trust's authority to transfer the HRI assets to a wholly owned subsidiary even though, as a Foundation Trust we are receiving 'distressed funding'. – **AH/VP, prior to Board 4 January 2018**

**ACTION:** Execs/Non-Execs to co-produce a Draft Recovery Plan in the time before the next Finance & Performance Committee which will then go to the Board on the 1 February 2018. To include within the Recovery Plan a list of unpalatable /(unpleasant) decisions to be made by the Board – **GB, 30 January 2018**

**008/18 & 009/18** **FINANCIAL RECOVERY PLAN UPDATE & NOTES FROM THE FINANCIAL RECOVERY CALL WITH NHS I**

Both these items had been covered within the previous discussions.

**010/18** **CIP UPDATE**

In addition to the earlier discussions around CIP, the Chief Executive reported that the work which is being undertaken by Dave Thomas, Ex Turnaround Executive, is continuing and has proved useful. The information has been shared with Executive colleagues for feedback. A workshop is planned following the Board and the presentation will be shared prior to that meeting.

**172/17: 5 YEAR PLAN – BRIDGING THE GAP**

The Director of Finance presented the Committee with an update to the paper presented last month. It was noted that there is a projected gap to the deficit control total in 2018/19 and an increased deficit as a consequence into future years, alongside the commissioner risk, further actions will be required. The Trust is working together with Commissioners on a system wide basis to develop recovery actions. The detail of what will be discussed at a meeting with both regulators was described to the Committee within this paper.

It was also noted that across the Sustainability & Transformation Plan (STP) for West Yorkshire & Harrogate (WY&H) a 5 Year Financial Plan is being developed which will not go to regulators. A paper is being produced which will be brought back to Finance & Performance Committee when available. It was acknowledged that the numbers will be different as Trusts will be calling out affordability, a 'bridge' will be provided when the paper is shared.

**ACTION:** To add to Work Plan for February meeting – **GB, Friday 23 February 2018.**

The Committee received and noted the contents of the paper.

**011/18** **MONTH 08 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT**

The Committee noted the contents of the paper for information.

**012/18** **BOARD ASSURANCE FRAMEWORK (BAF)**

The BAF report would be discussed at the meeting to be held **30 January 2018**.

**013/18** **CNST HALF-YEARLY REPORT**

The Director of Finance reported that the premium for 2018/19 has increased by 1.9% with an overall increase in contribution of £320k which is a significant improvement from the plan. It was noted, however, that the lower than planned increase will not be seen as a benefit for the Trust's financial challenge as the Control Total will be adjusted accordingly by NHSI.

The Committee agreed that the improved position was the direct result of actions taken by the Trust to invest to ensure there is less harm leading to fewer claims in the pipeline.

The Committee noted the contents of the report.

**ACTION:** It was suggested that enquiries should be made by the Director of Finance to understand how other Trusts, nationally, are dealing with previously agreed control totals for 2018/19 that now cannot be delivered. **:– GB, 23 February 2018**

**014/18 MINUTES FROM SUB-COMMITTIES**

The Committee received and noted the following sub-Committee Minutes:-
**Capital Management Group** – 24 November 2017 & 14 December 2017 (Draft)
**Commercial Investment & Strategy Committee** - held 23 November 2017 (Draft)

**015/18 WORK PLAN**

The Work Plan was received by the Committee it was noted that the IPR Deep-dive and the Recovery Plan would take place at the meeting to be held 30 January 2018. The Work Plan would be reviewed for next month due to the number of complex issues which need to take priority.

**016/18 MATTERS TO CASCADE TO THE BOARD**

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

- Re-forecast and work to be done on the Recovery Plan
- Decision had been made to re-forecast this month.
- SPV – need to be clear with regard to the benefits and the governance required for Auditors at year-end.
- 5 Year Plan – STP further meetings taking place and the published report will be issued and brought back to a future F&P.
- CNST and the improvement in premium.

**017/18 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. It was noted that the reduced agenda had allowed for focus and in-depth conversations. It was a helpful meeting prior to the Board of Directors.

**018/18 ANY OTHER BUSINESS**

There were no items to discuss.

**DATE AND TIME OF NEXT MEETING**

Tuesday 30 January 2018, 9.00am – 12.00noon
**Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE**

**CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**

**Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Tuesday 9 January 2018, 3.00pm – 5.00pm, Room 4, 3rd Floor, Acre Mill Outpatients, Huddersfield**

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| **PRESENT:** | |
| David Anderson | Non-Executive Director |
| Stephen Baines | Council of Governors |
| David Birkenhead | Medical Director |
| Brendan Brown | Chief Nurse |
| Alastair Graham | Non-Executive Director |
| Karen Heaton | Non-Executive Director (Chair) |
| **IN ATTENDANCE:** | |
| Andrew Haigh | Chairman |
| Azizen Khan | Assistant Director of Human Resources |
| Charlotte North | Assistant Director of Human Resources |
| Tracy Rushworth | Personal Assistant, Workforce and Organisational Development |
| Claire Wilson | Assistant Director of Human Resources (for agenda item 13/18) |

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| 01/18 | **WELCOME AND INTRODUCTIONS:**<br><br>The Chair welcomed members to the meeting. |
| 02/18 | **APOLOGIES FOR ABSENCE:**<br><br>Helen Barker, Chief Operating Officer<br>Jason Eddleston, Director of Workforce and Organisational Development<br>Vicky Pickles, Company Secretary |
| 03/18 | **DECLARATION OF INTERESTS:**<br><br>No declarations of interest were received. |
| 04/18 | **MINUTES OF MEETING HELD ON 13 DECEMBER 2017:**<br><br>The minutes of the meeting held on 13 December 2017 were approved as a correct record. |
| 05/18 | **ACTION LOG (items due this month)**<br><br>The action log for December 2017 was received. Items due this month were discussed in the meeting. |
| | **MAIN AGENDA ITEMS** |
| | **FOR ASSURANCE** |
| 06/18 | **WELL LED REVIEW**<br><br>AH advised the Trust had a PWC well led governance review in 2015 which identified areas of strength and areas for improvements. From this the Trust developed an action plan for improvement. BB agreed to share the action plan with the Committee.<br><br>Discussion followed on what the Trust could demonstrate further in terms of the activity and |

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| | progress made, examples being clinical and non-clinical leadership development (CLIP Programme), improvements in recruitment and retention, workforce planning and improved governance arrangements.<br><br>BB committed to providing Committee members with a script for CQC preparations that will provide more granular detail of achievements.<br><br>**ACTION: BB to share action plan following the previous PWC well led review and provide Committee members with a CQC prep script.**<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the position. |
| 07/18 | **WORKFORCE (WELL LED) COMMITTEE ASSESSMENT**<br><br>KH advised that each Board sub-committee is required to produce an assessment of its effectiveness by taking the views of committee members across a number of themes.<br><br>The results will be anonymised and collated for review. Any recommendations will be formulated into an action plan for use by the Committee. The action plan will also be incorporated into the Trust's annual report.<br><br>**ACTION: TR to circulate self-assessment checklist (to be completed and returned by 26 January 2018).**<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the position. |
| 08/18 | **NATIONAL WORKFORCE STRATEGY**<br><br>The draft Health and Care Workforce Strategy for England to 2027 and the Health Education England Workforce Strategy presentation had been circulated with papers to the Committee meeting.<br><br>AK provided an outline of the need and purpose of the Strategy and gave focus to the key points to consider as described in the presentation.<br><br>By July 2018 the health service will have its first national health and care workforce strategy for 25 years. The draft document informs a conversation about what staff need, what the health service needs and how we shape the future we all want.<br><br>A period of consultation is open until March 2018. The consultation is based on a set of six principles set out in the presentation. NHS Employers will be gathering views to submit a collective response on behalf of employers in the NHS.<br><br>AK agreed to collate the Committee's initial suggested feedback and share for further comment.<br><br>**ACTION: AK to circulate Committee's suggested feedback for further comment/additions.**<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the position. |
| 09/18 | **WORKING EFFECTIVELY SKILL MIX AND ROLE REVIEW**<br><br>AK provided a verbal update to the Committee.<br><br>Work is progressing in the 6 'live' service areas. There are 12 colleagues who have been trained as facilitators in the Calderdale Framework and they are working in pairs in each |

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| | service area. Each service area has a project team and the project lead will report progress on a monthly basis to the Programme Board. The first Programme Board will meet on 23 January 2018. It was noted that it would be 2-3 months into the project before the exact cost savings would be identified but each project would be asked to identify a ball park figure by the 1 March 2018.<br><br>**ACTION: AK to provide regular updates to the Committee.**<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the update. |
| 10/18 | **STAFF HEALTH AND WELLBEING CQUIN**<br><br>CN provided a verbal update on progress of the 3 CQUIN elements since the last Committee meeting.<br><br><u>Part 1a Improvement of Health and Wellbeing of NHS staff</u><br>Staff Survey – the survey closed 1 December 2017. Final report available later February/early March 2018. The risk to not achieving the targets is not quantifiable as the results are unknown.<br><br><u>Part 1b Healthy food for NHS staff, visitors and patients</u><br>Achieved the full CQUIN value worth £213,082 over 2 years.<br><br><u>Part 1c Improving the uptake of Flu vaccinations for frontline healthcare workers</u><br>Flu vaccination uptake is currently at 65%. The Committee noted there was a need to achieve 70% (internal target 75%) to secure the full CQUIN value of £225k<br><br>**ACTION: CN to provide regular updates to the Committee.**<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the update. |
| 11/18 | **BREXIT – ELECTRONIC STAFF RECORD DATA**<br><br>The report had been circulated with papers to the Committee meeting.<br><br>CW confirmed that in September 2017 the Workforce Business Intelligence Team reported that the Trust employed 129 non-British EU nationals. However, at this time 1,388 colleagues had not identified their Nationality in the Electronic Staff Record (ESR).<br><br>A data quality exercise has resulted in ESR now showing that of the 6,003 people the Trust employs, 131 are non-British EU nationals, 213 are non-EU nationals and 161 colleagues with an unidentified nationality.<br><br>Work is progressing to confirm the Nationality of the remaining 161 colleagues.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the updated position. |
| 12/18 | **BREXIT – WORKFORCE IMPLICATIONS**<br><br>The report had been circulated with papers to the Committee meeting.<br><br>CN reported part of the UK/EU agreement on the UK's withdrawal from the EU has secured the rights of EU citizens living in the UK after withdrawal. This means that:-<br><br>• People who, by 29 March 2019, have been living in the UK for five years will be able to apply to stay indefinitely by obtaining 'settled status' (which would replace any permanent residence status). Applications for settled status will start during the second half of 2018 and |

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| | remain open for at least two years after the UK leaves the EU.<br>• People who arrive in the UK by 29 March 2019, but won't have been living here lawfully for five years when the UK leaves the EU, will be able to apply to stay until they have reached the five-year threshold. They can then also apply for settled status.<br>• Family members who are living with, or join, EU citizens in the UK by 29 March 2019 will also be able to apply for settled status, usually after five years in the UK.<br>• Close family members (spouses, civil and unmarried partners, dependent children and grandchildren, and dependent parents and grandparents) will be able to join EU citizens in the UK after exit, where the relationship existed on or before 29 March 2019.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the report. |
| | **PERFORMANCE** |
| 13/18 | **WORKFORCE PERFORMANCE REPORT (DECEMBER 2017)**<br><br>The report had been circulated with papers to the Committee meeting.<br><br>CW provided an overview of the main highlights from the December 2017 report:-<br><br>• Both headcount and full-time equivalent had decreased<br>• Number of vacancies increased from November<br>• Turnover increased<br>• Appraisal year to date compliance rate had decreased<br>• Sickness absence increased to 4.03% (target 4%) but lower than last year<br>• Return to work interviews decreased<br>• Mandatory training (5 elements) increased but still below target<br><br>CW advised a weekly update paper on Mandatory Training is to be submitted from 11 January 2018 to Executive Board detailing current compliance rates and the action being taken by the Workforce and Development Directorate with Divisions to deliver the 95% target by the end of March 2018.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the report. |
| | **INFORMATION** |
| 14/18 | **WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS (WYAAT) WORKFORCE AND OD COLLABORATION**<br><br>AK provided a verbal update to the Committee. The WYAAT Workforce Directors discussed the position with regard to each organisation's progress on setting up a wholly owned subsidiary. Airedale and Harrogate advised that their respective Boards were clear on the potential for industrial action given the trade unions position on setting up wholly owned subsidiaries.<br><br>Other work being progressed by the WY HRDs was consistency in payments so organisations did not pay above cap. ICU was one area that was being looked and further conversations would be taking place in this regard. Also increasing apprentice numbers was being explored and what opportunities were available to draw on from the apprentice levy.<br><br>CW advised the WYAAT streamlining group looking at areas of duplication in recruitment between Trusts including juniors doctors, mandatory training, Occupational Health, recruitment checks. Work is progressing and sub groups are being arranged. |

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| | CN provided a verbal update on the WYAAT collaborative bank work, she reported that progress has been slow and the solution to having a collaborative bank may mean gain/lose share to be agreed by Chief Executives as all Trusts are operating at different levels of successful internal banks and using varies different technology platforms. The group is intending to submit a proposal to the next committee in common.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the update. |
| | **ITEMS TO RECEIVE AND NOTE** |
| 15/18<br><br>15/18.1<br><br><br><br><br><br><br><br><br><br>15/18.2 | **ANY OTHER BUSINESS:**<br><br>SB asked for an update on the wholly owned subsidiary.<br><br>AK advised that discussions were held at Board of Directors meetings on 7 December 2017 and 4 January 2018 regarding the establishment of a wholly owned subsidiary of Calderdale and Huddersfield NHS Foundation Trust which is intended to host estates and facilities and procurement services. The Board agreed to create a new company as a wholly owned subsidiary and will retain oversight of the establishment of the new company. The proposed date for the new company is 30 June 2018**.**<br><br>**ACTION: To provide an update at the next Committee meeting.**<br><br>DA advised the Committee that a network of Champions and Ambassadors will be established in order to support the work of the Freedom to Speak Up (FTSU) Guardian. Champions/Ambassadors will provide a further source of support for colleagues who wish to raise a concern but may feel safer or more confident doing so in a more local setting. The proposal is to develop a structure which provides for a FTSU Champion on each hospital site supported by a team of ambassadors from all staff groups. The network has a planned launch date of 1 April 2018.<br><br>**ACTION: DA to circulate paper regarding establishment of network of Freedom to Speak Up Champions** |
| 16/18 | **MATTERS FOR ESCALATION:**<br><br>There were no matters for escalation. |
| | **DATE AND TIME OF NEXT MEETING:**<br><br>Wednesday 14 February 2018, 10.00am – 12 noon, Room 4, Acre Mills Outpatients, Huddersfield |